



Community Health Commission
Andy Katz, Chair
Kassandra Bacon, Vice-Chair
Kellie Knox, Staff Secretary

Community Health Commission

Thursday, March 26, 2026, 6:30 – 9:00pm

Meeting Location:

Judge Henry Ramsey Jr. South Berkeley Senior Center
2939 Ellis Street, Berkeley, CA 94703
Phone: 510-981-5170

AGENDA

Preliminary Matters

1. Call to Order by Chair
2. Roll Call by Secretary
3. Land Acknowledgement – (Attachment 5)
4. Announcements & Introductions
5. Public Comment – The public may comment about any item **not** on the agenda. Public comments are limited to two minutes per speaker.

Discussion and Action Items

Public comments regarding agenda items will be heard while the Commission is discussing the item. Public comments are limited to two minutes per speaker.

1. Presentation of Results-Based Accountability Basics – Janice Chin, Manager, Public Health Division, HHCS
2. Public Health Officer Report
3. CHC Chair's Report
4. Approval of Draft Minutes from 02/26/2026 Regular Meeting – (Attachment 1)
5. Environmental Health Restaurant Inspection Audit Update – (Attachment 6)
6. Proposed Project to Resume Operations of BEAR Program – Action (Attachment 7)
7. Community Health Improvement Plan – Discussion (Attachment 8 and 9)
8. Commission Workgroups - Action
9. Election of Officers - Action

Future Agenda Items:

- PH Program Presentations
- Long Term Care Facility Referral
- Budget Process Engagement
- MIH/CP pilot and CARE/Health One presentation
- Briefing on Housing funding by Homeless Panel of Experts or Housing Action Committee
- Environmental Justice/Safety Elements Presentation Plan – May
- California Institute of Regenerative Medicine Presentation Request

Adjournment

Attachments

A Vibrant and Healthy Berkeley for All

1. Draft minutes from 02/26/2026 CHC Regular meeting
2. CHC 2025-2026 Work Plan
3. CHC Meeting Calendar 2026
4. City Council and Community Health Commission Timeline 2026
5. Land Acknowledgement
6. Environmental Health Restaurant Inspection Audit Update
7. BEAR Program Proposal and Information
8. Community Health Improvement Plan – World Café notes
9. Community Health Improvement Plan – Proposal by Commissioner

The *next meeting* of the Community Health Commission is scheduled to be held on Thursday, April 23, 2026 with a *deadline of Tuesday, April 14, 2026 for the public's submission of agenda items and materials for the agenda packet*. **Dates are subject to change.** Please contact the Commission Secretary to confirm.

Any writings or documents provided to a majority of the commission regarding any item on this agenda will be made available for public inspection at Health, Housing & Community Services Department located at 2180 Milvia Street, 2nd floor, Berkeley, CA 94704 during regular business hours. The Commission Agenda and Minutes may be viewed on the City of Berkeley website: [Boards & Commissions | City of Berkeley \(berkeleyca.gov\)](#) (SB 343)

CONFLICT OF INTEREST INFORMATION: City commissioners, pursuant to Government Code section 1090, are responsible for recusing themselves from all commission discussions and actions in which they may have a conflict of interest. If your affiliation, paid or unpaid, with other agencies has changed since the last meeting of this commission, your ability to participate in commission activities may have changed. Individual guidance is available from the City Attorney's Office (CAO). Commissioners are encouraged to consult with the CAO if they have questions, concerns, or would like clarification about matters related to potential conflicts of interest.

The CAO may be reached at:

Email: attorney@cityofberkeley.info

TEL: (510) 981-6950 TDD: (510) 981-6347, FAX: (510) 981-6960

2180 Milvia Street 4th Floor, Berkeley, CA 94704 - Office Hours: Mon-Fri, 8am-5pm

COMMUNITY ACCESS INFORMATION: This meeting is being held in a wheelchair accessible location. To request disability-related accommodation(s) to participate in the meeting, including auxiliary aids or services, please contact the **Disability Services Specialist at 981-6418 (V) or 981-6347 (TDD)** at least three business days before the meeting date. Please refrain from wearing scented products to this meeting.

Communications to Berkeley boards, commissions or committees are public records and will become part of the City's electronic records, which are accessible through the City's website. Please note: e-mail addresses, names, addresses, and other contact information are not required, but if included in any communication to a City board, commission or committee, will become part of the public record. If you do not want your e-mail address or any other contact information to be made public, you may deliver communications via U.S. Postal Service or in person to the secretary of the relevant board, commission or committee. If you do not want your contact information included in the public record, please do not include that information in your communication. Please contact the commission secretary for further information.

Secretary:

Kellie Knox

Health, Housing & Community Services Department

2180 Milvia Street, 2nd Floor, Berkeley, CA 94704 510-981-5301 kknox@berkeleyca.gov



Att-01

Community Health Commission
Andy Katz, Chair
Kassandra Bacon, Vice-Chair
Kellie Knox, Staff Secretary

Community Health Commission
DRAFT MINUTES
Regular Meeting, Thursday, February 26, 2026

The meeting convened at 6:38 p.m. with Commissioner Katz presiding.

ROLL CALL

Present: Commissioners Bacon, Charney, Herzer-Baptiste, Katz, Reese, and Vasquez.

Absent: Commissioner Salve.

Excused: None.

Staff present: Kellie Knox, Dr. Noemi Doohan

Community Members: Manel Kappagoda

COMMENTS FROM THE PUBLIC: None.

ACTION ITEM

1. M/S/C (Bacon/Reese): Motion to adopt minutes from the January 22, 2026 meeting.

Ayes: Commissioners Bacon, Charney, Reese and Katz.

Noes: None.

Abstain: Commissioners Herzer-Baptiste and Vasquez.

Absent from vote: Commissioner Salve.

Excused: None.

Motion Passed.

A Vibrant and Healthy Berkeley for All

ACTION ITEM

5. M/S/C (Herzer-Baptiste/Charney): Motion to adjourn meeting

Ayes: Commissioners Bacon, Charney, Herzer-Baptiste, Katz, Reese, and Vasquez.

Noes: None.

Abstain: None.

Absent from vote: Commissioner Salve.

Excused: None.

Motion Passed.

DISCUSSION ITEMS:

2. Public Health Officer's Report - Discussion
3. CHC Chair's Report – Discussion
4. Election of Officers - Discussion

Future Agenda Items

Election of Officers (March)

Presentation by PH Programs

Environmental Health Restaurant Inspection Update (March)

Long Term Care Facility Referral

Budget Process Engagement

Response to the Community Health Improvement Plan

This meeting adjourned at 9:00 p.m.

Minutes will be reviewed and approved on Thursday, March 26, 2026.

Respectfully submitted,

Kellie Knox, Commission Secretary _____

Community Health Commission 2025-26 Work Plan

Guiding Philosophy: To look at health through an equity lens in order to address, ameliorate, and abolish health inequities in Berkeley while addressing and supporting public health efforts in collaboration with the City of Berkeley City Council, City of Berkeley Public Health staff, and community members.

I. Mission/Purpose:

- A. Collaborate with the community, the City of Berkeley Health Officer Unit, Public Health Division, and Berkeley City Council to eliminate health inequity by: Advocating to the City Council for policies that have the potential to improve the health of Berkeley residents and that can be implemented, monitored and evaluated.
 - 1. Representing the diversity of the community through the diversity of this commission's membership.
 - 2. Increasing public education and engagement to develop greater understanding and awareness of public health issues.
 - 3. Advocating with the residents of Berkeley most affected by institutional, social, and organizational inequities and disparities.
 - 4. Providing a public forum for all community members to share their public- health related concerns and ideas
- B. Achieve progress in attaining general good health for all Berkeley residents by being responsive to community needs and facilitating general health and safety.

Overall issues to be addressed through a health equity lens.

- a. Be responsive to recommendations that will help Berkeley residents, care providers, and clinics cope with spending cuts to local, state, and federal funding.
- b. Continue to be a community advocate to City Council to address structural, institutional, and health inequities impacting all underserved populations, taking into account the social determinants of health.
- c. Evaluate and act on health status data such as the 2018 Health Status Report, and data updated in the Community Health Assessment and other periodic reports.
- d. Increase healthy food security, particularly preparing for SNAP/CalFresh changes, including advocating for the necessary support for the Berkeley Food Network / Pantry, and access to fresh groceries.
- e. Support expansion of affordable housing as a part of addressing root causes of health disparities.
- f. Work to support policies and initiatives that advance Universal Health Care such as Medicare for All.

- g. Advise the City Council as HHCS and Public Health Division develop the strategic plan and Results-Based Accountability framework, Community Health Assessment, and Community Health Improvement Plan.

II. General steps and actions needed to meet priorities:

- A. Conduct outreach to encourage Berkeley community members to engage with the CHC, inclusive of diverse communities.
- B. Collaborate with other commissions to share resources and support recommendations.
- C. Form focused/specialized work groups, as needed.

1. Basic Needs Security

- a. Focus on healthy food security and affordable/accessible housing.
- b. Advocate for affordability and accessibility of healthy foods by supporting programs in Berkeley that address these issues.
- c. Advocate for affordable housing and rent protections for Berkeley residents.
- d. Connect with community-based organizations and appropriate City of Berkeley departments to acquire information about available resources for Berkeley residents.

2. Chronic Disease Prevention

- a. Recommend interventions to address diabetes, obesity, heart diseases, and other chronic conditions highlighted by the updates to Berkeley health status report and Community Health Assessment.
- b. Engage with Public Health Division staff development of Results-Based Accountability framework and evaluation of public health programs.

3. Health Equity

Engage with Public Health staff and community members to advocate for the implementation of strategies that will reduce health inequities, detailed in the Health Status Report:

- a. Monitor the utilization and support outreach for the West Berkeley Family Wellness Center.
- b. Continue to support the development of the African American Holistic Resource Center.
- c. Investigate and implement efforts to improve immigrant access to health care.

4. Health Facilities

- a. Address the planned closure and replacement of Alta Bates Hospital to maintain acute care services for Berkeley residents, including evaluation and advocacy of the adequacy of the number of replacement beds in the successor acute care hospital facility, and the inclusion of critical care services such as Labor and Delivery, Cardiac Catheterization, and Burn Units.

- b. Continue to engage with and monitor city council actions related to implementation of the Commission's recommendation and council referral on ombudsperson funding and safe staffing at long-term care facilities.

