2022-2023

Cultural Competency Plan Update

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH (SF DPH)

BEHAVIORAL HEALTH SERVICES (BHS)

Office of Justice, Equity, Diversity & Inclusion (JEDI)

Fall 2023

Last revised: April 11, 2024

2022-2023 Cultural Competence/Humility Plan Summary

San Francisco County and BHS Demographics

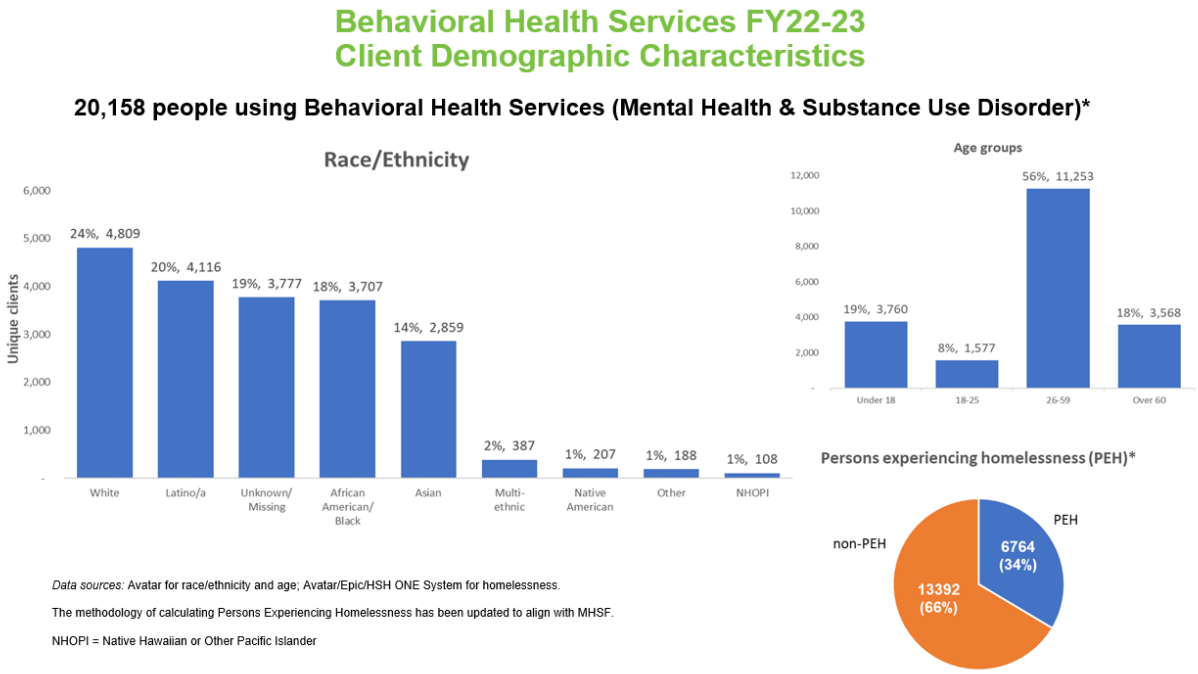
In 2020, San Francisco's population reached about 874,000. Since then, San Francisco County has seen a decrease in population. As of 2022, the population was estimated to be about 808,000. It remains a minority-majority city, as those classified as "White alone-not Hispanic" made up 39 percent of the population. Asians make up the largest non-White racial group about 36 percent of the population. The Black/African American community continues to decrease in population, sitting at 4.6 percent of the county total. Those of Hispanic/Latina/e origin made up 16 percent of the population.

	San Francisco County, California
Label	Estimate
Total:	808,437
White alone	315,764
Black or African American alone	37,361
American Indian and Alaska Native alone	8,086
Asian alone	289,678
Native Hawaiian and Other Pacific Islander alone	4,071
Some Other Race alone	56,617
Two or More Races	96,860

The demographics of BHS members receiving services differ from the general population to a significant degree, hinting at some of the disparities in access and overall outcomes because of various circumstances, from existing stigmas to socioeconomic factors. Of the roughly 20,000 people accessing either Mental Health or Substance Use Disorder (SUD Services), 24 percent identify as white, 20 percent Latina/e, 18 percent as Black/AA, 14 percent Asian and small percentages of Native American and Pacific Islanders. At 19 percent, a vast number of members did not have their racial background documented.

Beyond the city's racial breakdown, age and economic status also reveal themselves in the snapshot of BHS' member population. With an overall population that is typically on the older side relative to others, it isn't surprising that the vast majority of BHS members are adults ages 26 and older, with 59 percent in the 26-59 range and 18 percent being 60 and older. Youth up to 18 years of age make up 19 percent of members and those 18-25 the remaining 8 percent.

A reflection of the increase in homelessness over the past decade, just over one-third (34 percent) are considered persons experiencing homelessness (PEH).



Planning for Equity Moving Forward, 2022-2023

The San Francisco Department of Public Health (SF DPH), Behavioral Health Services' (BHS) mission is to provide equitable, effective substance use and mental health care and promote behavioral health and wellness among all San Franciscans. This mission allows us to develop culturally responsive care that serves populations experiencing the most severe health inequities need to receive the most resources.

In addressing equity, the focus is on service provision to clients, including accessibility of services or program design. However, BHS has come to the realization that the outward projection of equity necessitates an internal review of equity within the agency. In doing so, the benefits on the community network would manifest itself.

As BHS' chief facilitators in this work, the **Office of Justice, Equity, Diversity and Inclusion (JEDI)** aims to improve client health outcomes through ushering the following foundational objectives:

- Understand the impacts of racism and discrimination on our workforce and communities;
- Build workforce capacity to provide culturally congruent care for our communities with the greatest health inequities;

- Innovate, implement, and improve systemwide anti-racist practices and policies.

Racism is a public health crisis, and racial equity is everyone's job at BHS. Due to the severity of racism in our systems and communities, intensive foundational learning and interpersonal relationship building are necessary to ensure BHS leaders and staff are prepared to engage in meaningful and impactful antiracist practices and policy change. This begins with JEDI's 16-week, 80+ hour Antiracism Leaders Fellowship with facilitators Dante King and Robin DiAngelo. Fellowship participants learn and unlearn antiblackness, white supremacy, internalized superiority, internalized racism, white supremacy characteristics and moves, historical, and perpetual conditions. In FY22-23, nine BHS cabinet members, 14 BHS executives, and 9 JEDI managers participated in the fellowship, along with 1:1 executive coaching, racial affinity groups, a cabinet retreat, and cabinet Health Equity Antiracism Leadership Competencies, priorities, self-assessments, and action plans.

The competencies include structural competence, data management, management for equity, communications, collective impact and partnerships, budget planning and financial management, and clinical competencies. Cabinet member priorities include the following examples: Utilizing BHS workforce data to inform implementation of top ten policies and procedures to impact racial inequities in recruitment, hiring, retention, and promotion; Developing Epic dashboards and reports based on BHS health inequities outcomes reports to improve clinical competencies; Analyzing prescribing data by race/ethnicity and determining antiracist interventions as needed.

The Anti-racism Leaders Self-Assessment is structured by foundational knowledge, emotional resources and communication, race consciousness, translating knowledge into action, and motivation and prioritization. In December 2023, during a BHS all-staff town hall focused on racial equity, BHS cabinet members presented reflections from their experiences in the fellowship, along with their leadership competency priorities and commitments.

In FY24-25, BHS executives and cabinet members will participate in a combined all day in person retreat with Dante King, focused on self-assessments and action plans. Our Antiracism Leaders Fellowship cohort #2 will include direct reports of cabinet members and executives, who will all participate in a 360-Degree Antiracism Leadership Survey, in which leaders will receive and integrate feedback from staff on their antiracism behaviors and practices.

BHS Cultural Heritage Month Acknowledgements

Starting in FY 2022-23, the BHS Office of Justice, Equity, Diversity, and Inclusion (JEDI) began to standardize and operationalize recurring Cultural Heritage Month Acknowledgements. The Acknowledgements not only serve as a way to uplift our staff and communities' unique cultures, but also as a way to provide important updates on Culturally Congruent Programs and services. In addition, they act as an accountability tool for our racial equity priorities. One of the key principles in the process has been collaboration. The first step involved reaching out to internal staff such as other JEDI team members and the BHS Racial Equity Action Council (REAC) which

had representation from members in the BHS Racial Affinity/Accountability Groups and various Systems of Care. From there, we created small Workgroups made up of staff who were interested in contributing to the Acknowledgements. Each Acknowledgement had its own unique Workgroup where relevant topics and ideas would be discussed pertaining to the specific Cultural Heritage that was being celebrated. Once the Acknowledgement was ready, it was submitted to the BHS Communications Team to add to the BHS Biweekly Newsletter to all BHS staff. The following Cultural Heritage Months were recognized in FY 22-23: Latina-o-e-x Heritage Month, Native American Heritage Month, Black History Month, Asian Heritage Month, Native Hawaiian & Pacific Islander Heritage Month, Pride Month, and Juneteenth. Below are two examples of monthly acknowledgements.

2023 BHS Black History Month Acknowledgement

San Francisco Health Network
Behavioral Health Services

Black History Month

As Black History Month comes to an end, we would like to recognize Black history as American history, and every month as Black history month. We would like to invite all staff to continue to learn and grow in our combined efforts to dismantle anti-Black racism and white supremacy culture here at BHS and beyond.

The following resources, updates, and shared space are here for you now and moving forward.

BHS Black History Month Community Message Board

https://padlet.com/sharonlu1/2023-bhs-black-history-month-acknowledgement-qxl91eivrnh5z9i5

determine how the findings can impact the work we do as the SFDPH. For additional information email: BAAHI@sfdph.org.

