Community Health Commission

Thursday, April 23, 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

Community Health Commission
Andy Katz, Chair
Kellie Knox, Staff Secretary

AGENDA

Preliminary Matters

1. Call to Order by Chair
2. Roll Call by Secretary
3. Land Acknowledgement –(Attachment 6)
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. Public Health Officer Report
2. CHC Chair's Report
3. Approval of Draft Minutes from 02/26/2026 Regular Meeting – (Attachment 1)
4. Approval of Draft Minutes from 03/26/2026 Regular Meeting – (Attachment 2)
5. Environmental Health Restaurant Inspection Audit Update – (Attachment 7)
6. Proposal to Resume Operations of BEAR Program – Action (Attachment 8)
7. City Manager's FY 2027 & 2028 Proposed Budget Balancing Plan – Action (Attachment 9)
8. Community Health Improvement Plan – Discussion (Attachment 10)
9. Commission Workgroups -Action
10. Election of Vice Chair
11. Work Plan review -Discussion (Attachment 3)

Future Agenda Items:

- PH Program Presentations
- 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 – July or September
- California Institute of Regenerative Medicine (CIRM) Presentation Request May
- Work Plan - June

Adjournment

Attachments

1. Draft minutes from 02/26/2026 CHC Regular meeting
2. Draft minutes from 03/26/2026 CHC Regular meeting
3. CHC 2025-2026 Work Plan
4. CHC Meeting Calendar 2026
5. City Council and Community Health Commission Timeline 2026
6. Land Acknowledgement
7. Environmental Health Restaurant Inspection Audit Update
8. BEAR Program Proposal and Information
9. City Manager's FY 2027 & 2028 Proposed Budget Balancing Plan
10. Community Health Improvement Plan –

The *next meeting* of the Community Health Commission is scheduled to be held on Thursday, May 28, 2026 with a *deadline of Tuesday, May 19, 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 writing 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

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.

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

Community Health Commission

DRAFT MINUTES

Regular Meeting, Thursday, March 26, 2026

The meeting convened at 6:39 p.m. with Commissioner Katz presiding.

ROLL CALL

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

Absent: Commissioner Bacon.

Excused: None.

Staff present: Kellie Knox, Janice Chin

Community Members: Matthew Reese

COMMENTS FROM THE PUBLIC: None.

ACTION ITEM

9. M/S/C (Charney/Reese): Motion to elect Andy Katz to the office of Chair of the Community Health Commission.

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

Noes: None.

Abstain: None.

Absent from vote: Commissioner Bacon.

Excused: None.

Motion Passed.

Discussion and Action Items

1. Presentation of Results-Based Accountability Basics – Janice Chin, Manager, Public Health Division, HHCS – Discussion.
2. Public Health Officer Report – None provided.
3. CHC Chair's Report - Discussion
4. Approval of Draft Minutes from 02/26/2026 Regular Meeting- No Action taken.
5. Environmental Health Restaurant Inspection Audit Update – No Discussion or Action taken.
6. Proposed Project to Resume Operations of BEAR Program – Discussion and No Action taken.
7. Community Health Improvement Plan – Discussion
8. Commission Workgroups – No Discussion or Action taken.
9. Election of Officers – Action taken to fill Chair position. No action for Vice-Chair position.

Future Agenda Items:

- PH Program Presentations
- Long Term Care Facility Referral – draft ordinance.
- 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
- Work Plan –June

This meeting adjourned at 9:08 p.m.

Minutes will be reviewed and approved on Thursday, April 23, 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-05

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

Updated 10/22/25

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

HHCS COMMISSIONS
2026 COUNCIL MEETING TIMELINE

COUNCIL MEETING	Thursday Commission needs to take action by	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
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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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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

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-07

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 report[1] 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

Attachment 1

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

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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

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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

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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]

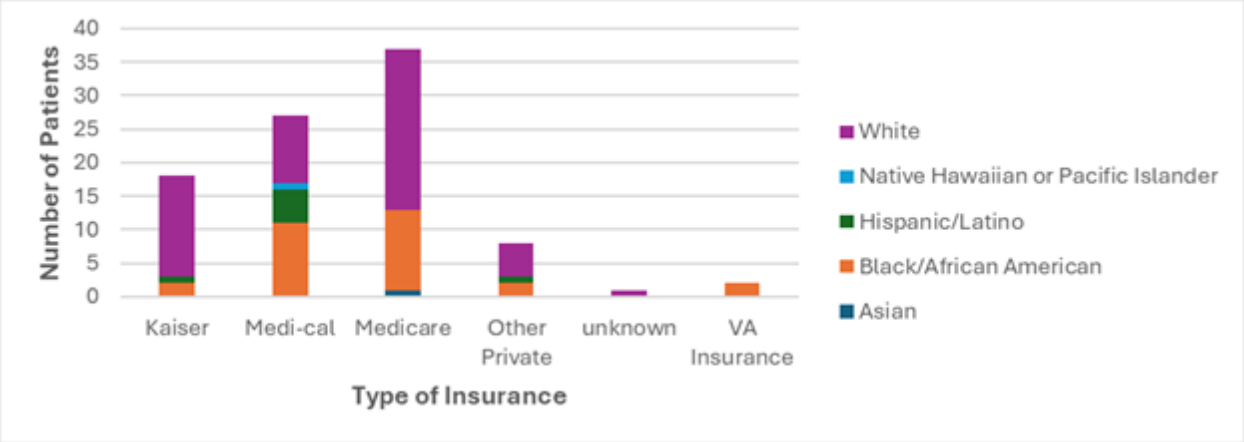
Attachment 1: Understanding the BEAR Unit's Impact: A Data-Driven Analysis

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.

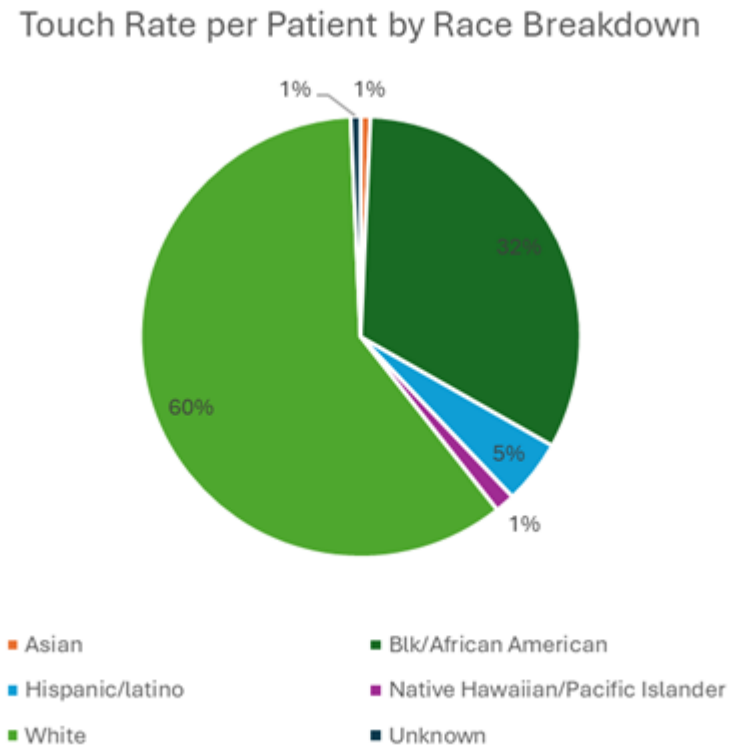
Type of Insurance for BEAR Unit Patients



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).

