ATTACHMENT III

CITY OF HAYWARD
HEART OF THE BAY

City of Hayward Communications Center

HEART Program Data Analysis Recommendations Report

August 30, 2022

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"Unleashing the Power of Technology"
Federal Engineering®

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Executive Summary

Federal Engineering, Inc. (***FE***) is pleased to provide the City of Hayward with this *HEART Program Data Analysis Recommendations Report*. To prepare this report, ***FE*** conducted in-person and virtual interviews with stakeholders to obtain an understanding of the workflow and relationships between and within agencies. Following the initial interviews, ***FE*** recognized that a collaborative session involving all stakeholders would help to further understand the complexities of the Hayward Evaluation and Response Team (HEART) and the other components involved in the continuum care for Hayward's vulnerable citizens. More importantly, ***FE*** realized that a workshop would provide the first opportunity for *all* stakeholders to gather together to share, collaborate, and build capacity for future development of knowledge, evidence, and process to support the HEART program goals.

On June 21st an in-person and virtual workshop was held at the Hayward Public Library. The session began with a discussion to identify and confirm the goals of the program. Leadership articulated the key performance indicators (KPIs) required to measure HEART's success.

The ***FE*** Team facilitated a Business Process Analysis for the Mobile Evaluation Team (HMET) and Mobile Integrated Health Unit (MIHU) to walk the group through the step-by-step processes currently in place. Each segment of the call for service was described in detail starting with how an initial request is received, to the response, the actions taken, the report, the data entry, the data mining capability and finally, the current opportunities for program review and improvement. The analysis was intended to launch in-depth discussions around the identified gaps in process and data, and possible solutions to those challenges. ***FE*'s** subject matter experts (SMEs), then analyzed the information gleaned from the session and applied their collective experience and knowledge to provide recommendations and strategies for the HEART program to move forward to best achieve their goal of improving access to mental health support services and diverting police officers from social disorder calls for service.

1. Introduction

1.1 Background

In November 2021, ***Federal Engineering, Inc (FE)*** was contracted to provide the City of Hayward (the City) with professional consulting services to conduct a needs assessment and strategic planning effort for the Hayward Communications Center (HCC).

Phase 1 of the project was the Operational Assessment of the HCC, and Phase 2 was to provide recommendations and strategies to support the Hayward Evaluation and Response Team (HEART) Program.

1.2 Methodology

The initial assessment and analysis of the HEART Program involved in-person and virtual interviews with stakeholders to obtain a thorough understanding of the intricacies of the workflow and relationships between and within agencies. The objective of this effort was to identify opportunities for improvement, develop a future vision for solutions, and provide recommendations to support the program.

An excellent behavioral health crisis system is an essential community service very similar to police, fire, and EMS. It is an organized set of structures, processes and services that are in place to meet all types of urgent and emergent behavioral health crisis needs.

The Policy Innovations Workshop revealed citizens have an expressed desire for a highly effective behavioral health crisis response system to meet the needs of its population, just as it expects other essential community services. Knowing this, ***FE*** recognized that in order to make appropriate recommendations, it was necessary to conduct a workshop with all stakeholders, to effectively understand the HEART program including the other components of the Hayward behavioral health continuum of care. The City of Hayward accepted this request and set forth to organize and plan for the Data Workshop.

From the beginning, ***FE*** recognized that this workshop would first and foremost provide an opportunity for frontline personnel and leadership to come together to share, collaborate and build capacity for future development of knowledge, evidence, and process to support the HEART Program and HCC.

The stated purpose of the workshop was to build collective capacity to produce an improved understanding of the data required to support a collaborative risk-mitigation

process; and to facilitate a working linkage between the actual practitioners engaged in efforts to improve service to the vulnerable persons. A clear benefit of hosting such a workshop is the opportunity to involve key stakeholders and supporters of the program in this dialogue.

The topics explored in the event included a business process analysis, opportunities to overcome challenges in measurement, improve/strengthen the relationship between stakeholders, create performance indicators for HEART, and identify new methods for valid and reliable outcome measurements of the program.

The format of the workshop was largely discussion-focused, with ***FE*** facilitating the conversation. Each agency or program lead was asked to present an overview of their role and their primary challenges and goals. Following this, a thorough business process analysis of the Mobile Evaluation Team (HMET) and Mobile Integrated Health Unit (MIHU) was conducted to understand the service requests from start to finish. This included steps and process for:

- How a request for service is initiated
- The response
- Triage/assessment/treatment/referral
- How follow-up is conducted
- The documentation process for each team
- The type of data collected, provided, and analyzed, the systems used to collect it, and who has access to it
- Reporting

Finally, the stakeholders were invited to discuss the insights, perspectives and challenges of the data and programs. Most importantly, the emerging theme was that stakeholders realized early in the workshop that they had never before been at the table together to fully discuss and understand the work that each of their respective programs were carrying out. This not only provided a good opportunity for questions and responses but provided a healthy dialogue that sparked possible future solutions.