Tools to Improve Practice (TIPs) in working with Black/African American Communities

- https://sites.google.com/view/cyftips/diversity-tools/blackafrican-american
- https://sites.google.com/view/cyftips/racism-pandemic-tools

Kuumba Healing Project (KHP) Southeast Child and Family Therapy Center
https://bit.ly/KuumbaHealingProject

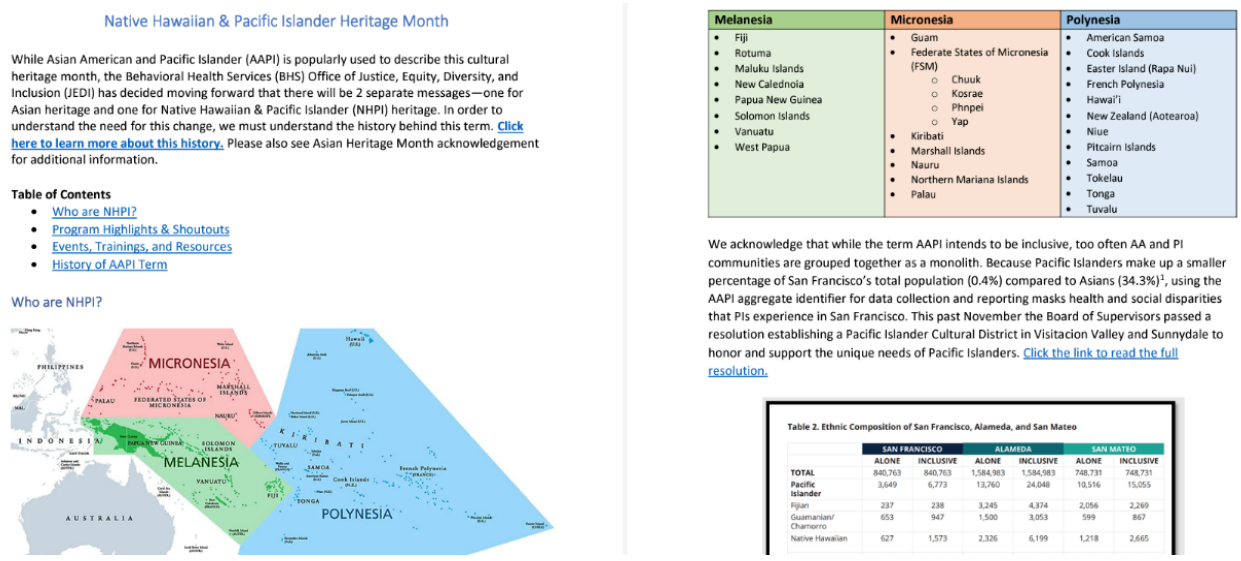
The roots of SECFTC's Kuumba Healing Project (KHP) are informed by the historical and cultural legacy of the community of African Descent in San Francisco. KHP's model utilizes Practice Based (PB) & Community Defined (CD) evidence, and builds on the unique strengths of children, adolescents, families and the communities of African descent in the Southeast district of San Francisco: Bernal Heights, Outer Mission, Excelsior, Bayview-Hunters Point, Little Hollywood & Visitacion Valley. KHP offers effective, community-based, culturally competent, family driven and youth guided behavioral health services through the provision of comprehensive psychotherapy and counseling services, school and agency consultations, medication support, parent training and referrals.

Homeless Children's Network Ma'at Program https://www.hcnkids.org/ma-at-program

The Ma'at Program is a supportive holistic therapeutic community, in which they center and work with Black/African American families in San Francisco. Ma'at uses a whole-person approach to provide Afro-centric, culturally responsive, heartfelt, behavioral health care. They provide effective treatment to increase equity of access at no cost to clients.

BHS Culturally Congruent and Innovative Practices for Black/African American Communities

2023 BHS Native Hawaiian & Pacific Islander Heritage Month Acknowledgement



Native Hawaiian & Pacific Islander Heritage Month

While Asian American and Pacific Islander (AAPI) is popularly used to describe this cultural heritage month, the Behavioral Health Services (BHS) Office of Justice, Equity, Diversity, and Inclusion (JEDI) has decided moving forward that there will be 2 separate messages—one for Asian heritage and one for Native Hawaiian & Pacific Islander (NHPI) heritage. In order to understand the need for this change, we must understand the history behind this term. Click here to learn more about this history. Please also see Asian Heritage Month acknowledgement for additional information.

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- Who are NHPI?
- Program Highlights & Shoutouts
- Events, Trainings, and Resources
- History of AAPI Term

Who are NHPI?

Melanesia	Micronesia	Polynesia

• Fiji
• Rotuma
• Maluku Islands
• New Caledonia
• Papua New Guinea
• Solomon Islands
• Vanuatu
• West Papua
	• Guam
	• Federate States of Micronesia (FSM)
	  ○ Chuuk
	  ○ Kosrae
	  ○ Phnpei
	  ○ Yap
	• Kiribati
	• Marshall Islands
	• Nauru
	• Northern Mariana Islands
	• Palau
		• American Samoa
		• Cook Islands
		• Easter Island (Rapa Nui)
		• French Polynesia
		• Hawai'i
		• New Zealand (Aotearoa)
		• Niue
		• Pitcairn Islands
		• Samoa
		• Tokelau
		• Tonga
		• Tuvalu

We acknowledge that while the term AAPI intends to be inclusive, too often AA and PI communities are grouped together as a monolith. Because Pacific Islanders make up a smaller percentage of San Francisco's total population (0.4%) compared to Asians (34.3%)[1], using the AAPI aggregate identifier for data collection and reporting masks health and social disparities that PIs experience in San Francisco. This past November the Board of Supervisors passed a resolution establishing a Pacific Islander Cultural District in Visitacion Valley and Sunnydale to honor and support the unique needs of Pacific Islanders. Click the link to read the full resolution.

Table 2. Ethnic Composition of San Francisco, Alameda, and San Mateo

	SAN FRANCISCO		ALAMEDA		SAN MATEO	
	ALONE	INCLUSIVE	ALONE	INCLUSIVE	ALONE	INCLUSIVE
TOTAL	840,763	840,763	1,584,983	1,584,983	748,731	748,731
Pacific Islander	3,649	6,773	13,760	24,048	10,516	15,055
Fijian	237	238	3,245	4,874	2,056	2,269
Guamanian/ Chamorro	653	947	1,500	3,053	599	867
Native Hawaiian	627	1,573	2,326	6,199	1,218	2,665

BHS Racial Equity Action Council

The BHS Racial Equity Action Council (REAC) is a monthly meeting for internal staff to learn and get involved in larger equity initiatives happening throughout BHS and SFPDH as well as a space for staff to get support on their individual and team's equity projects and challenges. The REAC has representation across various teams including SOC leadership, Health Commission, Peers, BHS Racial Affinity/Accountability Group members and more. Some of the previous discussion topics from FY 22-23 has included BHS REAC New Hire Data and Equity Interventions, Cultural Heritage Month Acknowledgements, BHS A3 updates, and Equity Leadership Competencies Discussion. The following screenshots reflecting feedback and discussion that took place during past REAC sessions.

8-25-22 REAC Reflection & Discussion

What came up for you when reviewing the BHS employee and new hire data?

Feelings

- What comes up on a feelings level is anger and frustration
  - I just want to second this comment.
- Troubling that we continue to lack African American representation in Director/Manager and limited representation below
- Disappointed that there isn't Latino representation in higher leadership. Feel like there's a lot talk about equity but it doesn't reflect.
- Given the demographics of SF, the lack of Latino ececs is glaring lds)
- The Latin American population is highly represented in our service communities and it is highly upsetting that we are not reflected in leadership… Curious about the challenge in hiring more Black and Latino/a/x/e clinical staff.
- Seeing people with melanin-deficit (White) hiring significant % increase &/or minimally be impacted, while Asian %'s decreased & Latinx % experienced more severe negative changes, is problematic for me.
- Super appreciate this presentation. It is so important to zoom out and look at our workforce demographic data when making individual hiring decisions.

Demographic Data

- Multiracial people are also considered BIPOC. Why didn't we also highlight trends/changes for them in hiring? It feels exclusive, and like we are dismissing the experiences of folks here who also matter and have equally relevant BIPOC experiences.
- Who are mixed-race people? Can we break this down?
- Agree with further breakdown of ethnicities/lang abilities of staff.
- A story that is not being told is around the lack of data for Native Hawaiian and Pacific Islanders. We should always be included in demographic data even if n=0 because that story is important to tell too. And if we are still being grouped with Asian, that is a problem. (we did show up on the side from the Office of Equity…we need to be more consistent about this)
- Interesting reflections on DPH BIPOC staff. Would have loved to seen Latinx folks called out for BHS on the org chart as well. It was a stunning visual.
- Is there data on applicants vs. hires? Might be good to see who is not making it into the door in that way.

8-25-22 REAC Reflection & Discussion

As BHS REAC members, what equity recruitment, hiring, and retention interventions and advocacy efforts do you want to prioritize and/or actively participate in?

Internal Advancement

- Access to information is limited e.g. HR HW to HPC coaching in response to Local 21 and SEIU proposal
- Can HR allow open recruitment for internal and external candidates who are or interested in health workers, 2930s/2932s and health program coordinators to be able to apply for various classifications in order to be more inclusive and easier to apply and be considered on respective lists beyond, e.g., only exams? We lose a lot of good internal people rejected across classifications due to old processes that deny strong relevant experiences
- Is there a way to develop career pathways for employees to pursue clinical education and licensure, particularly with those underrepresented?
- Agree with the need for career pathways. We have an amazing BIPOC Health worker who is doing higher level work who can't seem to break into the Health Coordinator series. And would be wonderful to have support for BIPOC folks to get support/schedule flexibility around clinical education. Keep and retain and develop the BIPOC folks we do