5. Environmental Health

- a. Monitor and engage with city council actions responding to the City Auditor's audit of restaurant health and safety.
- b. Monitor environmental health division programs regarding vector control and other programs to protect environmental health and safety.
- c. Engage with the Planning Division to provide input to the City of Berkeley General Plan Environmental Justice element.

2026 Commission Meeting Schedule

Please complete this form and email it to the commission@berkeleyca.gov by: **Wednesday, January 7, 2026**

Name of Commission: Community Health

Commission Secretary: Kellie Knox

Example

Month	Meeting Day	Meeting Date	Time
February 2026	Wednesday	2/11/2026	7:00 pm

Month	Meeting Day	Meeting Date	Time
January 2026	Thursday	1/22/2026	6:30 pm
February 2026	Thursday	2/26/2026	6:30 pm
March 2026	Thursday	3/26/2026	6:30 pm
April 2026	Thursday	4/23/2026	6:30 pm
May 2026	Thursday	5/28/2026	6:30 pm
June 2026	Thursday	6/25/2026	6:30 pm
July 2026	Thursday	7/23/2026	6:30 pm
August 2026	Thursday	No Meeting	
September 2026	Thursday	9/24/2026	6:30 pm
October 2026	Thursday	10/22/2026	6:30 pm
November 2026	Thursday	No Meeting	
December 2026	Thursday	12/03/2026	6:30 pm

HHCS DEPARTMENT 2026 COUNCIL MEETING TIMELINE

Att-04

COUNCIL MEETING	THURSDAY 5:00 PM Reports Due to Director	THURSDAY 12:00 PM - Day 33 - DEPT. REPORTS DUE TO CLERK	THURSDAY 12:00 PM - Day 19 - AGENDA COMMITTEE PACKET TO PRINT	MONDAY 2:30 PM - Day 15 - AGENDA COMMITTEE MEETING	WEDNESDAY 11:00 AM - Day 13 - FINAL AGENDA MEETING (PRINT AGENDA ON WED.)	THURSDAY By 5:00 PM - Day 12 - COUNCIL AGENDA DELIVERY
Winter Recess [December 3, 2025 through January 19, 2026]						
Jan 20	12/4	12/18	1/2 (Fri)	1/5	1/7	1/8
Jan 27	12/11	12/26 (Fri)	1/8	1/12	1/14	1/15
Feb 10	12/26	1/8	1/22	1/26	1/28	1/29
Feb 24	1/8	1/22	2/5	2/9	2/11	2/11 (Wed)
Mar 10	1/22	2/5	2/19	2/23	2/25	2/26
Mar 24	2/5	2/19	3/5	3/9	3/11	3/12
Spring Recess [March 25 through April 13, 2026]						
Apr 14	2/26	3/12	3/26	3/31 (Tue)	4/1	4/2
Apr 21	3/5	3/19	4/2	4/6	4/8	4/9
Apr 28	3/12	3/26	4/9	4/13	4/15	4/16
May 12	3/26	4/9	4/23	4/27	4/29	4/30
May 19	4/2	4/16	4/30	5/4	5/6	5/7
Jun 9	4/23	5/7	5/21	5/28 (Thur)	5/28 (Thur)	5/29 (Fri)
Jun 16	4/30	5/14	5/28	6/1	6/3	6/4
Jun 30	5/14	5/28	6/11	6/15	6/17	6/18
Jul 7	5/21	6/4	6/18	6/22	6/24	6/25
Jul 14	5/28	6/11	6/25	6/29	7/1	7/2
Jul 28	6/11	6/25	7/9	7/13	7/15	7/16
Summer Recess [July 29 through September 14, 2026]						
Sep 15	7/30	8/13	8/27	8/31	9/2	9/3
Sep 29	8/13	8/27	9/10	9/14	9/16	9/17
Oct 13	8/27	9/10	9/24	9/28	9/30	10/1
Oct 27	9/10	9/24	10/8	10/13 (Tue)	10/14	10/15
Nov 17	10/1	10/15	10/29	11/2	11/4	11/5
Dec 1	10/15	10/29	11/12	11/16	11/18	11/19
Dec 15	10/29	11/12	11/25 (Wed)	11/30	12/2	12/3
Winter Recess [December 16, 2026 through January 18, 2027]						

VTO Affected Dates	Holiday Affected Dates	Religious Holiday Affected Date
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Updated 10/22/25

Reports not submitted by the deadlines listed will not be included on the agenda.

HHCS COMMISSIONS 2026 COUNCIL MEETING TIMELINE

Att-03At

COUNCIL MEETING	Thursday	THURSDAY 5:00 PM	THURSDAY 12:00 PM - Day 33 -	THURSDAY 12:00 PM - Day 19 -	MONDAY 2:30 PM - Day 15 -	WEDNESDAY 11:00 AM - Day 13 -	THURSDAY By 5:00 PM - Day 12 -
	Commission needs to take action by	Reports Due to Director	DEPT. REPORTS DUE TO CLERK	AGENDA COMMITTEE PACKET TO PRINT	AGENDA COMMITTEE MEETING	FINAL AGENDA MEETING (PRINT AGENDA ON WED.)	COUNCIL AGENDA DELIVERY
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Apr 28	3/5	3/12	3/26	4/9	4/13	4/15	4/16
May 12	3/19	3/26	4/9	4/23	4/27	4/29	4/30
May 19	3/26	4/2	4/16	4/30	5/4	5/6	5/7
Jun 9	4/16	4/23	5/7	5/21	5/28 (Thur)	5/28 (Thur)	5/29 (Fri)
Jun 16	4/23	4/30	5/14	5/28	6/1	6/3	6/4
Jun 30	5/7	5/14	5/28	6/11	6/15	6/17	6/18
Jul 7	5/14	5/21	6/4	6/18	6/22	6/24	6/25
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Summer Recess [July 29 through September 14, 2026]							
Sep 15	7/23	7/30	8/13	8/27	8/31	9/2	9/3
Sep 29	8/6	8/13	8/27	9/10	9/14	9/16	9/17
Oct 13	8/20	8/27	9/10	9/24	9/28	9/30	10/1
Oct 27	9/3	9/10	9/24	10/8	10/13 (Tue)	10/14	10/15
Nov 17	9/24	10/1	10/15	10/29	11/2	11/4	11/5
Dec 1	10/8	10/15	10/29	11/12	11/16	11/18	11/19
Dec 15	10/22	10/29	11/12	11/25 (Wed)	11/30	12/2	12/3
Winter Recess [December 16, 2026 through January 18, 2027]							

VTO Affected Dates	Holiday Affected Dates	Religious Holiday Affected Date
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Updated 10/22/25

Reports not submitted by the deadlines listed will not be included on the agenda.

Land Acknowledgement Statement

The City of Berkeley recognizes that the community we live in was built on the territory of xučyun (Huchiun (Hooch-yoon)), the ancestral and unceded land of the Chochenyo (Cho-chen-yo)-speaking Ohlone (Oh-low-nee) people, the ancestors and descendants of the sovereign Verona Band of Alameda County.

This land was and continues to be of great importance to all of the Ohlone Tribes and descendants of the Verona Band.

As we begin our meeting tonight, we acknowledge and honor the original inhabitants of Berkeley, the documented 5,000-year history of a vibrant community at the West Berkeley Shellmound, and the Ohlone people who continue to reside in the East Bay.

We recognize that Berkeley's residents have and continue to benefit from the use and occupation of this unceded stolen land since the City of Berkeley's incorporation in 1878.

As stewards of the laws regulating the City of Berkeley, it is not only vital that we recognize the history of this land, but also recognize that the Ohlone people are present members of Berkeley and other East Bay communities today.



Office of the City Manager

Att-06

INFORMATION CALENDAR
February 24, 2026

To: Honorable Mayor and Members of the City Council
From: Paul Buddenhagen, City Manager
Submitted by: Scott Gilman, Director, Health, Housing, and Community Services
Subject: Restaurant Inspection Audit Status Report

INTRODUCTION

On July 10, 2024, the City Auditor submitted an audit report¹ on the status of Restaurant Inspections to the City Council, including recommendations to improve the overall delivery of services for the food safety inspection program. This is the third status report updating the City Council on the implementation of those recommendations.

CURRENT SITUATION AND ITS EFFECTS

The audit included nine recommendations. As of the writing of this report:

- Two recommendations are fully implemented.
- Five recommendations are partly implemented.
- One recommendation has started.
- One recommendation has not yet started.

Recommendations currently tracked as "partly implemented" need longer-term tracking and the implementation of technological solutions, such as the completion of the upgrade to the Accela database.

The Environmental Health Division (EHD) is currently staffed with four food inspectors and a supervisor.

EHD has developed a detailed policy for maintaining the inventory list of food facilities with data quality at the forefront. This includes confirming risk designations for all facilities and validation that the inventory is accurate.

City staff are currently in the process of working with a third-party vendor to convert to a new database on the Accela Civic Platform, as the current database is sunsetting. This

¹ [Berkeley Restaurant Inspections: Chronically Understaffed Program Did Not Meet Targets](#)

conversion process involves reviewing and automation of all applications and permits for all programs, analysis of the workflows, and development of a public portal.

Additionally, EHD has recently completed a division-wide fee study to address revenue concerns as well as evaluate current staffing needs to determine adequacy for the food safety inspection program and other departmental responsibilities, including vector control, noise complaints, stormwater inspections, swimming pools and spas, retail tobacco, and body art. New fee schedule recommendations and a placarding program proposal will be presented to Council as part of the budget process.

For a detailed table of audit report recommendations, corrective action plans, and implementation progress, see Attachment 1. The next status report to Council is anticipated in Fall 2026.

BACKGROUND

Local health jurisdictions are responsible for determining the frequency of inspections based on the needs of the community and available resources. In 2015, EHD transitioned to a risk-based food inspection process, following the guidelines established by the Federal Food and Drug Administration's (FDA) Voluntary National Retail Food Regulatory Program Standards. This program categorizes permitted food facilities (restaurants, grocery markets, schools, bars, etc.) based on the complexity of food handling and populations served, assigning them to one of four "Risk Categories" (RC-1 to RC-4). Each RC designation dictates the minimum number of annual inspections a facility receives. During the early stages of the COVID-19 pandemic, EHD staff were reassigned to assist with the pandemic. In addition, EHD faced staffing shortages due to promotions to other departments, prolonged staff illnesses, and hiring freezes in FY2021 and FY2022. Once the hiring freeze was lifted, EHD experienced additional budgetary challenges and a limited pool of qualified applicants for a vacant supervisor and inspector positions, a statewide issue for jurisdictions providing environmental health services. Unfortunately, during this time the City's food inspection policies were not adjusted resulting in audit findings of delinquent inspections.