2. Hayward Behavioral Response Model

2.1 Hayward Evaluation and Response Team (HEART)

The City of Hayward has implemented a pilot project as a response to recommendations made by the City's Policy Innovations Workshop. The *Hayward Evaluation and Response Teams (HEART) Program* is a diversion program with the goal of improving access to medical, mental health and other support services, as well as reducing the need for police officers to intervene in calls for service involving people experiencing mental illness, substance-use disorders, as well as the unhoused.

It is also intended to ensure that the Hayward Police and Fire Departments are working to establish an integrated continuum of options allowing for the most appropriate responses to calls to the Hayward 9-1-1 Emergency Communications Center (HCC). The current program mandate is to demonstrate reduced police violence or escalation in mental health calls by deploying two different mobile response teams, the Mobile Evaluation Team (HMET) and the Mobile Integrated Health Unit (MIHU).

2.2 HCC Involvement in the Continuum of Care

There are currently two different processes for 9-1-1 response to behavioral health events:

- Medical calls transferred to the Alameda County Regional Emergency Communications Center (ACRECC) from HCC that utilize Community Assessment and Transport Team (CATT)
- Police calls identified as 'psych calls' that dispatch the Hayward Police Department (HPD) either with or without EMS transport of '5150' calls

2.3 Components of the Continuum of Care

2.3.1 Community Assessment and Transport Team (CATT)

Medical 9-1-1 calls down-streamed to ACRECC can utilize the Community Assessment and Transport Team (CATT) deployed by Alameda County Behavioral Health and Falck Ambulance. CATT partners a mental health professional and a paramedic to respond to non-violent psychological emergency calls for service and provides mental health assessment, crisis intervention, medical assessment, information, referral, and transportation to a variety of voluntary settings. If the nature of the call is behavioral health or substance abuse related, and meets the criteria for CATT, a CATT unit can be

requested by the officers or paramedics at the scene. CATT requires police to be on scene to determine if the scene is safe and the subject is cooperative. CATT is dispatched by ACRECC and is available seven days a week from 7 AM to 11 PM. CATT is not accessible directly by the public.

2.3.2 9-1-1 Calls for Psychological Incidents (Psych Call)

The HCC currently utilizes an informal process intended to intercept 'psychological' calls for service to ensure an HPD unit is dispatched. The intent is to have HPD attend first to declare the scene 'safe' and to determine if EMS is required for a mental health warrant (5150). This process is heavily reliant on the caller to self-disclose the nature of the call. HCC staff are not provided with policy, training, or process to interrogate callers to glean specific information that would indicate the call is appropriate for this type of response. Additionally, there is no specific procedure to dispatch the HMET team. HCC staff will notify the team by radio or phone if they 'feel' the call is appropriate and if they note HMET is available for service.

The following describes the typical psychological call triage process:

- When EMS is requested the HCC call-taker will verify the location of the emergency and enter "Medical" in the Computer Aided Dispatch (CAD) narrative/notes.
- The call-taker will then obtain further details such as nature of the medical call, patient's age, sex, and COVID screening questions. If EMD instructions are required, the call-taker will enter this information into CAD and ask the caller to stay on the line while they transfer them to ACRECC.
- When the caller indicates the medical call nature is for a "psych" (psychological) call, the call-taker will interrogate further to determine additional resources. The call is not transferred to ACRECC.
- A psych call will get police response first - the call will be entered and dropped into the Comm 1 Comms Operator CAD for dispatch. Police will respond first to determine if the patient is "5150" and if they qualify for EMS response. If they do, HCC will contact ACRECC and request an ambulance 'Code 2 5150' to the location of the incident.
- The status of the ambulance arrival is relayed from the HPD officer on scene to the 'Comm1' Operator and is updated in CAD.
- Once the call is complete, the officer will mark themselves back in service on their mobile data terminal (MDT) and the call will transfer out of CAD.

2.3.3 Hayward Mobile Evaluation Team (HMET) Overview

Launched in June of 2021, the Hayward Mobile Evaluation Team (HMET), pairs a mental health and negotiation trained Hayward Police Officer (District Command) with a behavioral health clinician from Alameda County Behavioral Health Care Services (ACBHCS). HMET is designed to respond to any call suspected of involving a crisis situation to provide on-scene crisis intervention and referral. HMET assistance is requested by Dispatch or Patrol via radio. HMET is operational 40 hours a week, Monday through Friday, during business hours only, and the team is not available for call-out. However, the Sergeant in charge of the unit, although not on call outside of business hours, is frequently contacted for support and assistance for HMET calls outside of the program operating hours.

There are two possible scenarios for data collection and documentation that can occur for HMET calls:

Scenario 1:

- Data collection and documentation is completed by both ACBHCS and HMET.
- For each call, the ACBHCS clinician enters incident information (whether in the initial contact with a client or in a follow up call) into the Alameda County Health database. These clinical records are generated in the City's Youth and Family Services Bureau (YFSB) Salesforce database for clinical record keeping.
- The responding HMET officer will complete their routine police report and documentation using CAD.
- HMET will complete a supplemental report for the Investigating Officer for any incidents that involves crimes or require an arrest report.

