HEART Program Update

HEART Program Overview

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.

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
When is the team active?	Monday-Friday 8:00 AM – 4:00 PM	Monday-Saturday 8:00 AM – 8:00 PM	Monday-Friday 8:30 AM – 6:30 PM

Total Individuals Served

Among those who could be identified, 469 individuals received services provided by the LINK and MIHU teams between September 2023 and September 2024. This does not include HMET's County Clinician data due to challenges with the County's recent database upgrade. The HMET team includes a Clinician provided by the County who records client information including disposition and individual demographics. While the County's 2023-2024 data remains incomplete, staff has formalized a data sharing process with the County to have ongoing access to data collected by the County Clinician on the HMET team and the data will be available once the County completes upgrades to its data system.

Total Individuals Served by the HEART Program Teams

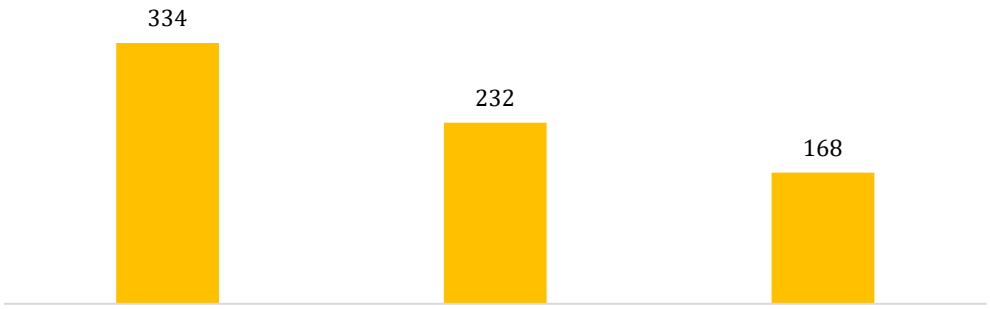
	Individuals Served
Hayward Mobile Evaluation Team (HMET)	Unavailable
Mobile Integrated Health Unit (MIHU)	395
Case Management and Mental Health Linkages Team (LINK)	74
Total Individuals Served	469

LINK Services and Demographics

Between September 2023 and September 2024, LINK had 286 contacts with 74 unique individuals and opened ongoing cases for 48 individuals who have received extended clinical or case management services from LINK staff. 16 are high utilizers of the 911 system. 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.

From September 2023 to September 2024, the LINK team provided a total of 734 instances of case management and mental health linkages. Among the total number of services provided (n-734), 33% of services provided were offered to three individuals.

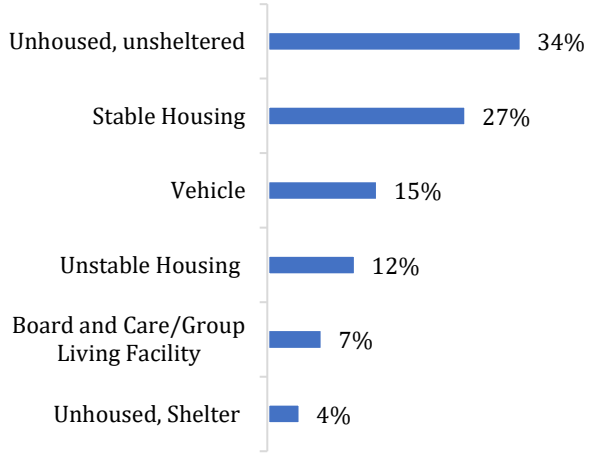
LINK Case Management and Mental Health Services Provided (n=734)



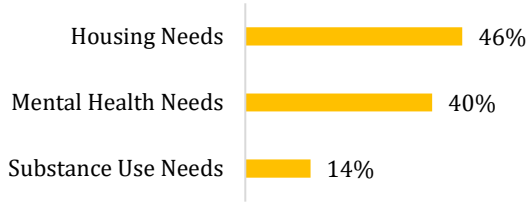
*Data collected between September 2023 – September 2024

Among those unique individuals for whom data is available (n=64), over one third (38%) were unhoused with the majority living outside, and over a quarter (27%) had stable housing. 15% were living out of a vehicle and 12% had unstable housing. These numbers are reflective in LINK's client needs which are housing needs (46%) and mental health needs (40%).

