Project Summary

County:	**Alameda County**
Date submitted:	4/13/2018
Project Title:	**Community Assessment and Transport Team (CATT)**
Total amount requested:	$9,878,082
Duration of project:	5 years

General Requirement	Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
Primary Purpose	Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes

Problem

Many counties and cities struggle with developing a crisis response system that is efficient and effective – getting clients to the right services at the right time, without unnecessary use of first responder and client time, and in a respectful and non-stigmatizing manner. In Alameda, there have been a various efforts made to improve crisis response, but the impact has been limited:

- Alameda has the highest rate of 5150 holds in California;
- Of those on a 5150 hold transferred to the psychiatric emergency services unit (PES), 75-78% did not meet medical necessity criteria for inpatient acute psychiatric services;
- People who do not qualify for 5150 holds are not linked to planned services and continue to over-use emergency services;
- First responders spend many hours addressing behavioral health related 911 calls that would be better served in a different manner;
- While Alameda's practice of having ambulances transport individuals on a 5150 hold has many benefits, it is an expensive approach to transport; diverts resources from life threatening emergencies; and leads to clients, law enforcement, and other responders experiencing lengthy wait times for ambulances.

There are many agencies that play a role in crisis response. This project hypothesizes that in order to effectively change the Alameda County crisis response system from one with the highest rates of 5150 holds to a model of efficient and effective response, a collaborative effort to support creative solutions is required. (Winters, S. Inter-professional collaboration in mental health crisis response systems: a scoping review. *Perspectives in Rehabilitation.* Jan 14, 2015).

Project

Alameda County proposes to test two primary strategies to improve the crisis response system:

1) A collaboration among core Alameda County Health Care Services Agency programs - *Behavioral Health Care Services, Emergency Medical Services, and Alameda Care Connect (Whole Person Care)* – as well as other partners – *911 dispatch, the County Sheriff's Office,*

city police departments, city health and human services, and other relevant services - to ensure the crisis response system is effective and efficient. For example:

- Participating partners will provide the staff time, training, and support to ensure that in-the-moment client services are responsive, such as keeping records up to date so the mobile crisis teams have current information about the client and available services.
- Conduct ongoing Continuous Quality Improvement process to ensure that system improvements are made in a timely manner, resulting in better outcomes, such as understanding why clients in crisis continue to be routed to services they do not meet eligibility criteria for and developing systemic solutions to get them routed correctly.

2) Combining a unique crisis transport staffing model with current technology supports to enable them to connect clients to a wider array of services in the moment.
   a. A mental health provider and an Emergency Medical Technician in a van to provide mental and physical assessment and transport to a wide range of services.
   b. Technological support, such as ReddiNet to provide current availability of beds and Community Health Records to provide up-to-date information about the client's physical and mental health history. This assists with connecting a client to the most appropriate service in the moment, especially if they are not on a 5150 hold.

This project proposes to make the collaborative process the focus of the project and evaluation, recognizing that this is essential to making the level of systems change that is needed. This will allow Alameda to put the necessary time and resources behind working together to design the system improvements, monitoring the results, and making timely course corrections.

Evaluation (See Logic Model for more details)

Alameda County has two primary learning goals:

1. Determine if and how collaboration among agencies responding to mental health crises can contribute to developing an effective and efficient crisis response system.
   - Actions taken to improve the crisis response system, and the results
   - Collaborative members perception of the effectiveness of the collaboration
2. Determine if and how the changes in the crisis response system result in community and county priorities: better client services and more efficiency in the system.
   - Number of clients served
   - Number of clients not on 5150 hold that are transported to services

This project is beyond adding a discrete service to a challenged system, it is a *test of concept for how to improve the system* through a focused collaborative approach and innovative change in staffing model paired with technological support. If successful, it will contribute to increased efficiency for the emergency system, more appropriate services for the client, and a model that other counties can adopt or adapt to significantly improve their crisis response system.

Budget

Salaries *$7,435,761*	BH Clinicians Emergency Medical Technicians Clinical Supervisor Program Specialist to coordinate the program
Operating *$403,875*	Data plan for tablets, mobile phones, fuel, vehicle maintenance
Non-Recurring *$0*	Vehicles, radios, vehicle modifications, Tablets, phones, laptops, software Staff training
Consultants *$750,000*	Peer/family stipends to assist with data gathering and analyzing data Evaluator
Indirect *$1,288,446*	15% for BHCS to administer project

Other funding: Measure A, a local funding source, and MediCal billing will cover additional costs.

Community Assessment and Transport Team (CATT) **Logic Model**

Situation: Alameda has the highest rate of 5150 holds in California; people who do not qualify for 5150 holds are not successfully linked to planned services and continue to over-use emergency services; and first responders spend many hours addressing behavioral health related 911 calls that would be better served in a different manner.

Inputs	Outputs		Outcomes -- Impact		
	Activities	*Participation*	*Short*	*Medium*	*Long*
Collaboration (INN) Personnel Time: - Program Specialist - Clinical Supervisor - Behavioral health clinician/EMT teams (INN) Technology: shared records, ReddiNet (INN) Modified vans, technology hardware Training Evaluator with Peer/Family	Monthly meetings Mental & physical assessments, de-escalation, pre-transport services (10,794) Transport clients to range of services (5,594 – 5150 holds) (2,600 – non-5150) Training in CATT approach and technology Eval: CQI, process, numbers served, outcome, client satisfaction	BHCS, EMS, Whole Person Care, 911 dispatch, law enforcement, others CATT (BH clinician and EMT) (with law enforcement) CATT (BH clinician and EMT) (with receiving entities) CATT staff, collaborative partner staff Evaluator, Peer/Family, Collaborative partners	Collaborative partners design and implement policies and practices that improve crisis response (protocols, up to date records, ReddiNet expanded, etc.) Collaborative quickly identifies and addresses areas for improvement Clients served by CATT are connected to wide range of services at time of need (5150 and non-5150)	Clients transported to most appropriate service (5150, non 5150) due to: - up to date client and service availability records - expanded assessment and pre-transport services Clients engage in planned services (900) Clients satisfied with services, including perceptions of stigma (60%)	CATT service is more efficient than other options (25%) Reduction in 5150 transports to ED for medical clearance (25%) Reduction in 5150s (30% of those served by CATT) Reduce time spent on psychiatric crises: - Law enforcement (30%) - Ambulances (50%)

Assumptions
BH clinician and EMT team, supported by technology, will increase transport to most appropriate and non-emergency services. Transport at time of need to non-emergency services will increase engagement in planned services. Engagement in planned services will reduce use of emergency services.

External Factors
- Level of law enforcement partnering with CATT regarding assessments and transport.

INNOVATIVE PROJECT PLAN DESCRIPTION

County: Alameda **Date Submitted** 4.13.18
Project Name: Community Assessment and Transport Team (CATT)

I. Project Overview

1) Primary Problem

In the United States between 2009 and 2014 the number of police encounters with individuals experiencing a mental health crisis increased 43-50%. In Alameda County, the primary means of addressing these encounters is for law enforcement officers to place the individual on a California Welfare and Institutions Code Section 5150 hold – a 72 hour involuntary hold for psychiatric evaluation. The California Department of Health Care Services (DHCS) report on involuntary detentions for FY2015-16 shows Alameda County with the highest rates of 5150 detentions at 75.3/10,000 for children and 195.7/10,000 for adults. **Of those on a 5150 hold transferred to the psychiatric emergency services unit (PES), 75-78% did not meet medical necessity criteria for inpatient acute psychiatric services.**

In Alameda, individuals on 5150 holds are generally transported by ambulance, rather than police vehicles, to reduce stigma, trauma and possible negative outcomes due to law enforcement involvement. In 2016, this resulted in 13,143 individuals on psychiatric holds being transported by ambulance. This represents 11% of all ambulance transports. **This is a very expensive approach to transport; diverts resources from life threatening emergencies; and leads to clients, law enforcement, and other responders experiencing lengthy wait times for ambulances.**

Those placed on a 5150 hold experience one of two options:

- In 2016, 56% were determined to require a medical clearance and therefore were transported to a medical emergency department (ED) before going to Psychiatric Emergency Services (PES). The wait times between a 5150 hold and formal mental health evaluation can be 12 hours or more.
- In 2016, 44% did not need a medical clearance and therefore were transported directly to the PES unit. The wait times from 5150 hold to a formal mental health evaluation can be two or more hours.

Common issues that result in unnecessary 5150 holds and/or long waits include:

- Law enforcement has limited options for responding to psychiatric crises;
- 5150 holds can only be discontinued by psychiatrists in designated facilities;
- Psychiatric crisis situations are usually not medical emergencies, and therefore are not prioritized by the ambulance transport system;

- Paramedics' scope of practice, as set by the state, only allow them to transport behavioral health clients to an Emergency Department (ED) or Psychiatric Emergency Service (PES) in Alameda;
- Wait times at EDs and PES are often long, and
- The number of agencies involved in responding to one client often leads to lack of coordination of care, and therefore unnecessary or inappropriate care.

Another limitation of the current system is that **individuals in a psychiatric crisis who are not eligible for 5150 holds receive essentially no services.** If a law enforcement officer has the capacity, they may provide information about resources, but the individual is left in place with no effective linkage to needed services. Unfortunately most counties are familiar with the cycle that leads to over-utilization of emergency services: **When an individual interfaces with an emergency service, they often do not get successfully connected to the appropriate planned services, resulting in repeated use of crisis services.**

There are many agencies that play a role in crisis response. In addition, a number of efforts have been made to improve the system, without achieving the level of success desired. This project hypothesizes that in order to effectively change the Alameda County crisis response system from one with the highest rates of 5150 holds to a model of efficient and effective response, a collaborative effort to support creative solutions is required.

a) *Describe what led to the development and prioritization of the idea for your INN project*

Alameda County stakeholders have consistently raised concerns about the high rate of inappropriate 5150 holds, the lengthy process for transport and engaging in resulting services, and the difficulty of getting clients to services if they are not assessed to qualify for a psychiatric hold. In the planning process for the most recent MHSA Three Year Program and Expenditure Plan "Persons experiencing mental health crises" were identified as the second most "underserved population" (www.ACMHSA.org under Documents/MHSA Plans). The first most underserved population identified was those experiencing homelessness, many of whom will benefit from this project.