9-22-22 BHS Latino-a-e-x Heritage Month Acknowledgement

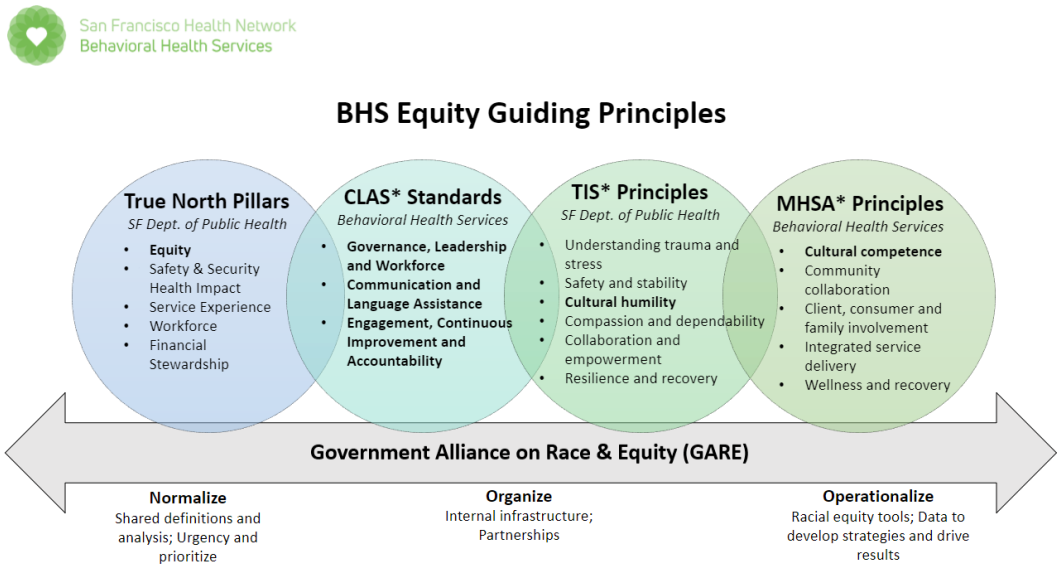
Notes

- Need Latinx staff to be seen in a meaningful way (honduran, guatemalan, immigration, normalizing immigration, we are all immigrants unless we are indigenous)
- Padlet for contributions from staff re: Latinx homogenization, isolation of Latinx staff and language
- Questions: How do you identify? Latino-a-e-x? Nationality? History of colonialization? Indigenous cultures/languages
- Regions that shared languages based on colonial pasts
- What brings people together and what separates?
- Staff meeting share outs- diversity among populations (e.g. API month) not just clients, your colleagues
- Offer discussion info/questions for staff meetings (use acknowledgement as baseline?)
- Food/culture share?
- Do you feel isolated as a member of your racial/ethnic group within your team?
- We're not a race

Origins of this Shift

Prior to FY 22-23, namely 2019, SFDPH saw major developments on the equity forefront. Mandating the Office of Racial Equity and the subsequent Office of Health Equity (OHE) laid down the foundations for organizational self-evaluation. BHS would declare its Equity Guiding Principles through four sets of standards:

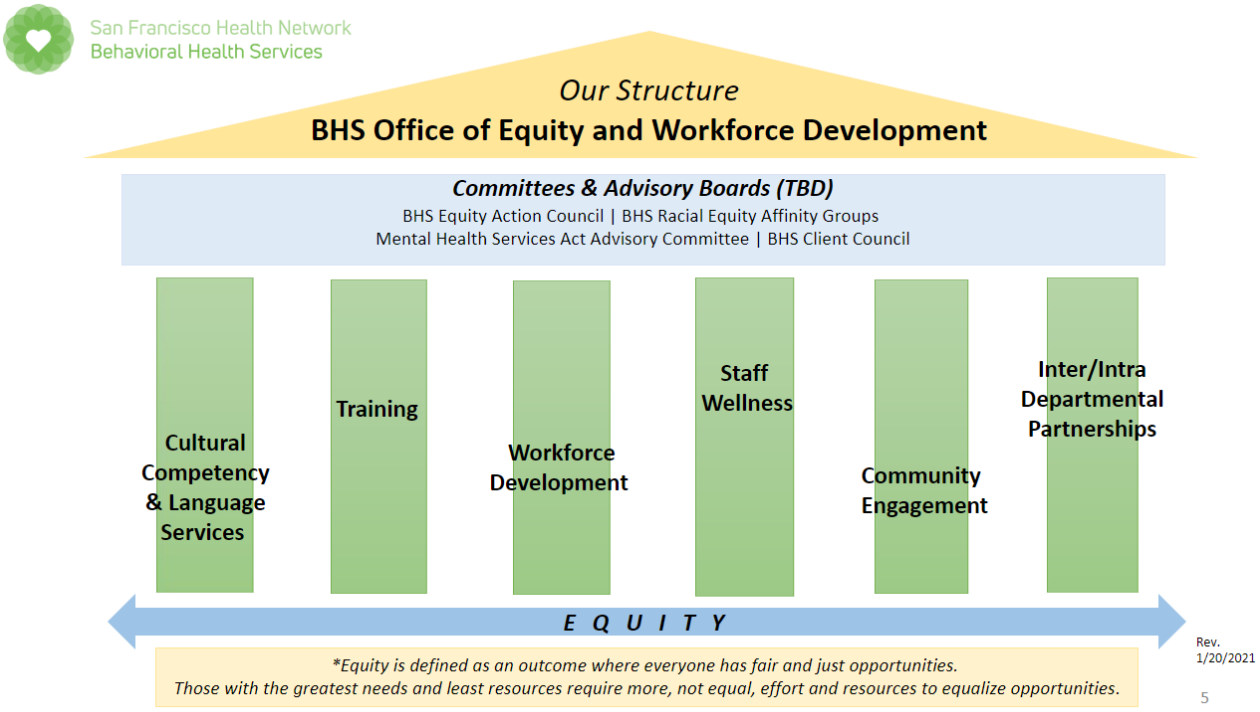
- DPH True North Pillars
- Culturally and Linguistically Appropriate Services (CLAS)
- DPH Trauma Informed Systems Principles (TIS)
- Mental Health Services Act Principles (NHSA)
- Government Alliance on Race & Equity Principles (GARE)



Normalize: The COVID-19 pandemic, the racial justice protests of 2020, and political rhetoric from nation's capital highlighted the degree of urgency needed to address inequities and injustices faced by people of color and other minority groups. COVID-19's disparate impact on Black and Latina/e communities manifested itself in many ways, such as:

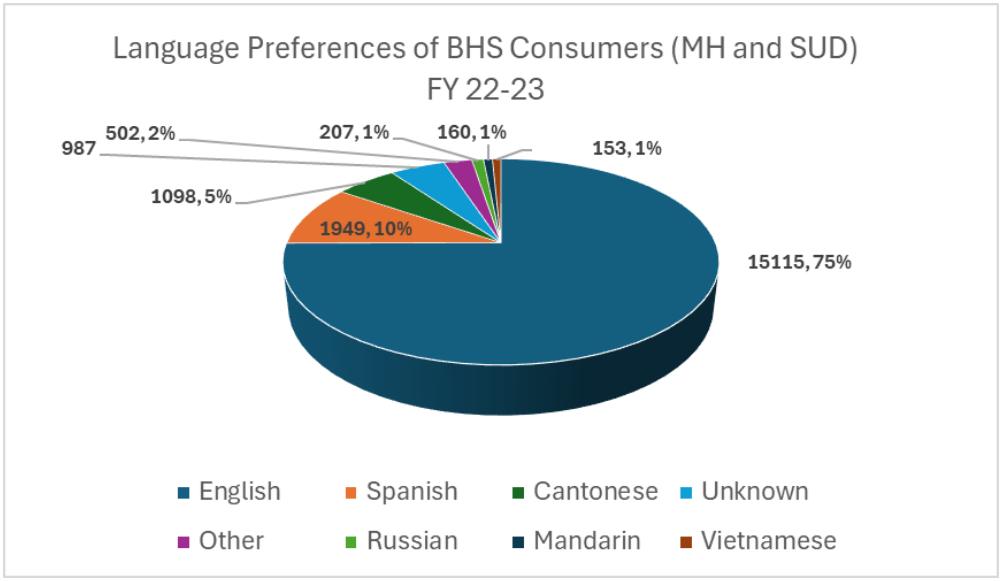
- housing insecurity or overly dense living situations (i.e. SROs, multi-generational households),
- large proportion of these communities in occupations falling under *essential worker* status – restaurant, grocery stores, janitorial, security, etc.
- school/childcare closures on youth with inadequate/no internet access for remote learning.

These realities, most often witnessed (or even experienced) by frontline staff, made their way up to leadership and have become a major priority of the system. Through new data, more training, and better, more sustained dialogue, the language and analysis of equity issues has become more standardized.



Organize: JEDI was formed to serve as the focal point for BHS matters pertaining to equity. As the diagram below illustrates, equity is entwined within each core area of the unit's work and serves as the common primary goal. As such, there is the enhanced focus on collaboration with internal/external agencies, community partners and of course the clients being served.

Operationalize: Many shortcomings of the past were the result of poor or inadequate data. Directives from the state and federal levels have demanded expanded procurement of quality data. BHS Quality Management, JEDI and the BHS Systems of Care (SOCs) have begun developing improved metrics and data collection tools to facilitate equity-driven strategic program/service improvement measures.



Maintaining Language Access for BHS Clients

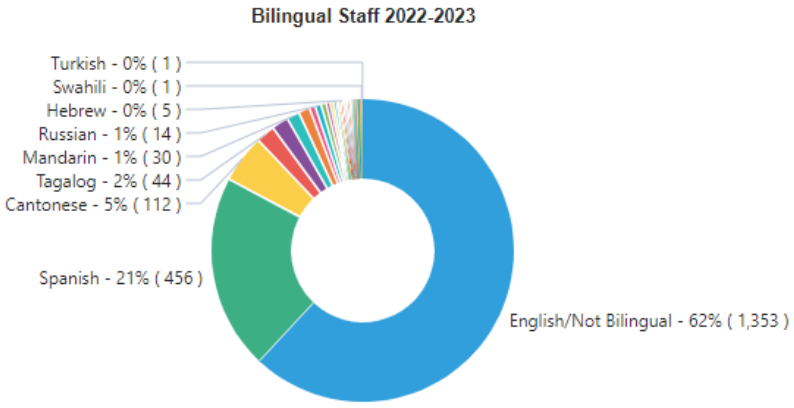
Language Access and Cultural Humility go hand in hand as a foundation of JEDI's

push towards equity. BHS continues to ensure that language/linguistic issues are not barriers to members of public accessing mental health or substance abuse services. It does this on two fronts: Internal bilingual staffing and access to contracted interpretation/translation services.

BHS has a decent number of internal bilingual clinicians dispersed throughout its clinic sites and programs. The same applies for the many contracted community-based organization (CBO) partners in the BHS network. As reflected in the pie chart on the previous page, English is by far the most common language among members (75 percent of total cases). **Spanish** and **Cantonese** remain the most prominent non-English threshold languages, with 10 percent (1950 cases) and 5 percent (1100 cases) of all cases, respectively. Russian, Vietnamese, and Mandarin and all have between 150-200 cases, rounding out the remaining threshold languages.