Housing Status of LINK Clients (n=64)



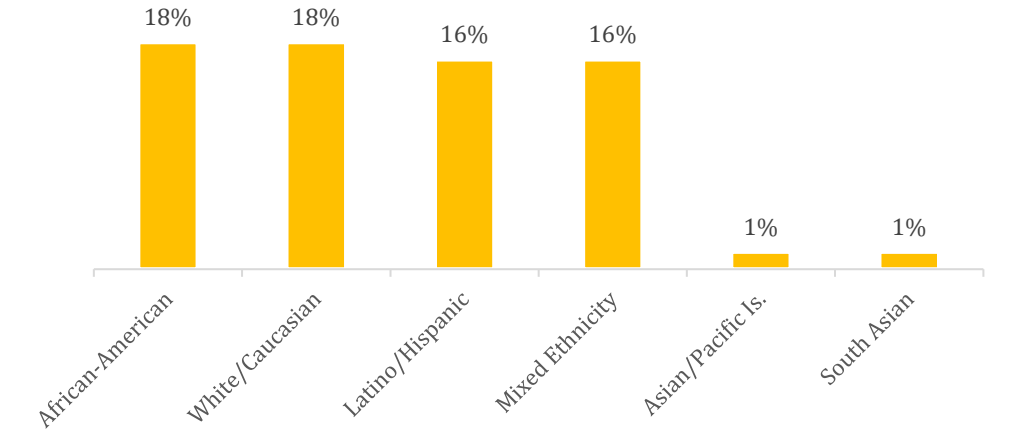
LINK Individual Client Needs



**Data collected between September 2023 – September 2024

Among those unique individuals for whom race data is available (n=52), most are African American (n=13, 18%) and White (n=13, 18%), followed by Latino/Hispanic (n=12, 16%) and Mixed Ethnicity (n=12, 16%).

LINK Client Race Data (n=52)



*Data collected between September 2023 – September 2024

Across all LINK clients, past and ongoing (n = 74):

- Most are between 45 years old and 64 years old (n=25, 34%) or are over 65 years old (n=23, 31%)
- 61% (n= 45) identify as female and 39% (n=29) identify as male.
- 86% (n=64) speak English, 12% (n=9) speak Spanish, and 1% (n=1) speak Tagalog.

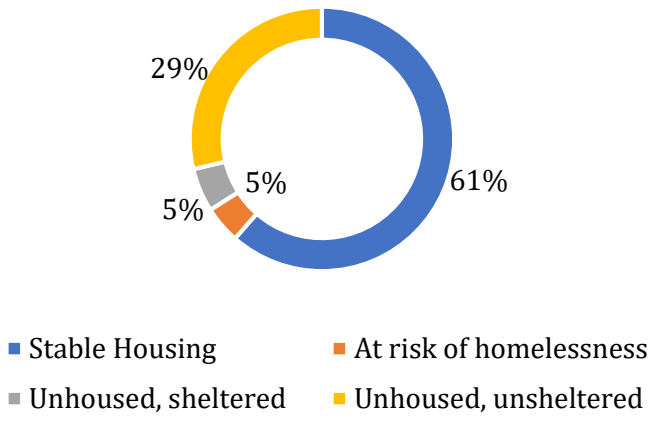
MIHU Services and Demographics

Of the 667 calls responded by MIHU, 437 unique individuals could be identified, 395 of whom received some type of service. Among those who could be identified, four individuals had at least five calls for service making up 4.5% of all MIHU calls. Less than 10% of individuals refused evaluation and care.

Among those unique individuals for whom data is available (n=395), over two thirds (61%) were stably housed, and over one third (34%) were unhoused, with most of those who were unhoused living outside. Another 5% were at risk of becoming homeless.

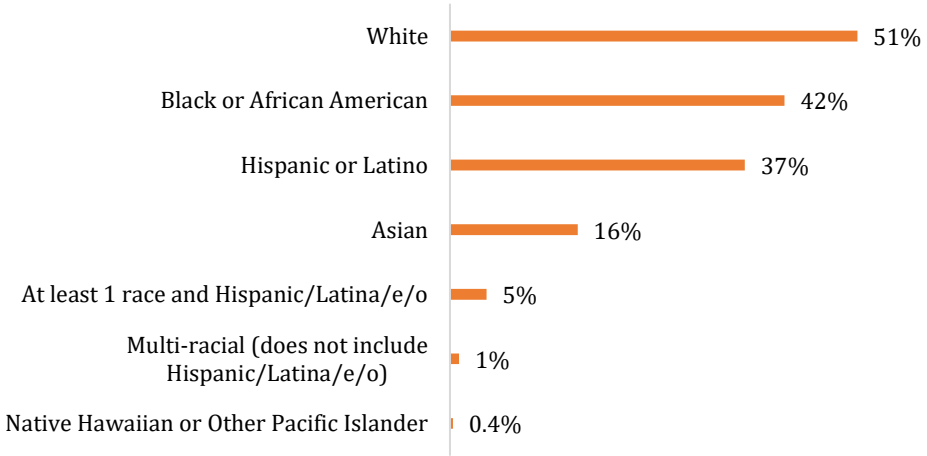
Among those unique individuals for whom race data is available (n=299), the majority are White (n=134, 51%) and African American (n=110, 42%), followed by Latino/Hispanic (n=97, 37%) and Asian (n=42, 16%).

