DATE: December 5, 2023

TO: Mayor and City Council

FROM: City Manager
Fire Chief
Police Chief

SUBJECT: HEART Pilot Program: Implementation Updates Regarding the Hayward Evaluation and Response Team Program

RECOMMENDATION

That the Council receives an update on implementation of the HEART program and provides feedback on implementation progress.

SUMMARY

The Hayward Evaluation and Response Teams (HEART) program began implementation in June 2021 and has continued to evolve as staff adapt to changing environments, funding availability, and community needs. HEART is a cross-departmental and inter-agency program between the City Manager's Office, Police and Fire Departments, and Alameda County Behavioral Health Care Services developed to improve access to medical, mental health, and other support services. The program aims to achieve two main goals:

1. Reduce the need for police officers to intervene in calls for service involving people experiencing chronic mental illness, substance use disorders, and homelessness; and
2. Reduce reliance on emergency services for individuals needing long-term case management and follow-up services.

HEART now consists of three teams that each respond to different levels of need and types of calls for service throughout Hayward:

- Hayward Mobile Evaluation Team (HMET)
- Mobile Integrated Health Unit (MIHU)
- Case Management and Mental Health Linkages Team (LINK)

This staff report provides updates regarding program changes and the implementation timeline for each HEART team. It also provides implementation highlights and challenges, including initial descriptive data to understand what types of calls HEART is responding to and who is being served. Staff recommend that Council review this report and share any

feedback and questions about implementation for staff consideration as the program moves forward.

BACKGROUND

The HEART program was developed through the Public Safety Policy Innovation Workshop, which were held from February through April 2021. During the workshop, teams of community members and City staff, including participants from the Hayward Police Department (HPD) and Hayward Fire Department (HFD), participated in a 10-week workshop to identify possible policy solutions to issues identified through extensive community engagement efforts in 2020.[1] Workshop participants were tasked with reviewing community feedback, interviewing key stakeholders, refining their understanding of the problems, and developing and prioritizing possible solutions.[2] Council authorized funding for and directed staff to begin implementing nine of the projects that emerged from the workshop.[3] This included three projects that collectively made up the original HEART program:

- Mobile Mental Health Response Team
- District Command Behavioral Health Clinician
- Behavioral/Mental Health Coordinator

DISCUSSION

The HEART program is a cross-departmental and inter-agency program between the City Manager's Office, Police and Fire Departments, and Alameda County Behavioral Health Care Services developed to improve access to medical, mental health, and other support services. HEART aims to achieve two main goals:

1. Reduce the need for police officers to intervene in calls for service involving people experiencing chronic mental illness, substance use disorders, and homelessness; and
2. Reduce reliance on emergency services for individuals needing long-term case management and follow-up services.

HEART has evolved in response to community needs since its inception in the Public Safety Policy Innovation Workshop. Originally, the program consisted of two teams, which have changed over time and, as of June 2023, a third team has been added to the program. This discussion section focuses on the HEART program as it currently operates with three teams, including a description of the current teams, a summary of the implementation timeline and changes to the model, and initial implementation data for the program.

---

[1] October 27, 2020, City Council staff report and materials: https://hayward.legistar.com/LegislationDetail.aspx?ID=4677304&GUID=52E170E7-7C7A-4B62-AEA8-32BB683AC71D

[2] December 16, 2020, City Council staff report and materials: https://hayward.legistar.com/LegislationDetail.aspx?ID=4730803&GUID=B7016A74-469D-4B54-A400-B830088097E7

[3] For additional information about the funded public safety innovation workshop projects, please visit the City's website: https://www.hayward-ca.gov/your-government/departments/city-managers-office/hayward-safe/project-implementation-dashboard

HEART Program Description

Each team in the HEART program responds to a different type of call for service or referral, ensuring the right response is targeted for the right call or referral. Table 1 below summarizes the composition, response, referral process, and hours of each team that makes up the HEART program.