Bilingual Staffing

This same pattern holds true amongst staff across the BHS network (including civil service and CBOs), according to the Cultural Competence Tracking System, a platform programs use to self-report and document staff (clinical and support) demographics and language capacities. Among programs that submitted their staff information for FY 22-23, bilingual Spanish-speaking staff were the most widely represented at 21 percent, or 456 individuals. From that same sample, 5 percent (approx. 110 staff) listed themselves as bilingual Cantonese. The remaining languages for which there were ten or more staff with capacity were Tagalog, Mandarin and Russian, all of which are also considered threshold languages for SF County. The Tracking System is not capable of filtering these figures to only include clinicians. If it did, the percentages of bilingual capacity would be even less, yielding an even more disproportionate ratio of monolingual, non-English speaking clients to clinicians with the relevant language skills. The figures indicate an ongoing critical need for more bilingual staff. BHS is fully aware of this, hence JEDI's many efforts with DPH-Human Resources that take aim at reimagining recruitment and hiring. In the interim, many of the services are supported through interpretation services.



Interpretation/Translation Services

JEDI has been the intermediary by which BHS programs and sites access language support in the form of interpreters and translations (for written materials). This support is provided by vendors contracted with JEDI. LanguageLine Solutions is the biggest of these vendors, with a city contract that covers multiple city departments. LanguageLine's primary service is 24/7

telephone interpretation support (including video calls), staffed by a network of interpreters that span the globe. The other vendors are local and smaller in scale. They are primarily used for translation services and providing on-site interpretation at functions like community meetings or more intimate settings such as family/client counseling sessions. Of course, with the onset of the pandemic, these local vendors have also adopted teleconferencing platforms such as Microsoft Teams and Zoom.

Internal BHS usage of interpreters/translators has grown over the past few years, and the pilot program introduced at the start of FY 19-20 (see next section) has caused a significant increase in the number of requests for language support.

Language Resources for CBO Partners Pilot Program

In July 2019, the then Office of Equity, Social Justice and Multicultural Education (now JEDI) launched a pilot program that granted BHS' contracted providers with access to the interpretation services that were regularly used by internal clinics and programs. The idea of such a pilot program was born out of discussions on two platforms: The Cultural Competence Task Force, whose membership consists of several leaders of contracted community-based organizations, and the results of the annual Cultural Competence Report Questionnaire.

Within the Task Force, the issue of language access was a constant topic. A member of the DPH-Contract Development & Tech. Assistance team and some CBO representatives noted that language resources are never mentioned as a line item for CBOs when negotiating contracts with BHS. As such, while required to offer language resources to their clients, most CBOs are responsible for obtaining funding and access to those resources. Since these resources are absent in negotiations, no DPH funds go towards it, and many CBOs lack additional funds to provide them, leaving gaps in service provision as potential clients would most likely be directed towards other agencies that have the needed language capacity.
The Cultural Competence Report Questionnaire for FY 2018-19, which asked all BHS programs about their developments, tools and capacities in the area of cultural/linguistic competence for that year, saw a considerable number of responses from CBOs highlighting the inability to meet the needs of monolingual members whose language needs weren't covered by existing staff.

In response to this feedback from CBOs, the Office of Equity, Social Justice and Multicultural Education decided it would explore a pilot program whereby those contracted agencies that needed support in providing language access could tap into those being used by civil service sites and programs. OESM consulted with the Budget Office to ensure that it could secure additional funds that would go towards this purpose, and the development of the pilot was underway. The parameters of the program were set to providing in-person interpretation for individual/group appointments or community events. Use of document translation services and access to BHS' 24/7 Language Line account for telephone interpretation would not be included, except in rare cases, and only after a more thorough review of the request. A simple request form was developed for use by the CBO needing support. This is submitted to OESM, who then initiates contact with the vendor and coordinates rendering of the service. In July 2019, the pilot program was announced first through a memo sent throughout the BHS network, and in

the following months in person at provider meetings for each system of care. The request form is then used to document each request on a spreadsheet, taking information such as the requesting agency, agency contact, event type, language requested and more.

Over the course of FY 19-20, OESM received nearly three dozen requests for language support sent by CBO providers. As mentioned before, requests were mostly limited to interpretation, with 27 of the 30 requests being for that purpose and the remaining three simple translations of informational materials. Of the twenty-seven requests for interpretation, only one was not for some form of therapy (individual, family, group), assessment or counseling. That one instance was for a cross-cultural summit. All of the interpretation requests came from just six agencies, with Felton FSA and RAMS being the most frequent users of the pilot program.

As FY 2019-20 neared its conclusion, it was decided that the pilot program for CBOs would continue through the following fiscal year. Furthermore, more outreach was done to promote the pilot amongst contractors. Going forward, BHS leadership is likely to look at the feasibility of making the program permanent. When rolled out, the pilot was meant to serve as both a lifeline for contractors and as a means of inducing them to focus on providing these services themselves. The third benefit was that it could potentially consolidate language resources usage data. In March 2018, updated data reporting requirements from DHCS' Managed Care Final Rule Network Adequacy Standards put the onus on counties to collect data from contracted providers on their usage of language services. That undertaking would be costly in terms of man-hours. The idea of avoiding those tasks spawned the initial discussion of the county funding language services outright to centralize and consolidate vendor and usage data across the system. Since launching, the positive impact the pilot program has had for CBO partners has only grown. Further analysis of the data from the pilot program will be the guide on what's feasible moving forward.

Overview of Language Resources

In trying to meet the National CLAS Standards, JEDI has tried to monitor the extent to which those standards are being implemented throughout the BHS system. Each year, JEDI generally issues a Cultural Competence questionnaire as a means of getting agencies (both civil service and CBOs) to report on their internal developments aimed at addressing one or more of the CLAS Standards. The last questionnaire was issued in July 2019 (none in 2020 due to COVID), taking a comprehensive look at efforts on CLAS through FY 18-19. However, the most thorough information came from the questions on Language Resources. As mentioned earlier, many of the following findings would go on to inspire the pilot program to support CBOs with expanded language access.

1. **General Practices**

The general practices used to assist LEP clients can vary greatly from one agency to another. Among all programs, the first step is determining the need of the member, either from the first encounter or by way of documentation during the initial intake session. Once determined, the member is informed of their right to an interpreter at no cost to them. The language capacities

of the different agencies also vary in range. Most will first look internally to see if there is someone on their staff that can meet the language preference of the member. If the need can't be met by an internal staff, different approaches are taken to ensure the client gets the service they need.

From years of learned experience, many agencies have staff with linguistic capacities that match the needs of the community they serve. For example, Mission Neighborhood Health Center and Instituto de la Raza are heavily staffed with bilingual Spanish clinicians who are equipped to serve the Latin American population there. In cases where the need can't be met, civil service sites will either present the options of having on-site interpreters come to sessions or using the telephone interpretation via Language Line. These are facilitated by making a request through JEDI. They may also make a referral to a different program/agency that better meets the language needs, using the Cultural Competence Tracking System (database) to find clinician with the relevant capacity. CBOs also use the Cultural Competence Database or call in to the Behavioral Health Access Center for the referral. From the data, it became evident that some CBOs referred to similar use of interpretation services, but incorrectly cited BHS as being the supplier of these. The policies regarding language resources are such it is the responsibility of the CBO to provide those services on its own, given that the JEDI has limited funds with which to provide support for civil service programs. Going forward it is imperative that the contract language regarding the allocation of funds for language resources should be a more prominent part of the negotiations process. It should be noted however that many agencies are aware of this and have established relationships with vendors or utilize other sources to meet address any service gaps due to language. For example, UCSF-run programs located at Zuckerberg San Francisco Hospital (ZSFG, formally known as San Francisco General Hospital (SFGH)) can utilize either the hospital's Interpreter Services Unit or draw from the resources contracted with UC itself. Others like RAMS have contracts with vendors such as Language Line.

2. Procedures to Manage Capacity

As first alluded to in the previous section, the language need of an LEP member is identified soon after initial contact, usually at intake. This holds true for both CBOs and civil service agencies. Following this assessment, determination is made on how to handle the case. Programs with the capacity will usually create a plan whereby a clinician with the desired language is assigned to the member. In the event there isn't, they will explore the other options, either external language resource or a referral, as mentioned before. Many of the programs stated that the language preference information taken at intake is documented, whether it be on Avatar or some other platform. Most of the agencies reported that this data was used to inform their staffing needs. With a constantly updated look at what populations make up the community, greater emphasis in made to incorporate language capacity needs in the recruiting efforts of HR units. In job postings, preference or even requirements for bilingual status have become commonplace to ensure future staffing reflects the language needs of the community if it doesn't already.

Very few CBO programs offer financial incentives for those who are bilingual. Only Baker Places and Project Homeless Connect made any mention of providing stipends for bilingual staff. Others such as Instituto and Homeless Children's Network noted their use of student interns, who are presumably unpaid. This is in stark contrast to the civil service system, which grants some extra compensation per pay period for those with bilingual status (granted based on results of proficiency exam). This discrepancy highlights an ongoing issue for CBOs, many of which find their administrative and clinical staff leaving for jobs in the public sector (i.e. DPH). Going forward, this too will need to be something mentioned during negotiations, if BHS is to retain the expectation that CBOs provide their own language access resources to clients.

3. Language Resource Vendors

All the BHS civil service agencies/programs draw from the same stable of vendors. This is done at the discretion of the JEDI, who oversees the contracts with each vendor for the duration of the fiscal year. For 24/7 on-demand telephone interpretation, the vendor is exclusively Language Line Solutions, which has a city-wide contract across all departments. For translations and in-person interpretation, the vendors were International Effectiveness Centers, Studio Melchior and Auerbach International. Bay Area Communication Access is the interpreter used for all ASL requests, the contract for which is managed by Interpreter Services at ZSFG.

The CBOs used a variety of vendors, including Language Line. Others used were Language Circle of California, Language Bank, TransPerfect Connect, Certified Languages International, Avid Translation and more. As mentioned previously, some of the CBOs erroneously listed BHS and its contracted vendors as their own resources. While BHS is always ready to refer its contractors with its certified vendors, they can't request services from the same vendor contracts without going through the pilot program. Other agencies used highly skilled volunteers from organizations such as the Volunteer Health Interpreters Organizations (VHIO).

The results revealed a mixed bag with regards to agencies' understanding of where to access language resources. While many were proactive and have tapped into the services of a vendor directly, some operate under the assumption of shared resources with the department. Furthermore, there are others who are aware of the department's limited ability to help and turn to alternatives, whether through qualified volunteers or by way of less than satisfactory methods such as using Google Translate.

4. Data Tracking of Interpreter Usage

As it pertains to tracking data on interpretation usage, few programs collected this information themselves. In nearly all cases of programs using a vendor, monthly invoices were referenced as the sole source of information. These invoices usually have information on the following:

- Date/time of calls,
- Language being requested/used,
- Duration of the calls.