Housing Status of Patients Seen by MIHU (n= 395)



*Data collected between September 2023 – September 2024

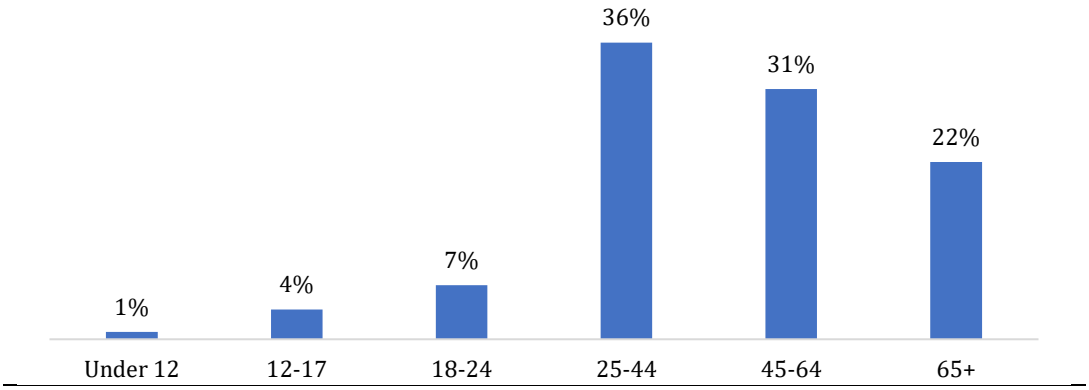
MIHU Patient Race Data (n=399)



*Data collected between September 2023 – September 2024

The majority of those served by MIHU are over 25 years old. The largest proportion are those between 25 years old and 44 years old (n=159, 36%) and 31% are between 45 years old and 64 years old (n=134).

MIHU Patient Age Data (n=437)



*Data collected between September 2023 – September 2024

Calls Responded and Referrals

From September 2023 to September 2024, the HEART program teams responded to 1846 calls in total. The nature in which each team receives referrals varies and is specific to each team's scope described in the table below. While both HMET and MIHU teams respond to emergency response type calls or on-the-spot referrals, the LINK team receives more follow-up referrals which includes a wide range of engagement depending on the level of need of the client.

Total Calls Responded by the HEART Program Teams

	Calls Responded
Hayward Mobile Evaluation Team (HMET)	893
Mobile Integrated Health Unit (MIHU)	667
Case Management and Mental Health Linkages Team (LINK)	286
Total Calls Responded	1846

HEART Referrals Process

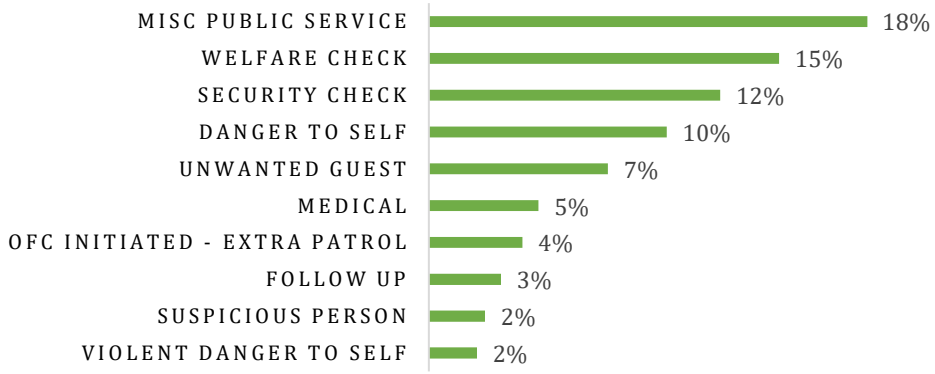
Hayward Mobile Evaluation Team (HMET)	Directly from HPD patrol officers, 911 Dispatch center, calls received by the County Clinician, outpatient mental health providers, community members' family or loved ones, schools, other community members, and directly from individuals experiencing crises themselves.