ENVIRONMENTAL SUSTAINABILITY AND CLIMATE IMPACTS

There are no identifiable environmental effects associated with the subject of this report.

POSSIBLE FUTURE ACTION

On September 24, 2024, Council made a budget referral to the November 2024 budget process of \$100,000 for the City Manager to engage an independent consultant to conduct an analysis of the current structure of the Environmental Health Food Inspection Program and provide recommendations for alternative models, staffing levels, and increased use of technology to improve customer service. To date, this referral has not been included in final budget proposals.

FISCAL IMPACTS OF POSSIBLE FUTURE ACTION

As noted above, the cost for conducting this analysis of the EHD programs is estimated to be \$100,000, which would be funded by the City's General Fund.

CONTACT PERSON

Scott Gilman, Director, Health, Housing, and Community Services (510) 981-5100

Attachments:

1: Food Inspections Recommendations Status Update Table – Jan 2026

Audit Title: Berkeley Restaurant Inspections: Chronically Understaffed Program Did Not Meet Targets

Issue Date: July 10, 2024

Finding	Recommendation	Department	Last Period: Status	Current Status Update
The Division was significantly behind on inspections in 2023, increasing health risk.	1.1 Develop a plan to improve coverage of routine inspections throughout the City, which may require the Division to prioritize health and safety duties over other responsibilities. As part of this process: (a) Evaluate inspection targets to determine if current inspection frequencies are achievable or establish different temporary targets to adapt to periods of understaffing. (b) Establish a baseline of inspection coverage for all permitted food facilities in the City and prioritize inspection of facilities with high risk and very high risk designations that were not inspected in 2023.	HHCS	Implemented	Implemented. The Division developed new policies that include revised inspection targets for periods of short staffing and a baseline of at least one inspection per year. According to the Division, all high and very high risk facilities that were not inspected in 2023 have now been inspected.
The Division was significantly behind on inspections in 2023, increasing health risk.	1.2 Develop a plan to ensure timely response to complaints involving alleged foodborne illness, which may require the Division to prioritize health and safety duties over other responsibilities.	HHCS	Partly Implemented	Implemented. The Division has strengthened its internal policy for addressing complaints in a timely fashion. Policy improvements include documented responsibilities for staff to ensure complaints are received by admin staff and/or other designated staff and prioritized by inspectors within 24 hours or one business day.
The Division did not track spending and left critical positions vacant.	2.1 Work with the Budget Office to track how the food inspection program revenues are used.	HHCS	Partly Implemented	Partly implemented. The Division is now using program-specific codes to track revenues and expenditures related to food facility inspections. A comprehensive report comparing revenues and expenditures for a full fiscal year was not yet available. Our team will reassess the status of this recommendation once the FY 2026 report is available.
The Division did not track spending and left critical positions vacant.	2.2 Take the following steps to fill positions and assess program staffing: (a) Open recruitment for the supervisor position. (b) If the recruitments for the supervisor and food inspector positions do not yield qualified candidates, work with the Human Resources Department (HR) to develop targeted recruitments for the inspector and supervisor roles.	HHCS	Partly Implemented	Partly implemented. The Division worked with a consultant to complete a fee study, which council will consider soon. According to the Division, and subject to Council approval, fee changes based on the study's results study could potentially help support increased staffing. In a future update, the Division will need to show that they have

Finding	Recommendation	Department	Last Period: Status	Current Status Update
	This may include conducting an analysis of compensation or other factors that affect recruitment. (c) Develop a trainee program to build a pipeline into the Division's inspector positions. (d) Work with HR as needed to identify staffing resources needed to meet inspection targets.			assessed staffing resources to meet inspection targets. We will also follow up on the Division's plans to develop a training program once staffing stabilizes.
The Division did not track spending and left critical positions vacant.	2.3 Make the following updates to the inspection data: (a) Add a risk designation to all food facilities in the Envision database. (b) Correct the date of last inspection in the Envision software that inspectors use during inspections or develop a workaround to ensure inspectors have an accurate list of facilities prioritized by last inspection date. (c) Develop a process to regularly verify that the Envision database includes all food facilities that should be permitted and inspected.	HHCS	Partly Implemented	Partly implemented. The Division has updated its policies to include stronger requirements for data management to ensure that risk designations are documented for all facilities and that the inventory of food facilities is complete and up to date. To mark this recommendation as implemented, the Division would need to confirm that the new database can produce an accurate list of facilities prioritized by the last inspection date.
The Division did not track spending and left critical positions vacant.	2.4 Work with the Department of Information Technology (IT) to develop list of database functionalities and/or data points needed to help meet the Division's targets and produce reports. If the current database cannot provide this functionality, document the limitations of the current database and include these requirements in the future request for proposals for a new database.	HHCS	Partly Implemented	Partly implemented. The Division estimates that the new database will be live in June 2026. We will reassess the status of this recommendation once the new database is in place.
The Division did not track spending and left critical positions vacant.	2.5 Identify performance metrics and report them to the public at least annually.	HHCS	Partly Implemented	Partly implemented. After developing and identifying preliminary performance metrics for the Food Safety and Inspection program, the Division has paused this project while staff focus on migrating to the new database.
Public information about food safety was limited.	3.1 Work with Department of Information Technology (IT) to update the online system for sharing information on food inspections. As part of this process: (a) Develop internal guidance informed by state code that details what information the Division will share with the public online and defines responsibility for managing the data. (b) Make inspection history available online for all permitted food facilities in Berkeley. This could include	HHCS	Not Started	Not started. After removing information about food inspections from the City's Open Data Portal, the Division updated its webpage to include instructions for requesting individual inspection reports from the Environmental Health Division. However, the food inspection data is still not posted on the Open Data Portal. According to the Division, the estimated timeline for the new

Finding	Recommendation		Department	Last Period: Status	Current Status Update
		sharing a copy of the most recent inspection report.			public portal featuring inspection reports is summer 2026.
Public information about food safety was limited.	3.2	Develop a plan to implement placarding in Berkeley once staffing levels are stable. As part of this process: (a) Assess resources needed to implement placarding. (b) Consider adding elements such as community engagement for designing and implementing evidence-based, equitable placarding.	HHCS	Not Started	Started. In their upcoming report to City Council on the recently completed fee study, the Division developed a budget and staffing proposal for implementing and sustaining a placarding program based on information from the study. Additionally, the Division reported that program supervisor has completed training in inspection standardization to support an evidence-based placarding program. The Division plans to implement standards across the Division in 2026.

Agenda Item

To: City of Berkeley Community Health Commission

Meeting Date: March 26th, 2026

Subject: Direct City of Berkeley Health, Housing & Community Services Department (HHCS) and Berkeley Fire Department, in coordination with relevant partners, to pursue a joint project to resume operations of the BEAR program (“BEAR 2.0”) with an updated service model, governance structure, and evaluation framework.

Recommended Action

Adopt a Commission recommendation to City leadership that HHCS and Berkeley Fire/EMS jointly re-initiate the BEAR program as a cross-department, health-equity-oriented alternative response / community care function (BEAR 2.0), leveraging prior program documentation and previously compiled BEAR outcomes summaries, and returning to the Commission with an implementation plan, budget options, and evaluation metrics.

Suggested Model

Move that the Community Health Commission recommends that City Council and the City Manager:

1. Direct HHCS and Berkeley Fire/EMS to co-lead a BEAR 2.0 Planning & Implementation Workgroup and deliver a written BEAR 2.0 Implementation Plan within 90 days.
 2. Require the Implementation Plan to include:
 - Service model and dispatch/intake pathway(s)
 - Staffing plan and clinical governance
 - Data-sharing and privacy compliance plan
 - Funding strategy and budget scenarios (pilot + scale)
 - Performance metrics and evaluation design
 - Community engagement plan and equity impact approach
 3. Authorize City departments to pursue external funding (grants, county/state/federal, philanthropy) and to formalize partnerships via MOUs as needed.
 4. Direct HHCS and Fire/EMS to launch a time-limited pilot (e.g., 6–12 months) upon identification of a feasible funding package and operational plan.
-

Background and Need

The City previously operated a 6 month pilot of the BEAR program to address non-urgent, low-acuity, and medically/socially complex community needs through a proactive, field-based response model. Prior internal BEAR documentation and data summaries prepared for City stakeholders indicate that the program supported residents with significant unmet needs (including high medical vulnerability and under-insurance) and helped connect individuals to care, resources, and follow-up services.

The Commission notes that Berkeley has experienced evolving demand patterns on emergency and public safety systems, including repeat callers and residents with complex behavioral health, substance use, chronic disease, and housing insecurity needs—often best served by coordinated community care rather than repeated emergency department utilization or law enforcement involvement. In addition, the City has faced gaps in specialized field response capacity over time (including the loss/changes of certain specialized units - namely the SCU), reinforcing the need to restore a durable, health-led field response pathway.

This agenda item is intended to align health equity objectives with practical system goals: improving resident outcomes, reducing unnecessary 911/ED utilization when clinically appropriate, and strengthening linkages between field response and HHCS care systems.

Purpose and Goals of BEAR 2.0

BEAR 2.0 would be re-established as a joint HHCS–Fire/EMS program designed to:

- Advance health equity by providing compassionate, clinically appropriate, low-barrier field response and follow-up for residents with complex medical and social needs.
 - Reduce avoidable utilization of emergency departments, ambulance transports, and law enforcement involvement when not required for safety.
 - Improve continuity of care via warm handoffs to HHCS programs, community-based providers, and County systems.
 - Create a durable post-contact follow-up pathway for residents repeatedly interacting with crisis services.
 - Measure outcomes transparently and continuously improve program performance.
-

Proposed Service Model (Draft Concept for Planning Purposes)

The Commission recommends HHCS and Fire/EMS evaluate a BEAR 2.0 model with the following core components:

1) *Target Population (initial focus)*

- Residents with frequent 911/ED use linked to unmet medical/social needs
- Unsheltered or housing-insecure residents with high medical vulnerability
- Individuals requiring post-incident follow-up (e.g., after non-transport encounters)
- Residents appropriate for non-emergency field care + connection, not requiring lights-and-sirens EMS

2) Response Functions

- Low-acuity medical assessment (non-emergent)
- Basic treatment within scope, referral coordination, and safety planning
- Navigation and linkage to primary care, behavioral health, substance use treatment, benefits enrollment, and shelter/housing services
- Follow-up visits / outreach (including scheduled follow-up for high-risk individuals)

3) Dispatch / Intake Pathways (multiple on-ramps)

- 911 triage referral pathway (criteria-based) - This is the model that Seattle's CARE Dept utilizes but I believe that more proactive outreach by the BEAR unit is required for a city like Berkeley.
- HHCS referral pathway (case managers, outreach teams)
- Hospital/ED referral pathway for high-utilizers
- Community partner referrals (with safeguards and eligibility criteria)
- *** A mix between 1 and 2

4) Staffing and Clinical Governance

- Fire/EMS + HHCS co-staffing model (e.g., EMT/paramedic + clinician/case manager)
- HHCS-led outreach clinicians with EMS consult support as needed
- Medical direction / clinical oversight structure and protocols

NP-Led vs Paramedic-Led Alternative Response (How the Distinction Impacts Clinical Implementation)

This item contemplates two viable clinical staffing models for a BEAR-style alternative response program—Nurse Practitioner (NP)-led and Paramedic-led—each optimized for different call types, risk tolerances, and system goals. Both models can be effective when paired with clear dispatch criteria, medical oversight, and strong pathways for follow-up care and social service linkage.