Scenario 2:

- If the incident is behavioral in nature only, and no police support is required, only ACBHCS creates a report as per the process in Scenario 1.
- HMET does not complete any documentation of their response or assessment of the call. There is no report entered into the HPD Records Management System (RMS), only the CAD chronology exists as HPD documentation. The number of calls responded to by HMET can be obtained by running the CAD Unit History on District Command 33 (Unit Designator).

2.3.4 Mobile Integrated Health Unit (MIHU) Overview

Launched in January of 2022, the Mobile Integrated Health Unit (MIHU) pairs a Hayward Fire Department paramedic with a mental health clinician. The Mental Health Clinician currently splits their time between the MIHU role and the Behavioral Health Program Coordinator position. The Behavioral Health Coordinator assists the Program Administrator with data, organizing the team, capacity building, and assisting clients with navigating systems to connect them with the appropriate resources to address their needs.

MIHU is never dispatched directly from HCC; their current mandate is pre and post crisis response. MIHU's pre-crisis intelligence led response, (responding to locations known to have a high number of social disorders calls for service) enables the team to proactively connect with high users of service to build relationships and attempt to connect the person with appropriate services to decrease the likelihood of that person ending up in a crisis situation.

Post-crisis response comes from referrals for service made by HFD units following the primary response. These referrals are created via the HFD Records Management System (ESO) where call response reports are completed and stored. These follow up referrals from HFD often result from repeat calls for service or recognition that a subject requires assistance with system navigation to obtain support and services appropriate to their circumstances. Once the referral is received, MIHU will connect with the subject to assess, provide medical services, educate, and/or connect to appropriate services. MIHU is operational 20 hours per week, during business hours only. Currently, oversight of this program is assigned to one HFD employee who works 20 hours on his days off, outside of his regularly scheduled rotation as a firefighter paramedic to both develop the program and respond as the MIHU provider.

MIHU data is documented by both the attending paramedic and the clinician, but each uses their own separate process and system.

MIHU Paramedic

- MIHU initiates the call by contacting HCC by phone or radio to request a 'Call for Service' be created in CAD. Once the call is completed, the MIHU paramedic completes a report via ESO which captures the information for Electronic Health Record (EHR) purposes. The paramedic is entering data in a way that will enable data mining of specific, MIHU calls for service.

Mental Health Clinician

- The MIHU team clinician uses a Microsoft form to enter call response and client information. The Microsoft forms remain within the unit as their 'shift notes' that contain the narrative of their interactions. This form was developed to report on program outcomes without identifying the subject of the interaction. The information reported in ESO is cross-referenced to the Microsoft form by the unique incident number created by HCC Dispatch. By cross referencing the two forms, specific client information can be obtained if necessary.

2.3.5 HMET Business Process

HMET is dispatched to crisis situations in progress via HCC. The team also monitors the radio and self-dispatches to appropriate events. There is no criteria or specific call type that triggers HCC to dispatch them, the team responds to any call type involving a crisis situation. HMET never attends a dispatched call without backup, including 5150 calls, unless it's located in a care home. There needs to be absolute minimal risk before they attend the scene on their own.

Following is the step-by-step process for call response, triage, treatment/action and documentation and reporting:

- Once the scene is cleared by the frontline patrol unit, the District Command Officer and clinician will make contact with the individual in crisis,
- The team will build rapport, de-escalate, and then determine risk and treatment or action.
- If subject does not meet 5150 criteria, they are referred to other services. HMET has developed extensive contacts and knowledge of resources for mental health and substance abuse. They are skilled at navigating the complex systems that exist within the City of Hayward to connect the person with the appropriate resources and attempt to reduce the need for future police response.
- HMET officers do not create an HPD report in the HPD Records Management Systems (RMS) for behavioral health calls, therefore there are no details regarding call response, action taken, or outcomes on the police side. The team uses a clearing code (HMET5150) to track data in CAD.
- If an incident is larger and there is crime involved, HMET will provide a supplemental report to the investigating officer for his report. HMET will never complete the arrest or primary report.

- The CAD chronology is generic and will only contain location, reporter, and transport information. However, CAD can pull the number of calls for service for DC33 utilizing the HMET5150 code.
- Additionally, the use of force from Commander's Watch report and Internal Affairs have been used anecdotally to report on measures of success of the program, by comparing historical statistics with current state. There has been a dramatic decrease in use of force instances since the team was deployed.
- An incident report is completed by the ACBH Clinician for all incidents. Specific details are documented in Salesforce reporting software and 'tell the story' of what occurred at the scene, the referrals provided, the outcome and any follow-up actions that are necessary.

Additionally, Internal HPD units utilize email or the 'Access Hayward' CRM to communicate with HMET about situations when the team was required but were off duty and not available to respond. This assists greatly with tracking the need for program hours expansion, incident types and support that could have been provided by HMET.