In Alameda, the cities with the most 5150 transports are shown here:

5150 Hold Transports by Emergency Medical Services in 2017*

	Emergency Dept.	Psychiatric Facility	Total
Oakland	2762	2537	5299
Hayward	754	588	1342
San Leandro	660	546	1206

**Berkeley is not included in this list, as it has a separate MHSA funding allocation.*

Increases in homelessness, marginally-housed individuals, and the opioid epidemic have put a tremendous strain on law enforcement, Emergency Medical Services (EMS), emergency

departments, and psychiatric crisis services. **Various agencies have made efforts to improve the situation without achieving the level of success desired. This is clearly a "persistent, seemingly intractable mental health challenge" in Alameda that other counties also struggle with. At this point, Alameda County Emergency Medical Services, Behavioral Health Care Services, and others are actively coming to the table to address this.** In addition, Alameda County was awarded Whole Person Care funding for four years. The Whole Person Care effort provides a supportive context for this Innovation plan, but does not itself include a crisis services component.

2) What Has Been Done Elsewhere To Address Your Primary Problem?

Alameda County proposes to transform itself from the county with the highest 5150 rate, to one with a model psychiatric crisis response system that gets clients to the *right place at the right time.* In order to do this, a significant collaboration among various agencies will be required to design, support and effectively implement multiple strategies. A key strategy is combining a behavioral health provider and Emergency Medical Technician (EMT) with up-to-date technology and information in a non-emergency vehicle to provide mobile crisis assessment and transport. **Alameda has not been able to identify another program that uses this collaborative approach, staffing model, and technological access to increase the efficiency and effectiveness of their crisis response system.**

BHCS conducted internet and literature research into transport for persons experiencing a psychiatric crisis that included identifying existing models throughout the United States, understanding federal funding sources, and understanding local legal code (Appendix A: MET Recommendations). Based on that research, the development of a crisis response team that includes a behavioral health provider and an EMT was recommended for a number of reasons. EMTs have fewer restrictions than paramedics on where they can transport clients. A team of an EMT and a behavioral health clinician can assess a client's mental and physical health, transport in a non-emergency vehicle, and conduct procedures such as a TB screening – resulting in more potential dispositions for the client in a more timely manner than most team staffing models. Potential transport destinations go beyond an emergency department or psychiatric facility to include crisis residential, sobering centers, and other non-emergency behavioral health services.

An internet search on related literature provided support for the need for collaboration to support change in mental health crisis response systems, but indicated a lack of conceptual clarity, lack of client perspectives, and need for further research (Winters, S. Inter-professional collaboration in mental health crisis response systems: a scoping review. *Perspectives in Rehabilitation.* Jan 14, 2015).

In addition, BHCS research and county-to-county networking identified projects that provided insight into staffing and transport models. There have been a number of projects implemented

addressing mobile crisis response, especially with SB82 funds. A few most relevant to Alameda's proposed model:

- San Diego crisis teams include a paramedic and behavioral health staff. Including an EMT on the team instead of a paramedic, as Alameda proposes, increases the disposition options the team has to address a client's need. San Diego's pilot project was specific to clients on 5150 holds, while Alameda's proposed project will include assessing and transporting clients *not* on holds.
- San Mateo developed a program to train paramedics in assessing patients in mental health crisis and placing 5150 holds. A single paramedic responds in an unmarked car with a barrier that can transport the patient to their PES or a local Emergency Department. The single paramedic can contact the psychiatrist at PES when consultation is needed. This program has resulted in fewer patients being placed on a 5150 hold, but they report the impact is limited due to the staffing model, as many situations call for more specialized mental health expertise.
- San Mateo also has a Crisis Collaboration that convenes quarterly. This collaboration includes BHRS supervisors, law enforcement, fire, EMS, hospitals, PES, Kaiser, community partners and others. Much of the focus is on educating providers about available services and when to refer to those services. Alameda proposes a more targeted collaborative that addresses systems improvement.

Alameda County has implemented a number of efforts to improve the crisis system of care:

- BHCS, EMS, and Care Connect all participate in the Alameda County Multi-Disciplinary Forensic Team (MDFT), a voluntary coalition of law enforcement, BHCS, and allied providers. The MDFT functions similarly to San Mateo's Crisis Collaboration, sharing resources and determining appropriate referrals for individuals in the justice system who have mental health, substance use or developmental disabilities.

- Crisis Response Program (CRP): In 1988, the CRP began providing short-term case management for adults with serious mental health diagnoses to reduce unnecessary hospitalizations – generally accessed through walk-in and appointments. In addition, teams of two (2) mental health clinicians provide mobile crisis response (not transport) in Oakland Monday-Friday from 10:00 am to 8:00 pm.

- Transition Age Youth Triage (SB82): The Hope Intervention Program (HIP) provides crisis prevention services to TAY (16-24). HIP aims to reduce use of crisis services by addressing services gaps, including mobile outreach (not transport), developing individualized crisis support plans, targeted intensive case management and linkage.

- Mobile Evaluation Teams: Beginning in 2014, behavioral health providers have been teamed with police officers in Oakland to reduce unnecessary 5150 holds by having the behavioral health provider conduct the assessments. While it has had some impact on 5150's, it does not address transport. This INN project develops crisis teams that can transport individuals to a range of services, whether or not they are on a 5150 hold, increasing the likelihood

individuals will get connected to needed services, and reducing the likelihood they will over-utilize emergency services.

- SB82 Proposal: BHCS was recently partially funded for a proposal to the Investment in Mental Health Wellness Act Round 2 Triage program. That proposal funds a few discrete services to fill gaps in the crisis continuum, including expanding the existing Mobile Crisis Team, a Post Crisis Follow-up Team, Education and Consultation Hotline, and Transition Age Youth (TAY) Multi-Disciplinary Team (MDT) for TAY in Santa Rita jail. None of these services provide transport.

This Innovation proposal does not just provide a discrete service, it is a test of concept to improve crisis response through a collaborative approach and change in staffing models paired with technological support and transport. Before adopting this staffing model across the system, this INN project will allow for testing whether it improves the transport system, and how it does this. INN will also support the testing of a robust collaboration to ensure effective changes are implemented, since the model requires active involvement in systems improvement from multiple agencies.

3) The Proposed Project

a) *Provide a brief narrative overview description of the proposed project.*

Given that Alameda has the highest rates of 5150 holds, has implemented strategies to address this with limited results, and has some uncommon crisis system features– a PES not attached to an ED and a reliance on ambulance transports – it seems necessary to **develop an interagency collaboration to design, implement and support a crisis response system that reduces the rate of involuntary detentions and increases the efficiency and effectiveness of linking clients to needed services. This system would include an innovative combination of staffing, technology, and collaboration to maximize the options available to the mobile crisis response team when assessing and transporting clients to needed services.**

The CATT project will promote interagency collaboration among core Alameda County Health Care Services Agency programs - *Behavioral Health Care Services, Emergency Medical Services, and Alameda Care Connect (Whole Person Care)* – as well as other partners – *911 dispatch, the County Sherriff's Office, city police departments, city health and human services, and other relevant service* - to develop a highly responsive and efficient mobile psychiatric crisis response system. A Senior Program Specialist will coordinate the collaboration to meet regularly throughout the project to design system changes; clarify each partner's role in implementation; ensure training, staffing and policies support the determined changes; ensure course corrections are made in a timely manner; and oversee program evaluation.

Examples of issues the collaboration will address:

- Criteria for determining the most appropriate service to transport a client to

- Understanding why clients in crisis do not meet criteria to receive certain services, such as PES, and developing systemic solutions to routing clients appropriately
- Ensuring client records and service availability is up to date and accessible to CATT

This collaboration will develop, implement, support and evaluate changes to the crisis system in order to achieve the desired outcomes. Two core changes that will be implemented are:

1) A mobile crisis team comprised of a behavioral health provider and an Emergency Medical Technician (EMT) in a non-emergency vehicle. This staffing model enables assessment and transport for a broad range of dispositions (PES, CSU, sobering center, emergency departments, etc.). The staffing model, as well as the collaboration, will contribute to the team successfully accessing all available dispositions. The staffing model will provide the professional capacity to assess and refer to the dispositions. EMTs are able to transport to a wider range of destinations than paramedics, while also being able to conduct medical assessments and initiate medical requirements, such as TB screening, to assist with transition into services. Mental health clinicians can conduct assessments to determine the most appropriate behavioral health service. An unmarked non-emergency vehicle reduces stigma and increases possible transport destinations ambulances cannot transport to. The collaboration will help ensure the disposition sites efficiently and successfully receive the clients.

2) Technical support that provides the greatest capacity for the team. This includes:
   - ReddiNet: A web-based emergency communications system. Alameda has been using it since 2008 to track hourly bed availability for emergency departments and during multi-casualty incidents. The collaboration will work with ReddiNet to expand the system to include beds, appointments and slots in crisis stabilization units, crisis residential sites, sobering/detox centers, and other behavioral health services, as well as alerting providers when the psychiatric emergency services is on diversion. In addition it sends alerts to all EDs, ambulances, transport teams, and other pertinent agencies if Alameda's regionally dedicated PES or other behavioral health facilities are close to full. ReddiNet has been implemented in a number of counties in California, although likely they do not all use the bed capacity feature. Alameda BHRS aims to achieve full utilization of the bed capacity feature through this project's collaboration by ensuring all relevant partners participate and keep it up-to-date.
   - Video translation services: A program to provide a translator on screen.
   - Shared client records: In 2019, BHCS clinicians will have access to Community Health Records through Alameda's Care Connect (Whole Person Care), including physical and mental health history and information about providers engaged with client, as well as allowing them to add the current episode to the shared records. The EMT can maintain clinical records in the existing electronic patient record that is used by 911 ambulance system. The collaboration will be essential to ensuring these records are updated, useful and accessible.

The project would provide services from 7:00 am until midnight, seven days per week – as those are the times when the large majority of 5150s are placed in Alameda County. Teams of one behavioral health clinician and one EMT will be deployed in unmarked vehicles fitted with appropriate technological capacities and safety features. Safety features include special seating for clients, a barrier between the driver and back passenger seats, customized locks and windows, locking storage cabinets, and other modifications similar to the inside of a police vehicle. The services would be dispatched by the 911 system for behavioral health related calls. A police officer would arrive first to assess safety.

- By developing a strong relationship between the police department and BHCS, law enforcement can make it a practice to wait on making a determination regarding a 5150 hold until the crisis team arrives. This should reduce unnecessary 5150 holds.
- If a hold is appropriate the CATT can transport the client to PES or to an ED for medical clearance prior to PES. The EMT physical assessment will reduce the number of clients on a 5150 hold needing to be taken to the ED for medical clearance. This can be achieved in two ways: 1) the EMT can clear people who are not required to be taken to the ED based on protocol, but might have been taken to the ED as a precaution, and 2) Adjusting current protocols regarding who must be take to the ED. For example, the current requirement that all clients over the age of 60 must be taken to the ED could be amended for those served by CATT. This should reduce the time law enforcement and ambulance staff, as well as ED staff, spends on behavioral health calls.
- The CATT can also assess, refer and transport individuals *not on a hold* to programs such as a sobering center, crisis residential, crisis stabilization unit, or peer respite. The EMT can complete an initial medical evaluation required before transport to the ED, PES or Sobering Center, as well as completing checklists that will streamline intake for programs such as crisis residential. Use of ReddiNet will help ensure there are services available before a client is transported. This should increase the ability to efficiently link clients not on a 5150 hold to services. Over time this should lead to an increase in use of planned services and reduction in use of emergency services. (ReddiNet will be expanded to include beds, appointments and slots available at crisis stabilization units, crisis residential sites, sobering/detox centers, and other behavioral health services, as well as when PES or emergency department go on diversion. In case services are at capacity, PES will always accept clients from the field.)
- Use of BHCS electronic records, as well as Community Health Records, will increase accuracy of assessments and continuity of care.