NP-Led Alternative Response (Advanced Clinical "Closure")

An NP-led model centers a clinician with advanced assessment and care-planning capacity who is typically better positioned to address the underlying drivers of repeat low-acuity 911 use—particularly among patients with chronic illness, complex medication regimens, post-discharge needs, or gaps in primary care access. At a high level, NP-led response tends to be strongest when the goal is clinical closure in the field (e.g., medication reconciliation, care coordination, definitive referral planning, and linkage to longitudinal services). This model may be especially valuable for the “complex care” bucket—frequent utilizers, older adults, and medically fragile residents—where the presenting 911 call often reflects a broader failure of continuity of care rather than an emergent physiologic crisis.

Key strengths typically include: broader clinical decision-making for low-acuity medical complaints; stronger ability to develop and document longitudinal care plans; and deeper integration with primary care, behavioral health, and public health pathways. The primary tradeoff is that NP-led models generally require tighter dispatch triage and robust back-up escalation, because NPs are not inherently structured as emergency response resources in the same way as EMS units, and the program must guard against mis-triage of time-sensitive emergencies or unpredictable scenes.

Paramedic-Led Alternative Response (Operationally “Forgiving” 911 Diversion)

A Paramedic-led model anchors BEAR response in personnel trained and culturally embedded in 911 operations—scene management, rapid stabilization, and escalation decision-making under uncertainty. Paramedic-led response is typically strongest when the City’s near-term objective is safe diversion of low-acuity medical calls from traditional EMS transport, particularly when call details are incomplete, the patient presentation is variable, or the environment is operationally complex. Because paramedics are trained to assess and manage emergent deterioration risk, this model is often more “forgiving” of imperfect triage and better suited to rapid deployment within existing Fire/EMS command structures.

Key strengths typically include: high reliability in dynamic field conditions; strong integration with dispatch/CAD and EMS medical direction; and rapid escalation to ALS/BLS transport when needed. The primary tradeoff is that paramedic-led models may have less capacity for “downstream closure” on the complex care drivers of repeat 911 use unless the unit is explicitly designed with enhanced referral pathways, dedicated follow-up time, and integrated social/behavioral health partnerships.

Practical Implication for Program Design

In practice, many jurisdictions implement a hybrid approach: paramedic-led response for unscheduled low-acuity 911 diversion, with NP capacity (in-person or via consult) for higher-complexity medical decision support, post-discharge follow-up, and frequent utilizer care planning. The appropriate model for Berkeley should be guided by: (1) the proportion of BEAR-eligible calls that are *pure low-acuity* versus *complex care*; (2) the City’s risk tolerance for mis-triage; (3) available medical oversight and partner clinics; and (4) the desired balance

between immediate operational relief for 911 and longer-term reductions in repeat callers through clinical and social stabilization.

Partnership Framework (Suggested Stakeholders)

The Workgroup should include, at minimum:

- City of Berkeley Health, Housing & Community Services Department (HHCS) (co-lead)
 - Berkeley Fire Department (operational lead)
 - City of Berkeley Public Health Division (co-lead)
 - Berkeley Police Department offering coordination, diversion interfaces, safety protocols
 - Alameda County Health Care Services Agency offering behavioral health, care coordination, Medi-Cal pathways
 - Alameda Health System and/or other local hospitals/EDs offering high-utilizer coordination
 - Community-based organizations serving unsheltered residents, behavioral health, harm reduction, and re-entry populations
 - A liaison from City of Berkeley Disaster and Fire Safety Commission, Housing Advisory Commission and other relevant commissions (as appropriate)
-

Data, Privacy, and Compliance Considerations

The Workgroup must develop a HIPAA- and confidentiality-compliant operational plan that enables appropriate care coordination while protecting resident privacy. Key deliverables should include:

- Clearly defined minimum necessary data elements (e.g., referral reason, risk flags, consent status, outreach disposition)
 - Consent workflows for follow-up services
 - Interdepartmental data-sharing agreements and partner MOUs
 - Aggregated reporting methods for public transparency without disclosure of protected information
 - Documentation standards, QA/QI processes, and incident review pathways
-

Technology and Operational Modernization

As part of BEAR 2.0 feasibility, the Workgroup may evaluate operational tools that reduce dispatcher burden and improve triage and coordination, including structured triage decision support and workflow systems such as Prepared911 (or comparable platforms), ensuring:

- Transparent procurement approach and privacy review
 - Equity and bias review for any algorithmic triage support
 - Clear clinical/operational ownership of protocols
-

Budget and Funding Strategy (Direction for Staff Report)

The Commission is not authorizing expenditures through this item; however, it is requesting that departments return with budget options. The Implementation Plan should include:

A) Budget Scenarios

1. Planning + small pilot (6 months): minimal staffing, limited hours, defined geography
2. Full pilot (12 months): dedicated unit, expanded hours, robust follow-up capacity
3. Scaled program: multiple units / citywide coverage, integrated intake pathways

B) Funding Sources to Pursue

- Reallocation opportunities tied to cost avoidance (ED transports, repeat calls, overtime impacts)
- County/state/federal grants (behavioral health, homelessness, community paramedicine, health equity)
- Hospital/community benefit partnerships
- Philanthropic support for evaluation and start-up

C) Cost Avoidance / ROI Framework (required in plan)

The Workgroup should propose a cost-avoidance table using reasonable benchmarks such as:

- Avoided ED visit and/or avoided ambulance transport estimates
- Reduced repeat calls from high-utilizer cohort
- Improved linkage to ongoing care (primary care, behavioral health, SUD treatment)
- Reduced law enforcement involvement in non-criminal health events

(The Commission requests that staff use conservative assumptions and clearly label estimates vs. measured outcomes.)

Equity and Community Accountability

BEAR 2.0 must be designed with an explicit equity lens:

- Prioritize communities experiencing disproportionate morbidity/mortality and barriers to care

- Establish community feedback loops (service user voice, CBO partners, neighborhood input)
 - Publish periodic, aggregated outcome reports (race/ethnicity where appropriate and legal, geography, service outcomes, linkage metrics)
 - Ensure language access and culturally competent care approaches
-

Deliverables and Reporting Back

Within 90 days, HHCS and Fire/EMS should return with:

1. BEAR 2.0 Implementation Plan (including pilot design)
2. Proposed budget + funding strategy
3. Draft MOUs/data-sharing approach
4. Evaluation plan with defined metrics and reporting cadence
5. Proposed timeline for pilot launch

Within 6 and 12 months after launch, return with interim and final pilot evaluations and recommendations for sustainment or scaling.

Attachments

Staff and Item's sponsor will compile, as applicable:

- Prior BEAR program memos and summaries (including the previously drafted "Understanding the BEAR Unit's Impact: A Data-Driven Analysis" materials shared in Commission-related drafting)
- Any prior correspondence referencing BEAR/alternative response/community care concepts
- Draft partner list and initial concept of operations

Grant Application to CA EMSA and CARESTAR

Project Title: Berkeley MIH-CP: Community-Based Mobile Integrated Health & Paramedicine for Health Equity, Access, and Illness Prevention

Applicant Organization: City of Berkeley Fire Department (BFD)

Project Location: City of Berkeley, Alameda County, California

Grant Request To: California EMS Authority & CARESTAR Foundation – Community Paramedicine / CP-TAD/MIH funding stream

Requested Amount: \$50,000 (for CARESTAR CP/TAD), with potential EMSA match or state approval

Grant Period: 18 months (or as permissible by CARESTAR/EMSA for CP/TAD)

Project Start Date: June 2026

Project Contact: David McPartland, Emergency Medical Services Chief, Berkeley Fire Department

Signature of Authorized Official:

Executive Summary

The Berkeley MIH-CP Initiative will deploy a multidisciplinary, community-based mobile integrated health team (paramedic + social / behavioral health navigator) to deliver in-home follow-up, care coordination, and outreach for high-utilizer 9-1-1 callers, frequent emergency department (ED) users, and medically and socially complex residents in Berkeley and the surrounding underserved North and West Oakland corridor.

Our goals are to reduce avoidable 9-1-1/ED utilization, improve chronic disease management and behavioral-health linkage, advance health equity in historically underserved communities, and establish a replicable model for the Alameda County EMS system.

This request leverages the state's recognition of CP/TAD/MIH programs (through EMSA's CP/TAD page) and the CARESTAR Foundation's grant program that "supports expansion of community paramedicine (CP) programs across California" for Local EMSAs.

The grant funds will support the initial implementation phase: needs assessment, staffing/training, operational protocols, data tracking/quality improvement, and community engagement. The program will be developed in coordination with the Alameda County LEMSA and local hospital/primary care partners and will position for sustainable funding beyond the grant period, including Medi-Cal, value-based partnerships, and EMS transport alternatives. Evidence shows MIH/CP programs can improve access and reduce acute care utilization.