The HMET team meets regularly with stakeholders to educate, discuss data, and make improvements to the program.

2.3.6 MIHU Business Process

MIHU is not dispatched by HCC at this time. When MIHU was initially implemented they were conducting pre-crisis response while they created the post-crisis response process. Pre-crisis is no longer the focus, as the referral process through ESO is now operational and the primary response methodology.

Following is the step-by-step process for call response, triage, treatment/action and documentation and reporting:

- MIHU is referred by HFD personnel via ESO following an EMS or Fire response to a call for service. Patients are referred through a custom tab created with a form and recommendations in ESO. Additionally, the Behavioral Health Coordinator may take direct referrals for MIHU from HMET or HPD on occasion.
- MIHU currently responds to homelessness, substance abuse, and mental health referral calls for service.
- Once the referral is deemed appropriate, MIHU contacts HCC to create a call for service.
- HCC uses the CAD type 'MEDICAL' and dispatches MIHU as Medic1.

- MIHU will connect with the subject, build a rapport, and offer support, either medical or behavioral health, and/or connect to other appropriate services.
- MIHU will either conclude the call outright with the appropriate treatment or referral to another agency or will follow up with a phone call.
- All notes are documented in ESO by the attending MIHU paramedic, and in Microsoft Forms by the attending Mental Health Clinician.
- ESO tracks the medical aspect of the response. The Microsoft Forms sheet tracks additional demographics and the success metrics.
- The incident number assigned in CAD by HCC connects the CAD call and the Microsoft Form so that both can be utilized for further data analysis.

3. Workshop Findings

3.1 Overview

FE's initial understanding from leadership was that the ultimate goal for the HEART Program was diversion at the HCC level. The goal was to have HCC obtain information and triage calls to determine risk with the necessary tools to make the decision as to whether or not a call is appropriate for HMET or MIHU response.

"*Connecting the right team to the right service…" **FE's*** task, as understood, was to ensure that HCC had the necessary staffing and the tools to assess risk to send the appropriate HEART team first instance.

There is a national movement calling for alternative responses to traditional police response, largely correlated to the 'de-fund' the police initiative. Dispatching police first to calls that may not require it is very expensive and possibly traumatic to persons requiring behavioral health response. Additionally, sending police to calls where they are not required carries significant societal costs. When frontline police responders are stretched thin by low-acuity 9-1-1 calls, there is less capacity to respond to high priority, life threatening calls in a timely manner.

Also, when police spend their days racing between calls, officers have few opportunities to proactively build relationships and gather intelligence from community members. Quite simply, sending law enforcement is not the best response to resolve certain types of calls for service. The police, for instance, are regularly required to respond to people with mental health or substance use disorders. Yet officers are not hired for their skill in managing *complex* behavioral health needs, nor do they have the necessary training or resources to do so effectively or safely.

Traditional police response does not have the options or resources to provide the necessary quality of service, therefore police response can create negative outcomes for people with chronic or acute behavioral health conditions. Often, the only option for police response is arrest and custody, which can exacerbate the medical needs of a person.

Additionally, police officers may unintentionally escalate a situation, simply by showing up on the scene. The simple presence of a police officer can be triggering for people with behavioral health disorders, as these individuals are more likely to have experienced negative or traumatic contacts with the justice system. Police may not understand how a particular disability manifests and may assume that an individual's reaction—or lack of reaction—to law enforcement is a show of defiance. Historically, the nation has seen many of these calls for service result in unnecessary fatalities.

3.2 Incident Evaluation

Although currently operational, no formalized policy or process has been developed for HCC to identify, categorize, triage or dispatch calls that are appropriate for HMET or MIHU, or EMS response. There is currently an 'informal' HCC process intended to intercept 'psychological' calls for service to ensure an HPD patrol unit is initially dispatched (ideally a unit with an officer trained in Crisis Intervention).

HPD must attend first to declare the scene 'safe' and to determine if EMS is required for a mental health warrant transport (5150). This process is very reliant on the caller to self-disclose the nature of the call. HCC staff are not provided with training or process to interrogate callers to glean specific information that would indicate the call is 'psychological' in nature.

The stated goal of the HEART Program is to 'create an integrated continuum of options allowing the right team or resource to respond to the right call for service, improving access to medical, mental health and other support services and reducing the need for police officers to intervene in calls for service involving people experiencing mental illness, substance abuse and homelessness'.

The focus thus far has been on improving access to mental health and support services, and there is ample data to support that HMET has been successful in delivering this objective. MIHU is still figuring out where it fits into the continuum, yet still has excellent examples of success in connecting clients to appropriate resources. The goal 'to reduce the need for police officers to intervene in social disorder calls', has not yet been achieved. In fact, the current process of dispatching patrol and HMET together is a duplication of services, as HMET waits at the scene for patrol to first declare the scene safe before they take over.