Table 1. HEART Program Team Descriptions

	Hayward Mobile Evaluation Team (HMET)	Mobile Integrated Health Unit (MIHU)	Case Management & Mental Health Linkages Team (LINK)
Who is on the team?	HPD District Operations police officers & Alameda County behavioral health clinicians	HFD community paramedics	City mobile mental health clinicians & lead program assistant (case manager), supervised by the behavioral health coordinator
What does the team respond to?	Calls or referrals that indicate someone is in acute mental health crisis, requests for a 5150/5585 assessment of danger to self or others, and welfare checks	Calls or referrals that indicate someone has a medical need and is homeless and/or experiencing substance use or mental health issues (but not in an active crisis)	Calls or referrals for cases that require mental health, social services, and case management and ongoing follow-up and support
How is the team referred or dispatched?	Calls for service through 911 dispatch or direct referrals from HPD or County	Calls for service through 911 dispatch or direct referrals from HFD, or HPD	Calls for service through 911 dispatch or direct referrals from HFD, HPD, other City departments, and community members
When is the team active?	Monday-Friday 8:00 AM – 4:00 PM	Monday-Friday 8:00 AM – 8:00 PM	Monday-Friday 8:30 AM – 6:30 PM

HEART Implementation

<u>Program Changes & Timeline</u>

Initial HEART operations began in June 2021 with the start of HMET, the HPD team that pairs specially trained District Operations police officers who focus on community policing with a behavioral health clinician from Alameda County's Behavioral Health Care Services (ACBHCS). Next, the MIHU team began operations in January 2022. At that time, the team consisted of one community paramedic from HFD and a mental health clinician. The behavioral health coordinator supported the entire HEART program by primarily working on resource mapping

and developing the infrastructure needed to establish referral pathways for the vast network of community partners also providing services to HEART's target population.

The MIHU team has gone through some important changes since beginning operations, reflecting the team's flexibility and ability to adapt and grow. MIHU began part-time operations in January 2022, focusing on providing follow-up services after an initial service call and by proactively engaging with individuals who were known high utilizers of the 911 system. In the first six months of the pilot, there were challenges staffing the mental health clinician role, so the behavioral health coordinator joined the unit on weekly shifts. The team of one community paramedic and one clinician performed shared case management, responding to calls primarily through referral and by listening to 911 dispatch. There were delays working with an anticipated contracted provider and the City ultimately determined it would be more effective to staff the mental health clinician internally. In September 2022, MIHU expanded to four full-time community paramedics and began responding directly to calls for service in the community.

Starting in February 2023, MIHU shifted operations to clarify the type of calls they respond to, establishing the standard of responding to calls with a medical need that intersects with issues of homelessness, mental health, and/or substance use. This shift formalized processes that evolved at the start of the pilot. Finally, in June 2023, based on learnings from the first year of program implementation, the City moved the clinical staff from the MIHU ambulances to a separate third HEART team, called the Case Management & Mental Health Linkages Team (LINK).

The LINK team works closely with MIHU and HMET, as well as HPD patrol units; other City departments, including Code Enforcement, Maintenance Services, and Public Works/Utilities; and the City's non-profit partners, including Bay Area Community Services, First Presbyterian Church of Hayward (South Hayward Parish), La Familia, and Tiburcio Vasquez Health Center. LINK consists of the following staff from the Youth and Family Services Bureau (YFSB): two mobile mental health clinicians, a lead program assistant/case manager, and the behavioral health coordinator who supervises the unit. One mobile mental health clinician role is currently vacant, and staff are actively recruiting to fill the position. LINK staff spend much of their time in the field, connecting individuals experiencing mental illness, substance use issues, and homelessness to resources. Their goal is to provide warm handoffs to existing services when available and to provide clinical and case management services as needed to fill gaps while longer-term solutions are identified.

<u>Implementation Highlights & Challenges</u>

HEART staff work together as a collaborative team with a deep knowledge of the system of care.

A significant strength of the HEART program lies in its staff. HEART program staff are dedicated to the program's mission and are flexible, innovative, and persistent. They bring a strong understanding of the system of care for individuals experiencing mental illness, substance use disorders, and homelessness, which they leverage to connect individuals to the services they

need. The landscape of available services in Hayward and Alameda County changes frequently and the teams strive to maintain an up-to-date understanding of what is available for whom. The teams are collaborative, making referrals to each other as appropriate and meeting frequently to discuss specific cases, focusing on problem-solving with creative solutions.