Statement of Need

Community Profile & Problem Statement

- The City of Berkeley — along with adjacent North/West Oakland neighborhoods — has a high density of medically and socially complex residents with chronic disease, co-occurring behavioral health/substance use conditions, and significant housing instability. These factors directly drive repeat EMS activations and serial, avoidable ED utilization. The BEAR pilot confirmed this profile. The majority of BEAR patients were older adults: **68% were age ≥65**, and an additional 17% were age 55–64, **underscoring the disproportionate burden among seniors with impaired care access and complex chronic disease**. Medicare and Medi-Cal were the dominant payer types, reflecting structural reliance on public coverage pathways for higher-acuity, lower-resource individuals who disproportionately default to 9-1-1 as the point of entry to care. Geographic clustering was concentrated in four Berkeley ZIP codes (94710, 94702, 94703, and 94704), demonstrating clear “hot spot” characteristics and geographically targetable service patterns. Under the traditional EMS/transport-only model, this population is only engaged *after* crisis activation — representing both (1) escalating burden on EMS resources and (2) a missed opportunity for preventative stabilization. National and California evidence shows MIH-CP fills this gap by delivering proactive, longitudinal intervention — bridging EMS, primary care, behavioral health, housing/human services and case management at the home/community level. California policy alignment is strong: EMSA explicitly supports CP/TAD program models; the CARESTAR Foundation funds MIH-CP/TAD initiatives tied to measurable transport reduction, improved care linkage, and reduced avoidable ED utilization. As the first structured project task, a formal needs assessment will quantify baseline repeat-utilization cohort characteristics (e.g., ≥10 EMS activations/year and/or ≥3 ED visits in the prior 12 months), and will formally map geospatial hot-spots. This step will anchor pre/post outcome metrics and will enable the MIH-CP program to set numeric reduction targets based directly on the baseline patterns documented in BEAR.

Equity Focus

- The program intentionally focuses on historically underserved populations—Black, Indigenous, Latinx, and Asian residents in Berkeley/Oakland who experience disparate access to preventive care and over-reliance on emergency services.
- By aligning with CARESTAR’s equity-centered grant mission (“reimagining emergency and pre-hospital care with a racial equity lens”), the Berkeley MIH-CP program will integrate community stakeholders, community-based organizations, and culturally responsive approaches (e.g., bilingual outreach, navigator staff) to reduce disparities and improve trust in EMS/health systems.

Project Goals & Objectives

Goal 1: Reduce avoidable 9-1-1 calls and ED visits among the target high-utilizer cohort in Berkeley by 50% within 18 months.

- Objective 1.1: Identify and enroll high-utilizer residents during the first 6 months.
- Objective 1.2: For enrolled participants, deliver at least 2 home visits + regular tele-follow up within the first 90 days.
- Objective 1.3: Measure and report baseline vs. post-intervention 9-1-1 call rate and ED visits at 3, 6, and 12 month intervals.

Goal 2: Enhance connection to primary care, behavioral health, substance use services, housing/support services for participants.

- Objective 2.1: Within 90 days of enrollment, 90% of participants will have a documented linkage/referral to a primary care provider or behavioral health service.
- Objective 2.2: Provide medication reconciliation, health education, and social determinant screening for participants; at least 80% of those with identified unmet needs will receive a referral to appropriate services.

Goal 3: Build program infrastructure and data capability to support sustainability and replication.

- Objective 3.1: Develop program protocols, training curriculum for paramedic + navigator teams, and medical oversight by Local EMS Medical Director.
- Objective 3.2: Create data-dashboard that tracks key metrics (calls, transports, ED visits, social referral outcomes) and quarterly quality improvement reviews.
- Objective 3.3: Engage community stakeholders (CBOs, resident advisory committee) and produce a sustainability plan by month 12 that identifies revenue streams (Medicaid wrap, EMS reimbursement, hospital/community health partner contracts) for continuing beyond the grant.

Program Design & Methods

Staffing & Team Structure

- One dedicated Community Paramedic (CP) FTE, augmented by a Health/Social Navigator (.75 FTE) who has expertise in behavioral health, housing/social services, and community outreach.
- Medical oversight will be provided by the Alameda County EMS Medical Director (or appropriately designated local hospital physician) who signs off on scope of practice, protocols, and quality review.

- The program will partner with local hospital(s) – e.g., Alta Bates, Kaiser or Sutter and primary care networks to receive referrals (post-hospital discharge, ED frequent flyers) and close the loop on care transitions.
- Community engagement partner: a local CBO will serve on the advisory committee, help with outreach, cultural/linguistic adaptation, and assist with addressing social determinants.

Workflow & Intervention

- Referral/Enrollment: The paramedic team will receive referrals from 9-1-1 dispatch high-utilizer lists, hospital/ED discharge records, and self-referral with navigator outreach.
- Home Visit: The paramedic + navigator team conducts an in-home or community-based visit within 48h of enrollment (where possible), performs health assessment (vitals, medication review, chronic disease screening), social determinant screening (housing, food security, substance use, behavioral health), develops a service plan.
- Follow-Up: At least one additional home/tele-visit within 30 days; ongoing outreach (phone/text/telehealth) for at least six months. Navigator provides linkage to services (primary care, behavioral health, housing programs, substance use, community resources).
- Integration & Data Closing: The team logs all interventions, tracks referrals and outcomes, coordinates with primary care/behavioral health/hospital partners to share information (with HIPAA/compliance). Quarterly reviews of patient metrics and program quality improvement.
- Transition & Sustainability: At six months, participants move to “maintenance” status and are handed off to community health networks but may be re-enrolled if high-risk. The program will evaluate cost savings and prepare a case for longer-term funding.

Protocols & Training

- Training curriculum for CP team will be built based on national MIH-CP toolkits (see National Association of Emergency Medical Technicians MIH-CP Knowledge Center) [NAEMT](#) as well as the AAOS
- Protocols will include: home risk assessment, medication reconciliation, behavioral health screening, motivational interviewing, social determinant referral workflow, telehealth integration, documentation standards.
- Medical oversight ensures compliance with local EMS protocols and state regulatory requirements for CP/TAD/MIH.

Data, Evaluation & Quality Improvement

- Baseline data collection in first 3 months: number of 9-1-1 calls, transports, ED visits per target group, average cost per utilization, demographics, social determinant profile.
- Key performance indicators (KPIs):
 - Of enrolled participants

- Of home visits completed
 - % of participants with primary care/behavioral health linkage
 - Reduction in 9-1-1 calls, transports, ED visits (6 & 12 months)
 - Participant satisfaction (survey)
 - Cost-avoidance estimates (based on reduced transports/ED visits)
 - Quarterly quality improvement meetings with the team, medical oversight, advisory committee; issues identified and protocol revisions made.
 - Final evaluation report at 18 months summarizing outcomes, lessons learned, equity metrics (disaggregated by race/ethnicity/housing status), and sustainability recommendations.
-

Budget Summary

Below is a high-level outline (detail to be inserted):

- Personnel
 - Community Paramedic (1.0 FTE)
 - Health/Social Navigator (0.75 FTE)
 - Program Manager/Administrator (0.25 FTE)
 - Medical Director (in-kind supervision)
- Training & Curriculum Development
- Equipment & Supplies (laptop/tablet for field documentation; mobile telehealth kit; home visit supplies)
- Outreach & Community Engagement (materials, interpreter/translator services, resident advisory committee stipends)
- Data Systems & Evaluation (dashboard subscription, data analyst part-time)
- Travel/Field Costs (home-visit travel reimbursement)
- Indirect/Overhead (if allowable under funder guidelines)

Total Requested: [e.g., \$50,000]

Matching or In-Kind Contributions: [List partner contributions, e.g., hospital partner providing referral data, local EMS agency providing medical oversight in-kind, CBO volunteer hours, etc.]

Sustainability Plan: After the 18-month grant, we will pursue [Medicare/Medi-Cal reimbursement models, value-based partnerships with hospital networks, local government funding, fee-for-service contracts] to continue the program.

Alignment with Funder Priorities

EMSA / CARESTAR CP/TAD Grant:

- CARESTAR's "Community Paramedicine Grants" are designed to support expansion of CP (and/or TAD) programs across California. Applications available to Local EMSAs.
 - EMSA's CP & TAD page confirms that funding is available from CARESTAR for CP/TAD programs.
 - CARESTAR's broader mission: "reimagining emergency and pre-hospital care with a racial equity lens" emphasizes community voice, partnerships, and innovation.
 - Our project addresses these priorities by implementing a CP/MIH model, partnering with EMS, community organizations, and residents; targeting equity; building a replicable model in Alameda County.
-

Partner & Stakeholder Engagement

- Local EMS Agency (LEMSA): Alameda County Emergency Medical Services Agency – to provide oversight, data linkage, regulatory compliance.
 - Hospital/Health System Partner: [e.g., Alameda Health System or UCSF Benioff Children's Hospital Oakland (or other local acute care partner) – to provide referral pipeline, discharge coordination.
 - Community-Based Organization: [e.g., Berkeley Free Clinic or local non-profit serving underserved populations] – to assist with cultural/linguistic adaptation, outreach, and addressing social determinants.
 - Primary Care Network or other appropriate healthcare provider: To which participants will be linked for longitudinal care beyond the ongoing check ins from BFD staff
 - Resident Advisory Committee: to include individuals representing Black, Indigenous, Latinx, immigrant and low-income communities in Berkeley/Oakland to advise on program design, outreach, and equity.
-

Sustainability & Scalability

- We will develop a sustainability plan by month 15 of the project that outlines:
 - Operational cost per participant and cost-avoidance estimates (reduced transports/ED visits).
 - Potential revenue streams: contracts with local hospital for readmission avoidance; Medi-Cal/Medi-care reimbursement (pending regulatory/payment mechanism development in CA)
 - Expansion plan: pending success, scale to additional neighborhoods in Alameda County, integrate with Triage to Alternate Destination (TAD) and broader MIH system.
 - By demonstrating measurable reductions in acute care utilization, we will build the case for long-term integration into the local EMS/health system financing model.
-

Risk Assessment & Mitigation

- Recruitment/Enrollment Risk: If referral numbers are lower than expected, we will widen referral criteria to include hospital discharge referrals and outreach to community clinics.
 - Data Sharing / Privacy / IT Integration Risk: Secure appropriate agreements (HIPAA, HIE access) early and budget for IT support.
 - Sustainability Risk (funding sunset): From project inception we will engage hospital/health system partners to explore value-based relationships and begin reimbursement discussions.
 - Operational Risk (staff turnover): Cross-train navigator and paramedic roles; build institutional protocols rather than individual-dependent.
 - Equity Engagement Risk: Ensure resident advisory committee has a meaningful voice; schedule regular check-ins; if funds allow, compensate members for time.
-

Evaluation Plan

- Internal evaluation will be conducted quarterly by the program manager and medical director, including KPI tracking and QI reviews.
 - A final evaluation report will summarize: number of participants enrolled, demographic breakdown (race/ethnicity, housing status, language), number and type of interventions, referral outcomes, reductions in 9-1-1 calls/ED visits (pre vs post), cost-avoidance estimates, participant satisfaction, equity outcomes (improvements/disparities reduced).
 - Outcomes will be shared with EMSA, CARESTAR, partner stakeholders, and made publicly available (e.g., white paper) to contribute to the evidence base for MIH-CP in California, which the state identifies as needed.
-

Appendices (to include)

- Letters of support from partner organizations (hospital, CBO, primary care clinic, LEMSA)
 - Detailed budget (with line items, in-kind contributions)
 - Organizational chart
 - Draft timeline/Gantt chart for 18-month project
 - Data collection plan and logic model
 - Bios of key staff (paramedic, navigator, program manager)
 - Community/needs assessment summary (if available)
 - Policies & procedures drafts (home visit protocol, social determinant screening workflow)
 - Sustainability plan outline
-

Conclusion

The Berkeley MIH-CP Initiative offers an innovative, equity-focused solution to a pressing challenge in our EMS/health-care system: high utilization of emergency services by medically and socially vulnerable residents, and the gap in proactive, community-based intervention. By leveraging the state's policy momentum around CP/TAD/MIH models, aligning with the CARESTAR Foundation's mission, and forging strong local partnerships, this project has the potential to deliver meaningful healthcare and EMS system change — improved health outcomes, reduced 9-1-1/ED load, and a model scalable across Alameda County and California. We respectfully request your partnership in funding this project and look forward to collaboration.