Rarely is this information kept on hand but instead just looked up, with the invoices serving as the records. For example, all BHS sites rely on the CC Analyst to look up any interpretation usage data since it is JEDI that manages the contracts with each of the vendors. Similarly, a few CBOs like Mission Neighborhood Health Center and the Positive Resource Center use their financial accounting systems to track use of such services. Others like Hyde Street Community Services have pledged to establish data collection practices or will do so should it become a requirement by BHS. Programs located at ZSFG rely on that site's Interpreter Services unit to record such information. One of the few programs that did say they collected info on language requests was SF Suicide Prevention, which cross references their records with their language vendor's invoice. Several programs noted that they do record clients' requests for an interpreter via progress notes on Avatar, which is supposed to be standard procedure. While this is probably done across the system, it still doesn't make it easy with regards to aggregating information to convey a picture of the system's demand for interpretation.

As such, it would be wise to mandate standardized data collection requirements in response to the new Network Adequacy requirements, along with possibly having a standardized format/procedure of that process. Reliance on data from vendor invoices has limitations with regards to timeliness of access and simplicity of use. If information was recorded in real-time (i.e. as the interpretation request is made and while the service is being provided), this would cut out the need to extract data on the back end. Especially in the cases where no data is collected at all, the system clearly has a major information deficit that makes it more difficult to pinpoint where and with what language there is a growing need.

Vendors for Written Translations

Where it concerns written translations, the bulk of responses usually fell into one of several categories: those that did translations in-house, those that relied on the OCC for translated documents, those who utilized contracted vendors, a combination of the previous three, or those that lacked such resources at all. About a quarter of the programs said that they utilized vendors from their own contracts. This doesn't include all the BHS programs who in fact use vendors but do so through requests from OCC.

About five CBOs indicated that they rely upon BHS for their written translations. This is a bit unclear since a far greater number of programs receive their translated *vital* documents from BHS -which have been standardized across the system- but handle program-specific materials on their own, either by an outside vendor or internally. If the aforementioned five CBOs rely solely on BHS, it means they incorrectly assume that the department's language resources are accessible to them.

Those who do most if not all translations internally include RAMS, Felton FSA, Community Youth Center, Mission Neighborhood Health Center and others. The programs based at ZSFG uses Interpreter Services (SF DPH unit), which has a dedicated team and comprehensive translation system. For those translations done in-house, there is no indication that there is

any quality control, aside from the general quality of the staff's skills (to be discussed in the next section). Even for the OCC, with regards to vendors, it currently lacks a system of cross-referencing to ensure that its translations are accurate. As such, it is imperative that such a system is developed in the long run to ensure high quality.

Finally, those that don't really offer translation services reported using methods that are inadequate by system standards, such as using Google translate or having untrained relatives accompanying the client at appointments try to decipher clinical terminology written in English. These are the worst-case scenarios that should be corrected, at the risk of providing clients with inaccurate information. Contract language with CBOs must emphasize the necessity of having such translation services accessible, with funds set aside for this purpose. The scope of DPH support for this and interpretation should be clearly defined to ensure that resources are adequately budgeted and expectations set reasonably.

5. **Determining Qualifications of Bilingual Staff**

While those staff with bilingual status are listed on the Cultural Competence Tracking System, the qualifications for such status are not typically documented. Not all agencies have systems to determine bilingual skill level, and those that do take different approaches, usually occurring in the recruitment phase. All DPH hires that wish to obtain bilingual status must take a bilingual examination conducted by HR. As recently as 2018, DPH-HR, at the request of BHS Administration, began to administer a bilingual exam that was tailored specifically for those working in behavioral health. Prior to this, the testing was standardized across DPH and relevant to primary care only. This qualifications measure has been in effect for those applying for bilingual status since its introduction, but it has no impact on those who already had such status.

For many CBOs, language capacity requirements are often listed directly on the job posting, namely a dedicated bilingual position. The applicants who meet the linguistic requirements and make it to the interview stage are then either tested or asked to conduct a portion of the interview in the language the job demands, usually by a clinician or staff person who speaks that language. Programs with such a system include RAMS, CYC, Felton and others. Furthermore, the application process may entail getting letters of reference from past organizations verifying capacity and other forms of assessment.

Other programs specifically aim to hire native speakers, though this still fails to account for technical language that isn't typically spoken outside of the clinical environment. Many programs indicated that they have **no** process for determining language skill, with those claiming bilingual status simply self-reporting. Again, for the purposes of treatment this is insufficient and likely to result in communication gaps. As a system, it should be mandated that all language capacity be verified, either by formal internal processes or through an outside vendor that conducts examinations on skill level.

Immergence of Telehealth/Telepsychiatry

Telepsychiatry Feasibility Pilot Work Plan (pre-COVID-19 response) – JEDI, in partnership with Medical Services, SFDPH OCPA, and DPH IT, developed a Telehealth/ Telepsychiatry pilot work plan for BHS civil service clinics. Chinatown North Beach MH and Sunset MH were identified as pilot sites based on severe shortage of psychiatric service needs in Cantonese at CTNB MH. After reviewing other Bay Area county systems, BHS SOC and BHS IT, in consolation with BHS Privacy and Compliance Office, determined to utilize existing software, Microsoft Teams, for the telehealth pilot platform. In fall 2019, equipment was purchased, worksites were set up, and workflows were developed for the two sites. In March 2020, the formal pilot was launched and tested amongst a small group of clients from CTNB MH but did not go live due to COVID SIP. See Telehealth Pilot Project Timeline; BHS Telehealth Guidance

COVID-19 Telehealth Infrastructure and Implementation - As a result of COVID-19, widespread use of telehealth services was expedited across BHS. With face-to-face appointments minimized, BHS quickly adapted to serving clients via telehealth and telephone. Efforts included guidance, webinars, relaxed telehealth/telepsychiatry regulations, HIPAA-compliant Zoom accounts for all DPH employees, and a Federal Telehealth Grant (see SAMHSA Grant Overview) to procure and install webcams and microphones at all BHS civil service sites. Preliminary guidelines and scope of telehealth integration for BHS can be seen in the Telehealth Workstation Overview and Proposed Budget.

As the findings indicate, while progress has been made in lowering cultural or linguistic barriers to access of BHS programs, much work remains in areas such as building staff capacity and data collection. This is very much the case as BHS' experience with telehealth deepens. Community engagement, collaboration and training are key tools to facilitate improvement measures.

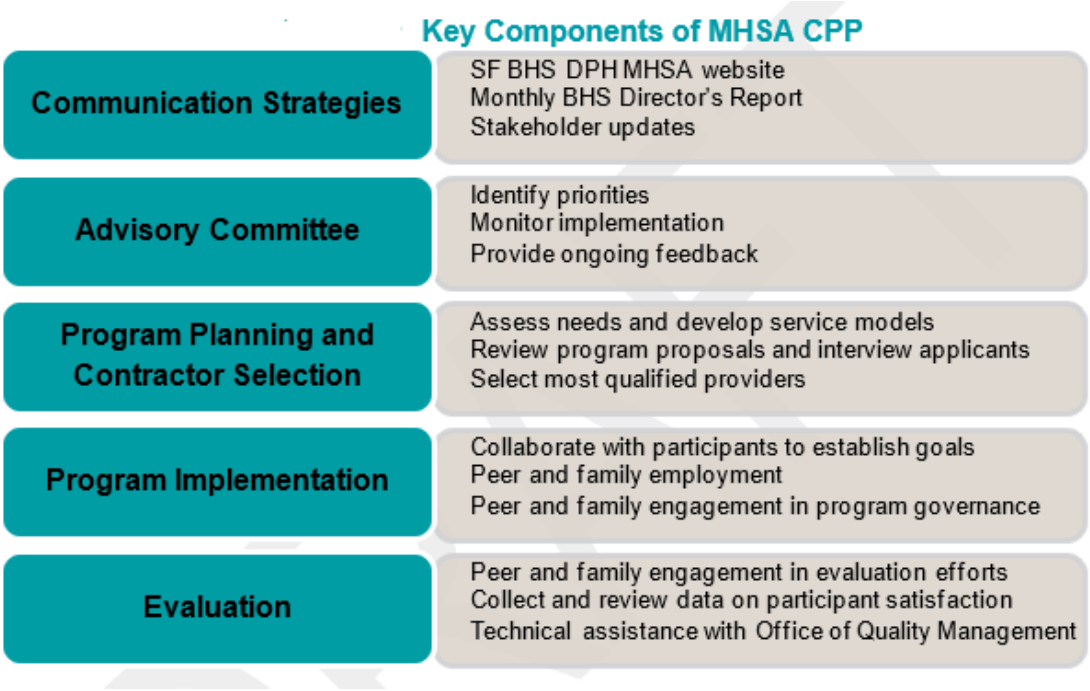
Mental Health Services Act (MHSA)

The Mental Health Services Act (MHSA) team works towards the stated goals of:

"raising awareness, promoting the early identification of mental health problems, making access to treatment easier, improving the effectiveness of services, reducing the use of out-of-home and institutional care, and eliminating stigma toward those with severe mental illness or serious emotional disturbance." These are met through the program's guiding principles:

- Cultural Competence
- Community Collaboration
- Client, Member and Family Involvement
- Integrated Service Delivery
- Wellness and Recovery

Central to these principles is constant engagement with community stakeholders, exemplified by a combination of joint projects with and providing funding to CBOs. Facilitating these are ongoing Community Program Planning (CPP) meetings, platforms for stakeholders to work with MHSA staff in identifying needs, assessing/reviewing service models and more, as seen here. There is also the MHSA Advisrory Committee, which provides guidance in the planning, implementation, and oversight of the MHSA, in addition to collecting feedback on programming and the needs of proprity populations. Recruitment for the Advisory Committee focuses on engagement with mental health community's underrepresnted communities, namely those with expertise in law enforcement and substance use, Transitional Age Youth, transgender individuals, and family members. Currently there are 25 members in total. MHSA also engages with other stakeholder groups such as the BHS Client Council and the SF Behavioral Health Commission.



FY 2022-2023 Notable Updates

BHS Training Unit

As a unit of JEDI, the Training Unit works with the Systems of Care leadership to organize a diverse and rich training schedule, along with other projects. In FY 22-23, the Training Unit's offerings included some that addressed anti-racism and gender-affirming care.