Along with other City staff, HEART staff are continuously building the data capacity and infrastructure for the program.

Since the implementation of HMET in June 2021, staff from HPD, HFD, the City Manager's Office, and the Information Technology Department have worked on building data capacity for the HEART program. Available data ranges based on the specific team, its length of operation, and staff capacity to enter, track, and cross-reference data across multiple systems. Within existing constraints, there are initial findings about who is being served and the amount of service being delivered by each HEART team. Additionally, staff have increased access to County-wide data systems to allow the teams to know what services individuals have already received, where they're already connected, and who may already have established service relationships with them. This information not only will contribute to the long-term evaluation of the program but also has significant practical implications for successfully engaging community members.

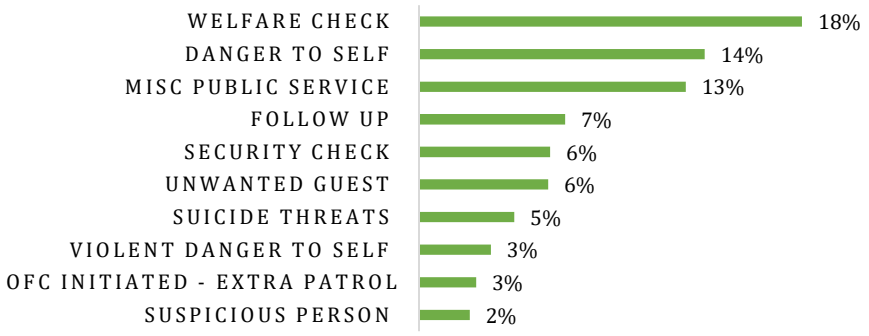
HEART teams are responding to the expected call types and serving a diverse population of community members in need. MIHU data indicates that individuals served are high utilizers of emergency services and that appropriate service linkages could reduce strain on the emergency response system.

Given that each team has been operating for different durations with varying levels of data availability, staff have analyzed available data for each team separately to provide an initial picture of the types of calls each team responds to and who has been served by each team. Within each team, there were programmatic changes over time that impacted data tracking and availability. Staff continue to build out the data infrastructure across teams to address these inconsistencies moving forward.

HMET Data

HMET has been operating at 40 hours per week since June 2021. Since its start through November 2023, HMET responded to around 1,900 calls for service. Referrals came through the 911 Dispatch center, HPD patrol officers, outpatient mental health providers, community members' family or loved ones, schools, other community members, and directly from individuals experiencing crises themselves. Approximately 65% of all HMET responses were generated by HPD (911 dispatch, patrol, or officer on view). As show in Figure 1, the most common originating call types to HMET are Welfare Check (18%), Danger to Self (14%), and Miscellaneous Public Service (13%), which can be a variety of issues including, but not limited to, a subject causing a disturbance at a business or residence.

Figure 1. Top HMET Call Types



*Data were collected from September 2021 through September 2023

In fiscal year 2022-2023, HMET served 176 unique individuals. The majority of HMET's calls for service resulted in connecting these individuals with the appropriate resources, including psychiatric hospitalization (5150/5585) when needed, but also crisis de-escalation in the field and follow-up with longer-term solutions including connecting individuals with their current mental health provider and referring them to the County's Behavioral Health Care Service's ACCESS Program. Among individuals served through HMET, there is a high representation of those who are between the ages of 26-59 (57%) and are White (24%), Black/African American (22%), Hispanic/Latino (21%), and Asian (16%), as shown in Figure 2 and Figure 3. Just over half (57%) of individuals served by HMET were women.