Thank you for your consideration.

[Authorized Signature]

[Date]

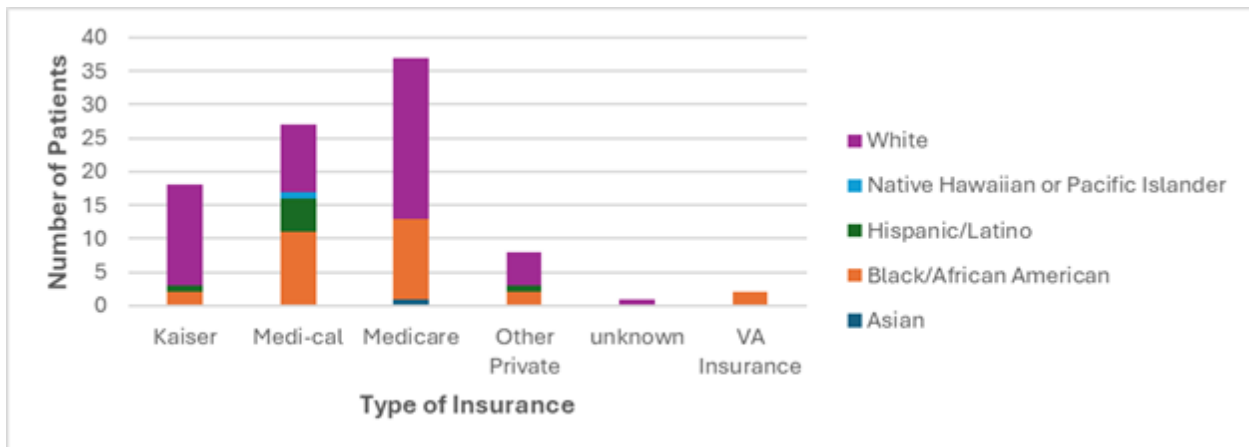
Attachment 1: Understanding the BEAR Unit's Impact: A Data-Driven Analysis

To provide a comprehensive understanding of the BEAR Unit's outcomes, the following charts offer an in-depth look at key program metrics, including demographics, areas served, and referral connections. These data points highlight the program's effectiveness in addressing non-urgent medical needs, reducing strain on emergency services, and connecting underserved members of the community to essential care and support.

The first chart provides an overview of the distribution of patients by insurance type. Medicare dominates as the primary insurance provider, covering the largest portion of patients. Medi-Cal follows as the second most utilized insurance, reflecting its significant role in providing coverage for low-income individuals and families.

Medi-Cal and Medicare was the most common type of insurance coverage for BEAR Unit patients. These patients may commonly end up in the ER because it is the most accessible option, not because their condition requires emergency care. This leads to overburdened hospitals, long ER wait times, and expensive ambulance transports which increase healthcare costs for the city. In contrast, private insurance options, such as Kaiser and Blue Shield, represent smaller yet notable patient populations.

Type of Insurance for BEAR Unit Patients

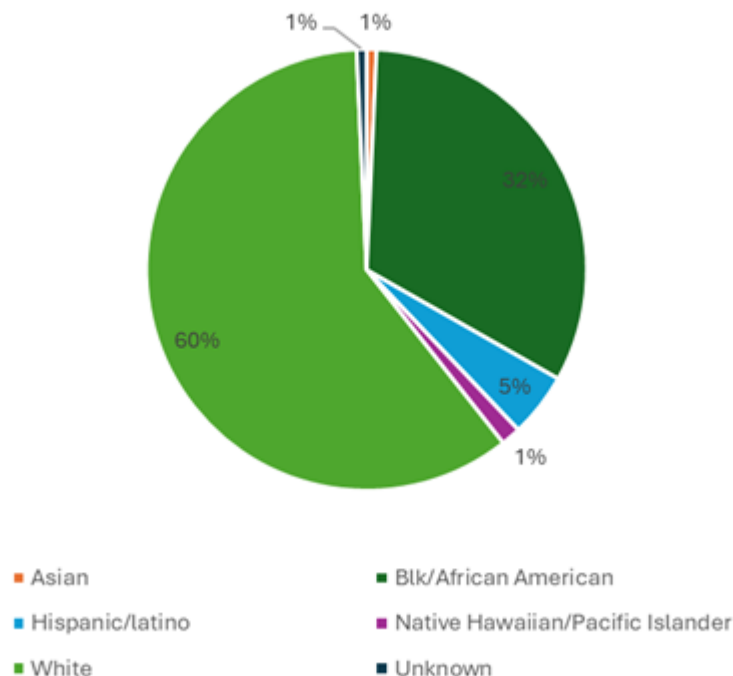


Calls by Race

There are prominent trends in the number of times the BEAR Unit staff have performed some type of follow-up—or patient touchpoints—across racial demographics. White patients make up the majority, accounting for 150 recorded touchpoints, followed by Black/African American patients with 77. Although there are fewer Black/African American patients (27 vs. 46 White patients), their touchpoint rate is nearly as high, indicating greater healthcare needs per individual within this population (3.2 and 2.9 touch ratio per patient respectively).

Smaller representations are seen among Hispanic/Latino and Native Hawaiian/Pacific Islander patients, with 9 and 4 touchpoints, respectively. The Native Hawaiian/Pacific Islander has the highest touch rate per patient, suggesting a small but highly engaged subset of individuals requiring repeated assistance in accessing care. Asian patients and those with unknown racial classification account for 2 touchpoints, while no interactions are recorded for American Indian/Alaska Native patients.

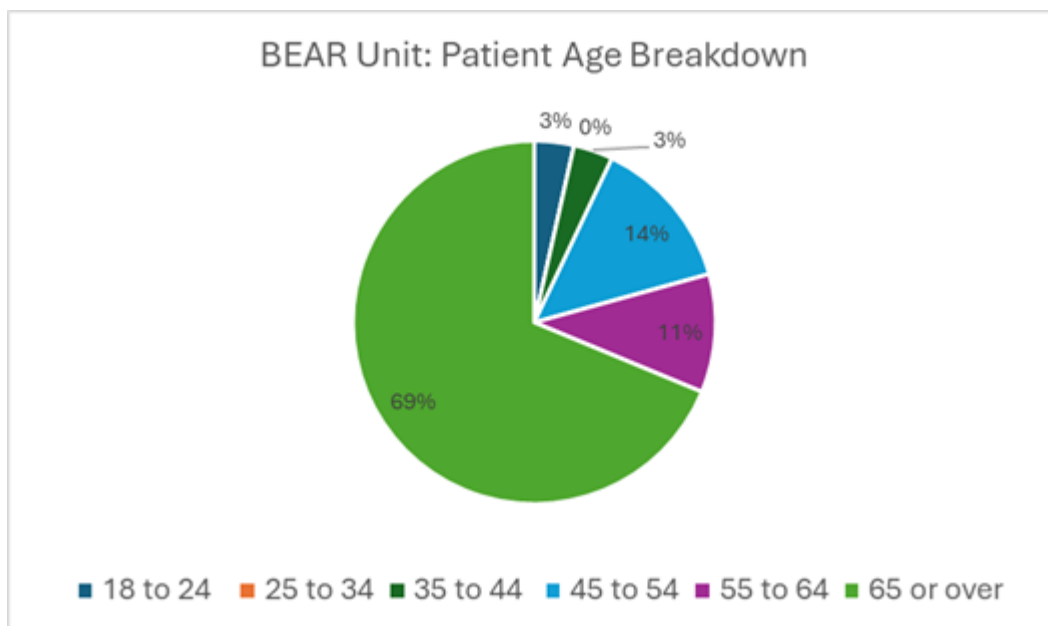
Touch Rate per Patient by Race Breakdown



Calls by Age Group

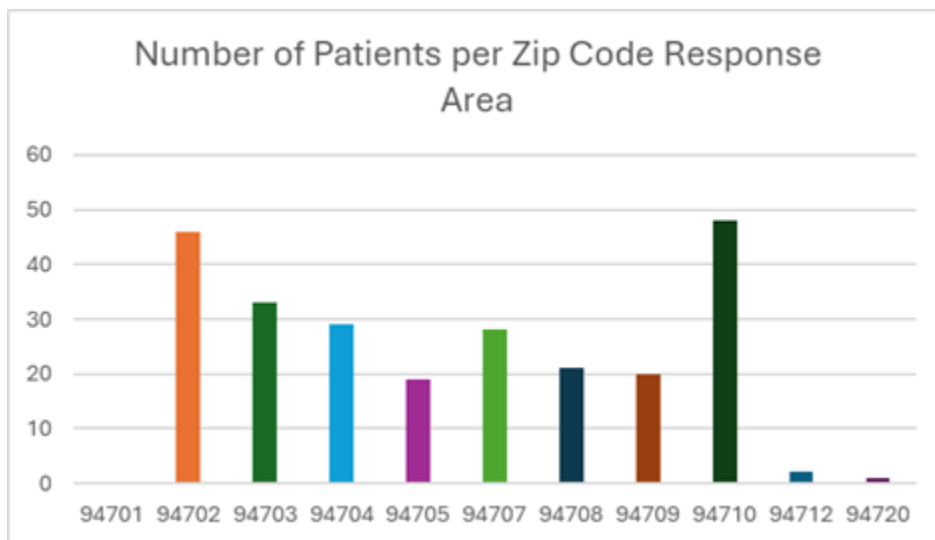
A significant number of patients are among older age groups. Patients aged 65 or over account for the majority demographic served by the BEAR unit, comprising 68% of all interactions. This reflects the challenges older adults face in accessing healthcare, especially those reliant on Medicare. The BEAR program's focus on providing primary care through the 9-1-1 system is critical in reducing unnecessary ambulance transports, medical costs, and medical related stress for this group.