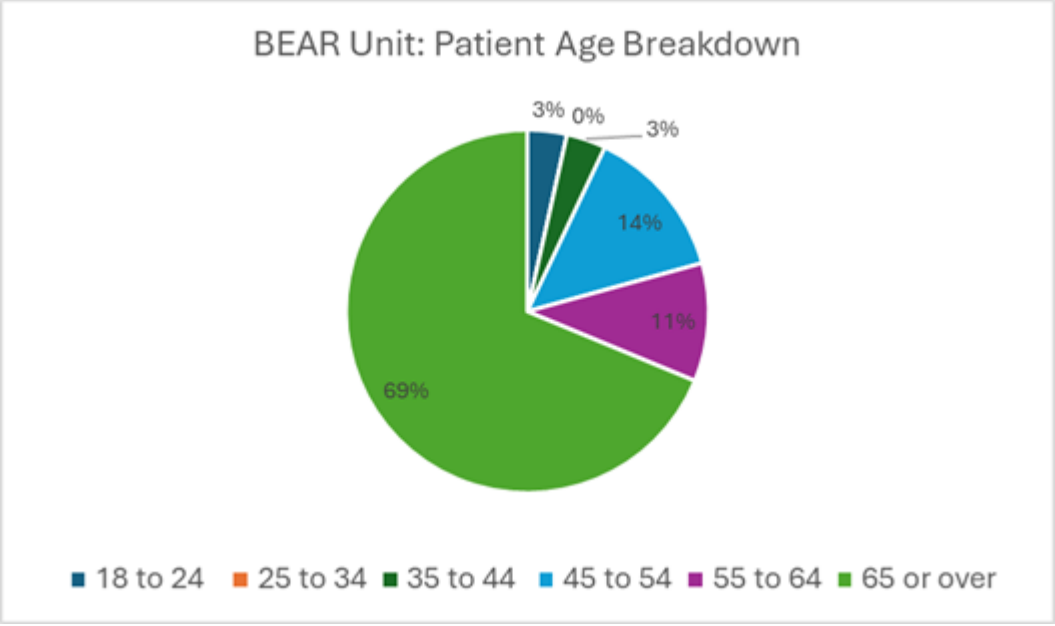
Smaller representations are seen among Hispanic/Latino and Native Hawaiian/Pacific Islander patients, with 9 and 4 touchpoints, respectively. The Native Hawaiian/Pacific Islander has the highest touch rate per patient, suggesting a small but highly engaged subset of individuals requiring repeated assistance 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.



Calls by Age Group

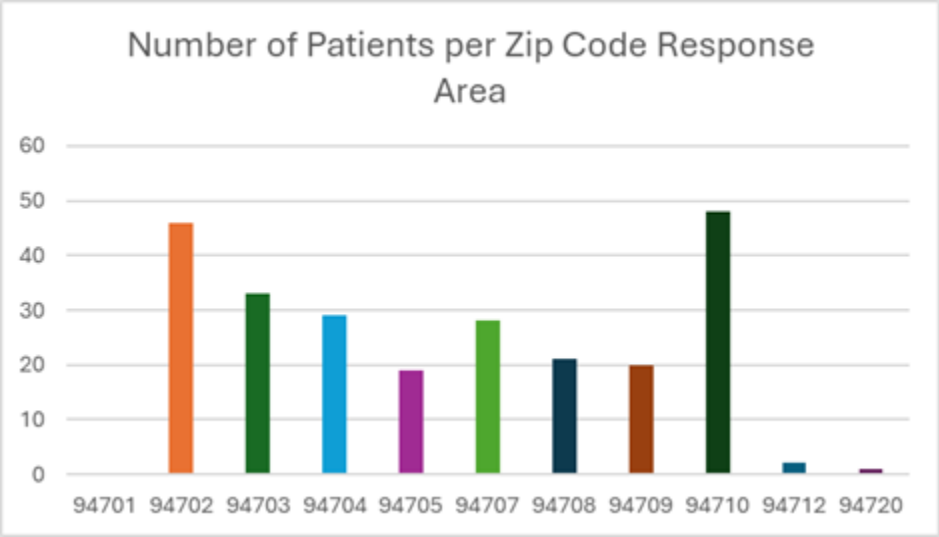
A significant number of patients are among older age groups. Patients aged 65 or over account for the majority demographic served by the BEAR unit, comprising 68% of all interactions. This reflects the challenges older adults face in accessing healthcare, especially those reliant on Medicare. The BEAR 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.