Figure 2. HMET Age Demographics

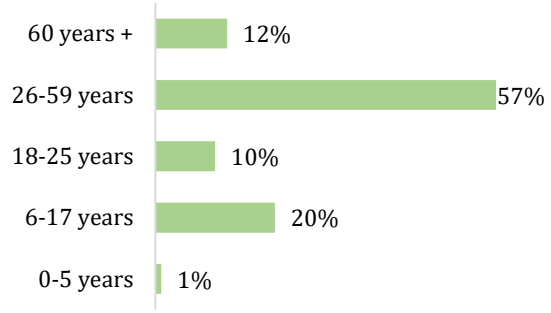
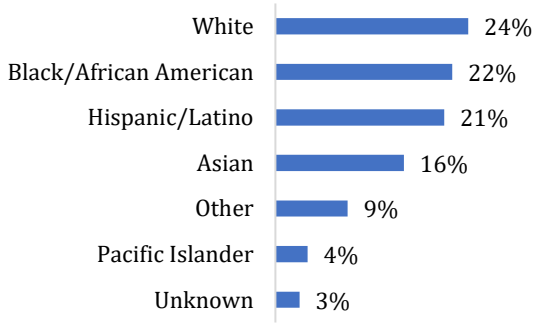


Figure 3. HMET Race and Ethnicity Demographics

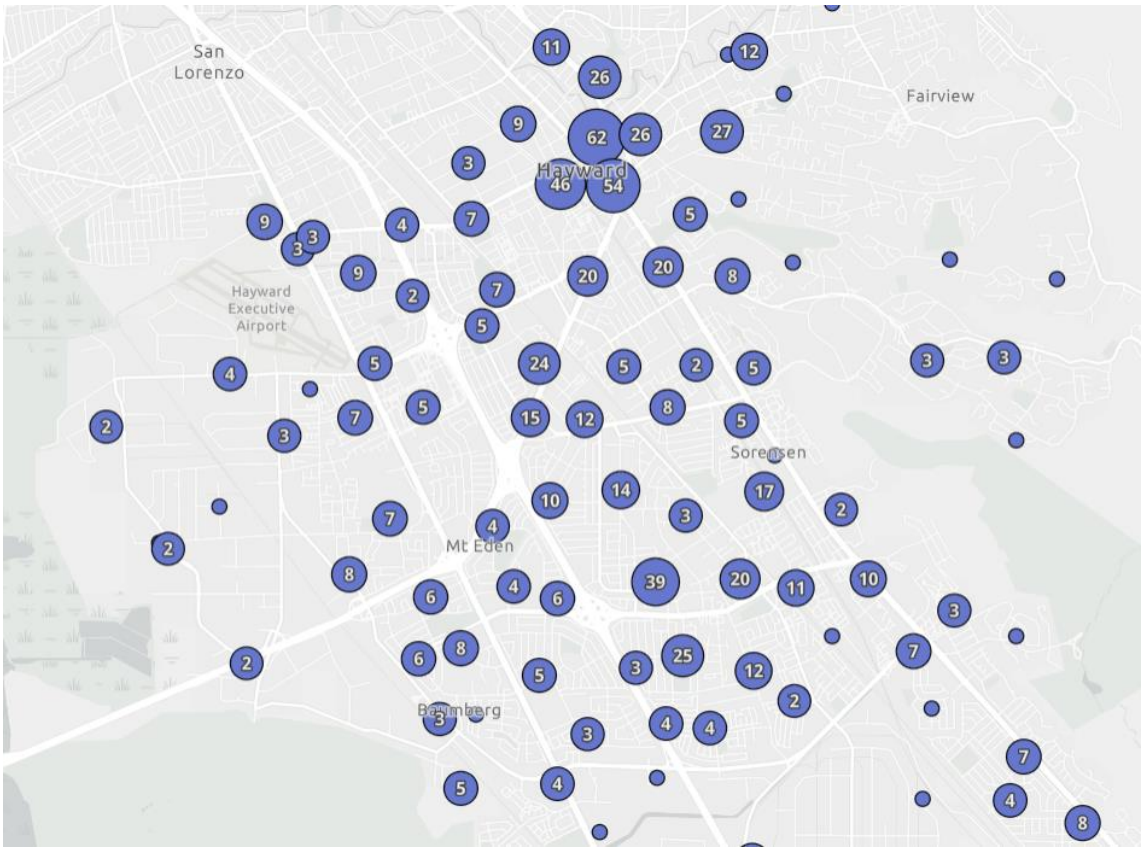


*N= 176

**Data collected during FY22-23, demographics represent duplicated totals

Finally, as shown in Figure 4, HMET covers much of Hayward's geography, with a higher density of calls in the downtown area and South Hayward along the Tennyson corridor.