Initially CATT will deploy two vehicles to serve two communities in Alameda County. San Leandro is the city with the fourth highest number of 5150 holds in Alameda County (1,206) (Appendix B: EMS 5150 Transports by City). It does not have an alternative crisis response, just police and EMS. San Leandro has committed to participation (letter of support pending). Hayward is the city with the second highest number of 5150 holds in Alameda County (1,342). It also does not have an alternative crisis response in place. Hayward has committed to participation (letter of support pending).

Piloting this project in these two communities will allow for testing out systems and ensuring they are functioning well before expanding to a more complicated environment. After 18 months, the project will expand to Oakland (letter of support pending). Oakland is the city with by far the highest number of 5150 holds (5,299). It has Mobile Evaluation Teams and a Crisis Response Program, neither of which provide transport. In order to see if the CATT project can have a significant effect on the overall crisis response system, it is essential to test it in Oakland. Two vehicles will be deployed in Oakland.

b) *Identify which of the three approaches specified in CCR, Title 9, Sect. 3910(a) the project will implement*

This proposal makes a change to an existing practice in the field of mental health. While there have been a variety of approaches to improving crisis transport systems, Alameda has not been able to identify another program that uses this collaborative approach, staffing model, and technological access to increase the efficiency, accuracy and number of disposition options.

c) *Briefly explain how you have determined that your selected approach is appropriate*

Alameda's experience with SB82 and other system change efforts underscores the need for an active collaboration to ensure that barriers that are encountered can be addressed in a timely manner in order to realize the potential of the efforts. Crisis response models in other regions have provided insight into the potential of alternative staffing models for mobile crisis teams. The recent progress in electronic capabilities provides additional opportunities.

4) Innovative Component

a) *If you are adapting an existing mental health model or approach, describe how your approach adds to or modifies specific aspects of that existing approach and why you believe these to be important aspects to examine.*

The MHSOAC's "Triage Grant Information Gathering Brief – June 29, 2017" pointed out central challenges experienced within the Triage programs under SB82 – implementation delays, developing and maintaining successful collaborations, and effective evaluation of the programs. This has influenced the Triage grants to increase the use of collaboration to achieve the primary goals of SB82. Literature reviews support the need for interagency collaboration to improve crisis systems, and find that such efforts have been limited. **This project proposes to make the collaborative process the focus of the project and evaluation, recognizing that this is essential to making the level of systems change that is needed in Alameda County. This will allow Alameda to put the necessary time and resources behind working together to design the system improvements, as well as monitor them and make timely course corrections to ensure effectiveness.**

The collaboration will:

- Design the system changes

- Ensure that the staffing, training and policies are in place for effective implementation of innovative changes, including the EMT/behavioral health clinician crisis team, the use of ReddiNet and other shared records that all agencies must keep up to date, and the transport of clients to non-emergency services that will receive the clients efficiently
- Conduct continuous quality improvement to ensure timely course corrections
- Document and evaluate the process to assist with replication

In addition, the central strategies to be implemented are informed by, but go beyond, previous efforts of Alameda and other counties. **This project tests the provision of crisis assessment and transport for clients (whether they are on a 5150 hold or not) by a team that includes a behavioral health provider and an EMT in a non-emergency vehicle with technology supports that provide information about bed availability and client history.** This team maximizes the number of disposition options available and enables more efficient transfer of clients into services. Transitioning clients from one program to another is frequently the cause of delays, lack of follow-through, and loss of care continuity. Ideally this project will reduce 5150s both by providing thorough assessments on the scene and by connecting clients to planned services, reducing use of emergency services in the future.

5) Learning Goals / Project Aims

a) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

Alameda County has two primary learning goals:

1. Determine if and how collaboration among agencies responding to mental health crises can contribute to developing an effective and efficient crisis response system.
    - This learning goal focuses on whether the actions of the collaboration result in:
        - An effective system: One that gets clients to the services that they need at the right time. Such as reducing unnecessary 5150 holds and getting clients not on a hold to a service, increasing their engagement with planned services.
        - An efficient system: One that reduces the time spent by clients waiting to be transitioned to a service and reduces the time law enforcement/ambulances spend on psychiatric crises.
    - The central hypothesis is that intensive collaboration is required to make significant improvements to crisis response systems. This project will evaluate the role that collaboration plays in making improvements in a timely manner.

2. Determine if and how the changes in the crisis response system result in community and county priorities: better client services and more efficiency in the system.
    - This project will evaluate whether combining a unique staffing model in a non-emergency vehicle with technology supports to provide crisis assessment and transport leads to improved outcomes, including:

- Better client services: Client are better served by a crisis response system if it results in them being connected to the services they need without stigma.
- Efficiency: Reduce the time clients wait to be connected to services and the time law enforcement/ambulances spend on psychiatric crisis response.

b) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

1. Determine if and how collaboration among agencies responding to mental health crises can contribute to developing an effective and efficient crisis response system.
    - Developing a collaboration to design, implement and support changes to the crisis response system is a key element of this Innovation plan. Based on past experience, the findings of SB82 Triage efforts to date, and existing literature, collaboration seems to be a necessary but not fully implemented element. This project will test this hypothesis, as well as inform sustainability and replication.

2. Determine if and how the changes in the crisis response system result in community and county priorities: better client services and more efficiency in the system.
    - The key change proposed is implementing a new crisis assessment and transport staffing model with appropriate technological support, resulting in the most disposition options for the client. This project will test if this new approach leads to success and how.

6) Evaluation or Learning Plan

1. Determine if and how collaboration among agencies responding to mental health crises can contribute to developing an effective and efficient crisis response system.

Data to collect	Data collection method
Who participates in the collaborative • Are the necessary partners participating Collaborative meetings and other activities • Is the collaborative meeting regularly	○ The Program Specialist will collect via membership rosters, sign-in sheets, meeting agendas, etc.
Continuous quality improvement efforts: • What issues are brought to the collaboration • How they are resolved • How quickly they are resolved • What the result is	○ The Program Specialist will collect via meeting minutes. ○ The evaluators will collect via observation and annual focus groups or key informant interviews with collaborative members.
Collaborative members actions • Are they taking actions to support:	○ The evaluators will collect via annual surveys and focus groups or key

shared client records; a system for tracking available service slots; timely access to crisis services; etc.	informant interviews with collaborative members.
Collaborative members perception of the effectiveness of the collaboration, including what contributed to or impeded success	○ The evaluators will collect via annual surveys and focus groups or key informant interviews with collaborative members.

2. Determine if and how the changes in the crisis response system result in community and county priorities: better client services and more efficiency in the system.

Short-Term Outcomes

Data to collect	Data collection method
Number of clients served by CATT *Estimated: 10,794*	○ Electronic health records, including number assessed and number transported *Estimate: See Numbers Served section*
Number of clients not on 5150 hold transported to services *Estimated: 2,600*	○ Electronic health records show number of transports including 5150 status and final disposition of client *Estimate: This includes individuals that would not have been put on 5150 hold before CATT, as well as those diverted from 5150 by CATT. Assumes 50% of non-5150 clients consent to transport.*
Number of transported clients not on 5150 hold who engage in services *Estimated: 900*	○ Electronic health records show what services clients engaged in. Analyze level of engagement in planned mental health, substance use, or other relevant services before CATT transport to after CATT transport. Look at records 3 months after CATT transport.
Client satisfaction, including perceptions of stigma *60% of clients will report satisfaction*	○ Post crisis survey call by peer provider

Long-Term Outcomes

Linking non-5150 clients to appropriate services should result in lowered use of crisis services. In addition, CATT response should result in less involvement from law enforcement and ambulances in psychiatric crisis. The evaluators will look at impacts on the crisis system that are related to CATT implementation. Some examples:

Data to collect	Data collection method
Efficiency of CATT	○ EMS measures ambulance response time to every request

response compared to other responses *CATT will take 25% less time to complete service than current system*	via 911 system, as well as time of transport to receiving destination and vehicle/crew time at receiving destination. This data will also be recorded for CATT. Data for EMS vs CATT will be compared, either by looking at matched cases or at comparable pools of cases.
Percent change in numbers of 5150 transports to ED for medical clearance *25% reduction*	○ EMS tracks number of 5150 transports by city broken down by ED and PES destinations. This data can be compared for each city with CATT services for the few years before CATT to data after CATT implemented.
Number of 5150 holds avoided *30% reduction among those served by CATT*	Data collection options: ○ Compare trends in 5150 hold rates by city before and after implementation. Compare changes between participating and non-participating Alameda County cities to increase the ability to show the impact of this program, versus other factors. ○ Compare trends in rates of clients brought to PES on a 5150 hold who meet medical necessity criteria for acute psychiatric services in Alameda before and after implementation. ○ Compare CATT client frequency of 5150 before and after CATT service ○ Perception of CATT responders as to portion of clients that might have been put on 5150 hold but were not due to CATT involvement
Change in time spent by law enforcement and ambulance services on psychiatric emergencies *30% reduction for law enforcement* *50% reduction for ambulance*	Evaluators will analyze change in time in cities with CATT services. Methods may include: ○ Analyze pre-CATT records to estimate likely change in time spent ○ Compare pre-CATT records to post-CATT records, taking into consideration other factors that affect # of calls and time spent

Data collection, evaluation and reporting for this project will be in alignment with the current Innovation Regulations. This includes collecting indicated demographic data, tracking changes made to the project in the course of implementation, and providing annual and final reports covering all required elements.

Evaluation of this project will be contracted out. The evaluators will assist in finalizing the evaluation plan, developing the appropriate tools, gathering and analyzing the data, and vetting the evaluation plan and tools with appropriate stakeholders. They will document factors that might affect the outcomes and will attempt to increase the validity of the results.

7) Contracting

The implementation of this project will be lead by BHCS staff. Some of the staffing will be provided by EMS.