3.2.1 Other Workshop Observations

Discussions during the workshop revealed that HMET is satisfied with the current system of outcome reporting and there is no intent or desire to change their current response methodology. Their current process is delivering positive outcomes and they have formalized a place within the crisis continuum that is working well with the frontline. Although they are not truly diverting at the dispatch point, they are frequently freeing up resources at the scene and preventing future crisis situations requiring police response.

MIHU is currently still trying to determine where exactly they fit into the crisis continuum. Still in its infancy stage, MIHU is exploring the possibility of 'first instance' dispatch by HCC to appropriate calls for service (Dispatch Diversion). MIHU has worked tirelessly to determine the capabilities of ESO to aid in the outcome reporting required for the program.

They have successfully developed the referral process for post-crisis response and are able to report on raw numbers of referrals and responses via ESO and CAD. The Microsoft form they developed provides the narrative of the incidents which can be connected to CAD via incident number.

3.3 HEART Program Challenges

Prior to the workshop, there were three challenges identified by leadership that needed to be addressed for the success of the HEART Program. The three repeated themes were:

3.3.1.1 Data

- How to either utilize CAD and RMS (change/add/create necessary CAD and disposition codes) to glean data to support and report on the outcomes of the HEART program
- How to develop a ‘dashboard’ to aggregate the data pulled from the various systems to appropriately report on the HEART Program outcomes

3.3.1.2 Process

- How to develop/adopt an agreed upon call-taking process to dispatch the HEART Program with an acceptable level of risk

3.3.1.3 Staffing

- The concern that HCC did not have the necessary staffing complement to take on a new process to dispatch the HEART Program safely and effectively

3.4 HEART Gap Analysis

MIHU and HMET have been operating separately. HMET has already established a deep connection with community resources and MIHU would benefit greatly from direct collaboration between the teams on a weekly basis The most successful alternative response programs arise from ‘systems’ based as opposed to ‘siloed’ delivery.

HMET and MIHU currently have disparate systems. There needs to be a method to effectively share and aggregate the data so that it can be synergistically reported.

There is currently no centralized repository for information for HEART stakeholders or the public to access vetted call information and data.

Currently, MIHU consists of one paramedic and one clinician. The paramedic dedicates 20 hours to MIHU weekly, these hours are on top of a regular 48-hour shift. The clinician splits time between the Behavioral Health Coordinator role and the operational MIHU behavioral clinician role (20 hours each position). Their capacity to respond to calls is very limited at this time. They are significantly taxed with the post-crisis referrals they are receiving via ESO. The dual role, required by the Behavioral health Coordinator, especially with the temporary absence of the (Youth and Family Services Bureau) Counseling Supervisor's absence, is challenging.

Currently the ESO and Microsoft Forms reporting methods are a work-around and are limited in their ability to accurately depict program impact, objectively or subjectively. MIHU needs to identify exactly what their role is before they can determine reporting requirements. Currently MIHU is responding exclusively to post-crisis events and the current CAD codes and disposition codes are sufficient as data pulled from MS Forms and ESO provide raw information on basic numbers of incidents and incident type.

3.5 HCC Gap Analysis

The capacity to take on new process to support HEART is limited in the HCC. However, there is no immediate process change identified that HCC needs to prepare for. As HEART establishes their role in the community, HCC needs to have a seat at the table for buy-in and to ensure the change management process is successful. HCC must be included in the conversation and the decision-making process so that there is mutual understanding, training considerations, and input when creating policy. Specific process with detailed steps and clear HCC direction is required when policy is implemented.

3.6 IT Gap Analysis

IT has worked closely with HMET to create new disposition codes and unit designators in order to mine the data they require to report on their success. This includes, number of calls responded to, response times, narrative, qualitative information, and incident conclusion times.

IT has created a unit designator for MIHU (Medic1) as well. IT will provide resources and support to create further customization if required.

CAD can be utilized to glean specific demographic data if there is a need. The challenge is often not the capability of CAD, but the capacity (time, resources, privacy) to enter the specific information that is valued. Also, whose responsibility is it to obtain and enter this data? If HCC is tasked with this, it will increase times spent on calls significantly. Also, of

concern is the reliance on caller reporting. There is no way to verify the information provided by the caller which means the data obtained may be incorrect or biased.

3.7 Systems Gap Analysis

A comprehensive and holistic approach to the management of the HEART Program will help to identify hidden blind spots and will create the best leverage points for change. Elevated transparency within and between MIHU and HMET with established shared data and governing processes will prevent duplication of services between the two teams. Full collaboration of stakeholders will increase understanding of resources and systems and create synergy. Development of a structure change management and communication strategy regarding decisions and changes in technology, data, process, and policy will ensure collective buy-in and engagement of stakeholders.

4. Recommendations & Strategic Next Steps

4.1.1 Systems Mapping

4.1.1.1 Recommendation 1: FE recommends the two teams work together to determine and formally delineate their roles to ensure efficient service delivery and to prevent duplication of services.