Figure 4. HMET Call Locations



*Data represents a one-year snapshot from September 2022 to September 2023.

MIHU

The Mobile Integrated Health Unit (MIHU) began part-time operations in January 2022 as a follow-up service with a community paramedic and mobile mental health clinician. In its first six months, MIHU consisted of a community paramedic and mental health clinician providing follow-up services for individuals within the Fire EMS system who were experiencing mental illness, substance use issues, and/or homelessness. In September 2022, instead of doing only follow-up services, MIHU shifted to being an active 911 response for calls involving mental illness, substance use issues, and/or homelessness.

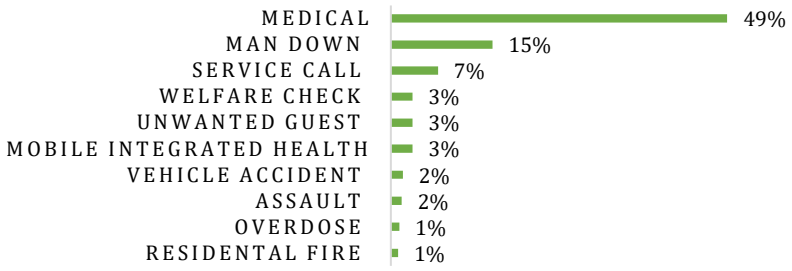
Staff presented data on the first six months of program implementation to Council on September 15, 2022.[4] This report provides updated data from September 2022 through September 2023. In this one-year period, MIHU responded to 469 calls for service, 86% of which came through the 911 dispatch system. While the dispatch center does not directly dispatch to MIHU, MIHU staff review calls to 911 in real-time to identify calls that fit the MIHU scope and either attach or exchange with other Fire units.

[4] September 15, 2022, City Council staff report and materials: https://hayward.legistar.com/LegislationDetail.aspx?ID=5936057&GUID=ECD8F03D-78E0-4B79-BEE5-49918518559B&Options=&Search=

Of the 469 calls received during this time, 199 unique individuals could be identified. Among those who could be identified, 20% had at least ten calls for service, with one individual making up 11% of all total calls. This trend suggests that a portion of individuals served by MIHU are high utilizers of emergency services.

As shown in **Error! Reference source not found.**, the most common originating call types to MIHU during this period were Medical (49%), Man Down (15%), Service Call (7%), Mobile Integrated Health (3%), Unwanted Guest (3%), and Welfare Check (3%). Medical calls, which make up most of MIHU's calls for service, include psychiatric problems, overdose, cardiac events, injury, and other illnesses.

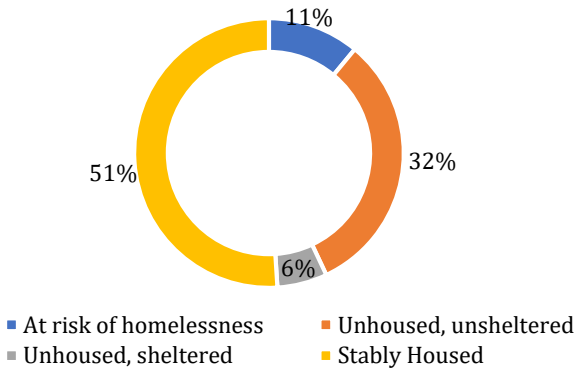
Figure 5. Top MIHU Call Types



*Data is collected from September 2022 through September 2023

Among those unique individuals for whom data is available (n=186), about half (51%) were stably housed, and over one third (38%) were unhoused, with most of those who were unhoused living outside. Another 11% were at risk of becoming homeless (see Figure 6).