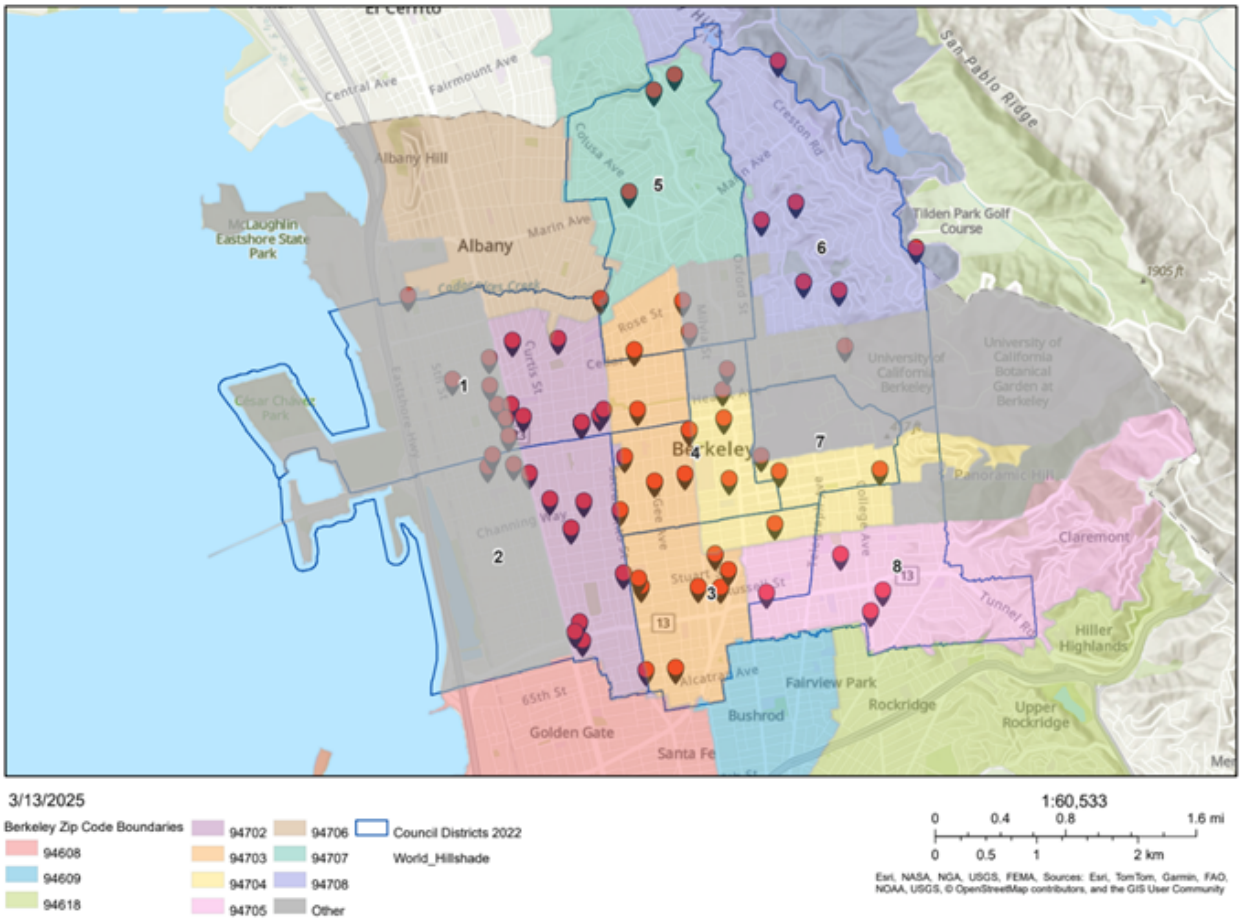


Calls by Zip Code

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

Berkeley Zip Code Boundaries
- 94608
- 94609
- 94618
- 94702
- 94703
- 94704
- 94705
- 94706
- 94707
- 94708
- Other

Council Districts 2022

World_Hillshade

1:60,533

0 0.4 0.8 1.6 mi

0 0.5 1 2 km

Office of the City Manager

Date: April 16, 2026

To: Budget & Finance Policy Committee

From: Paul Buddenhagen, City Manager

Submitted by: Maricar Dupaya, Budget Manager

Subject: FY 2027 & FY 2028 Proposed Budget Balancing Plan

RECOMMENDATION

Request that the Budget & Finance Policy Committee:

1. Receive, review, and discuss the City Manager's proposed FY 2027 and FY 2028 Budget Balancing plan.

2. Provide recommendations on any adjustments to the proposed plan.

SUMMARY AND BACKGROUND

The City of Berkeley has faced a persistent General Fund structural deficit for many years. The upcoming FY 2027–FY 2028 Biennial Budget continues this trend but with a critical shift. Rather than relying on one-time fixes, the proposed Budget Balancing Plan recommends long-term, structural adjustments to restore fiscal stability[1].

The City's financial outlook reflects the following:

- Ongoing structural General Fund deficit
- Ongoing programs supported by one-time funds
- Historical and projected increases in personnel costs associated with pensions, health

[1] As part of the FY 25 – FY 26 Adopted Biennial Budget (https://berkeleyca.gov/sites/default/files/documents/FY-2025-2026-Proposed-Biennial-Budget.pdf), the budget message indicated the need for structural reforms as part of the FY 27 – FY 29 Biennial Budget process (page 9): "Again, given the increase in expenditures, the General Fund is balanced through a combination of one-time solutions. These factors include (1) increase in assumed salary savings materializing from vacant positions; (2) not making any funding allocations to the workers compensation fund in either fiscal year; (3) due to the increase in pension costs, utilizing $3 million of funding from the City's Section 115 Trust toward pension expenses in each fiscal year, thereby allowing more General Fund to be redirected toward other expenditures and (4) the use of approximately $2-3 million of fund balance (prior years' savings) in FY25 and FY26 respectively. While these strategies lead to a balanced biennial budget, they are not sustainable and efforts to either increase revenues and/or decrease expenditures beyond the baseline budget will need to be undertaken as part of the FY26 Mid-Biennial Budget Update and as part of the budget development process for fiscal years 2027 and 2028."

care, and labor agreements
- Inflationary increases in contracts, utilities, and materials
- Increasing insurance costs
- State and Federal imposed revenue limitations
- Increased service demands and community expectations
- Deficits in enterprise and special funds (e.g., Parking, Marina, Building Maintenance, Mental/Behavioral Health) and the Capital Improvement Fund
- Delayed facility maintenance and growing unfunded liabilities attributed to aging infrastructure
- Economic uncertainties and other external factors

The City developed its General Fund (GF) baseline expenditure budget from December 2025–January 2026. This resulted in a projected $32.3 million deficit in FY 2027 and $33.2 million in FY 2028 (FY 2027 and FY 2028 Biennial Budget Update 1.22.2026)[2].

To address this gap, the City launched a citywide budget balancing exercise from January through March 2026. Departments and Charter Officers were asked to:

- Identify 10% and 12.5% General Fund reductions;
- Address deficits in other structurally imbalanced funds (if applicable); and
- Propose revenue-generating ideas.

On February 26, 2026, the Finance Department released updated General Fund revenue projections for FY 2026, as well as for FY 2027 and FY 2028 (FY 2026 Mid-Year General Fund Revenue Report)[3]. These updated revenues reduced the projected General Fund deficit to $27.1 million in FY 2027 and $24.9 million in FY 2028.

These departmental submissions, combined with citywide strategies, and updated revenue projections, form the basis of the proposed balancing plan and reflect the City's commitment to:

- Protecting essential and safety-net services
- Advancing community wellbeing
- Maintaining long term fiscal sustainability
- Minimizing service disruptions and workforce impacts
- Ensuring transparency and accountability

[2] https://berkeleyca.gov/sites/default/files/legislative-body-meeting-attachments/Item 02 BFPC-FY2728 Budget Update_Final_01.22.26.pdf.
[3] https://berkeleyca.gov/sites/default/files/legislative-body-meeting-attachments/Item 02 General Fund Revenue Update and Overview of Revenue Enhancements %28FY 2026 Mid-Year General Fund Revenue Report-Final%29.pdf.

CURRENT SITUATION

The City Manager, along with the Deputy City Manager, Budget Manager, Human Resources Director, Finance Director, and Department Directors, reviewed departmental proposals to develop the proposed Budget Balancing Plan ("Plan") that is now before the Budget and Finance Policy Committee for discussion.

The proposed Plan reflects several key points:

- Proposed reductions in staffing and non-personnel expenditures to address the structural deficit in the General Fund as well as other funds, including the Off-Street Parking Fund, Building Maintenance Fund, Building Purchases and Management Fund (1947 Center Street), Marina Fund, Capital Improvement Fund, IT Cost Allocation Plan Fund, and multiple funds supporting Mental Health and Behavioral Health Services.

- Reallocating personnel and non-personnel expenditures (referred to as cost shifts throughout this report) to other funds that are not in fiscal distress and for which the shifted expenditures are appropriate.