Mobile Integrated Health Unit (MIHU)	Reviews calls to 911 in real time to identify calls that fit the MIHU scope which can include either attaching to or exchanging with other Fire units or attaching to HPD calls within their scope. MIHU also receives referrals from the Case Management and Mental Health Linkages Team (LINK) and community partners.
Case Management and Mental Health Linkages Team (LINK)	The majority of referrals are from HPD/HMET (44%), MIHU (10%), and Youth and Family Services Bureau (YFSB) (6%). As the main follow-up to resources and services team, LINK does outreach to those identified by the City's emergency responders as well as City staff, community partners, and community members.

Calls for Service

The most common originating call types to HMET are Miscellaneous Public Service (18%), which can be a variety of issues including, but not limited to, a subject causing a disturbance at a business or residence; Welfare Check (15%); Security Check (12%); and Danger to Self (10%).

Top HMET Call Types

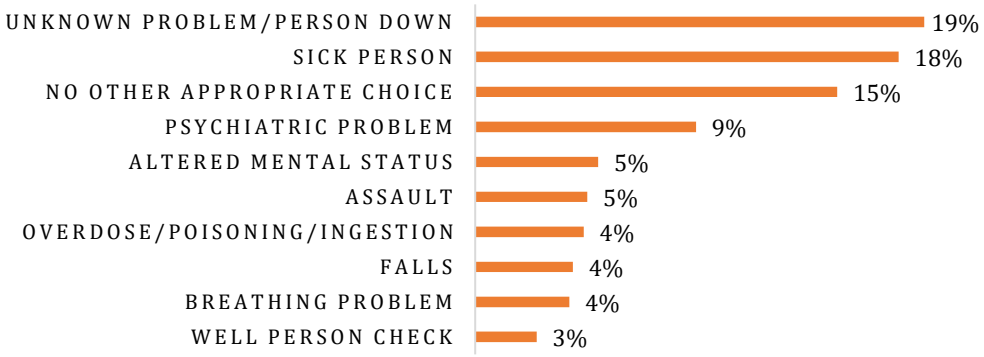


*Data were collected from September 2023 through September 2024

The most common call types to MIHU include Unknown Problem/Person Down (19%), Sick Person (18%), No Other Appropriate Choice (15%), and Psychiatric Problem (9%). The chart below shows data collected from HFD's Emergency Systems Operation (ESO) database which is reported by the MIHU Community Paramedics. MIHU Paramedics self-dispatch themselves by reviewing 911 dispatch calls in real time and often don't have all the details that one would get if an emergency medical dispatch called them directly to provide the most accurate call

descriptions. While the City's Computer Aided Dispatch (CAD) Systems also records MIHU call type information, CAD call types are generic and show 49% of MIHU call types as "Medical".

Top MIHU Call Types



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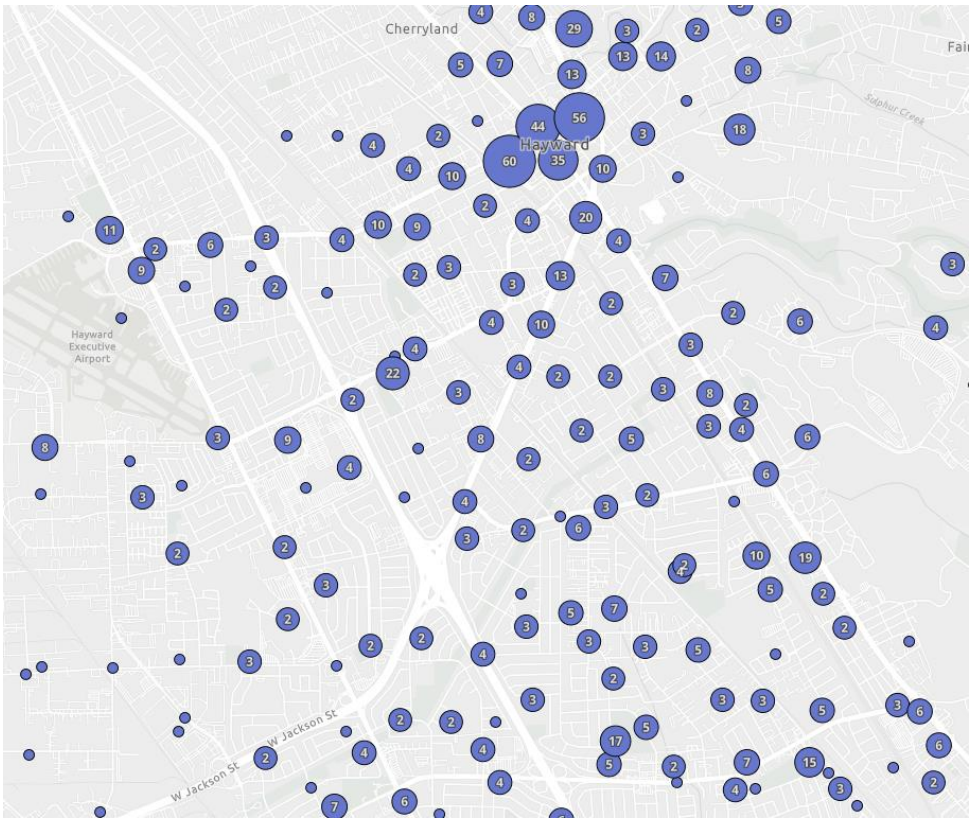
Call Locations