Figure 6. Housing Status of Patients Seen by MIHU

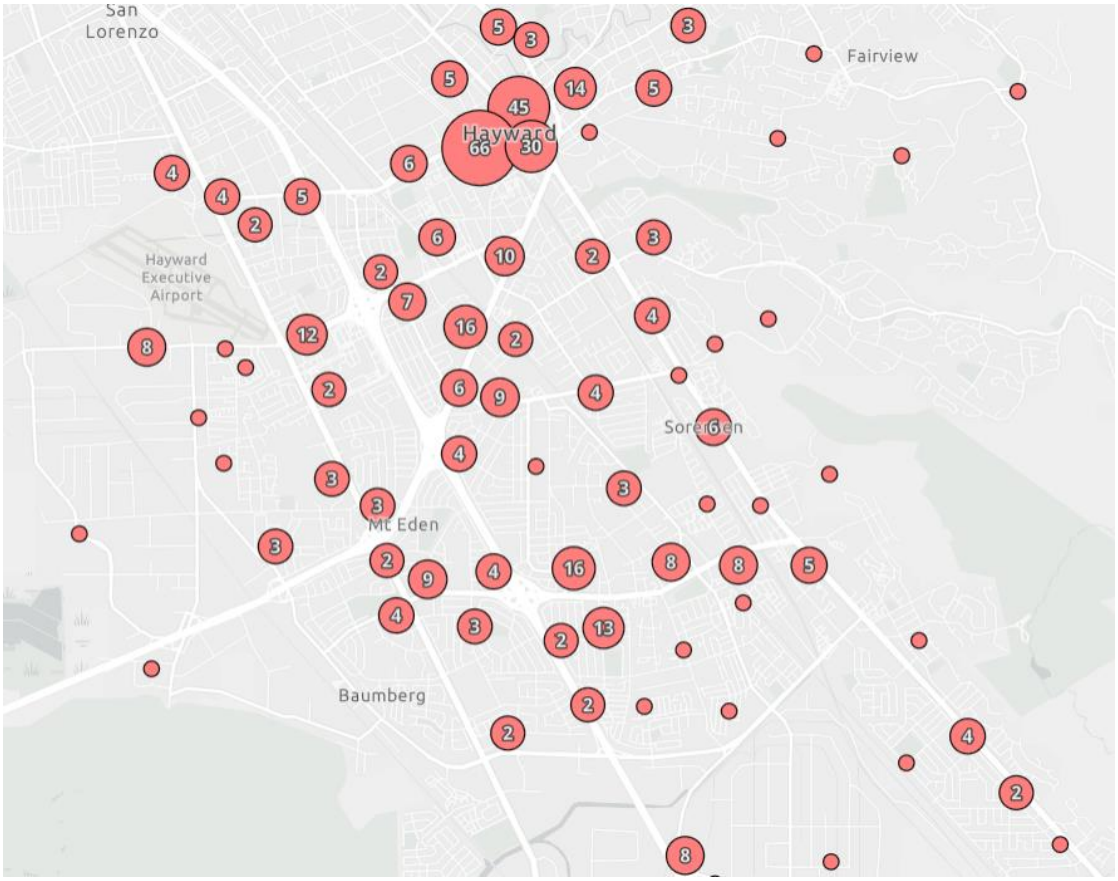


*N= 186
**Data collected between September 2022 – September 2023

While the MIHU staff collects race and ethnicity data, at the time of this report writing an error in the software that exports data prevented staff from querying race and ethnicity data from the system. Staff are working with the software provider to address the error and provide access to this data in the future. Among the 199 individuals served from September 2022 through 2023, the majority were men (61%) and between the ages of 26 and 59 (64%).

Like calls to HMET, MIHU responded to calls covering much of Hayward's geography. MIHU responded to many calls in the downtown area, Jackson Triangle, and the Tennyson corridor.

Figure 7. MIHU Call Locations



*Data represents a one-year snapshot from September 2022 to September 2023.