This is followed by those aged 55 to 64, who make up 17%, and those aged 45 to 54, who are 10% of those served. Younger age groups, including 35 to 44 (4%) and 18 to 24 (1%), represent a much smaller proportion of the population served. Notably, no interactions are recorded for individuals aged 25 to 34. The large percentage of patients from 55 to 64 and 65+ suggests a growing need for services aimed at older adults, particularly those facing challenges with Medicare and healthcare system navigation. This breakdown highlights the predominance of older adults in healthcare engagement, emphasizing the importance of services tailored to this demographic.

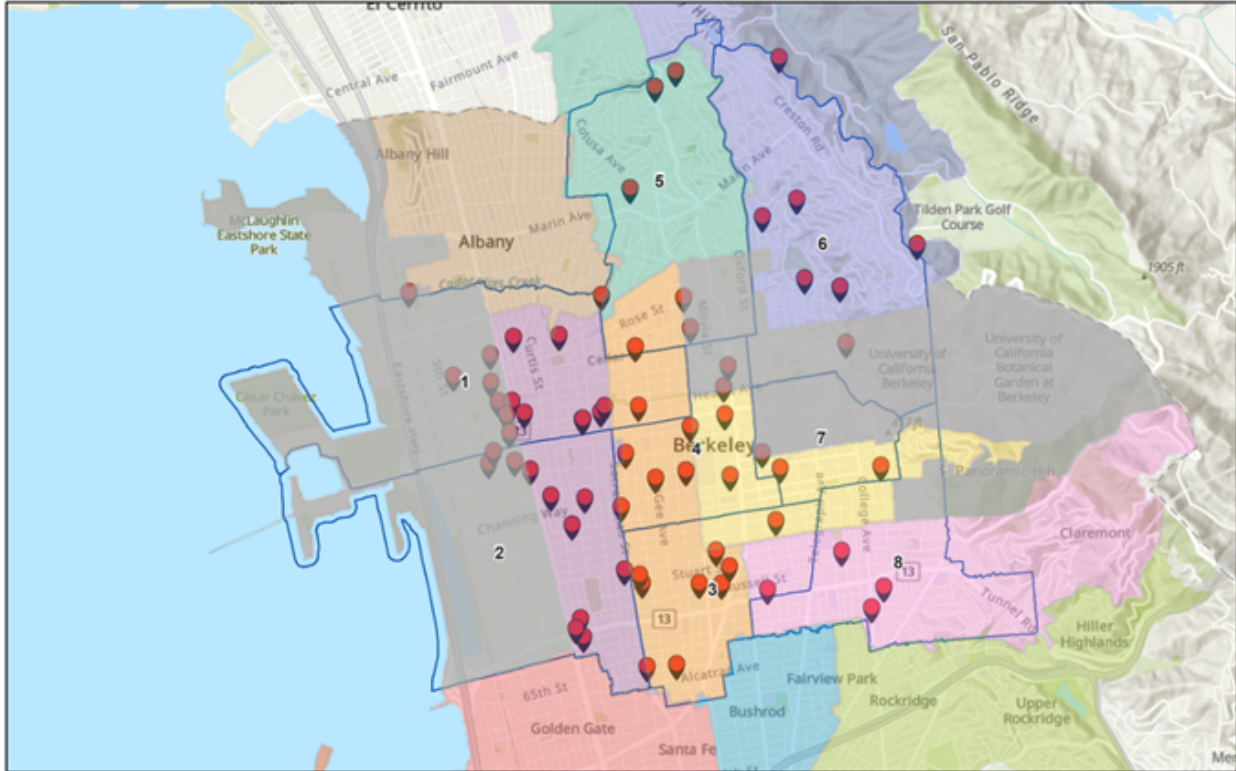


Calls by Zip Code

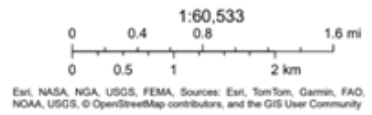
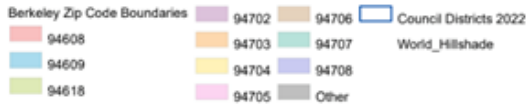
The BEAR unit provides critical primary and social services care to Berkeley's most vulnerable populations, particularly in ZIP codes with most patients in 94710, 94702, 94703, and 94704. The data highlights that older adults using Medicare and Medi-Cal are concentrated in these areas, reflecting significant socio-economic and healthcare access disparities. The program's outreach in these zip codes is essential in addressing the unmet healthcare needs of these communities, ensuring equitable access to care, and reducing reliance on emergency services for primary healthcare.



BEAR Unit Calls by Zip Code and Council District



3/13/2025



A WORLD CAFÉ DISCUSSION

FOR THE CITY'S COMMUNITY HEALTH ASSESSMENT & HEALTH IMPROVEMENT PLAN

*Thanks for being here! Grab some food
and make yourself comfortable*



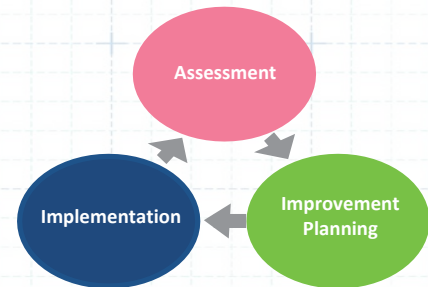
Group Agreements

1. Listen to understand, not to respond.
1. Space to fumble, responsibility to repair.
1. What's said here stays here, what's learned here leaves here.
1. Center your self-care.
1. Your voice matters. Share your thoughts in whatever way works for you.
1. This won't sit on a shelf! Think actionable, think collaboratively.

GUIDING PRINCIPLES

Four principles emerged from review of the CHA data, identified health priorities, and discussions about the desired approach for the BWB. These principles guided the identification of the objectives, strategies, and actions that follow and should be applied when making health-related policy and practice decisions in Berkeley.

1. Balance ambition with feasibility
2. Cultivate Cross-sector work
3. Emphasize prevention
4. Establish a long-term cycle



Goals

Address
Disparities
in Life
Expectancy

&

Increase
Community
Power and
Partnership

Health Topic Objectives

Housing

Decrease displacement and housing cost burden

Environmental Health

Reduce impact of poor air quality

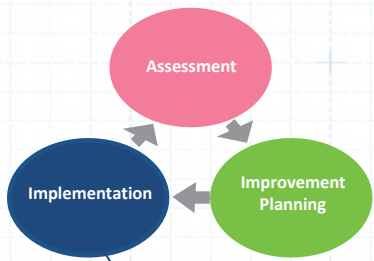
Behavioral Health

Decrease rates of depression, anxiety, and severe mental health crises

Community Safety

Improve walkability and walking safety

Welcome to the Implementation Stage



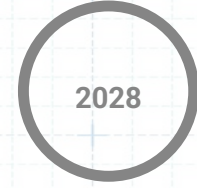
Preparation

Align efforts, communicate progress and identify people and processes for action period



Action

Sustain accountable action, implementat ideas, communicate progress, continue to engage city staff/community partnership.

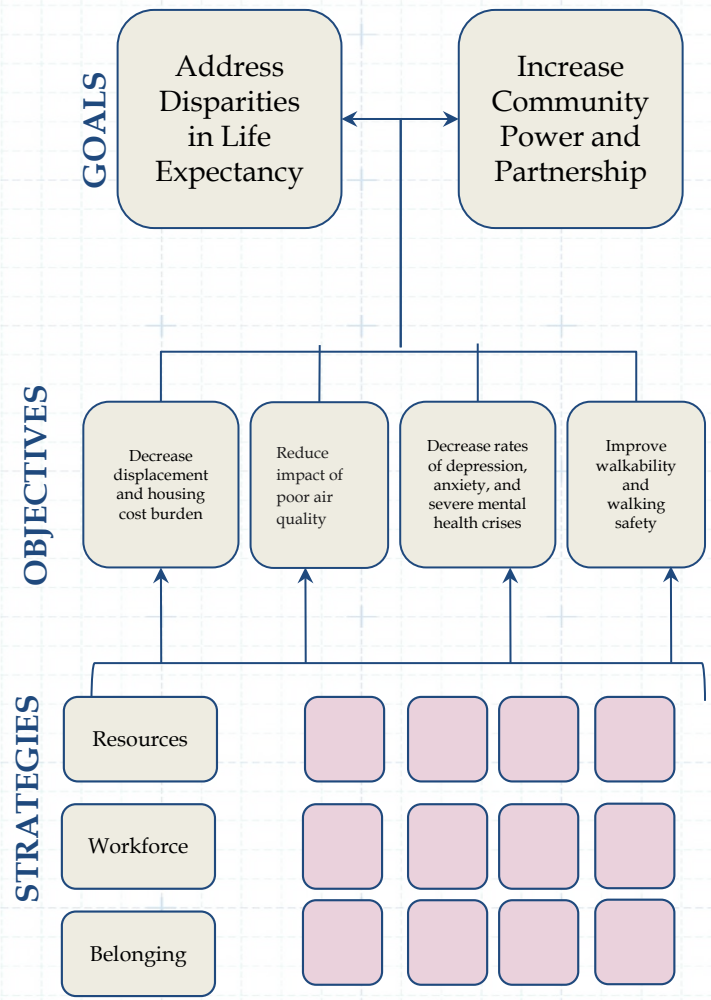


Refresh

Prepare for next CHA/CHIP cycle

Goals for Our Time Together

1. **Launch the Implementation Phase:** Discuss strategies to advance the CHIP including the four CHIP Priority objectives and the current, rapidly changing landscape (new funding, emerging issues)
1. **Map Collective Power:** Identify and map existing resources, assets, and funding streams (City, CBO, and Partner efforts) that can be immediately leveraged to break down silos.
1. **Identify Opportunities for Commitment and Collaboration:** Discuss ways we can leverage the great working we are already doing to advance the goals and objectives.



Flow of Today

Two rounds of table discussion

- Round 1 (30 minutes - 2 questions)
- Round 2 (20 minutes - recap + 1 question)

Gallery Walk

Final Question

Share Back

Next Steps

You Dot is for Round 1

Pink - Housing

Yellow - Community Safety

Orange - Behavioral Health

Green - Environmental Health

Round 2 - You Choose!