II. Additional Information for Regulatory Requirements

1) Certifications

2) Community Program Planning

The community planning process for the MHSA Three Year Plan was conducted from June – October 2017. During that process ACBHCS staff provided updates and information on current MHSA programs and community members provided input on mental health needs and services. There were three modes for providing input:

- Five large community forums (one in each Supervisorial District);
- Eighteen focus groups were conducted throughout Alameda County: Chinese speaking family members, African American family members, providers for refugees, providers for LGBTQ community, transitional age youth (2), Afghan immigrants, older adults, API and refugee providers and advocates, providers for individuals with developmental disabilities and mental illness, and Pool of Consumer Champions (BHCS's mental health consumer group);
- Community Input Surveys in all threshold languages: submitted by 550 unique individuals. Respondents were very diverse in age, race, and ethnicity. Fifty percent of respondents were from Oakland, while they make up only 30% of Alameda's population. Survey respondents included: Mental health consumers (25%), family members (17%), community members (15%), education agency (2%), community mental health providers (14%), homeless/housing services (6%), county Behavioral Health staff (1%), faith-based organization (2%), substance abuse services provider (<1%), hospital/provider care (4%), law enforcement (1%), NAMI (1%), Veteran/Veteran services (1%), other community (Non-MH) service provider (5%), other/decline to state (9%).

Details of the process are provided in the MHSA Three Year Plan (www.ACMHSA.org under Documents/MHSA Plans).

The BHCS Systems of Care and BHCS Housing Department were asked to submit proposals that addressed the needs identified in the community planning process. The proposed projects were vetted by MHSA staff based on whether they addressed community priorities, as well as other factors. For example, "Persons experiencing a mental health crisis" were identified as the second-most underserved population (54%). The first most underserved population identified was those experiencing homelessness, many of whom will benefit from this project.

This proposal was posted for 30-day public comment (April 13-May 13, 2018) and a public hearing was held on May 14, 2018. Substantive comments and responses are included here.

Comment: There is a definite need for improved crisis response systems for the consumers in Alameda County. Adding a mental health specialist as well as a transport team appears to be a promising idea. This will likely improve the onsite assessment process to determine the priority need for the individual at that point in time. Of all the proposals, it is great to see the one has plans to expand into Oakland, as Oakland is one of the most high need areas.

However, this proposal does not address the lack of resources available in the community for many of our consumers. As the housing market continues to rise, the number of vacancies in crisis residential homes, shelters, detox centers, etc. continue to decrease due to increased demand and longer lengths of stay because of limited long term housing options. While it is great that the consumer's needs will be better assessed in the crisis; systemic change may be limited by lack of placements for these individuals, thereby continuing to overflow the ED services.

Additionally, with the significant growing older adult population in Alameda County, there is not enough attention being paid to older adult needs. Will the transport vehicles be ADA accessible for individuals utilizing assistive devices and/or who have a physical limitation? Will the medical clearance still be required for any individual over the age of 60? Or will this transport team be able to provide that clearance? This medical clearance requirement often significantly delays older adults from getting the services they actually need when they need them.

In line with the Whole Person Care initiative, there is a need for increased medical and nursing services available in the community and in the homes for consumers. There are many situations in which a crisis appears psychiatric but may in fact be due to or combined with an underlying medical cause; however, the individual does not have enough supports available to assist them in maintaining their health in the community to prevent these crises. To streamline crisis services and over use of ED services, Alameda County needs a plan to address the individuals experiencing grave disability and need for increased medical care. It would be interesting to know how the new CATT team will be addressing individuals with these sorts of crises, because as it stands right now, these individuals will likely continue using the emergency services (one example being due to CCL licensing requirements prohibiting non-ambulatory individuals).

Response: Behavioral Health Care Services (BHCS) is aware of the shortage of resources for our client population and is working on this through other avenues and funding streams, i.e. a new crisis residential and crisis stabilization program is currently being built, a new crisis residential for TAY is also currently being built and almost completed, additional crisis services are in the planning phase, Full Service Partnership slots will be expanded as of July 1st as well as Substance Use Disorder (SUD) services. The CATT proposal is truly a test of concept to see if this model will be able to get people to the right resource to help stabilize them, reduce future crisis episodes and increase quality of life for Alameda County residents.

In response to the transport vehicles and ADA compliance: Vehicles will be easily accessible but not ADA compliant. If a client needs accommodation beyond what the vehicle affords, an

ambulance will provide the transport. If this project moves beyond a pilot, BHCS would consider adding some ADA type vehicles based on need identified during the pilot.

In response to the medical clearance question: The Alameda County Emergency Medical Services (EMS) Department is evaluating changing some physical health parameters, While they currently do not intend to change the requirement that individuals over 60 years old receive medical clearance in general, they may pilot a change to this requirement for those served by CATT. The head of EMS will have to make that determination as that is not within BHCS purview.

Comment by Family Member: I am concerned that this program may be intended to reduce 5150's and hospitalizations at places like John George. This is NOT NECESSARILY a measure of success. We need more beds at John George, etc., and longer stays- a few days or weeks for people who need them to stabilized and benefit!

Response: Thank you for your comment. While we expect a reduction of inappropriate 5150s, this project would not reduce appropriate 5150s or hospitalizations. This program is testing a concept to see if through this new model of collaboration, transportation, different staffing pattern and technology, BHCS can get clients to the services they are eligible for in the most efficient way. Once the project is approved an evaluation team will be brought on to work with multiple stakeholder groups including (but not limited to) the program staff, the MHSA Stakeholder Committee, family members and consumers to refine the outcome measures.

3) Primary Purpose

Promote interagency collaboration related to mental health services, supports, or outcomes.

4) MHSA Innovative Project Category

Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community.

5) Population

a) *If your project includes direct services to mental health consumers, family members, or individuals at risk of serious mental illness/serious emotional disturbance, please estimate number of individuals expected to be served annually. How are you estimating this number?*

This project serves people experiencing a behavioral health crisis in the community that results in a 911 response, but that does not require emergency medical services. Numbers to be served are based on the current rates of 5150 holds during the hours of operation. Approximately 70%

of 5150s are placed from 7:00 am to midnight. Numbers served include most of those currently put on 5150 holds between 7:00 am to midnight, as well as other psychiatric crises not resulting in 5150 holds.

Numbers Served

Start Date	Community Served	5150 /year	CATT Svc/day	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Oct 2018	San Leandro	1,200	~2	495	660	660	660	660	3,135
Oct 2018	Hayward	1,300	~2	513	684	684	684	684	3,249
Feb 2020	Oakland	5,300	~5	0	0	760	1,825	1,825	4,410
TOTAL		7,800	~9	1,008	1,344	2,104	3,169	3,169	10,794

b) *Describe the population to be served*

This table shows the demographics of the communities to be served.

	San Leandro	Hayward	Oakland
Total Population	90,465	144,186	412,040
Race/Ethnicity *			
Asian/Pacific Islander	32%	25%	17%
Black/African American	14%	12%	28%
Latino	40%	41%	25%
White	29%	34%	26%
American Indian	3%	1%	1%
Other/Unknown	8%	2%	3%

Adds up to more than 100% as some people may be more than one race/ethnicity

c) *Does the project plan to serve a focal population, e.g., providing specialized services for a target group, or having eligibility criteria that must be met? If so, please explain.*

This project serves people experiencing a behavioral health crisis in the community that results in a 911 response. Eligibility includes:

- Services are required in a location and during a time CATT is in service
- The situation must be assessed as safe by a law enforcement officer
- The individual cannot be in need of emergency medical services

BHCS and EMS will develop specific eligibility criteria in the initial phase of this project.

6) *MHSA General Standards*

a) Community Collaboration: The focus of this project is collaboration among BHCS, EMS, law enforcement, community providers and others. The roll-out of this project will also be presented to local consumer and family groups to provide information and get feedback. Alameda's Whole Person Care project, Care Connect, conducts consumer convenings to ensure community input. Updates on this project will be presented regularly at the convenings to solicit input on implementation and evaluation.
b) Cultural Competency: Program staff will receive cultural competency training. Efforts will be made to hire staff who reflect the diversity of the communities they will serve. Updates on this project will be presented regularly to BHCS' Cultural Competency Advisory Board to solicit input on implementation and evaluation.
c) Client-Driven: As described under Community Collaboration, ongoing input will be solicited from groups that include consumers. In addition, clients and family members will participate in development, implementation and analysis of the project evaluation.
d) Family-Driven: Care Connect records include crisis plans developed by consumers. These plans, and other means, will be used to repatriate clients with their support network as quickly as possible. At times families will participate in the "client satisfaction" phone surveys conducted, providing feedback about the services.
e) Wellness, Recovery, and Resilience-Focused: This program aims to reduce involuntary holds and increase access to services that support recovery.
f) Integrated Service Experience for Clients and Families: The goal of the collaborative is to integrate services toward efficiency and appropriate services. For example, sharing of records among agencies responding to crises, and particularly with the crisis teams, will lead to better coordination of care.

7) *Continuity of Care for Individuals with Serious Mental Illness*

Individuals with serious mental illness will be served by this project. Given that the services are crisis response services, if elements of this project do not continue, it will not disrupt continuity of care. Ideally, any changes that have been made and found to be successful will be sustained in one of three ways:

- The changes may be integrated into ongoing operations and will not require ongoing funding. This may include changes in policies and procedures, upkeep of shared data systems, collaborative relationships, etc.
- The changes may be sustained through non-MHSA funds. For example, once the billing for services has been established successfully the staffing model may be funded through reimbursements. Other costs may be covered by increased efficiencies.
- If other aspects of the project, such as the formal collaboration, need to be continued, BHCS will consider supporting these costs as described in question 9.

8) *INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement.*

a) *Explain how you plan to ensure that the Project evaluation is* ***culturally competent.***

The evaluation plan will be presented to BHCS' Cultural Competency Advisory Board (CCAB), the MHSA Stakeholder Committee and the Whole Person Care consumer convenings for feedback on the methods and outcomes. In addition, there will be regular presentations to the CCAB, MHSA Stakeholder Committee and consumer convenings as the evaluation is implemented in order to get ongoing feedback on issues that arise. Client/family satisfaction questions will be reviewed by members of the target groups prior to implementation and conducted in the appropriate language.

b) *Explain how you plan to ensure* ***meaningful stakeholder participation*** *in the evaluation.*

The collaboration participants will be actively involved in project implementation, including working with the evaluator to develop evaluations plans, tools, and data analysis. In addition, clients and family members will be paid to assist with planning and implementing the clients' satisfaction component, as well as data analysis. The CCAB, MHSA Stakeholder Committee and consumer convenings will contribute to evaluation planning, implementation, and analysis.

9) *Deciding Whether and How to Continue the Project Without INN Funds*

BHCS will support the continuation of this project or components of this project based on a number of internal and external factors and processes including: 1) the evaluation results from the project, 2) support and buy-in from the Adult & Older Adult System of Care 3) Continued buy-in from law enforcement 4) recommendations from the MHSA Stakeholder Committee & the CCAB, and 5) available funding. This project will be able to generate revenue through Medi-cal billing, which will help offset the overall costs and thus increase the probability of being sustained if there are positive results from the factors listed above. MHSA Community Services and Supports will be considered for costs not covered by Medi-Cal or other sources.