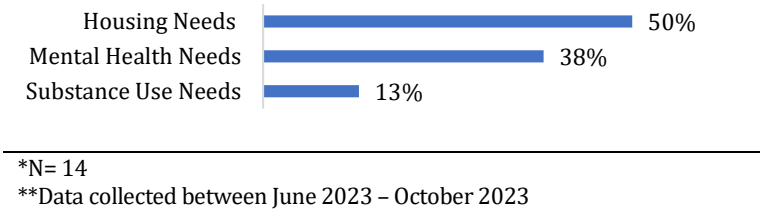
LINK

LINK has been operational as a distinct team since August 2023, so initial descriptive data about the program is limited. Staff began tracking data via the Salesforce database in May 2023. While still part of MIHU, the LINK team had 23 contacts with 22 unique individuals and opened ongoing cases for six individuals who have received extended clinical or case management services from LINK staff. Since August, LINK had 63 contacts with 56 unique individuals and opened ongoing cases for eight individuals. In total, since tracking began in May 2023, LINK opened ongoing cases for 14 individuals. When making brief contacts, LINK staff work to

connect individuals to existing services to reduce redundancy and ensure a strong continuum of care provision for individuals already engaged in services.

Of the 14 individuals who were engaged in ongoing case management and clinical care since May 2023, seven are still receiving services. As shown in Figure 8, housing is the most frequently cited individual client need among the 14 individuals receiving ongoing case management and clinical services from LINK. Four are high utilizers of the 911 system.

Figure 8. LINK Individual Client Needs



*N= 14
**Data collected between June 2023 – October 2023

The LINK team tracks case management service contacts (i.e., direct case management performed by a LINK team member) as well as collateral and advocacy contacts (i.e., interactions with other service providers and other forms of direct advocacy on clients' behalf). For the 14 individuals receiving ongoing services from LINK, staff on average makes one case management-related contact every two weeks and one collateral and advocacy contact every two weeks. It is important to note, however, that the number of these contacts ranges significantly depending on the level of need and the engagement of the client and that they happen at the same time as the dozens of brief contacts LINK staff have with other individuals. Additional implementation time will allow for a more informative picture regarding the frequency and volume of contacts made by the LINK team.

To avoid sharing identifiable information with such a small number of individuals served, staff are not sharing demographic information for individuals receiving ongoing LINK services in this report. LINK staff continue to track race/ethnicity data, age, and gender for those receiving ongoing LINK services, and that data will be shared in the future when the number of individuals served is greater.

HEART staff successfully secured over $2 million in grant funding for the program.

In addition to the large volume of individuals served and the strides made in building out the program's data capacity, HEART staff continue to seek sustainable funding, including through grants and developing reimbursement models for some of the services provided by MIHU and HMET. Staff have secured over $1.2M in federal grants and another $1.2M in additional state funding secured through State Senator Wahab's office to support program operations.

Several resources are available for community members to learn about the program and make appropriate referrals.

Another implementation success is the development of several resources for community members to understand the program, access services, and know where to go for the right level of care for individuals in need. Staff developed the following resources:

- **HEART program website**: The website is now updated with information about all three HEART teams, including their hours, service descriptions, and how to reach them. The website also references other key resources, including the 211 phone line to reach a broad range of services and the 988 suicide and crisis lifeline number.
- **HEART program summary**: Staff produced a two-page summary describing program goals, the services provided by each HEART team, hours of operation, and how the community can make referrals to the HEART program and other relevant services. The summary is available as Attachment II.
- **Homeless Response Resource Guide**: Staff also developed a frequently asked questions resource for Hayward's residential and business communities. The guide answers questions about how to respond to people camping near or on private property, how to refer people to services, and how to report concerns. The resource guide is available as Attachment III.

Service availability is a significant challenge for program implementation.

Implementation has not been without challenges. One primary barrier facing HEART teams is the availability of resources. There are limited shelter beds in Hayward, particularly for single adults who make up most of the unsheltered population. The Hayward Navigation Center has 60 short-term housing beds, and the South Hayward Parish emergency shelter has 18 beds. When HEART program staff interact with individuals who need shelter, the availability of shelter beds can often be a significant limitation. Staff are also constrained by the operational hours of other services that support HEART programs.

A portion of individuals served by the HEART program are not interested or ready to engage in services.