4.1.1.2 Recommendation 2: Identify method for diversion process at HCC call answer and triage point.

MIHU would benefit from identifying which approach to diversion at the point of HCC 9-1-1 call answer and triage is the best fit for their current model. Collaboration between MIHU, HMET, HCC and other important stakeholders to identify the community's existing crisis services would be a good first step to determining which gap is most appropriate for MIHU to fill.

4.1.1.3 Recommendation 3: Complete a systems-mapping exercise to determine HEART, MIHU and HMET program long term approach and integration of HCC and diversion at the point of dispatch.

Completing a systems-mapping exercise to inventory the existing resources and services would help to pinpoint not only how to respond but also what role MIHU should take in the continuum of care. System mapping provides information about the strengths and resources of a community and can help uncover solutions. Once community strengths and resources are inventoried and depicted in a map, one can more easily think about how to build on these assets to address community needs and improve health.

Additionally, asset mapping promotes community involvement, ownership, and empowerment. System, asset, and resource mapping is essentially documenting any aspect of the community that improves the quality of life of its citizens. Assets include both the capacities and abilities of community members and physical structures or buildings.

The map results will help determine new directions for the current programs and/or identify new programs that could be developed in the future to round out the continuum of care. If there is involvement from different community members in constructing the asset map, the process itself can be both an organization and collaboration tool.

It helps to define community boundaries, identify, and involve partners, and to determine what type of assets or partnerships need to be add to the list. Once it is documented, the information can be utilized to understand any gaps in crisis services and what resources are needed to ensure that the selected diversion approach will meet the community's needs.

If the teams are already at capacity, they may not be able to take on calls directly from HCC. HEART needs to decide exactly what type of diversion they are best suited for at this moment, and what long term approach and mandate they can transition to once they are ready to scale up.

4.1.2 Mental Health Specific Call Assessment

4.1.2.1 Recommendation 4: Create policy and procedure, along with training, for HCC staff to triage behavioral health calls in initial call-taking process.

Add specific mental health questions to primary call-taker assessment. The analysis of the initial calls placed to the HCC (9-1-1 and non-emergency) and basic/routine questions asked showed that no mental health analysis is done at the time of the call in general. Developing basic questions could help HCC staff accurately and consistently triage behavioral health calls. This creates the data and process to fully understand the number of mental health calls HCC receives and provide analytics to see patterns of mental health suspicion in repeat callers for two reasons:

- The implementation of the national 9-8-8 number for mental health crises shows potential for possible transfer of low-level mental health crisis calls to 9-8-8. If a non-emergency call is received by dispatch, a method could be developed for the call to be transferred to the 9-8-8 hotline so that a mental health professional could de-escalate the situation. This diversion would eliminate the need for police response. We know that until the public is educated fully on the 9-8-8 options, 9-1-1 will likely continue to receive most mental health crises calls. 9-8-8 presents an opportunity for change that could be utilized by the HCC to aid individuals going through mental health crises.
- Even though Hayward Evaluation and Response Teams are specifically trained to respond to mental health crisis, the current capacity is too low to meet existing needs on a 24/7 basis. Adding these questions would enable data mining to accurately determine the number of calls for service that could be diverted to appropriate alternative response teams.

4.1.3 Diversion of Eligible Calls

4.1.3.1 Recommendation 5: Identify which calls will be eligible for diversion to HMET and/or MIHU response.

Identify which calls will be eligible for diversion. If it is decided that one or both of the HEART units will be diverted at the dispatch point, the specific calls appropriate for diversion need to be determined. Deciding which calls can be effectively rerouted from a law enforcement response can be determined by several factors, including call type, call frequency, and call outcomes.

Once the nature of the calls that are appropriate for response have been determined, HEART, in collaboration with HCC and patrol, needs to develop clear policies and procedures so all law enforcement and HCC staff know what questions to ask to determine which calls to divert and which responders will receive the call (CALL PATHWAY).

4.1.3.2 Recommendation 6: Ensure data inputs and disposition codes accurately reflect behavioral health response.

Data - Collaborate with IT to review call and disposition codes to ensure that information about calls involving behavioral health needs or crises can be captured accurately. It may be necessary to add more disposition codes or specific narratives to identify and account for calls that are diverted to a behavioral health response.

4.1.3.3 Recommendation 7: Implement robust training for HCC staff and clinicians.

Training - There needs to be robust integrated training for HCC staff and clinicians. This training must include specific process to identify a mental health crisis call so that HCC Communications Operators can quickly determine if a call can be resolved by a behavioral health professional. If it cannot, Communications Operators need to know which emergency responders should be called to the scene, whether it is police, fire, emergency medical services, and how to react if situations escalate and enforcement is required at the scene immediately.

4.1.3.4 Recommendation 8: Create and implement a quality assurance and quality improvement process for HEART, HMET and MIHU.