10) *Communication and Dissemination Plan*

a) *How do you plan to disseminate information to stakeholders*

The CATT collaborative will be responsible for disseminating results to their agencies, other stakeholders, and other counties. Updates on the project will be provided to stakeholders on an ongoing basis via email and presentations at existing meetings. The final evaluation report for this project will be shared widely by posting it on the BHCS website and announcing via email to stakeholders, including to mental health directors, Alameda County Mental Health Board, MHSA coordinators, and EMS agencies throughout the state. In addition presentation will be made to the MHSA Stakeholder Group, the Cultural Competency Advisory Board (CCAB), the

Whole Person Care consumer convenings, other consumer groups, NAMI, the Board of Supervisors, and other appropriate entities.

b) *How will program participants or other stakeholders be involved in communication efforts?*

The CATT collaborative members will be responsible for sharing the results with their agencies, providing presentations to the organizations listed above, and forwarding email announcements to their stakeholders. The Program Specialist will be responsible for website postings and email announcements.

c) *KEYWORDS for search:*

Collaborative crisis response system; Mobile mental health crisis response; Multidisciplinary psychiatric crisis transport

11) Timeline

a) *Specify the total timeframe (duration) of the INN Project:* **5 Years**
b) *Specify the expected start date and end date of your INN Project:*

Start Date: October 2018 End Date: September 2023

c) *Include a timeline that specifies key activities and milestones*

Prior to implementation of the Innovation project, some aspects of the project will be underway due to Measure A funding (see budget narrative). This will include:

- MOUs in place with initial two participating communities
- Hiring of staff and contractors funded under Measure A
- CATT vehicles purchased and modified to CATT specifications
- Work with 911 dispatch to create system to dispatch CATT

Month	Milestone
Oct-Dec 2018	Assign Program Specialist from BHCS staff Begin monthly collaborative meetings Identify evaluator through competitive process Hire additional staff Staff training Begin program in two communities (San Leandro, Hayward)
Jan-Mar 2019	Develop evaluation plan Develop Continuous Quality Improvement (CQI) process Community Health Record access in all vehicles
Apr-Jun 2019	Begin implementation of evaluation plan
Jul-Sep 2019	Evaluation of program implementation to date
Oct-Dec 2019	Implement changes to project based on evaluation findings

	Staff hired for Oakland teams
Jan-Mar 2020	Staff training for Oakland teams Begin program in Oakland
Apr-Jun 2020	Begin evaluation of Oakland program
Jul-Sep 2020	Evaluation of program implementation to date
Oct-Dec 2020	Implement changes to project based on evaluation findings
Jan-Mar 2021	Begin sustainability evaluation and planning
Apr-Jun 2021	Continue CQI
Jul-Sep 2021	Evaluation of program implementation to date
Oct-Dec 2021	Implement changes to project based on evaluation findings
Jan-Mar 2022	Continue CQI
Apr-Jun 2022	Continue CQI
Jul-Sep 2022	Evaluation of program implementation to date
Oct-Dec 2022	Implement changes to project based on evaluation findings
Jan-Mar 2023	Continue CQI
Apr-Jun 2023	Preliminary data shared with stakeholders for input on data analysis Initial evaluation report shared with stakeholder to discuss sustainability
Jul-Sep 2023	Project completion Evaluation report completed, disseminated and presented Sustainability planning completed

This timeline allows for implementing the collaboration and new crisis response strategies in two communities to ensure the processes are running smoothly before implementing in Oakland, a much larger and more complex environment. Annual evaluation, Continuous Quality Improvement, and ongoing sharing of updates will ensure that evaluation and stakeholder input is supported. Time is allocated near the end of the project to allow for stakeholder input in data analysis and decisions about sustaining the project, as well as dissemination of final results.

12) INN Project Budget and Source of Expenditures

This INN Plan will use FY 08/09, FY 09/10 and part of FY 10/11 funds that were deemed reverted back to the county of origin under **AB 114.**

Alameda County has been awarded **SB82 funds** to initiate and expand a number of crisis response efforts to reduce crises and assist law enforcement with psychiatric crises. These projects are being implemented, but they do not address crisis transport and only support the level of collaboration needed to implement the discrete services in the SB82 projects.

This INN Plan is being implemented in partnership with Alameda County Emergency Medical Services (EMS). EMS has already secured **Measure A funds** through a competitive process to support the start-up of this project. Measure A was approved by voters in 2004 to support an

array of services for low-income residents of Alameda County. Leveraging Measure A and Innovation funds sets the groundwork for a robust collaboration.

Project Budget by Year - Narrative

Salaries

FY18-19: 9 months (Oct-Jun):

7.2 FTE BH Clinicians at $60 per hour = $777,600

7.2 FTE EMTs at $34.25 = $461,635

This staffing level allows for two mobile teams from 7:00 am until midnight, seven days per week.

1 FTE Clinical Supervisor at $150,000 annual wages and benefits = $112,500

1 Program Specialist at $135,000 annual wages and benefits = $101,250

Staff partly funded by Measure A. Total INN funds = $820,047

FY19-20: Jan-Jun 2020 the staff increases to a total of 14.4 FTE BH Clinicians and 14.4 FTE EMTs for Oakland teams = $692,453. This staffing level allows for four mobile teams from 7:00 am until midnight, seven days per week.

Staff partly funded by Measure A. Total INN funds = $1,775,301

FY20-21: Staff stays at same level. *No Measure A funds. MediCal billing factored in.*

Total INN funds = $1,613,471

FY21-22: Staff stays at same level. *No Measure A funds. MediCal billing factored in.*

Total INN funds = $1,613,471

FY22-23: Staff stays at same level. *No Measure A funds. MediCal billing factored in.*

Total INN funds = $1,613,471

FY23-24: 3 months (Jul-Sep): No additional costs incurred for final report dissemination and sustainability planning

Total INN Funds = $7,435,761

Operating Costs

Data plan for tablets, mobile phone plans, fuel, and vehicle maintenance. *Measure A will cover these costs in FY18-19.* Total INN funds = $403,875

Non-Recurring Costs

Vehicles, radios, vehicle modifications, Tablets, phones, laptops, software, staff training. *Measure A will cover these costs.* Total INN funds = $0

Consultant Costs/Contractors

Evaluation consultant costs at roughly 5% of project cost ($125,000) with the exception of Yr 4 which will be higher ($200,000) to allow for deeper evaluation and sustainability planning as we near end of project.

Peer/Family stipends to assist with gathering and analyzing data and outcomes:
$20/session x 500 sessions = $10,000 year

Total INN funds = $750,000

Indirect

15% for county administration of the project. Applies to Personnel, Operating and Contract expenditures to provide Human Resources, Accounting, Budgeting, Information Technology, Business Services Office, and Legal management of staff and contract positions; rent, utilities, insurance; and other expenses necessary to administer the project.

Total INN funds = $1,288,446

Expend by Fund Source - Narrative

Administration

- 68% of Program Specialist time will be spent on program development and implementation = $416,822
- Indirect expenses (see above) = $1,288,446

Total INN funds = $1,705,268

Evaluation

- 32% of the Program Specialist time will be spent on evaluation design and implementation = $200,213
- Evaluator (contracted) = $700,000
- Peer/Family stipends to conduct client satisfaction surveys, assist with evaluation planning and data analysis = $50,000

Total INN funds = $950,213

Non-MHSA Funding

- FFP: Once billing systems are developed, MediCal will reimburse for some services
- Other Funding: Measure A (described above)

B. New Innovative Project Budget By FISCAL YEAR (FY)*						
EXPENDITURES						
PERSONNEL COSTs (salaries, wages, benefits)	**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
1 Salaries	$820,047	$1,775,301	$1,613,471	$1,613,471	$1,613,471	$7,435,761
2 Direct Costs						$0
3 Indirect Costs	$ 123,007	$ 266,295	$ 242,021	$ 242,021	$ 242,021	$ 1,115,365
4 Total Personnel Costs	$ 943,054	$ 2,041,596	$ 1,855,492	$ 1,855,492	$ 1,855,492	$ 8,551,126
OPERATING COSTs	**FY 18-19**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
5 Direct Costs	$ -	$ 80,775	$ 107,700	$ 107,700	$ 107,700	$ 403,875
6 Indirect Costs	$ -	$ 12,116	$ 16,155	$ 16,155	$ 16,155	$ 60,581
7 Total Operating Costs	$ -	$ 92,891	$ 123,855	$ 123,855	$ 123,855	$ 464,456
NON RECURRING COSTS (equipment, technology)	**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
8 **Vehicles and Equipment**	$0					$0
9 **Training**	$0					$0
10 Total Non-recurring costs	$0	$0	$0	$0	$0	$0
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)	**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
11 Direct Costs	$135,000	$135,000	$135,000	$210,000	$135,000	$750,000
12 Indirect Costs	$20,250	$20,250	$20,250	$31,500	$20,250	$112,500
13 Total Consultant Costs	$155,250	$155,250	$155,250	$241,500	$155,250	$862,500
OTHER EXPENDITURES (please explain in budget narrative)	**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
14						$0
15						$0
16 Total Other expenditures	$0	$0	$0	$0	$0	$0
BUDGET TOTALS						
Personnel (line 1)	$820,047	$1,775,301	$1,613,471	$1,613,471	$1,613,471	$7,435,761
Direct Costs (add lines 2, 5 and 11 from above)	$135,000	$215,775	$242,700	$317,700	$242,700	$1,153,875
Indirect Costs (add lines 3, 6 and 12 from above)	$143,257	$298,661	$278,426	$289,676	$278,426	$1,288,446
Non-recurring costs (line 10)	$0	$0	$0	$0	$0	$0
Other Expenditures (line 16)	$0	$0	$0	$0	$0	$0
TOTAL INNOVATION BUDGET	$1,098,304	$2,289,737	$2,134,597	$2,220,847	$2,134,597	$9,878,082

C. *Expenditures By Funding Source and FISCAL YEAR (FY)*							
Administration:							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
1	Innovative MHSA Funds	$ 209,079	$ 386,411	$ 366,176	$ 377,426	$ 366,176	$ 1,705,268
2	Federal Financial Participation						
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding*						
6	**Total Proposed Administration**	**$ 209,079**	**$ 386,411**	**$ 366,176**	**$ 377,426**	**$ 366,176**	**$ 1,705,268**
Evaluation:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
1	Innovative MHSA Funds	$ 146,213	$ 182,250	$ 182,250	$ 257,250	$ 182,250	$ 950,213
2	Federal Financial Participation						$ -
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding*						$ -
6	**Total Proposed Evaluation**	**$ 146,213**	**$ 182,250**	**$ 182,250**	**$ 257,250**	**$ 182,250**	**$ 950,213**
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
1	Innovative MHSA Funds	$ 1,098,304	$ 2,289,737	$ 2,134,597	$ 2,220,847	$ 2,134,597	$ 9,878,082
2	Federal Financial Participation			$ 1,150,000	$ 1,150,000	$ 1,150,000	$ 3,450,000
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding* (Measure A)	$ 920,293	$ 564,557				$ 1,484,850
6	**Total Proposed Expenditures**	**$ 2,018,597**	**$ 2,854,294**	**$ 3,284,597**	**$ 3,370,847**	**$ 3,284,597**	**$ 14,812,932**

*If "Other funding" is included, please explain.