One such example was the June 2023 virtual training series titled "Working with LGBTQIA+ and Gender Expansive Clients and their Families." This series aimed to highlight the use of gender affirmative care and gender expression care models for BH members (and family) from the LGBTQIA+ community, with a focus on best practicies and guidelines for psychotherapy/social supports. Also addressed were the clinical challenges faced by providers (especially with children/youth clients) , as well as a reflection on their own biases and assumptions that come with working with that particular community.

Another training that has been instrumental in educating BHS providers on equity and cultural humility matters has been the Anti-Racist and Culturally Humble (ARCH) Clinical Practices Training and Learning Academy. Kicking off in October 2022, this training series featured different sessions aimed at equipping providers with the skills to utilize anti-racist and culturally responsive approaches to clinical interventions. While some sessions were more broadly based on diversity and cultural responseiveness, others were focused on new or refined approaches for

working with specific populations, such as Latina/e or Asian American/Pacific Islander communities. For FY 22-23, there were a total of eight sessions, all of which are listed on the flyer below.Academy.

MSSP

Aside from these, the Training Unit also organizes the Multicultural Student Stipend Program (MSSP). The MSSP aims to support interns serving at internal or contracted BHS programs [within the Adult/Older Adult (A/OA) and Children, Youth and Families (CYF) systems of care] to encourage them to serving within the network. Essentially all the interns are currently enrolled in post-baccalaureate programs (mostly MSW, Psy.D) and possess cultural and/or linguistic knowledge and skills most relevant to the diverse populations being served in San Francisco.

The MSSP's funding comes from both CYF and A/OA, with total allotments exceeding just over $70k in each of the past two years, spread out over 30 stipend award winners over that same period. As part of the process, awardees are required to commit to attending two racial/cultural humility trainings, one for each disbursal of the award funds. In the MSSP application process, they must have also committed to at least applying for a permanent position within the BHS network. The ultimate goal of the MSSP is to retain the current generation of future clinicians and case managers in the system that most reflect the client diversity, especially where it concerns Latine and African American communities. This program is just one of many long-term efforts underway to address racial equity.

Children, Youth, and Families System of Care (CYF)

Demographics Reporting

Throughout FY 22-23, CYF engaged in several studies aimed at identifying areas in which the system of care could improve the member experience, particularly in the area of informed hiring practices with respect to the matching of providers' ethnicity and language with that of community needs, along with accounting for shared lived experiences. The overarching goal was to address the need to rebuild community trust and confidence in the City's mental health support apparatus in the post-COVID era. Among these studies was the *Workforce and Clients Demographics Study*, the aim of which was to:

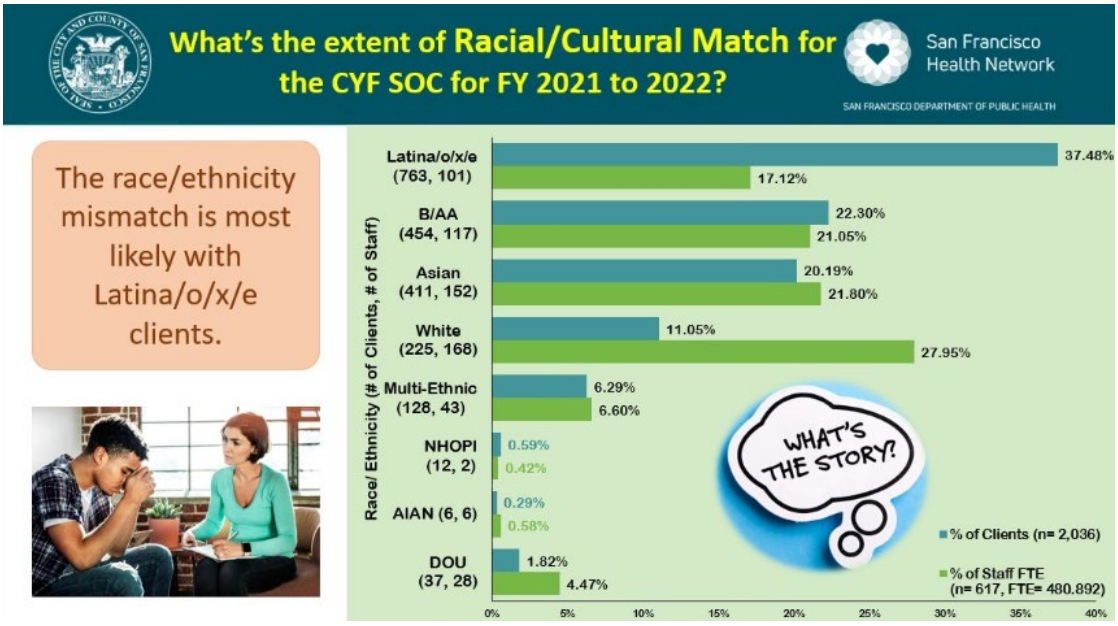
- Describe our current workforce regarding ethnicity and language capacity to examine where we may have gaps in our ability to serve San Francisco's diverse communities.
- To describe our current workforce regarding ethnicity and language capacity in order to examine where we may have gaps in our ability to serve San Francisco's diverse communities.

This study used FY 21-22 staffing data from the Cultural Competence Tracking System and client electronic health records from Avatar, drawing from programs that were matched according to whether their staffs administered Child and Adolescent Needs and Strengths (CANS) assessments. What resulted was a detailed look at where disparities existed and recommendations on improvement measures for the future. Below is an excerpt from the Executive Summary and Overview:

In CYF programs where client and staff data were available, the Hispanic/ Latina/o/x/e community made up 33.65% of unduplicated clients, followed by the Black/AA (23.21%), Asian (19.17%), and then White (11.37%) communities. In terms of the workforce, a majority of direct service staff FTE identified as Hispanic/ Latina/o/x/e (21.19%), followed by White (20.66%), Asian (18.74%), and Black/AA (11.23%). In summary, the system of care has proportionately matched Asian clients to the staff, but there is a need for more Hispanic/ Latina/o/x/e and Black/AA representation within the CYF direct service workforce to match the clients. This report further investigates match by a more granular look at subgroups of races and ethnicities. For example, although the difference in proportion between Asian clients and direct service staff was about 0.42%, 68.44% of those Asian clients identified as Chinese, compared to 52.71% of the direct service staff FTE, a gap of almost 15.73%. Similar breakdowns are available for Hispanic/ Latina/o/x/e, White, and Native Hawaiian or Other Pacific Islander. To further meet the needs of clients, CYF programs have also dedicated efforts to match the preferred languages of the clients served. The top three non- English languages preferred by CYF clients were Spanish (19.68%), Cantonese (7.11%), and Mandarin (1.28%). Meanwhile, 19.58% of staff could provide treatment in Spanish, 3.18% in Cantonese, and 1.70% in Mandarin. Although there is a gap between Cantonese clients and their respective clinical FTE, 5.7% of FTE reported they can converse with clients in Cantonese, closing or narrowing the language gap disparity.

Though the main objective of this report is to highlight disparities in cultural matching across CYF and help inform hiring practices, this report also informs practice improvement efforts to strengthen the cultural competence, responsiveness, and humility of our workforce to meet the growing diversity of clients served.

This summary compares the self-reported races, ethnicities, and languages of staff from 36 CYF programs, eleven civil service and 25 community-based organizations (CBO), to the clients from these same programs. A major critique of the report from fiscal year 2020-2021 was that the numbers presented did not match the perception of clinic directors in terms of who the clients receive treatment from. Because of this, the report will only directly compare clients to staff that provide direct services.



Above is just one example of the data uncovered in the study. The full report can be found here: BHS CYF D.A.S.H. - Workforce-Clients Demographics (google.com).

Also developed in FY 22-23 was CYF's adjacent report titled *Does Race/Ethnicity Match between Clients and their Providers Matter? An Exploration of CANS Outcomes in CYF Programs for Fiscal Year 2019-2020 thru 2020-2021.* Using data from the aforementioned fiscal years, this report's goal was to determine if matching clients and staff by race and ethnicity improved outcomes for CYF clients. The data was drawn from CANS assessment results for clients who were evaluated twice by the same clinician 90 days (or more) after their initial assessment. Below are the core findings from the Executive Summary:
Overall, matched clients exhibited equal or better outcomes than mismatched clients in 57% of CANS assessment domains. For Black/AA clients and Hispanic/ Latina/o/x/e clients, matching them with their clinician led to equal or better outcomes in 43% of domains. Within CANS domains with the most actionable items, matched clients showed about equal or better outcomes in 50% of Behavioral/ Emotional Needs items, 69% of Functioning items, and 55% of

Strengths items. In addition to these results, we explored other potential influences on outcomes. For zero thru five clients, all the domains had equal or better outcomes for matched clients.

For clients with Race/ Ethnicity, Socio-Economic Status, and Language cultural stress, 57%, 86%, and 29% of the domains, respectively, had equal or better outcomes with matched clients. Clients that were assessed for their first Mid-Year evaluation displayed equal or better outcomes when culturally matched for 57% of domains. Clients whose second evaluation was their Closing assessment had equal or better outcomes in 57% of domains. Finally, clients who were engaging with CYF for the first time showed better outcomes in 29% of the domains when their evaluator matched their race/ ethnicity.

The full report can be found here: BHS CYF D.A.S.H. - Racial/Ethnic Match and Outcomes (google.com)

Education

Beyond comprehensive studies, CYF has a platform offering a robust collection of guidelines and resources for its workforce. Among these is the **Tools to Improve Practice (TIPS)** website, the goal of which is to "provide a compendium of resources that can complement and strengthen the clinical work of our therapists…and other behavioral health providers." Furthermore, it does so in a way that accounts for "the impact of ongoing trauma, racism, and other cultural and systemic factors on the well-being of our child and youth clients." As such, in addition to assessment guides, telehealth trainings and the like, tools like the Anti-Racism Clinical Guide and the Culturally Responsive Guide, with culture-specific pages, can also be found. FY 22-23 focused on developing sections for Neurodiversity and the LGBTQIA2S+ community.

These Culturally Responsive Guides have been included in information that is distributed throughout the year during heritage months for respective groups. Another component of the heritage month information is culture-specific data stories and reflections meant to highlight each group's behavioral health needs and strengths, drawing from CANS and Pediatric Symptom Checklist assessments. This rich body of information can be found at CYF's Data Analytic Stories Hub.