- General Fund support for the City's legally obligated payments for debt service associated with the purchase of 1947 Center Street.

- Reducing the Parking Meter Fund transfer to the General Fund to stabilize parking operations and ensure that the City can satisfy bond obligations.

- Refining non-departmental budgets.

- Strategically using one-time resources to smooth the deficit across the two fiscal years and support programs and services to be funded until the outcome of a proposed Sales and Use Tax measure for the November 2026 ballot is determined[4].

[4] On January 27, 2026, City Council approved a referral to the City Manager to include, as part of the upcoming community survey for the November 2026 election, a question assessing the perspectives of likely Berkeley voters on a potential increase to the City's sales and use tax rate. This would result in a sales and use tax that is comparable to surrounding jurisdictions. On March 17, 2026, the results of the community survey were presented to the City Council (https://berkeleyca.gov/sites/default/files/2026-03/2026-03-17%20Special%20Item%2001%20Presentation%20and%20Discussion.pdf) and the results of the survey indicated that there was majority support for a sales and use tax increase to address the City's budget deficit.

As summarized in the Table below, after the adjustments outlined above, **the General Fund deficit in FY 2027 is $29.3 million and $29.5 million in FY 2028**.

City of Berkeley Annual General Fund Deficit
FY 2027 - FY 2028 Biennial Budget

	FY 2027	FY 2028
General Fund Deficit	27,144,582	24,915,773
Add: 1947 Center Street Debt Service	1,630,454	1,623,581
Add: Parking Funds Stabilization	1,050,938	1,050,938
Total Deficit Before One Time Resources	**29,825,974**	**27,590,292**
Add: Adjustments to Non-Departmental	1,523,365	1,942,666
Less: One Time Resources for Deficit	2,100,000	0
Total Deficit After One Time Resources	**29,249,339**	**29,532,958**

These figures represent the gap in the General Fund that is being addressed by the proposed Budget Balancing Plan in advance of the FY 2027 – FY 2028 Biennial Budget Adoption.

It is important to note that the budget continues to evolve, and these amounts may shift as revenue projections, expenditures, and other assumptions are refined leading up to the adoption of the Biennial Budget. It is currently anticipated that the Biennial Budget will be adopted at a Special Meeting of the City Council on June 23, 2026.

Use of One-Time Resources – General Fund

To preserve essential services and avoid deeper cuts in FY 2027, the proposed Plan allocates $12.06 million in one-time funds for one-time uses, including:

- **$4.18 million** set aside in operating reserve, see pages 14 and 16 of the First Amendment to the FY 2026 Annual Appropriations Ordinance (AAO#1)[5]

- **$7.88 million** from the Dissolution of Successor Agency County Transfer to the City.

[5] https://berkeleyca.gov/sites/default/files/legislative-body-meeting-attachments/2025-11-06 Item 02a First Amendment to the FY 2026 Annual Appropriations Ordinance AAO%231 Presentation.pdf.

The Table below summarizes available one-time resources and outlines how they are deployed as part of the proposed Budget Balancing Plan.

City of Berkeley One Time Resources
General Fund
FY 2027 - FY 2028 Biennial Budget

Sources	
Operating Reserve	4,177,541
Dissolution of Successor Agency County Transfer to City	7,877,572
Total	**12,055,113**
Uses	
Proposed Sales and Use Tax	9,443,000
Address Difference in FY 2027 and FY 2028 Deficit	2,100,000
Carrying Costs Associated with Impacted Employees	500,000
Total	**12,043,000**
Remaining One Time Funds	**12,113**

This strategic use of onetime funds allows the City to **avoid immediate service reductions** in public safety and youth and adult services in anticipation of a 0.5% increase in the Sales & Use Tax being placed on the November 2026 ballot and manages the uneven deficit between FY 2027 and FY 2028.

The proposed Budget Balancing Plan presents two paths:

Scenario 1: Proposed Sales & Use Tax Measure Passes (November 2026)

- Preserves positions and services in the Police, Fire, and Parks, Recreation and Waterfront Departments to avoid the closure of a fire station, diminished capacity to respond to 9-1-1 calls for service and proactively address crime, and reductions in programs and services for youth and adults that will be supported by one-time funds in FY 2027.

- Provides ongoing revenue to stabilize the General Fund and support staffing and programs and services that are supported by one-time funds in FY 2027.

- Allows the City to continue long-term structural reforms.

The Table below outlines the positions that are proposed to be allocated to the Sales and Use Tax measure. In total, there are 33 positions allocated to the Sales and Use Tax – nine (9) are in the Fire Department to prevent the closure of a Fire Station, 21 are in the Police Department to ensure that the Police Department can continue to effectively respond to 9-1-1 calls for service and address public safety, and three (3) are in the Parks, Recreation, and Waterfront Department to minimize the impacts to youth and adult services such as reductions in afterschool programs, camps, as well as pool and community center operating

hours.

General Fund Budget Reduction Plan: Positions Allocated to Proposed Sales and Use Tax
FY 2027 - FY 2028 Biennial Budget

	FY 2027	FY 2028
Fire Department		
Firefighter	3	3
Fire Apparatus Operator	3	3
Fire Captain	3	3
Police Department		
Police Officers	15	15
Dispatchers	6	6
Parks Recreation and Waterfront		
Assistant Recreation Coordinators	2	2
Sports Official	1	1
Total	**33**	**33**

Of the total number of positions allocated to the proposed Sales and Use Tax, 18 are filled and 15 are vacant.

Scenario 2: Proposed Sales & Use Tax Measure Fails

- The City would need to implement deeper cuts to balance the budget as all positions and services that are supported with one-time funds in FY 2027 would no longer have dedicated funding.

SUMMARY OF DEPARTMENTAL GENERAL FUND BUDGET BALANCING PLANS
All departments submitted proposals identifying a mix of personnel savings and non-personnel reductions that are summarized below.

The FY 2027 and FY 2028 baseline expenditures are based on data as of January 15, 2026. For FY 2027, the Tables below indicate that before allocations to the proposed Sales and Use Tax, the proposed Plan reduces General Fund expenditures by $29.3 million or 10.3% of Department and Charter Office expenditures. After the proposed Sales and Use Tax, in FY 2027, the proposed Plan reduces General Fund expenditures by approximately $19.8 million or 7.0% of Department and Charter Office expenditures.