Measure A are local funds already secured by Alameda County Emergency Medical Services for this project. See Budget Narrative.

APPENDIX A.

MEMORANDUM

To: Kate Jones

From: Mary Skinner

Re: MET Transport Challenges and Recommendations

A. Transportation Challenges for MET

The challenge of providing relief to MET members waiting for transport for persons having a mental crisis revolves around the use of an ambulance. Ambulances may take some time to arrive because medical emergencies take priority. Not only is the person having the mental crisis waiting in the back of a police vehicle, the on scene officers are spending considerable time waiting. These wait times heightens stress and create stigma to an already difficult situation for those involved.
Three facets of California's current EMS statutes and regulations impede the development and implementation of most EMS/paramedicine programs:

1. The requirement that callers to 911 must be taken to an acute care hospital having a basic or comprehensive ED (Health & Safety Code Division 2.5, section 1797.52).

2. The locations where paramedics can practice — i.e., at the scene of a medical emergency, during transport to an acute care hospital with a basic or comprehensive emergency department, during inter- facility transfer, while in the ED of an acute care hospital until responsibility is assumed by hospital staff, or while working in a small and rural hospital pursuant to sections 1797.52, 1797.195, and 1797.218 (California Code of Regulations [CCR], title 22, section 100145, and Health & Safety Code 2.5, section 1797).

3. The specification of the paramedic scope of practice. Specific procedures and medications approved for use are contained in regulation (CCR, title 22, section 100145 and Health & Safety Code 2.5, section 1797).

Paramedics have a larger scope of practice that is designed to assist with significant medical and trauma related conditions that are rarely needed by patients with an acute mental health crisis.

Despite a more limited scope of practice, EMT's don't have the same restrictions and can transport patients to a variety of institutions (Emergency departments, PES, sobering centers, unlocked CIU's, residential crisis beds, clinics)

There are many cities and counties that have same or similar programs as Alameda County's MET. However, the most glaring difference is that they do not require an ambulance for transportation, nor do they have regulations precluding use of a paramedic for transportation to a facility that is not an "acute care hospital". Unless there is a medical need, individuals are transported directly by the law enforcement officers who are members of the mobile crisis program, or by the clinician/peer team member.

Cities/counties commonly use unmarked vehicles or what one referred to as the "therapeutic transport team". (All transports required referrals to the receiving facility.)
This doesn't discount there are city and counties struggling with the obligation of transporting psychiatric patients in ambulances. Their struggle is the same as Alameda County. The ambulance takes time away from answering medical emergencies, and the ambulance creates a stigma for the person in crisis. Allina Health, which owns Abbott Northwestern and 11 other hospitals statewide in Minnesota, now keeps an unmarked Ford Escape among its fleet of ambulances at its emergency medical base in Mounds View, a city considered part of Twin Cities Metropolitan Area.

The state of Minnesota has been struggling with the same issues of transporting persons having a mental health crisis. There, the issue surrounding wait time is transport may take hours not only because of responding to medical emergencies, but because facility locations can be miles away. Some as far as a three hour drive. Minnesota Legislature created a special class of non-emergency transports under state law. Advocacy groups are trying to include non-emergency transport as a reimbursable expense under Medical Assistance, Minnesota's version of Medicaid because many of these transports go unpaid.

There are other cities/counties/states that use non-emergency vehicles. Atlanta is one such city. Their vehicles are vans with a partition so patients are separated from the driver. The most unique is the state of Tennessee. Under TN state law, a sheriff or third party designated by the sheriff may make the transport for an involuntary admission. Though this doesn't sound unique, the waiting time is: by law, the receiving facility is notified and given an estimated time of arrival; if the sheriff or agent arrives within the stated time frame, the sheriff or agent waits no longer than 1 hour and 45 minutes for evaluation; if they do not arrive in the stated time, then they must stay at the facility for the duration. This law does not apply to counties with more than 600,000 people.
Here, they only have to deliver the person to the facility. No waiting involved.

B. EMT inclusion/replacement within MET

Although there are no mobile crisis team models which is EMT and clinician based responding on scene, Charleston, South Carolina (area covered encompasses two counties: Charleston and Dorchester) is rolling out a program which will be EMS and telehealth based. The model is basically an EMT using a video type service (much akin to Skype, Facetime, etc.) that is HIPPA compliant to consult with the clinician on duty while the EMT is on scene. The EMT will then be able to transport, if necessary, the person to a facility or other services that may be required. Charleston-Dorchester's model is interesting not only because of its EMT usage, but the coverage area, approximately 545,000 people, is spread out across two counties (approximately 1,937 square miles). They also have the majority of mental health crisis contacts in one area, North Charleston, just as Oakland encompasses the majority of Alameda County's contacts.
Charleston-Dorchester's roll out begins the week of March 27th. The Director of Special Operations, Melissa Camp, has agreed to share information regarding "lessons learned" as the pilot program progresses.
A close second model is in the state of North Carolina. NC's model is called Community Paramedicine Behavioral Health Crisis Response which began in 2013. In response to overwhelmed EDs and rules that EMS agencies would not be able to bill unless the patient went to the ED, the state decided more effective strategies were needed. Regional mental health authorities and communities provided developed advanced training for EMS departments and their paramedics. The EMS personnel now obtain specialized training for treating mental illness and substance use to assist in diverting individuals in mental health crisis from hospital EDs to other facilities. EMS staff consult with a doctor before bypassing ED. WakeBrook Crisis Center in Raleigh (Wake County) redirected 250 patients away from the ED saving 3,400 ED bed hours. Wake EMS was on track to redirect more than 320 patients in 2013.1

In CA, Stanislaus County is doing a pilot program modeled on North Carolina. The program focuses on Medi-Cal and uninsured patients though it includes insured and Medicare patients. Stanislaus obtained an approval from OSHPD (Office of Statewide Health Planning and Development) because CA law prohibits EMS from transporting patients to alternate facilities and places limitations on an EMS' scope of practice. Here, the community paramedic is called per request of the ambulance EMS, or police. If patient requires transport, an ambulance is used. The evaluation report for first-year results is due in 2017. (See Attachment A for One Page Notes)

C. Recommendations to EMT Preclusions

In order for EMS personnel to be used to improve transportation challenges and EMS assisting MET, an amendment to Health
& Safety Code Division 2.5 and California Code of Regulations, Title 22, Division 9: Prehospital Emergency Medical Services (See Attachment B for codes) would need to be amended. One of the hopeful outcomes from the Stanislaus County pilot program is a change in legislation.

Alameda County could apply to OSHPD under a Health Workforce Pilot Projects (HWPP) Program. This is the program Stanislaus County obtained approval for their pilot program. The programs allows organizations to test, demonstrate, and evaluate new or expanded roles for healthcare professionals or new healthcare delivery alternatives before changes in licensing laws are made by the legislature. However, the review process could take up to or more than six months and there is no guarantee for approval.

Another possibility is instead of an EMT, using a nurse practitioner in the same role. There are no statutes or regulations that limit the scope of practice on nurses as specifically as the EMT regulations do. Although an NP has extended training and medical knowledge over an EMT, an EMT's skill set for direct community interaction, especially exposure to persons with mental health crisis, may be greater. (Note: NPs are merely being suggested because they were used in a successful San Francisco program begun in 2004 and ended in 2009 due to lack of funds. See Attachment C)

D. Optional Recommendation: Psychiatric Advance Directives (PAD)

The National Alliance on Mental Illness' position is that "PADs should be considered as a way to empower consumers to take a more active role in their treatment, and as a way to avoid conflicts over treatment and medication issues." Proponents suggest that PADs:

- promote autonomy
- foster communication between patients and treatment providers
- increase compliance with medication
- reduce involuntary treatment and judicial involvement.2

PADs improve psychiatric and recovery-oriented outcomes by empowering consumers with serious mental illness to take an active role in their own care.3 In the spirit of increasing satisfaction with clients, an Advance Directive can be a measure of empowerment to clients because they are involved in their treatment choices when it is found they are incapable of making healthcare decision. Psychiatric patients having a joint crisis or advanced directive plan compared to a group of psychiatric patients without a plan showed a reduction in compulsory admissions and treatment, 13% and 27% respectively.4 A similar study with patients who developed advanced directives without assistance from the outpatient health team were compared to patients without a PAD.5 No difference was found in the number of psychiatric hospital admissions. These two studies suggests a positive impact of a joint advanced directive plan developed by the patient and his or her outpatient treatment team on hospital admission outcomes.

The CalMHSA article "*Recovery Focused Hospital Diversion and Aftercare...*" states Marin County has a crisis residential program which includes assistance for people to develop crisis plans. In Marin County, a person with lived experience in the mental health system facilitates the development of Advance Directives as a component of this program.6 However, at the time of this writing, I have been unable to confirm they use PADs and if they do, what is their protocol. Otherwise, there are no other cities who have incorporated PADs into their follow ups.

Although no cities/counties use PADs in follow ups, there are a few states that use a state registry that file PADs either with the Secretary of State or with the state's division of mental health (New Jersey has such a registry). Registry access is generally given only to the directive holder, then persons the holder has given permission to access the registry. However, two states, New Jersey and Washington, have their registry accessible to both health and mental health providers.

California has a registry for advance directives. It does not accept PADs. Accordingly, the directive holder should keep a copy; an additional copy sized for a wallet; copy to their PAD agent; and mental health facilities and programs they may access. It is also suggested to give a copy to a trusted friend or family member.

How effective PADs would be for marginalized community members is unknown. However, the studies show promise in their usage, and discussion of availability may bring empowerment to a disenfranchized population.

1 http://www.northcarolinahealthnews.org/2013/11/08/mental-health-crisis-initiative-announced/

2 National Alliance on Mental Illness. Psychiatric advance directives. http://www.nami.org/Template.cfm?Section=Issue_Spotlights&Template=/Tagg.....

3 Swanson JW, Tepper M, Backlar P et al. Psychiatric advance directives: an alternative to coercive treatment? Psychiatry 2000; 63:160-72.