HMET covers much of Hayward's geography, with the highest density of calls in the downtown area.

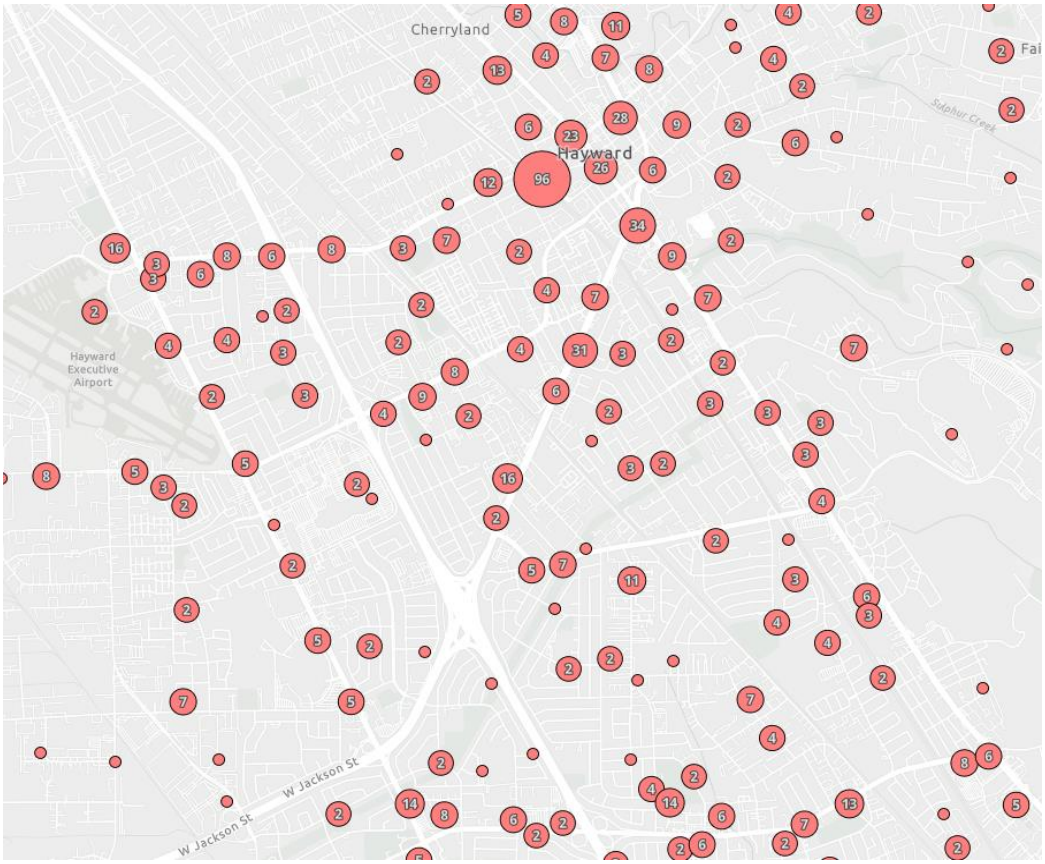
HMET Call Locations



*Data represents a one-year snapshot from September 2023 to September 2024.

Like calls to HMET, MIHU responded to calls covering much of Hayward's geography with the highest density of calls in the downtown area.

MIHU Call Locations



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