In partnership with its programs, CYF developed sections of the TIPS site for resources for specific groups/communities: For example, it worked with Chinatown Child Development Center (CCDC) on resources for the AANHPI community found here. https://sites.google.com/view/cyftips/sf-cyf-resources/health-and-treatment.

Finally, to address workforce development efforts around cultural adaptation of clinical practices, CYF was a partner with the BHS Training Unit in developing the aforementioned ARCH Training Academy and the *Working with LGBTQIA+ and Gender Expansive Clients and their Families* series.

The CYF System of Care remains at the forefront of addressing cultural humility needs and taking innovative measures to strive for equity for the youngest members of the SF community as a whole.

Adult/Older Adult System of Care & San Francisco Mental Health Services Act

Culturally Congruent and Innovation Practices for Black/African American Communities Pilot Project

The Culturally Congruent and Innovation Practices for Black/African American Communities Project is a 5-year pilot project that seeks to create more diversity in the mental health workforce to better engage members and implement culturally responsive services that meet the need of these communities. It is funded by San Francisco Mental Health Services Act Innovation funds and in line with Innovation funding regulations, seeks to test out a new culturally congruent approach with this underserved community.

This project is being implemented at 4 civil service sites in San Francisco:

- Mission Mental Health Clinic: African American Alternatives Intensive Case Management Program (AAAICM)
- South of Market Mental Health Integrated Service Center: ONYX Program
- Transitional Age Youth Civil Services Clinic: African Americans Inspiring Minds Program
- Outer Mission/Ingleside (OMI) Family Center: IMANI Program

This project aims to improve retention and engagement of Black/AA clients. Services are provided by clinicians, health workers and peers with lived experience with Black/AA Communities. Trauma-informed, culturally congruent interventions drawn from a curriculum created by Dr. Heather Hall will be implemented with clients starting in FY24-25, and these will be the focus of the project evaluation.

Project staffing includes 7 clinicians as well as health workers and peer specialists. In FY23-24, over 250 culturally congruent support groups will be provided in addition to an array of comprehensive mental health support services. Group outings and special event activities around holidays, like Kwanza, and Black History Month provide an opportunity for clients to build social connections.

Services provided to clients include:

- Individual and group therapy, crisis intervention, screening and assessment, psychiatric evaluation, medication management and case management, intensive support, service linkage and system navigation.
- Outreach services, prevention and early intervention, health promotion, peer support
- An array of groups including: harm reduction, women's groups, art groups, UMOJA group: Soul Searching Nourishment.
- For transitional age youth: Hip-Hop Poetics group, Basketball group, "What's the Tea" narrative therapy and traditional African healing modality group, "Let's Be Friends" social skills group.

Peer specialists from NAMI SF are conducting outreach to Black/AA communities, including hosting mental health fairs, providing trainings and connections to community resources. They are providing Mental Health 101 and In Our Own Voice presentations at faith centers and community organizations. They will also lead peer led support groups at churches, linking individuals to support at project sites.

In FY23-24, they aim to provide 10 mental health presentations at faith community locations, two mental health fairs, and train 8 peer support group facilitators to provide support groups at churches.

Transitional Age Youth (TAY) System of Care Updates

The TAY System of Care had several equity-related highlights in FY 22-23 in several areas.

Recruitment/Hiring/Retention Practices:
In conjunction with JEDI's ongoing work with DPH-Human Resources, TAY has begun using updated equity-related questions during interviews. These questions not only explore the level of knowledge a candidate has but can also serve as a means of exploring the degree of one's lived experience with the communities in which that position may serve with the most impact. In related developments, TAY has hired 4-5 new civil service staff who identify as Black/AA or Latina/e. Furthermore, two Black/AA identifying staff were promoted into Senior Behavioral Health Clinician positions.

Staff and Leadership Development
The Director of TAY SOC, Kali Cheung, took the lead in facilitating, participating and planning for the first iteration of BHS' Asian Affinity Group. This entailed crafting agendas, finding/sharing relevant literature on the Asian American experience, in and beyond the realm of behavioral health and fostering an environment where intimate and complex conversations could be held safely.

TAY undertook the effort to redesign a reporting tool and launch an initial pilot to capture missing staff demographics data across the continuum of TAY programs. This was done to track the diversity and representation of the communities being served.

The TAY civil service clinic is part of a culturally congruent for Black/AA services launch. Clinic staff were hired in this fiscal year and participated in the ongoing development of a Black/AA workgroup.

Finally, TAY leadership has actively participated at monthly REAC meetings.

Substance Use Disorders (SUD) Updates

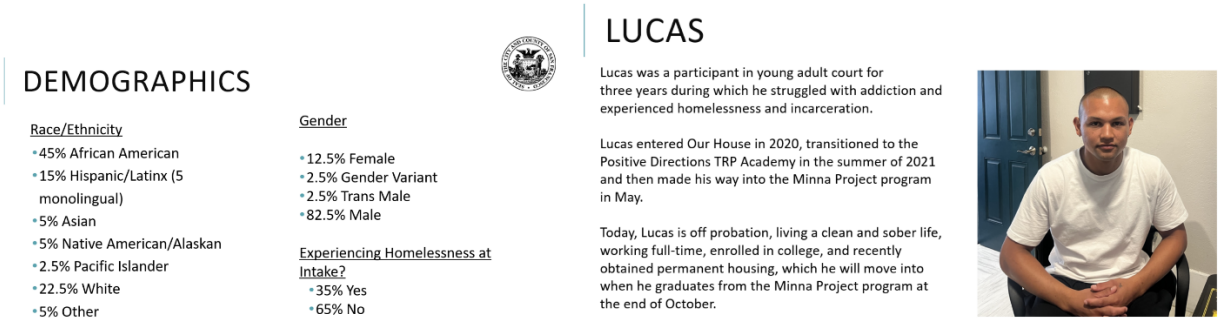
SoMa RISE Equity A3

In response to CalAIM goals, SUD is in the process of developing a health plan enrollment equity A3. When stratifying the SoMa RISE population by insurance status (i.e. uninsured vs insured) by different demographic categories, such as race and ethnicity, sexual orientation and gender identity, and homelessness status, there was no discernable disparity between groups. However, in another CalAIM CS Eligibility A3, we found that there is a disparity in patient zip code addresses across all SFHN Community Supports as 1% of uninsured clients versus 8% of insured clients live in Nob Hill, 28% of uninsured clients versus 24% of insured clients live in the Tenderloin, and 38% of uninsured clients versus 25% of insured clients live in the Mission District. Districts like the Tenderloin and Mission are majority Black/AA and Hispanic populations while Nob Hill is majority white, revealing how uninsured CS clients are more likely than insured CS clients to be from majority Black/AA and Hispanic populations and low-income neighborhoods. As of current, the SoMa RISE A3 has not proposed any countermeasures meant to specifically address insurance disparities based on certain demographic groups. However, SoMa RISE serves many underrepresented populations that would greatly benefit from efforts meant to expand Medi-Cal enrollment and preventative healthcare access (the charts below provide the demographic data of SoMa RISE patients in 2023) . This presents a potential opportunity enroll historically marginalized clients in SF managed Medi-Cal, thus transitioning the cost of services from the General Fund to SF MCP reimbursements, improving access to preventative healthcare services, and increasing Medi-Cal revenue for SF Health Network (SFHN).

Enhancing Spanish Language Competency

Minna Project:

This transitional housing program was funded under Prop C. It specifically serves clients who have dual with criminal justice history, i.e. all or most have current CJS involvement. The program has 75 beds, and typically operates at 90% capacity. In the first three months of operation from June - Oct 2022, approximately 15% of residents were Spanish-only speakers, some without citizenship. This enrollment continued through 2023, with many having achieved permanent housing (as of October 2022).



SoMa RISE:

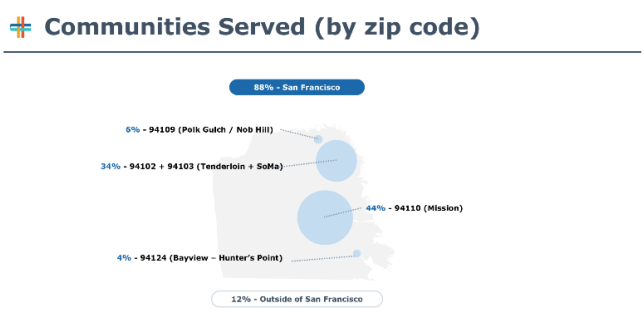
As reported in our 1-year pilot summary (released Oct 2023), SoMa RISE has many Spanish speaking staff (on multiple shifts) to meet documented needs, and the Program Manager (available 40hrs/week) is bilingual bi-cultural. The request for Spanish-only services was lower than anticipated, but participation by Spanish identified participants was comparable to MHSF identified constituents. 40% of participants to SoMa RISE came from the Mission district (as of October 2023).

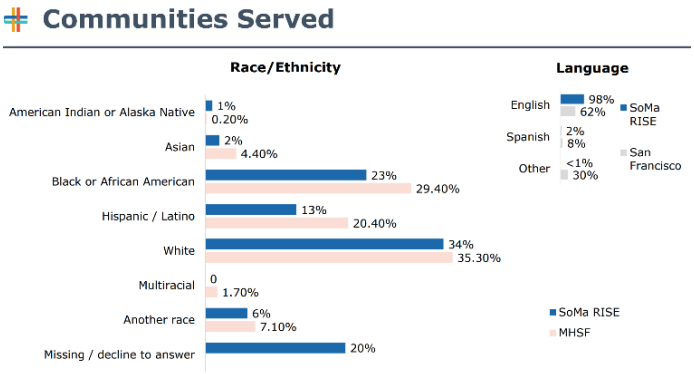
Out of County SUD programs (new)

two new programs have been added to SUD continuum, both are Spanish language competent.
Cronin House: 2 contracted SUD Dual Dx Beds. (Nov 2023) Spanish language competent. Both director and manager are bilingual-bicultural.
Center Point: 10 contracted SUD Dual Dx beds. (Jan 2024)Spanish language competent. Accepts criminal justice and jail referrals.