FY 2027 General Fund Budget Balancing Plan by Department (Baseline vs. Proposed After Reductions)

Department	FY27 Baseline Expenditures	$ Reduction Before Sales & Use Tax	FY27 Budget After Reduction	% Reduction Before Sales & Use Tax	Sales & Use Tax Allocation	$ Reduction w/Sales & Use Tax	% Reduction after Sales & Use Tax
City Clerk	3,952,847	210,456	3,742,391	5.3%	0	210,456	5.3%
CMO	18,713,660	2,489,487	16,224,173	13.3%	0	2,489,487	13.3%
Finance	9,887,235	684,356	9,202,879	6.9%	0	684,356	6.9%
Fire	55,650,689	6,653,092	48,997,597	12.0%	3,631,106	3,021,986	5.4%
HHCS	37,548,665	3,561,672	33,986,993	9.5%	0	3,561,672	9.5%
HR	5,212,918	625,774	4,587,144	12.0%	0	625,774	12.0%
IT	1,150,454	185,391	965,062	16.1%	0	185,391	16.1%
PRW	13,233,201	1,190,950	12,042,251	9.0%	466,004	724,946	5.5%
Planning & Dev.	3,666,161	458,269	3,207,892	12.5%	0	458,269	12.5%
Police	106,198,574	10,588,717	95,609,857	10.0%	5,345,885	5,242,832	4.9%
Public Works	8,135,147	779,771	7,355,377	9.6%	0	779,771	9.6%
IT Cost Allocation		600,000			0	600,000	
Total	**263,349,551**	**28,027,935**	**235,321,616**	**10.6%**	**9,442,995**	**18,584,940**	**7.1%**

FY 2027 General Fund Budget Balancing Plan by Charter Office (Baseline vs. Proposed After Reductions)

Charter Offices	FY27 Baseline Expenditures	$ Reduction Before Sales & Use Tax	FY27 Budget After Reduction	% Reduction Before Sales & Use Tax	Sales & Use & Tax Allocation	$ Reduction w/Sales & Use Tax	% Reduction after Sales & Use Tax
City Attorney	7,696,001	0	7,696,001	0.0%	0	0	0.0%
City Auditor	3,929,199	288,560	3,640,639	7.3%	0	288,560	7.3%
ODPA	1,289,953	71,708	1,218,245	5.6%	0	71,708	5.6%
Mayor & Council *	6,899,331	863,145	6,036,186	12.5%	0	863,145	12.5%
Total Charter	**19,814,484**	**1,223,413**	**18,591,071**	**6.2%**	**0**	**1,223,413**	**6.2%**

*Mayor & Council baseline budget reflects funding for the Mayor's Office and Districts 1-8 and excludes budgeted salaries for the Mayor and Councilmembers.

FY 2027 Total General Fund Budget Balancing Plan (Baseline vs. Proposed After Reductions)

	FY27 Baseline Expenditures	$ Reduction Before Sales & Use Tax	FY27 Budget After Reduction	% Reduction Before Sales & Use Tax	Sales & Use Tax Allocation	$ Reduction w/Sales & Use Tax	% Reduction after Sales & Use Tax
Total Citywide	**283,164,035**	**29,251,348**	**253,912,687**	**10.3%**	**9,442,995**	**19,808,353**	**7.0%**

For FY 2028, the Tables below indicate that before allocations to the proposed Sales and Use Tax, the proposed Plan reduces General Fund expenditures by $29.8 million or 10.3% of Department and Charter Office expenditures. After the proposed Sales and Use Tax, in FY 2028, the proposed Plan reduces General Fund expenditures by approximately $20.1 million or 7.0% of Department and Charter Office expenditures.

FY 2028 General Fund Budget Balancing Plan by Department (Baseline vs. Proposed After Reductions)

Department	FY28 Baseline Expenditures	$ Reduction Before Sales & Use Tax	FY28 Budget After Reduction	% Reduction Before Sales & Use Tax	Sales & Use Tax Allocation	$ Reduction w/Sales & Use Tax	% Reduction after Sales & Use Tax
City Clerk (1)	3,998,036	94,456	3,903,580	2.4%	0	94,456	2.4%
CMO	19,041,413	2,432,623	16,608,790	12.8%	0	2,432,623	12.8%
Finance	10,178,435	715,714	9,462,721	7.0%	0	715,714	7.0%
Fire	57,206,818	6,800,791	50,406,027	11.9%	3,703,328	3,097,463	5.4%
HHCS	38,021,381	3,455,468	34,565,913	9.1%	0	3,455,468	9.1%
HR	5,387,455	622,032	4,765,423	11.5%	0	622,032	11.5%
IT	1,150,454	185,391	965,062	16.1%	0	185,391	16.1%
PRW	13,382,163	1,205,811	12,176,353	9.0%	477,313	728,498	5.4%
Planning & Dev.	3,763,360	470,419	3,292,941	12.5%	0	470,419	12.5%
Police	107,356,946	10,789,378	96,567,568	10.1%	5,453,304	5,336,074	5.0%
Public Works	8,302,692	1,084,523	7,218,169	13.1%	0	1,084,523	13.1%
IT Cost Allocation Plan		600,000			0	600,000	
Total	**267,789,153**	**28,456,605**	**239,332,548**	**10.6%**	**9,633,945**	**18,822,661**	**7.0%**

(1) Excludes $1,071,990 one-time reduction due to allocation to election, which does not occur in FY 2028. These resources will be deployed to address increases in insurance costs that exceed the City's initial projections.

FY 2028 General Fund Budget Balancing Plan By Charter Office (Baseline vs. Proposed After Reductions)

Charter Offices	FY28 Baseline Expenditures	$ Reduction Before Sales Tax	FY28 Budget After Reduction	% Reduction Before Sales & Use Tax	Sales & Use Tax Allocation	$ Reduction w/Sales & Use Tax	% Reduction after Sales & Use Tax
City Attorney	7,828,432	0	7,828,432	0.0%	0	0	0.0%
City Auditor	4,061,371	367,458	3,693,914	9.0%	0	367,458	9.0%
ODPA	1,339,846	71,708	1,268,138	5.4%	0	71,708	5.4%
Mayor & Council*	7,014,592	877,248	6,136,365	12.5%	0	877,248	12.5%
Total Charter	**20,244,241**	**1,316,414**	**18,927,827**	**6.5%**	**0**	**1,316,414**	**6.5%**

*Mayor & Council baseline budget reflects funding for the Mayor's Office and Districts 1-8 and excludes budgeted salaries for the Mayor and Councilmembers.

FY 2028 Total General Fund Budget Balancing Plan (Baseline vs. Proposed After Reductions)

	FY28 Baseline Expenditures	$ Reduction Before Sales & Use Tax	FY28 Budget After Reduction	% Reduction Before Sales & Use Tax	Sales & Use Tax Allocation	$ Reduction w/Sales & Use Tax	% Reduction after Sales & Use Tax
Total Citywide	**288,033,394**	**29,773,019**	**258,260,375**	**10.3%**	**9,633,945**	**20,139,074**	**7.0%**

This section summarized each department's General Fund reductions and their impact on the baseline and the projected deficit, expressed in both dollars and percentages. Collectively, these reductions close the projected General Fund deficit in FY 2027 and FY 2028.

Citywide Fiscal Pressures Beyond the General Fund

As the City's primary and most discretionary fund, the General Fund was the main focus of the citywide budget balancing exercise. However, it is not the only fund experiencing fiscal pressures. Several non-General Fund sources, such as enterprise, special revenue, internal service, and capital funds, are also facing deficits. Departments responsible for these funds conducted parallel budget balancing analysis and developed reduction plans.