Round 1:

Which of the existing strategies or what new strategies can be done in the next 3 years to move the needle on this health objective?" **Add sticky notes and put a dot next to the ones you believe should be prioritized**

What emerging issues have surfaced since the CHIP was finalized that should be added as a priority area to address? **Add sticky notes and put a dot next to the ones you believe should be prioritized**

Round 2:

What other efforts and/or funding relate to these strategies?

- What are the funding streams? What are the specific efforts?

Round 3:

What are you willing to do? What is one concrete, measurable step you or your group can commit to advance this CHIP objective?

Agenda Item

Title: Amendment to the Community Health Commission 2025–26 Work Plan to Align with the Berkeley Wellness Blueprint (CHA & CHIP)

Meeting Date: March 26th, 2026

Submitted by: Taj Herzer-Baptiste, Commissioner

Requested Action: Discussion and possible action

RECOMMENDED ACTION

Adopt revisions to the Community Health Commission (CHC) 2025–26 Work Plan to formally align Commission priorities, focus areas, and workgroups with the findings, goals, and priority health topics identified in the Berkeley Wellness Blueprint Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP).

BACKGROUND

In 2023–2025, the City of Berkeley Health, Housing, and Community Services Department, in partnership with community members and the Community Steering Committee, completed the Berkeley Wellness Blueprint, consisting of a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP).

The CHA identifies significant disparities in health outcomes, including life expectancy gaps of up to 13 years by neighborhood and race/ethnicity, with particularly adverse outcomes for Black/African American residents, residents of South and West Berkeley, LGBTQIA+ residents, Latine/x residents, and youth

The CHA further finds that health outcomes in Berkeley are strongly shaped by housing affordability, environmental health conditions, behavioral health access, and community safety, and that community trust depends on transparency, collaboration, and follow-through.

The CHIP translates these findings into a citywide framework for action, establishing two overarching goals:

1. Address disparities in life expectancy, and
2. Increase community power and partnership, supported by four priority health topic objectives:
 - ❖ Housing (decrease displacement and housing cost burden)
 - ❖ Environmental Health (reduce impacts of poor air quality and climate risk)

- ❖ Behavioral Health (decrease depression, anxiety, and severe mental health crises)
- ❖ Community Safety (improve walkability and reduce injuries).

While the current CHC 2025–26 Work Plan reflects a strong equity-centered mission, it does not fully take into account priorities outlined in the CHA and CHIP and does not fully or explicitly align Commission workgroups, priorities, or evaluation activities with the City’s adopted community health framework.

Aligning our Work Plan with stated City priorities

This item proposes updating the Community Health Commission Work Plan to:

- Ground Commission priorities in the most current, community-validated health data;
- Align CHC advisory, advocacy, and oversight functions with the CHA findings and CHIP goals;
- Improve accountability and coordination between the Commission, City departments, other commissions, and community-based organizations; and
- Ensure that Commission work is focused on root causes of health inequities, particularly those driving disparities in life expectancy.

Proposed Work Plan Alignments

If approved, the revised Work Plan would:

1. Affirm the CHA as the Commission’s primary data and equity reference, to be cited in recommendations, letters, and policy analysis.
2. Align Commission priority areas and workgroups with the CHIP’s four priority health topics:
 - Housing
 - Environmental Health
 - Behavioral Health
 - Community Safety
3. Refocus chronic disease and health equity efforts toward upstream drivers identified in the CHA (housing stability, air quality, neighborhood conditions, access to care).
4. Integrate life expectancy disparities as a standing equity metric informing Commission advocacy.
5. Strengthen cross-commission collaboration, particularly with commissions addressing housing, transportation, disaster preparedness, and environmental justice.
6. Emphasize prevention and systems change, consistent with the CHIP’s guiding principles, rather than solely crisis response.

Fiscal Impact

There is no direct fiscal impact associated with adopting revisions to the Commission Work Plan. This action concerns alignment of advisory priorities and governance functions. Any future recommendations involving budgetary impacts would be brought forward separately.

Environmental and Equity Considerations

The proposed alignment explicitly advances health equity by centering populations and neighborhoods experiencing the worst health outcomes, as identified in the CHA, and by prioritizing environmental health risks, housing instability, and safety conditions that disproportionately affect South and West Berkeley residents.

Next Steps (If Approved)

- Direct staff and/or a designated CHC ad-hoc working group to draft a revised 2025–26 Work Plan reflecting CHA and CHIP alignment.
- Return the revised Work Plan to the Commission for final adoption.
- Use the aligned Work Plan to guide CHC agenda-setting, annual priorities, and communications with City Council and HHCS.

COMMUNITY HEALTH COMMISSION

2025–2028 WORK PLAN

Aligned with the Berkeley Wellness Blueprint (CHA & CHIP)

Guiding Philosophy

The Community Health Commission (CHC) approaches health through an equity and prevention lens, recognizing that health outcomes in Berkeley are shaped primarily by housing stability, environmental conditions, behavioral health access, community safety, and structural inequities. The Commission's work is grounded in community-defined priorities and data from the Berkeley Wellness Blueprint Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP), with a focus on eliminating disparities in life expectancy and strengthening community power and partnership.

I. Mission and Purpose

A. Mission

The Community Health Commission advises the Berkeley City Council, Health, Housing, and Community Services Department (HHCS), and Public Health Division by advancing policies, systems, and partnerships that measurably reduce health inequities and improve health outcomes for all Berkeley residents, with particular attention to populations and neighborhoods experiencing the worst outcomes. The primary and overarching goal of this commission is to serve as a crucial interface between the Berkeley community and the city's health initiatives. This involves a dedicated commitment to efficiently and effectively capturing, analyzing, and responding to community feedback related to all facets of community health. Furthermore, the commission is tasked with developing and formulating well-informed recommendations and policy proposals. These recommendations must be meticulously aligned with and directly responsive to the qualitative and quantitative feedback received from community members, ensuring that the commission's work directly reflects the genuine needs and priorities of the Berkeley population.

B. Core Functions

The Commission fulfills its mission by:

1. Using current community health data to inform policy recommendations.
 2. Centering the voices and lived experiences of populations disproportionately impacted by health inequities.
 3. Advocating for prevention-oriented, cross-sector solutions that address root causes of poor health.
 4. Providing a transparent public forum for community health concerns, ideas, and accountability.
 5. Monitoring progress toward Citywide health equity goals identified in the CHA and CHIP.
-

II. Data and Accountability Framework

The CHC formally adopts the following as guiding reference documents:

- Berkeley Wellness Blueprint – Community Health Assessment (CHA)
- Berkeley Wellness Blueprint – Community Health Improvement Plan (CHIP)

The Commission will:

- Cite CHA findings and CHIP goals in all formal recommendations.
 - Use CHIP objectives and high-level measures to assess progress.
 - Request periodic updates from City departments on actions advancing CHIP priorities.
-

III. Overarching Goals (CHIP aligned)

GOAL 1: Address Disparities in Life Expectancy

Focus Commission efforts on policies and systems that reduce racial, geographic, and socioeconomic disparities in health outcomes, particularly in South and West Berkeley, where life expectancy is significantly lower than the citywide average.

GOAL 2: Increase Community Power and Partnership

Advance governance practices that promote shared decision-making, transparency, accountability, and sustained collaboration between the City and community members, particularly those historically excluded from power.

IV. Priority Health Topics and Objectives

Consistent with the CHIP, the CHC organizes its work around four interconnected priority health topics:

1. Housing

Objective: Decrease displacement and housing cost burden as core drivers of health inequity.

Commission Role:

- Advocate for housing policies that improve health stability.
- Assess health impacts of housing displacement and affordability trends.
- Collaborate with housing-focused commissions and departments.

2. Environmental Health

Objective: Reduce the health impacts of poor air quality, climate change, and environmental hazards.

Commission Role:

- Monitor policies related to air quality, wildfire smoke, and environmental justice.
- Advocate for prevention-oriented investments that reduce asthma and respiratory illness.
- Coordinate with disaster preparedness and environmental oversight bodies.

3. Behavioral Health

Objective: Decrease rates of depression, anxiety, and severe mental health crises through prevention, access, and coordination.

Commission Role:

- Support policies that expand early intervention, crisis prevention, and access to care.
 - Monitor system integration across behavioral health, housing, and emergency response.
 - Advocate for community-based and culturally responsive models of care.
-

4. Community Safety

Objective: Improve walkability, pedestrian safety, and conditions that support physical and mental wellbeing.

Commission Role:

- Advocate for injury prevention and safe public spaces.
 - Coordinate with transportation and public safety commissions on health-informed safety strategies.
 - Elevate community concerns related to safety and access.
-

V. Priority Populations

Informed by the CHA, the Commission prioritizes policies and actions that address disparities affecting:

- Black/African American residents
- Latine/Latinx/Hispanic residents
- LGBTQIA+ residents
- Residents of South and West Berkeley
- Youth

This prioritization does not exclude other populations, but ensures resources and attention are directed where inequities are greatest.

VI. Commission Structure and Workgroups

A. Standing Workgroups

Workgroups shall align directly with the four CHIP priority health topics:

1. Housing
2. Environmental Health
3. Behavioral Health
4. Community Safety

Each workgroup will:

- Track relevant data and policy developments.
- Develop recommendations tied to CHIP objectives.

- Coordinate with relevant City departments and commissions.

B. Ad-Hoc Workgroups

The Commission may form time-limited workgroups to address emergent issues, funding changes, or urgent public health concerns.

VII. Cross-Sector and Cross-Commission Collaboration

Where possible, the CHC commits to active collaboration with other City commissions and departments whose decisions materially affect health outcomes, recognizing that health equity requires shared responsibility across systems.

VIII. Community Engagement and Transparency

The Commission will:

- Ensure engagement processes provide feedback, follow-through, and clear communication.
 - Advocate for community participation that includes shared decision-making and, where appropriate, compensation.
 - Publicly report on progress toward CHIP-aligned goals.
-

IX. Prevention and Long-Term Impact

The CHC prioritizes prevention-focused strategies that reduce downstream emergency, clinical, and social service demand, consistent with the CHIP's emphasis on long-term, sustainable health improvement.

X. Review and Update Cycle

This Work Plan:

- Shall be reviewed annually.
- Shall be updated following each CHA/CHIP cycle.

- Serves as the basis for Commission agenda-setting, recommendations, and annual reporting.

ADOPTION

Adopted by the Community Health Commission on: _____