Quality Improvement - Once baseline data is established at the outset, key metrics such as the total number of behavioral health crisis calls, and related outcomes can be established and tracked moving forward. These metrics will be utilized to adjust process, and report on program success. Program managers should work together with frontline staff to establish which data points are important to capture, then meet regularly to review both the diverted calls and non-diverted calls and compare the outcomes from each. This analysis will help to determine if the selected crisis diversion approach is working well and if additional training, resources, or adjustments to policies and procedures are needed for the program to function effectively.

4.1.4 Data Reporting and Sharing

4.1.4.1 Recommendation 9: Implement a Data Analyst position exclusively for the support and success of the HEART program.

Regardless of which system or application Hayward decides to utilize, it is imperative that a Data Analyst is assigned exclusively to the HEART Program. MIHU and HMET team members cannot be expected, nor do they have the capacity or expertise, to enter and analyze data to effectively report on the quantitative and qualitative impact of the program. Further, a Data Analyst plays a key role in reducing the disparate processes, systems, and siloes by having perspective on the need for holistic program data collection, integration, and analyses.

The Data Analyst position, at a minimum, will be responsible for:

- Ensuring workflows from all HEART (HMET, MIHU and any future additional) programs include the collection of program data to a central repository or system for central data aggregation, analysis, and reporting.
- Assisting with implementation of a system (typically a vendor product/program) that allows HMET and MIHU responders seamless and streamlined data entry from calls they respond to and provides a central program and data base that allows the entering and tracking of call information and data from the different programs.
- Assisting with the implementation of a data dashboard to report on program outcomes.

4.1.4.2 Recommendation 10: Create a process for data reporting and sharing to bridge the gap between HMET and MIHU and eliminate siloed services and approaches within the HEART program.

Data reporting and data sharing has been a continued concern for the City of Hayward when reporting on program outcomes. A solution is required to bridge the gap between siloed services and programs aimed at improving their communities through collaboration and data sharing.

Quality measures are required to effectively report on the HEART program. Quality measures should include:

Value Based Measures - These measures report on the program providing timely, safe, accessible, equitable, and effective response to community issues.

Actionable Measures - These measures ensure accountability and address structure, process, and outcomes in alignment with the mission and goals. They ensure continuous improvement of programs.

Collaborative Measures - These measures are developed in collaboration with community stakeholders and align with community needs.

Systemwide Quality Dashboard - Timely and accurate reporting of core quality metrics is a deliverable of all programs that are part of the crisis continuum. These measures are aggregated into a dashboard that is routinely and transparently disseminated to relevant stakeholders.

Quality Improvement (QI) Measures - The programs require the development of a quality assurance/performance plan that is transparent, shared with all stakeholders, includes relevant quality metrics, and aligns with program goals. These quality metrics should demonstrate attention to all aspects of crisis system performance that addresses subjective perspectives of both the community member and the program staff. Structure, process, and outcome measures should be included. Examples include but are not limited to number of crisis calls that are resolved without having to dispatch police; number of HEART Program encounters resolved in the field without EMS or police transport; and number of crisis calls connected to community resources.

Flow Metrics - HEART is responsible for defining quality metrics that reflect expectations for timely care and efficient flow at each level of care in the continuum. In addition to the other metrics, performance should be monitored to include speed of answer; call processing time; response time; and duration of time on-scene.

Community Stabilization - Performance metrics should include referrals to community resources, decrease in repeat calls for service, and long-term stabilization/housing.

Response Plans - Response plans for immediate fluctuations in demand and trends over time. QI processes and plans must monitor and respond to real-time fluctuations and dictate altered response to trends over time.

Improvement Plans - Improvement plans for systemic barriers to flow. HEART should utilize data to identify gaps and collaborate to create solutions for the systemic barriers that exist in the community. For example, the ability for the teams to make appointments with any provider, regardless of time of call by working with providers to review and modify admission requirements that slow down or disrupt movement through the system.

Accountability - Often program success requires that one entity become accountable for the individuals it serves. If it is determined that HEART (MIHU or HMET) should take on a ‘case management’ role for their clients, to ensure that follow-up support is provided by other community resources, then additional positions and appropriate platforms/dashboard can be implemented by all involved agencies to track and report on outcomes.

5. Similar Programs

A successful program that is similar to the current MIHU model is the Denver Support Team Assisted Response (STAR) program. STAR is a community response program that provides mobile crisis response to community members who are experiencing problems related to mental health, depression, poverty, homelessness and/or substance abuse issues.

STAR sends a paramedic and a mental health provider to low-risk behavioral health calls to de-escalate and connect a resident in distress with appropriate services. STAR employees are not armed and do not perform any law enforcement duties. STAR will not respond to incidents which involve violence or life-threatening medical situations. The STAR program does not replace the Denver Police Department (DPD) co-responder program (similar to HMET), but rather is an additional resource to help address mental health and substance abuse issues.