4 Henderson C, Flood C, Leese M, Thornicroft G, Sutherby K, Szmukler G. Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomized controlled trail. BMJ. 2004; 329:136–138.

5 Papageorgiou A, King M, Janmohamed A, Davidson O, Dawson J. Advance directives for patients compulsorily admitted to hospital with serious mental illness. Brit J Psychiatry. 2002; 181:513–519. 6 CalMHSA, Recovery Focused Hospital Diversion and Aftercare – Transformation in Services Will Equal Transformation in Lives, June 2015, Pub #CM62.01; 34.

ATTACHMENT A
(This is an excerpted page from the Overview)

CALIFORNIA'S COMMUNITY PARAMEDICINE PILOT PROJECTS

January 2017

In response to a 911 call, community paramedics transport patients with behavioral health needs, but no emergent medical needs, to a mental health crisis center instead of to an emergency department (ED).

Results (as of September 30, 2016)

- 98% of patients were evaluated at the behavioral health crisis center without the long delay of a preliminary ED visit.
- Less than 3% of patients required subsequent transfer to the ED, and there were no adverse outcomes. After refining the field medical evaluation protocols, the rate of transfer to an ED fell to zero.
- The project yielded savings for payers, primarily Medi-Cal, because screening behavioral health patients in the field for medical needs and transporting them directly to the mental health crisis center obviated the need for an ED visit with subsequent transfer from an ED to a behavioral health facility.
- For uninsured patients, the amount of uncompensated care provided by ambulance providers and hospitals also decreased.

How It Works

Many California EDs are overcrowded. Some of the patients served in an ED could be treated safely and effectively in other settings, including some who arrive via ambulance.

Behavioral health patients are often transported to an ED for medical clearance or when there is no capacity to evaluate them at a crisis center. These patients can spend hours in an ED waiting for medical clearance, and in some cases they can spend days in the ED waiting for a bed at an inpatient behavioral health center, without getting definitive behavioral health care during their ED stay.

In Stanislaus County, community paramedics are dispatched in response to 911 calls that a dispatcher determines to be a behavioral health emergency or when another paramedic or a law enforcement officer identifies a patient with behavioral health needs. Community paramedics are also dispatched to the mental health crisis center to assess patients who arrive on their own and who need to be medically cleared before being admitted to the county's inpatient psychiatric facility. The community paramedics provide these services as needed in addition to responding to traditional 911 calls.

Once on scene, a community paramedic assesses the patient for medical needs or intoxication due to alcohol or drug consumption. If the patient has no emergent medical needs, is not intoxicated, and is not violent, the community paramedic contacts the mental health crisis center to determine bed availability at the county inpatient psychiatric facility. Upon a patient's arrival, mental health professionals on the crisis center staff evaluate the patient to determine the most appropriate level of care for their condition. Eligibility is limited to nonelderly adults who are uninsured or enrolled in Medi-Cal because the county inpatient psychiatric facility does not accept patients with other health insurance.

Partners

LOCAL EMS AGENCY	LEAD AGENCY	HEALTH CARE SYSTEM PARTNER	EMS PROVIDER PARTNER	LOCATION
Stanislaus County	Mountain Valley EMS	Stanislaus County Behavioral Health and Recovery Services	AMR Stanislaus County	Stanislaus County

ATTACHMENT B

California Health and Safety Code Division 2.5

§1797.52. (Advanced Life Support) **"Advanced life support" means special services designed** to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital. (*Amended by Stats. 1984, Ch. 1391, Sec. 4.*)

California Code of Regulations Title 22

§100145. Scope of Practice of Paramedic.

(a)) A paramedic may perform any activity identified in the scope of practice of an EMT-I in chapter 2 of this division, or any activity identified in the scope of practice of an EMT-II in chapter 3 of this division.

(b)) A paramedic shall be affiliated with an approved paramedic service provider in order to perform the scope of practice specified in this Chapter.

(c)) A paramedic student or a licensed paramedic, as part of an organized EMS system, while caring for patients in a hospital as part of his/her training or continuing education under the direct supervision of a physician, registered nurse, or physician assistant, or while at the scene of a medical emergency or during transport, or during interfacility transfer, or while working in a small and rural hospital pursuant to section of the Health and Safety Code, may perform the following procedures or administer the following medications when such are approved by the medical director of the local EMS agency and are included in the written policies and procedures of the local EMS agency.

(1) Basic Scope of Practice:

(A)) Perform defibrillation and synchronized cardioversion.
(B)) Visualize the airway by use of the laryngoscope and remove foreign body(-ies) with forceps.
(C)) Perform pulmonary ventilation by use of lower airway multi-lumen adjuncts, the esophageal airway, and adult oral endotracheal intubation.
(D)) Institute intravenous (IV) catheters, saline locks, needles, or other cannulae (IV lines), in peripheral veins and monitor and administer medications through pre-existing vascular access.
(E)) Administer intravenous glucose solutions or isotonic balanced salt solutions, including Ringer's lactate solution.
(F)) Obtain venous blood samples.
(G)) Use glucose measuring device.

(H)) Perform Valsalva maneuver.
(I)) Perform needle cricothyroidotomy.
(J)) Perform needle thoracostomy.
(K)) Monitor thoracostomy tubes.
(L)) Monitor and adjust IV solutions containing potassium, equal to or less than 20 mEq/L.
(M)) Administer approved medications by the following routes: intravenous, intramuscular, subcutaneous, inhalation, transcutaneous, rectal, sublingual, endotracheal, oral or topical.
(N)) Administer, using prepackaged products when available, the following medications:

1. 25% and 50% dextrose;
2. activated charcoal;
3. adenosine;
4. aerosolized or nebulized beta-2 specific bronchodilators;
5. aspirin;
6. atropine sulfate;
7. bretylium tosylate;
8. calcium chloride;
9. diazepam;
10. diphenhydramine hydrochloride;
11. dopamine hydrochloride;
12. epinephrine;
13. furosemide;
14. glucagon;
15. midazolam;
16. lidocaine hydrochloride;
17. morphine sulfate;
18. naloxone hydrochloride;
19. nitroglycerine preparations, except intravenous, unless permitted under (c)(2)(A) of this section;
20. sodium bicarbonate; and
21. syrup of ipecac.

(2) Local Optional Scope of Practice:

(A)) Perform or monitor other procedure(s) or administer any other medication(s) determined to be appropriate for paramedic use, in the professional judgement of the medical director of the local EMS agency, that have been approved by the Director of the Emergency Medical Services Services Authority when the paramedic has been trained and tested to demonstrate competence in performing the additional procedures and administering the additional medications.

(B)) The medical director of the local EMS agency shall submit Form #EMSA-0391 dated 1/94 to, and obtain approval from, the Director of the EMS Authority in accordance with section

ATTACHMENT C

Case Study 1

San Francisco Program to Address the Needs of Chronic Inebriates

San Francisco developed a program to appropriately address the needs of chronic inebriates — The San Francisco Fire Department (SFFD) Homeless Outreach & Medical Emergency (HOME) Team. The program was developed in response to a small number of individuals who were chronic inebriates that frequently called 911, had extensive ED use, and incurred high uncompensated health care costs.

The San Francisco HOME Team was designed to connect at-risk individuals with a system of care to better serve their needs and to stop the unproductive cycle of ambulance transports and hospital stays. Analysis by the HOME Team found that heavy EMS system users are typically 40- to 60-year-old homeless male chronic inebriates who have comorbid mental illness and medical conditions, and high mortality rates. Prior to this program, San Francisco General Hospital estimated a total of $12.9 million in annual uncompensated charges associated with 225 frequent users.

The HOME Team program started in October 2004 under the SFFD EMS through a joint effort of SFFD, San Francisco Department of Public Health, and San Francisco Human Services Agency. The team was led by one paramedic captain and included intensive case managers or outreach workers as well as nurse practitioners. Typical response involved outreach to find all frequent users, connect them to community- based care (typically, substance abuse treatment and medical detoxification), and advocate for long term care when necessary. The program was able to develop a web of resources and partners including case workers, mental health professionals, primary care providers, housing resources, substance abuse treatment programs, and law enforcement. These partners came together to create and evaluate systems of care for the frequent users. This clinical planning brought forth new long term care placement options for dual diagnosis patients with both mental health and substance abuse conditions, including locked programs and boarding programs with care management. Over an 18-month period, there were reductions in ambulance activity for high users and a decrease in ED diversion rates at local hospitals. The HOME Team was funded by the San Francisco Department of Public Health at approximately $150,000 annually; however, funding was rescinded due to the department having other budget priorities, and the program has been on hiatus since June 2009.

(Source: *The San Francisco Fire Department HOME Team: An Urban Community Paramedic Pilot Project,* presentation by Captain Niels Tangherlini, June 27, 2012. [Cited from *Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care*, Kizer, K. W.; Shore, K.; Moulin, A.; July 2013.])

APPENDIX B.

Alameda County EMS 5150 Transports 2017						
	Emergency Department Destination		Psychiatric Facility Destination		Grand Total	
Response City	Distinct count of Arrived at Hospital	% of Total Distinct count of Arrived at Hospital along Table (Down)	Distinct count of Arrived at Hospital	% of Total Distinct count of Arrived at Hospital along Table (Down)	Distinct count of Arrived at Hospital	% of Total Distinct count of Arrived at Hospital along Table (Down)
Oakland	2,762	37.0%	2,537	47.8%	5,299	41.5%
Hayward	754	10.1%	588	11.1%	1,342	10.5%
Berkeley	764	10.2%	535	10.1%	1,299	10.2%
San Leandro	660	8.8%	546	10.3%	1,206	9.4%
Fremont	709	9.5%	166	3.1%	875	6.9%
Alameda	217	2.9%	232	4.4%	449	3.5%
Livermore	307	4.1%	115	2.2%	422	3.3%
Pleasanton	236	3.2%	102	1.9%	338	2.6%
Castro Valley	204	2.7%	127	2.4%	331	2.6%
Union City	210	2.8%	84	1.6%	294	2.3%
Emeryville	151	2.0%	86	1.6%	237	1.9%
Dublin	164	2.2%	65	1.2%	229	1.8%
Newark	169	2.3%	38	0.7%	207	1.6%
San Lorenzo	99	1.3%	63	1.2%	162	1.3%
Albany	51	0.7%	24	0.5%	75	0.6%
Piedmont	18	0.2%	3	0.1%	21	0.2%
Sunol	7	0.1%	1	0.0%	8	0.1%
Total	**7,482**	**100.0%**	**5,312**	**100.0%**	**12,794**	**100.0%**

ALAMEDA COUNTY
Behavioral Health Care Services

ALCOHOL, DRUG & MENTAL HEALTH SERVICES
CAROL F. BURTON, MSW, INTERIM DIRECTOR

Alexander Jackson, LCSW
Transition Age Youth Division Director
Child and Young Adult System of Care
2000 Embarcadero Cove, Suite 400
Oakland, California 94606
Office: (510) 567-8123
Fax: (510) 567-8130
E-Mail: alexander.jackson@acgov.org

May 21, 2018

To: Mental Health Services Oversight and Accountability Commission

This letter is sent on behalf of Alameda County Behavioral Health Care Services (BHCS) Transition Age Youth (TAY) Division in support of the Community Assessment and Transport Team (CATT) project. TAY experiencing mental health issues are at risk for mental health crises. We know that many times a young person experiencing early signs of psychosis come into contact with crisis services, but are not successfully engaged in planned services. We are working to better address this, and believe that the CATT project will be a great contribution. We fully support taking a collaborative approach to systems improvement. Often systems improvement is slow, but the approach proposed in this project offers the opportunity to learn how to do it more quickly.