Proposed Dual Diagnosis RFP language (currently under contracts review, March 2024)

The project contractor will be responsible for hiring a staff that is fully capable of providing sensitive, responsive, and culturally competent services to all clients who avail themselves of facility services, including clients from diverse ethnic, cultural, linguistic, gender, age, sexual,





and socio-economic backgrounds. The contract will ensure that all services are in alignment with the DPH Culturally and Linguistically Appropriate Services (CLAS) standards while availing itself of cultural and linguistic competency trainings for staff. Direct client contact staff will be expected to mirror the diverse characteristics of the facility population to the extent possible, including with regards to ethnicity and bilingual capacity, including Spanish.

Towards Equity Within

While measures like expanded language access for clients reflects an outward projection of ensuring equity, the reality is that a tremendous amount of internal equity work is needed to not only improve the BHS members experience but also the workplace experiences for the staff. These are inextricably linked, strengthening the potential of every facet of BHS

programming and services. This is best reflected in the BHS Equity Workplan and the BHS Racial Equity Action Plan which were developed.

Many of the Equity Workplan goals are still works in progress and have in fact been incorporated into the Racial Equity Action Plan. Others have been sidelined due to capacity and budget issues. Regardless, so far these goals have collectively pushed equity to the forefront of BHS leadership's priorities. The next section will introduce the Action Plan and the path forward.

BHS Racial Equity Action Plan Priorities

In the first month of 2021, JEDI began the initial phase of operationalizing racial equity. Phase 1 was comprised of the following:

- 360 Degree Anti-Racist Leadership Reviews
- Racial Equity Champions Affinity Groups and Racial Equity Empowerment Committee
- Staff Wellness Retreats
- Training, Equity Learning Requirement, and Internship Program
- Recruitment, Hiring Offers, Salary Gaps, and Exit Interviews
- Culturally Congruent Behavioral Health Approaches
- Community Engagement

The **Anti-Racist Leadership Reviews** will increase staff engagement to enforce greater management accountability to reduce racial bias that results in inequitable disciplinary actions. This will entail mangers participating in anti-racist training and JEDI partnering with HR to fund consulting support.

Fall 2019 saw the launching of the **Racial Equity Champions Program** (REC), in which staff who applied and were accepted into the program would dedicate a certain percentage of the work time (4 hours/month) to get educated on racial equity and work independently or with JEDI to develop equity goals to improve the system. After a year of this, program completion would lead the Champions to graduate into the Equity Fellows Program, where they would be trained to become trainers, leading monthly Racial Affinity Groups and their own trainings. This would entail a 6-10-hour commitment per month. Most of the REC Champions were forced to pause their efforts due to COVID-19 response work, but as those deployments end, JEDI is rededicating efforts to bring them back into the fold and have them continue with their equity learning.

As mentioned in the earlier section on the Training Unit, **training and equity learning** are major priorities for building capacity within the BHS staff. Racial equity training has been made a requirement of the Performance Plan and Appraisal Report (PPAR) for each employee. There will also be a push for more professional development opportunities for Black/AA, Indigenous,

People of Color (BIPOC) front line workers, in addition to more stipends that prioritize candidates from those communities.

Staff Wellness retreats will also make a return to reduce work-related stress amongst staff and foster better relations and communication within. Much of this will involve incorporating trauma-informed and equity frameworks. After a vacancy of over a year, JEDI recently hired a full-time Staff Wellness Coordinator to facilitate these actions.

In the areas of **recruitment, hiring and salaries,** JEDI has gotten more involved by providing guidance and oversight on HR processes. It will further analyze salary gaps among staff within the same classification to ultimately reduce them. Other work will involve pushing for Black/AA Hiring Waivers, examine disciplinary policies, and conduct/tract exit interviews for departing staff.

The **adoption of more culturally congruent BH approaches** will naturally involve further **community engagement**. This means using the aforementioned changes in recruitment and hiring to expand the currently deficient number of Black/AA and Latina/e clinicians to meet the needs of those communities. Also key is the development of wellness-oriented manualized curriculum for BH providers that emphasize historical trauma and anti-racist frameworks to build capacity. It will be community feedback that guides all these measures and more. Whether it is through MHSA's CPP meetings, the Cultural Competence Task Force, comprised of representatives from CBO and internal BHS providers, or other platforms, the voices of clients and other stakeholders will be pivotal to guiding JEDI and BHS policy. As such, next steps involve JEDI, BHS Leadership and MHSA collaborating to formalize a system-wide community engagement process.

Racial Equity A3

The 2023 BHS Racial Equity A3 on the next page was created to better visualize the racial equity issues facing BHS, the reasons behind them, and the goals and measurables to address them, with next steps needed to be taken. This is submitted annually to the DPH Office of Health Equity for review and feedback. As conditions within BHS and out in the community evolve, so too does the document. The nature of the A3 is such that new issues become easier to identify (as well as the underlying problems), and the new approaches to address them can be inserted or removed according to what the current conditions demand.

San Francisco Health Network
Behavioral Health Services

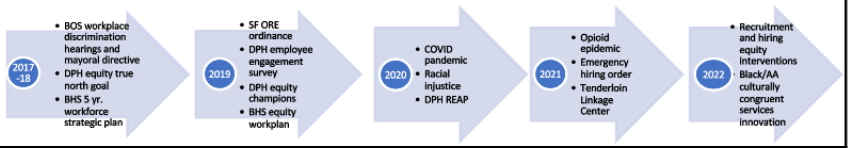
Title: Behavioral Health Services 2023 Racial Equity A3 **DRAFT**

Owners: Jessica Brown, Alicia St. Andrews, Michael Rojas, Sharon Lu

Ver: 2	Date: 2/23/23, Alicia St. Andrews

Background:

Since 2017, equity has been a True North goal of both DPH and BHS. BHS defines health equity as an outcome where everyone has a fair and just opportunity to be as healthy as possible. Those with the greatest needs and fewest resources require more effort to equalize opportunities.



Current Conditions:

1) In the 2019 Employee Engagement Survey, 55% of BHS respondents stated that their dept. is taking active steps to improve racial equity. Only 40% of B/AA staff agreed, the lowest for all races.
2) In the 2019 Employee Survey, 75% of BHS respondents stated that managers in their dept. treat staff from all racial/ethnic groups with respect. Only 65% of B/AA staff agreed, the lowest for all races.
3) Our workforce does not reflect our clients served nor those with the greatest health inequities. Only 10% of clinicians are B/AA, and 0% of 2021-22 newly hired directors were Black/AA, compared to 20% Black/AA client penetration rates.
4) The opioid overdoes epidemic exemplifies racial inequities in SF with Black/AAs experiencing 5 times more deaths.

Problem: Although extensive efforts have been made to reduce racial inequities in the workplace and community, more system wide strategies and coordination is necessary to improve outcomes.

Goal: Racial equity is everyone's job. Focusing efforts and resources on those with the greatest inequities results in the greatest improvements for all.

Selected Metrics	***Baseline***	***Target***	***Target***
% Black/AA directors (baseline, new hires)	27%, 0% (2021-22)	30%, 10%	Q4 2023
% Black/AA Clinicians (baseline , new hires)	10%, 13% (2021-22)	15%, 20%	Q4 2023
% Surveyed employees that respond affirmatively that their department is actively improving racial equity	61% (2020)	10%	Q4 2023
% Surveyed Black/AA employees that respond affirmatively that their department is actively improving racial equity	49% (2020)	10%	Q4 2023
# Racial equity focused PIPS for MH and SUD	0	3	Q4 2023
# Black/AA clients receiving culturally congruent services	0	TBD	Q42023

Analysis:

A) Recruitment and hiring: High stress, high burnout, toxic work environments, and delayed and inequitable hiring leads to challenges recruiting, hiring, and retaining staff.

B) Work culture: Lack of coordinated strategies, policies, communication, and engagement, lead to dismembered efforts towards culture change.

C) Health inequities: Lack of culturally congruent services and providers sets us up to fail the communities experiencing the greatest health inequities.

Countermeasures

Barriers	*Countermeasure*	*Description*	*Impact*	*Effort*
A	1. Recruitment and hiring equity interventions.	Develop, implement, and improve equity interventions.	H	H
B	2. Staff engagement and communications	Develop and communicate opportunities for staff to participate in racial equity strategies.	M	M
B, A	3. Manager accountability	Facilitate anti-racist training, assessment, and coaching for directors and managers in coordination with implementation of equity interventions.	H	H
C	4. Equity focused PIPs for mental health and SUD	Collaborate with Quality Management to prioritize the development of racial equity focused PIPs across systems.	H	M
C	5. Culturally congruent services	Develop, implement, promote, and improve culturally congruent services.	H	H

Implementation Plan

Counter-measures	*Activities*	*Measures*	*Owners*	*Start*
1	-Lived experience rating pilot training -Updated recruitment and hiring procedures	-# Hiring manager and HR analysts -New hire demographics	HR, Ops, JEDI	2/23
2	-Employee engagement survey -Staff wellness retreats -Racial equity training plan -Racial/ethnic/cultural affinity/accountability - groups -Racial Equity Action Council (REAC) -Racial equity exec -Community advisory council -BH commission	-% Equity question response rates -# Retreats -# Trainings and participant demographics -# groups -# members and demographics -Racial equity focused agendas and actions -# Equity trainings and strategies -# Commissioners and demographics	JEDI, Exec, BH Commission, MHSA	2/23
3	-Anti-racist strategic planning -Anti-racist 360 leadership reviews, coaching, and action plans	-Strategic plan -# Director/manager reviews and action plans	Exec, JEDI, consultants	4/23
4	-QM PIP team meetings with MH and SUD	-# Racial equity PIPs	QM, JEDI, SOCs	4/23
5	-Black/AA culturally congruent services -Cultural heritage month acknowledgements with culturally congruent services overviews, updates, and staff shout outs for Black/AA, Native Am, Latinx, Asian, Pacific Islander, and LGBTQ+	-# Staff, curriculum, # outreach/ healing circles, evaluation tool -# Acknowledgements with services, reports, and staff shout outs	Clinic directors, JEDI, REAC	2/23

Follow-Up: *How will you assure ongoing PDSA?*

Equity Exec, REAC, Affinity/Accountability Groups

Final Takeaways

San Francisco Behavioral Health Services, led by the JEDI team, continues to ramp up the efforts to address equity both internally amongst the workforce and externally for the diverse communities that rely on its services. Through developing the tools and capacity needed to address disparities faced among BHS members, along with cultivating an internal workplace culture of accountability, JEDI is spearheading organizational innovations that will improve the experience for everyone in the greater BHS network.

For more information, please contact Director of JEDI, Jessica Brown, Jessica.n.brown@sfdph.org.