The STAR program provides crisis de-escalation, connection, and system navigation for anyone utilizing the STAR dedicated phone number or 9-1-1 The Denver 9-1-1 Communications Center triages calls to determine if the call is appropriate for a STAR response. If more serious medical emergencies are encountered, STAR will request a fully operational Denver Health ambulance with ALS (Advance Life Support) capabilities. The goal of the STAR program is to address the initial crisis on the street, and to direct, refer, and transport the client to support services for long term solutions to issues of mental health and substance abuse.

STAR responds to the following nature codes, each of which has a unique decision tree created by Denver 9-1-1 to be utilized after the initial primary assessment is conducted. In addition to the call flow there are examples, non-examples and any additional considerations or notes.

- Assist
- Intoxicated Person
- Suicidal Series
- Welfare Check
- Indecent Exposure
- Trespass Unwanted Person
- Syringe Disposal

Denver 9-1-1 conducted a brief in-service training for their staff accompanied by a video overview of what the STAR program goals are, including information on exactly what a

behavioral health clinician is and does. This helped staff understand and accept that these clinicians have spent their career responding in the field and are experts at de-escalation.

Denver STAR program has responded to 5100 calls since the inception in June 2020, and none have required any police assistance. STAR is dispatched by Denver 9-1-1 via radio. A short-hand code is utilized so that dispatch knows to dispatch STAR, and this 'code' is used to track the CAD data as well. All calls that are STAR eligible are tracked, regardless of whether STAR is available or does respond.

The similarities between Denver co-responder program and Denver STAR program to HMET and MIHU are extensive. MIHU could easily adapt the Denver STAR model and utilize their current system if the decision is made to go in that direction. This overview is offered simply as a consideration for Hayward while considering recommendations.

6. Dashboard Programs for Consideration

6.1 Beacon Emergency Dispatch

Beacon Emergency Dispatch is a do-it-yourself mobile dispatch solution for response organizations that alerts, tracks and coordinates emergency responders using any mobile phone, with or without Internet. Beacon works with organizations to design, test, launch and be ready to scale their own community response system in one of three ways:

6.1.1 Standalone Crisis Hotline

Mental health crises are reported directly to an independent mental health support hotline or relayed from 9-1-1 dispatchers. The hotline staff then use Beacon to dispatch crisis counselors without 9-1-1 assistance.

6.1.2 Direct 9-1-1 Integration

9-1-1 dispatches crisis counselors via Beacon through an integration with the 9-1-1 call center's computer-aided dispatch (CAD) system.

6.1.3 Scanner-Assisted Dispatch

Crisis dispatchers listen to 9-1-1 scanners for mental health-related calls and then use Beacon to dispatch crisis counselors via Beacon web or mobile application.

Beacon offers individual responder reports, incident reports and agency reports that can be presented as a dashboard reporting on number of incidents, response time and time on scene.

6.1.3.1 Program Benefits for City of Hayward

A program of this nature allows easier tracking and reporting of resources and can provide dispatch of field responders who can receive call information with or without using a CAD or mobile CAD product. Responders can receive and respond to call information via an SMS text. This program would be beneficial for alternative response programs that are not partnered with EMS/HPD/HFD.

6.2 Social Solutions (Apricot)

Social Solutions is a case management software for public sector agencies that provide alternative responses with a focus on accountability into progress and outcomes. Their platform claims to improve data quality and reduce the time spent collecting, organizing,

cleansing, and reporting with robust security credentials. Advanced reporting allows a better understanding of trends to make informed, proactive decisions and coordinate tracking of data and outcomes. Their platform aims to aggregate data from multiple services and programs to articulate progress to meet reporting requirements.

6.2.1.1 Program Benefits for City of Hayward

The reporting aspects of this program provide the dashboard that Hayward has been asking for. However, a key factor is that in its current state, HEART, HMET, and MIHU use disparate workflows, programs, and processes to collect, report, and analyze their data. It is essential that information from the different systems and programs be entered into one system to report out on the entire program. As stated in "*Recommendation 8*", the work to integrate all program information into one repository to see and analyze the overall program data will be a key component to achieving success in program measurement, QA/QI, review and adjustments, informed decision making, and long-term success.

7. Conclusion

FE applauds the City of Hayward for the innovative and progressive approach they are taking to support its most vulnerable citizens and address the serious impacts that mental health, addiction, and unhousing is having in many of our communities and emergency services agencies across the continent. Partnerships between crisis care systems and first responders are essential for public safety, diversion, suicide prevention, and the success of a continuum of care in any community. The criminalization of social disorder issues and mental illness has been caused by a lack of robust crisis systems; thus, requiring first responders to become the agency of last resort. To that end, there is still a critical place for both police officers and paramedics in crisis situations; either as specialized mental health response or as a referral for 'warm hand-offs' where responders connect clients to the appropriate resources and service providers for their situation and needs.

The City of Hayward will require continued collaboration and development of partnerships to determine the best diversion programs for their community, as is the focus of this pilot project. Once the best pathway for the long-term HEART program has been determined, continued engagement and dialog will support ongoing quality improvement, and innovative and appropriate solutions which will continue to improve public safety and the diversion of mental health crises from criminal justice systems.