HEART program staff across the three teams have all interacted with individuals experiencing untreated mental illness and substance use disorders who do not meet the standards for psychiatric hospitalization (5150/5585 holds) and are not ready to accept referrals to appropriate services. Reticence to accept services creates a significant barrier for staff to link individuals to the appropriate level of care. HEART program staff continue to engage with individuals who are not ready to engage in services in several ways. For example, LINK staff, often in partnership with MIHU, proactively visit and check-in on high utilizers of emergency services to reduce the frequency of those individuals calling 911 for non-emergent care. HEART staff recognize that individuals who are not a threat to themselves or others still have agency to make choices for themselves. Staff remain persistent and engaged, building and maintaining relationships to understand individuals' unique barriers to service engagement so that when they ultimately do feel ready to accept services, the resources and relationships are available.

There are limitations to existing data systems and processes.

Data for the HEART program exists across several data systems that do not always intersect. Staff recognizes that, given that HEART works across several departments that have different procedures and data systems, data collection and analysis for HEART needs to be both effective and realistic. Data can be queried from the dispatch system, which provides important information like call type, call disposition, who responded, and how long they were on scene. However, the availability of demographic information is limited. For HMET, demographic

information is only available if the call ultimately ends in a report, which is not the case for most calls. There is demographic information available in the narrative notes from dispatch calls; however, that relies on information provided by the person calling dispatch so demographic information is inconsistent and unreliable. Despite significant improvements in both data infrastructure and staff's understanding and capacity, there continue to be challenges accessing indicators that will be important for future analysis. Staff continue to work with the City's IT Department as well as contracted data system vendors to address these issues.

Implementation of the HEART program is funded through temporary funding sources and one-time grant funding.

The HEART program is currently funded through a combination of HPD salary savings and grant revenue, both of which are not long-term funding sources as vacancies may be filled and the grants are term-limited. While staff are continuously working with the City's legislative partners to identify local, state, and federal funding sources, few of those sources fund ongoing operations. Without permanent funding commitments, it can be challenging to make long-term plans and investments for program implementation.

ECONOMIC IMPACT

There is a positive economic impact from reducing the use of the emergency response system for individuals with untreated or chronic mental illness, substance use disorder, and those who are experiencing homelessness. For example, HEART program staff conducted a case study analysis of some of the City's most frequent utilizers of emergency services and found that one individual can cost the emergency care system (e.g., HPD and HFD staff time, transportation costs, and emergency department visits) between $700,000 and $900,000 in a year. Connecting high utilizers of emergency services to benefits such as disability or MediCal and linking them to an ongoing case manager and dedicated health care team can significantly reduce this economic impact.

FISCAL IMPACT

HEART is still a pilot program that is currently funded primarily through HPD staff salary savings in the General Fund. As presented in the discussion section of this report, staff have secured over $2 million in state and federal grant funding; however, those are one-time allocations not intended for ongoing operational funding.

STRATEGIC ROADMAP

This agenda item supports the FY 2024-2025+ Strategic Roadmap priority of Enhance Community Safety and Quality of Life. Specifically, this item relates to the implementation of the following project:

Project Q1 Continue to implement and measure the HEART Pilot Program

PUBLIC CONTACT

There was no public contact associated with this progress update. Future long-term evaluation of the program may include data from interviews and surveys of program participants, depending on availability.

NEXT STEPS

Staff will continue to implement the HEART program in its current three-team structure and will return to Council with another implementation update in Fall 2024.

Prepared by: Amy Cole-Bloom, Community Services Manager
Jacqueline Bautista, Behavioral Health Coordinator
Frank Crespo, Firefighter/Community Paramedic/Physician Assistant
Zachary Fay, Police Sergeant
Emily Hwang, Management Analyst
Antonio Puente, Police Lieutenant
Danny Vickers, Fire Captain
Emily Young, Youth and Family Services Bureau Administrator

Recommended by: Regina Youngblood, Assistant City Manager
Garrett Contreras, Fire Chief
Bryan Matthews, Acting Police Chief

Approved by:

_____
Kelly McAdoo, City Manager