These broader pressures underscore the importance of managing the City's finances strategically and holistically across all funds. The Budget Balancing Plan presented to the Budget and Finance Policy Committee, and subsequently to the City Council, provides a comprehensive strategy to address these broader fiscal challenges. Detailed balancing strategies for these non-General Fund sources are provided in the Department-by-Department Overview Section below.

Position Summary Before and After Reductions (All Funds - By Department)[6]

The Table below shows the citywide, all-funds baseline position count for FY 2027–28, excluding the 45 positions left vacant and unfunded in the FY 2026 Mid-Biennial Budget. It reflects the proposed reduction of 138 FTE and the one-time FY 2027 resources used to retain 33 public safety and recreation positions. Without the Sales and Use Tax, the reduction from FY27 baseline is 8.85 percent; with the tax, 6.73 percent. Including the 45 positions removed in FY 2026 Adopted FTE (1,608.99), the cumulative reduction is 11.40 percent with the tax and about 9.3 percent without it.

[6] This analysis of staffing impacts is as of April 6, 2026. The actual number of filled and vacant positions that will be impacted by the proposed Budget Balancing Plan will vary over time due to several factors including, but not limited to retirements, promotions, and separations. The actual number of filled positions impacted will be determined when the Biennial Budget is adopted, which is anticipated to occur at a Special Meeting of the City Council on June 23, 2026.

Department	FY 2027–28 Baseline FTE (1)	Proposed FTE Reductions	Proposed FTE Allocation to Sales & Use Tax	Revised FTE Reduction After Sales & Use Tax	Proposed Position FTE Allocation After Sales & Use Tax
City Clerk	9	0	0	0	9
City Manager's Office	53	9	0	9	44
Finance	52	4	0	4	48
Fire	206	14	9	5	201
HHCS	240.75	45	0	45	195.75
HR	26	2	0	2	24
IT	49	4	0	4	45
PRW	116	6	3	3	113
Planning & Dev.	104.04	0	0	0	104.04
Police	290	39	21	18	272
Public Works	352	15	0	15	337
City Attorney	19	0	0	0	19
City Auditor	15.75	0	0	0	15.75
ODPA	4	0	0	0	4
Mayor & Council	23	0	0	0	23
Total (2)	**1,559.54**	**138**	**33**	**105**	**1,454.54**

(1) Excludes 45 vacant positions that were not funded as part of the adopted FY 25-26 Mid-Biennial Budget (General Fund = 44.4 FTE and Other Funds = 0.6 FTE)
(2) Excludes Library's FTE = 131.05 and Rent Board's FTE = 29.0 for total FTE Baseline of 1,719.59.

Below is a simplified Table showing the status of positions—Vacant or Filled—derived from the more detailed department-level position counts above.

Status	FY 2027–28 Baseline FTE (1)	Proposed Reductions	Proposed Allocation to Sales & Use Tax	Revised Reduction After Sales &Use Tax	Proposed Position Allocation After Sales & Use Tax
Vacant	211.69	100	15	85	126.69
Filled (2)	1,347.85	38	18	20	1,327.85
Total (3)	**1,559.54**	**138**	**33**	**105**	**1,454.54**

(1) Excludes 45 vacant positions that were not funded as part of the adopted FY26 Mid-Biennial Budget.
(2) As of April 6, 2026.
(3) Excludes Library's FTE = 131.05 and Rent Board's FTE = 29.0 for total FTE Baseline of 1,719.59.

Addressing the cumulative FTE reductions

In the FY 2026 Mid-Biennial Budget Update, the General Fund faced a structural deficit of approximately $29 million. The budget was balanced through one-time measures and increased General Fund revenues. As part of this strategy, 45 vacant FTE positions were held unfunded and are now being eliminated in this Biennial Budget to capture ongoing savings and support long-term fiscal stability.

The FY 2027-FY 2028 balancing plan includes the cumulative reduction in force (RIF):

- **45 Full-time Equivalent** (FTE) that were not funded in the FY 2026 Mid-Biennial Budget Update are eliminated as part of the proposed Budget Balancing Plan.
- **138.0 FTE reductions** proposed in FY 2027 & FY 2028 **without proposed Sales & Use Tax**. Of the 138.0 FTE, 38 are filled positions and 100 are vacant positions[7].
- **Cumulative reduction: 183 FTE** reduction in force (45 + 138) **without proposed Sales & Use Tax**. Of the 183 FTE, 38 are filled positions and 145 are vacant positions.
- **105.0 FTE reductions** proposed in FY 2027 & FY 2028 **with proposed Sales & Use Tax**. Of the 105.0 FTE, 20 are filled positions and 85 are vacant positions.
- **Cumulative reduction: 150 FTE** reduction in force (45 + 105.0) **with proposed Sales & Use Tax**. Of the 150 FTE, 20 are filled positions and 130 are vacant positions.

The Tables below demonstrate the cumulative impact of the RIF (FY 2026 and FY 2027 and FY 2028).

FY 26 Adopted FTE*	FY 26 Reduction in Force (RIF)**	FY 27 Baseline FTE***	FY 27 Proposed FTE Reduction	FY 27 Total FTE (net of Proposed Reduction)
1,608.99	45.00	1,559.54	138.00	1,421.54

FY 26 Adopted FTE *	FY 26 Reduction in Force (RIF) **	FY27 Proposed FTE Reduction	Total Cumulative Reduction in Force	Total Cumulative Percent Reduction in FTE
1,608.99	45.00	138.00	183.00	11.37%

FY 26 Adopted FTE *	FY 26 Reduction in Force (RIF) **	FY27 Proposed FTE Reduction (Allocation Sales & Use Tax)	Total Cumulative Reduction in Force (w/Sales & Use Tax)	Total Cumulative Percent Reduction in FTE
1,608.99	45.00	105.00	150.00	9.32%

* FY 26 Adopted Full-Time Equivalent (FTE) count includes RIF – positions that were authorized but not budgeted in FY 26.

** RIF – 44.4 General Fund positions; equivalent to 45 FTE count – All Funds

*** Baseline as of 01/15/2026; excludes RIF (45 FTE) and includes department adjustments (4.45 net FTE, removed temporary positions and expired project-based positions, reclassifications, relocation, new Measure FF positions, etc.)

[7] As of April 6, 2026. The number of filled positions by the time the Biennial Budget is adopted, which is currently anticipated to occur at a Special Meeting of the City Council on June 23, 2026.

DEPARTMENT-BY-DEPARTMENT OVERVIEW OF BUDGET BALANCING PLANS

Departments submitted budget-balancing proposals to the City Manager based on initial 10.0% and 12.5% General Fund reduction targets. After accounting for updated revenue projections from the Finance Department and a detailed review of departmental submissions, a refined budget balancing plan was developed that reflects revised revenues, departmental needs, organizational priorities, and community impacts. The Plan does not recommend across-the-board equal reductions. Rather, the proposed Plan reflects a strategic approach that reflects City needs considering severe resource constraints.

Department proposals from HHCS, IT, Public Works, and PRW also include reductions in applicable special funds. The following sections summarize each department's proposed reductions.