In addition, the CATT service model is one that is more likely to help TAY get the services they need. Families report many difficulties when they call 911 regarding their child. Having a team arrive in an unmarked car that can take the time to work with the youth and the family to de-escalate the situation, as well as do a thorough assessment, will lead to much more successful outcomes, as well a better experience for the client and family. Most importantly the team will be able to take the client to the services they need, whether or not they are appropriate for a 5150 hold. This will greatly increase the likelihood they get connected to services effectively.

The BHCS TAY Division will gladly participate in these collaborative efforts. We expect that what is learned through this project will improve crisis and planned services for our young clients.

Sincerely,

Alexander Jackson, LCSW
TAY Division Director
Behavioral Health Care Services

Candy DeWitt
Voices of Mothers and Others
1028 Buena Vista Ave.
Alameda, CA 94501

May 24, 2018

To: Mental Health Services Oversight and Accountability Commission

Re: Community Assessment and Transport Team model

I am the parent of a beautiful son who through no fault of his own became ill with the terrible illness of schizophrenia at the young age of 18. Sadly because of our inability to get sustained care in our current mental health system our family story ended in a great tragedy. Our son now sits at Napa State Hospital after being found Not Guilty By Reason of Insanity. The personal loss we have all suffered is unimaginable and the financial cost to our system is enormous.

At the time our son became ill I knew very little about serious mental illness and even less about our health care system. I soon learned very quickly about both. Our family repeatedly experienced a lack of coordination among crisis services during psychiatric emergencies that directly impacted the outcome of care for our son. This is not uncommon among the family-experience. I strongly believe the Community Assessment and Transport Team model that is being considered is critically important because agencies who are able to work together to develop a seamless process for individuals will help to ensure that people in mental health crisis get the services they deserve.

Having a team arrive in the course of a psychiatric emergency to assess and transport persons to the appropriate service in an unmarked vehicle would be also be a great improvement over the current procedure of police involvement. Police are often not trained on how to respond to persons who may be experiencing delusions, paranoia or hallucinations and for this reason situations can escalate and sometimes end up in heartbreak. In addition, calling the police for help for your loved one when in mental health crisis creates distrust and often harms the family relationship a bond that is vital to the care and support needed of loved ones for years to come if not the rest of their lives.

There are many changes we need to make in our system before we stop the revolving door of our hospitals and jails for our most severely mentally ill and so they instead get the help they so desperately need. However the opportunity to try this new approach of a Community Assessment and Transport Team is one solution that is certain to make a difference for individuals and their families.

Please support this proposal.

VTY

Candy DeWitt

voicesofmothersandothers@gmail.com 510.527.8770 510.523.3239

Voices of mothers and others

May 17, 2018

To: Mental Health Services Oversight and Accountability Commission

Fourteen years ago my son was in the early stages of his illness and refusing to meet with doctors. When he experienced his first psychotic break and began engaging in behaviors that put him at risk, his doctor recommended we call for a 5150. Unfamiliar at the time with this process, I thought a mental health professional would come to our house to meet with him. Instead, police showed up, handcuffed my son, and took him away in an ambulance. I will forever remember the disbelief in my son's eyes as he was escorted away; we have never recovered the trust that was lost that day and on so many others when we have felt we had no other recourse than to make that call for an intervention. Unfortunately, these desperate calls rarely result in sustained care that would justify the trauma that they cause. There has historically been little coordination between the varying levels of the system, and thus there is little continuity of care. Police who bring patients to Psychiatric Emergency Rooms often find that the individuals are back on the streets before their shifts are even over. Or a patient may be held for crisis stabilization services for days or weeks and then put back on the street with a prescription and a BART pass and without being connected to follow-up outpatient services.

Emergency Room services are the most expensive services available, and they should be reserved for those for whom they are truly needed. For others, a referral to a less restrictive placement may be more appropriate and would be less traumatic. It would also lessen the burden on Acute Inpatient facilities so they can hold individuals needing longer term inpatient care until sub-acute beds become available for them.

I feel strongly that the Community Assessment and Transport Team model can help various agencies work together to develop a more seamless process for individuals to get to the service that they need. Having a team arrive in the course of a psychiatric emergency that can assess and transport to the most appropriate service, in an unmarked van, is a better alternative than the current one which relies so heavily on police responders and the criminal justice system. The challenges with the crisis response system have been going on for a long time and new approaches are long overdue. As part of a larger re-alignment within the Behavioral Health System, it could help to end the revolving door of 5150s and arrests that does so little to alleviate the suffering of those with serious and untreated mental illness. But to be truly effective, this new program must be accompanied by other changes to the system such as increasing the number of inpatient beds to meet the demand of our demographic size, and the improvement of these facilities and the services they offer so that they provide more therapeutic settings for those who use them, enabling them to return rehabilitated to their families and communities.

Thank you for considering this proposal.

Sincerely,

Patricia Fontana-Narell

Voices of Mothers co-founder
prfontana@comcast.net

voicesofmothersandothers@gmail.com 510.527.8770 510.523.3239

Paramedics Plus

Mental Health Services Oversight and Accountability Commission

Community Assessment and Transport Team (CATT) Proposal

Alameda County Emergency Medical Services (ALCO EMS) is an integral partner with Behavioral Health Care Services (BHCS) and Paramedics Plus in developing the Community Assessment and Transport Team proposal. Alameda County chose to conduct 5150 transports via ambulances to reduce the stigma and risks associated with law enforcement transport. That was a significant improvement to the crisis system, but has resulted in many hours of EMS services engaged in psychiatric crisis response.

We expect the CATT model to improve the crisis system in a number of ways. A key aspect will be the focused collaboration among agencies involved in the system to work together to identify problems and test out solutions rapidly. Most of the time individual agencies work in silos, or when collaboration happens it happens much more slowly that necessary.

The CATT project pairs Paramedics Plus Emergency Medical Technicians (EMTs) with mental health providers to conduct assessments and transport. EMTs can conduct the necessary assessments to triage clients, as well as being able to transport clients to a wider variety of services than paramedics are legally able to. Adding technology like ReddiNet and shared client records will allow us to test out the full potential capacity of CATT to get clients to the most appropriate service quickly and efficiently.

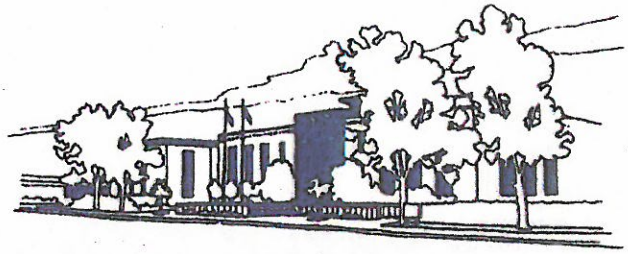
We are excited to be a part of this program and are working closely with ALCO EMS to deliver an excellent service model.

Sincerely,

Rob Lawrence

Rob Lawrence
Chief Operating Officer
Paramedics Plus

City of San Leandro
Civic Center, 835 E. 14th Street
San Leandro, California 94577
www.sanleandro.org



June 18, 2018

Mental Health Services Oversight and Accountability Commission
ATTN: MHSOAC Commissioners
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Commissioners:

It is with great enthusiasm that the City of San Leandro supports Alameda County's application for MHSA funding for the Community Assessment and Transport Team (CATT).

The City of San Leandro experiences the third highest 5150 emergency transport and repeat hold in Alameda County. Currently, our police department is the only personnel that may 5150 individuals in San Leandro. The City is committed to the health and human services needs of our community. In fact, 99 percent of our police force and 100 percent of the dispatch staff has completed the Crisis Intervention Training (CIT). Although the police are a very important part of the emergency system, they should respond to crises as deemed necessary. A potential mental health crisis without public safety concerns should be addressed by mental health professionals.

Additionally, the City of San Leandro commissioned a human services gap analysis and found 5150/mental health crises is one of the priority issues to be addressed by the City and County partners. Recently the City was awarded the California League of Cities/Helen Putnam Award for Innovation and Economic Development as a result of the close collaboration between the police and human services department and several community-based organizations to address homelessness. We are well-positioned to move forward with the County to implement the CATT.

The CATT team allows for a more appropriate emergency response for individuals to receive mental health services and enter into a system of care. Further, it will allow for the team to provide ongoing linkages for services. This is especially significant for those persons that are in a psychiatric crisis and not eligible for a 5150 hold. We would be eager to partner and leverage the findings from this project to other parts of the mental health system.

We very much look forward to your consideration and approval of MHSA funds for the CATT.

Sincerely,

Jeff Tudor, Chief
Police Department

Jeanette Dong, Director
Recreation and Human Services Department

Hospital Council
of Northern & Central California
Excellence Through Leadership & Collaboration

June 20, 2018

Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Members of the Commission:

On behalf of the Hospital Council of Northern and Central California and our hospital members in Alameda County, I am writing in support of the Alameda County Behavioral Health Care Services' application to fund the Community Assessment and Transport Team (CATT) project.

Currently, hospital emergency departments are experiencing high volumes, including a significant increase in the number of patients experiencing a mental health crisis. Taking care of these patients is complicated, time-consuming, and often requires a level of clinical expertise that many hospital emergency departments do not have readily available.

With the requested funding, Alameda County will be able to significantly improve its crisis services by having a professional team respond to an individual in the course of a psychiatric emergency, assess the individual, and transport them to the most appropriate service – potentially avoiding the need for an unnecessary emergency room visit.

The CATT project is an important and innovative step forward toward ensuring that individuals needing psychiatric services get the right care at the right time and place. We strongly support this project, which will greatly benefit our patients and the communities we serve as hospitals.

If you have any questions regarding this letter of support, then please do not hesitate to contact me at 925-746-1550 or rrozen@hospitalcouncil.org.

Sincerely,

Rebecca Rozen

Rebecca Rozen
Regional Vice President