City Clerk

The City Clerk Department has maintained a staffing level of 10.0 FTE since FY 2019. For the FY 2026 Mid-Biennial Budget Update, the department's vacant Office Specialist III position was removed from the budget, reducing total staffing to 9.0 FTE.

Since 2016, several major responsibilities have been added to the department without corresponding staffing increases:

- Independent Redistricting Commission
- Public Financing for Candidates
- Lobbyist Registration
- City Council Policy Committees
- Hybrid Commission Meetings
- SB 827 Financial Training Administration

Given these expanded mandates and the department's lean staffing structure, no additional position reductions are recommended.

FTE Changes – All Funds

Category	Baseline FTE	Proposed FTE	Change
Total Staffing	9	9	0

of Fire Station 4 will force responses from more distant stations, further degrading performance. Delayed emergency response increases risk of fatality and property loss for fires and medical incidents and elevates firefighter risk. Redistribution of calls will increase workload and fatigue at remaining stations, reduce training time, and heighten burnout. Reliance on mutual aid will rise but is unsustainable and delayed multi-unit responses will become more common. These impacts are high-risk, daily, and cannot be fully mitigated.

The City Manager recommends utilizing one-time funds, as outlined at the beginning of this report, during Fiscal Year 2027. This approach is intended to delay the closure of a fire station until after the results of the Sales and Use Tax measure, which will be decided in November 2026, are known.

This is the planned contingency based on the Sales and Use Tax Measure. Should voters approve the Sales and Use Tax measure, the resulting revenue is proposed to be allocated to maintain operations at the fire station. Conversely, if the measure does not pass, the proposed station closure will be reconsidered for Fiscal Year 2028. At present, this matter is considered critical, with the potential for significant impact across the entire City.

Health, Housing & Community Services (HHCS)

Faced with significant fiscal headwinds in both the General Fund and multiple special funds that support mental health and behavioral health services, HHCS engaged in a rigorous, principle-driven process to identify approximately $3.5 million in annual General Fund adjustments and a variety of other actions to correct special fund deficits. Due to the severity of the structural deficit, the recommendations are deep. While efforts were made to reduce the impact, the recommendations from HHCS are painful and impactful.

FTE Changes (All Funds)

Category	Baseline FTE	Proposed FTE	Change
Total Staffing	240.75	195.75	-45

Budget Changes (GF)

Category	FY27 Baseline Budget	FY 27 Proposed Budget	Change
Personnel	15,253,347	13,852,557	-1,400,790
Personnel – OT & Hourly	711,777	691,042	-20,735
Non-Personnel	21,583,541	19,443,394	-2,140,147

Category	FY28 Baseline Budget	FY 28 Proposed Budget	Change
Personnel	15,726,063	14,360,254	-1,365,809
Personnel – OT & Hourly	711,776.63	691,042	-20,735
Non-Personnel	21,583,541	19,514,617	-2,068,924

Impacts – General Fund

A. Aging Services Division

- A one-time shift to Fund 111 in the amount of $96,304 is implemented to reduce General Fund expenditures.

B. Environmental Health Division

- Eliminates one vacant Office Specialist II position. Intake workload will be absorbed through database modernization.
- Berkeley's Vector Control Program will be transferred to Alameda County, and the City will no longer provide this service. This change is anticipated to improve service quality and end ongoing General Fund subsidies in the amount of approximately $362,170 annually, for this work. As a result, two Vector Control positions will be eliminated (one filled and one vacant).

C. Mental Health Division

- Mobile Crisis Team:
    - Eliminates 2.6 filled FTE, representing the last General Fund–funded mental health crisis response positions.
    - The City will no longer provide crisis response services and will rely on Alameda County, which is a County responsibility. However, the County's ability to provide this service over the long-term remains uncertain due to budget challenges and policy shifts.
    - Responsibility for wellness checks and psychiatric emergencies will shift solely to the Berkeley Police Department.

D. Public Health Division

- Heart to Heart: The Heart-to-Heart program (1.0 FTE filled, 1.0 FTE vacant) is proposed to be eliminated to support a sustainable fiscal model. Blood pressure screenings and health education are offered by federally qualified health centers and primary care providers, enabling integrated clinical care.
- Targeted Case Management: Eliminates one vacant Public Health Nurse position. An existing Social Services Specialist staff will absorb responsibilities.
- Women Infants and Children (WIC) Program: Shifts 0.40 FTE from the General Fund to the WIC grant, enabling salary support without reducing service levels.

E. Housing and Community Services Division

- Vacant positions were held and eliminated, including one Program Manager II and several special-funded positions impacted by increased personnel costs. Although

service delivery is expected to continue, remaining staff will have higher workloads and reduced responsiveness in programs such as Shelter Plus Care and Labor Standards. Outreach and education capacity will also decline.

- **Community Agencies:** Where feasible, to preserve various community programs (i.e., BOSS Step-Up on University and a portion of funding for the STAIR Center) that serve our most vulnerable, funding was shifted to Measure U1 and other special funds / revenue sources. Notwithstanding, reductions are proposed for the following:
    - **Berkeley Winter Shelter:** Recommended for elimination due to the lack of a feasible location. This would reduce shelter capacity only during the winter months by twenty-five beds, mainly affecting highly vulnerable unsheltered individuals, often seniors. This program has been operated by Dorothy Day House, who also operates the City's Inclement Weather Shelter program during the winter months, which is not impacted by the Budget Balancing Plan. Savings generated are $358,750.
    - **STAIR Center:** A 23% reduction in operating funding is proposed for this program serving people experiencing homelessness. The program is located on Second Street in West Berkely. The proposed funding reduction aligns with the 25% reduction in bed capacity due to the shift to non-congregate sheltering and ADA improvements which both required more space. Also, the City is the sole funder for this program, even though participants enter through the Coordinated Entry System due to federal funding requirements. Staff recommend that BACS, who manage this program, diversify funding sources. Savings generated are $400,554.
    - **Rising Sun.** This program provides construction apprenticeship readiness to approximately six (6) residents. The current contract expires June 30, 2026, and funding was allocated outside of the Community Agency grant process. Savings of $50,000 are estimated by not extending the existing contract.
    - **Supply Bank.** This program provides school supplies and dental kits to approximately 1,300 Berkeley students. The current contract expires June 30, 2026, and funding was allocated outside of the Community Agency grant process. Savings of $35,000 are estimated by not extending the existing contract.

Impacts - Special Funds

In addition to the General Fund impacts outlined above, HHCS needs to implement additional reduction measures to address the loss of grant funding, the transition to the Behavioral Health Services Act (Proposition 1), and the loss of Medicaid revenue.

1. Aging Services – Information & Assistance (I&A)

Earlier this year, the Alameda County Area Agency on Aging notified the City of a cut to the Information & Assistance (I&A) program funding, effective July 1, 2026, totaling $156,803. This program is funded through the federal Older Americans Act funds that pass through to the Alameda County Area Agency on Aging (AAA). Berkeley has been a recipient of these funds for well over two decades and they have been deployed to social services to the older adult community. Funding allocated to a vacant position in Fund 320 will be deployed to maintain these vital services.

2. California Strengthening Public Health Initiative (CASPHI)

The Public Health Division received notice of an impending cut to this program's funding, effective February 11, 2026. While the announcement came out in January 2026, this cut has been the subject of a federal lawsuit and temporary restraining order. While the funding remains in limbo, the Department understands that funding will likely be cut. This program was designed to strengthen the public health workforce using data-driven planning, cross-sector partnerships, and an explicit commitment to health equity. Funding has expanded the Department's capacity to address disparities by supporting the creation of the Senior Health Management Analyst position, which has been essential for workforce development, data metric development, mentorship, and advancing the department's Equity Plan. Losing this funding and having to eliminate this program would jeopardize workforce expansion efforts and delay key deliverables, including the launch of a public-facing, equity-focused data dashboard aligned with the 2025 Community Health Improvement Plan. The estimated financial impact of this reduction is estimated at $650,928 total ($130,186 annually). Staff are actively developing a comprehensive plan to mitigate the effect of this reduction.

3. CalFresh Healthy Living (CFHL)

Earlier this year, the Department was notified of a cut to the CalFresh Healthy Living (CFHL) program funding, $162,390 annually effective May 1, 2026. The Public Health Division administers a portion of the United States Department of Agriculture (USDA) funded Supplemental Nutrition Assistance Program, known in California as CFHL. These resources are deployed to provide nutrition education and obesity prevention activities and interventions for low-income Californians. The focus of the project is to upstream public health approaches and individual and organizational health promotion to help the CFHL target audience establish healthy eating habits, a physically active lifestyle, and for primary prevention of disease. The specific target audience are SNAP participants and other low-income individuals who qualify for SNAP (CalFresh Food) benefits or other means-tested Federal assistance programs.

The program's core activities in Berkeley include direct education for children aged 0-5, aiming to increase healthy food and water consumption, boost physical activity, and reduce screen time, with an annual reach of approximately 650 children. Concurrently, direct adult education targets teachers, staff, and parents (ages 18-59), reaching around 300 individuals annually. The program also conducts monthly healthy food demonstrations for older adults (59+), typically reaching 320 individuals annually, and provides indirect education through healthy cooking resources at community events. The Department has identified alternative one-time funding to continue the program through the effective date of May 1, 2026. However, all CFHL services will be discontinued after May 1, 2026, and staffing will be redirected to other program areas with alternative available funding.

4. Services to Enhance Early Development (SEED)

In February, the Department received information of an impending cut to SEED program funding of $224,393, effective July 1, 2026. This is a revenue-generating contract with the Department of Children and Family Services (DCFS) of the Alameda County Social Services Agency to support a 0.8 FTE Public Health Nurse and 0.10 FTE Supervising Public Health Nurse. Staff provide services to children and their caregiver(s) throughout the county including Berkeley. They also coordinate and provide information to their counterparts (Child Welfare Workers, mental health clinicians, and parent advocates) in the SEED team regarding the ongoing medical needs of a child participant. The program's core activities in Berkeley include entering and reviewing information such as birth records, medical/dental records, immunization records, laboratory, and radiological reports in the Child Welfare System (CWS)/Case Management (CMS) and Health and Education Passport (HEP). The target population is Alameda County juvenile court-dependent children between the ages of zero to three years and 11 months. HHCS is currently working to shift employees allocated to this program to other vacant grant-funded activities. The program currently only provides services to one child in Berkeley and will have minimal impact on services.

5. Measure GG Revenue Transfer

As indicated in the Fire Department section above, Measure GG resources allocated to Public Health Emergency Preparedness are being reallocated to support Fire Department operations. As a result, HHCS’s emergency preparedness capacity will be significantly diminished. The Department will not have the capacity to coordinate comprehensive city-wide emergency readiness and response initiatives. The loss of this funding results in the elimination of two (2) existing positions (1 filled and 1 vacant) assigned to this work.

6. Mental Health Division

In addition to the reductions described above in the Mental Health Division, the Division proposes eliminating 32 positions (27 vacant and 5 filled), primarily long-vacant positions created during a previous expansion that was later undermined by changes in state funding. This is a "right-sizing" of the division following an ambitious expansion period.

Approximately four years ago, the Mental Health Division scaled up staffing in anticipation of CalAIM's promise of expanded Medi-Cal populations and increased service needs. However, mid-expansion, several vital changes occurred to state funding. The State shifted Medi-Cal to a fee-for-service model and implemented Behavioral Health Services Act (BHSA) / Proposition 1 changes. Berkeley, like County health jurisdictions, lost significant revenue for mental health services based on this fundamental Prop 1 system restructuring that mandates new spending requirements that prioritize housing and substance use disorders over general community programs. Additionally, as a small jurisdiction acting as a contractor to Alameda County for Medi-Cal, Berkeley was disproportionately penalized by these rate cuts effectively reducing the City's Medi-Cal revenue by 50%. Recognizing these fiscal shifts early on, the Division held many positions vacant.

With these changes, while the Mental Health Division will continue to provide specific intensive services, it will transition away from direct service delivery for non-contractual programs (i.e., Mobile Crisis Team discussed above) and focus on navigating residents toward county-level alternatives. This ensures that Berkeley remains a vital link in the behavioral health chain, utilizing limited resources to maintain intensive care where possible while ensuring residents have a clear pathway to all other mandated psychiatric and emergency services.

Human Resources

The proposal prioritizes maintaining core HR services within budget constraints, mainly through structural changes and contract eliminations. Two vacant positions will be cut. HR focus will shift from proactive and strategic efforts to a compliance-driven, baseline model.

FTE Changes (All Funds)

Category	Baseline FTE	Proposed FTE	Change
Total Staffing	26	24	-2

Budget Changes (GF)

Category	FY 27 Baseline Budget	FY 27 Proposed Budget	Change
Personnel	3,995,636	3,685,961	-309,675
Personnel – OT & Hourly	60,983	49,769	-11,214
Non-Personnel	1,156,299	851,414	-304,885

Category	FY 28 Baseline Budget	FY 28 Proposed Budget	Change
Personnel	4,170,173	3,838,760	-331,413
Personnel – OT & Hourly	60,983	49,769	-11,214
Non-Personnel	1,156,299	876,894	-279,405

Department	Original Proposed Reduction (Classification)	Filled/Vacant	Proposed Allocation to Sales & Use Tax	Revised Reduction After Sales & Use Tax Application
CMO	CMDEV PRJ CD	Filled		CMDEV PRJ CD
CMO	COMMUNICATIONS SPECIALIST	Filled		COMMUNICATIONS SPECIALIST
CMO	COMMUNICATIONS SPECIALIST	Filled		COMMUNICATIONS SPECIALIST
CMO	DIVERSITY, EQUITY AND INCLUSION OFFICER	Vacant		DIVERSITY, EQUITY AND INCLUSION OFFICER
CMO	ECODEV PRJ CD	Vacant		ECODEV PRJ CD
CMO	OFFICE SPECIALIST II	Vacant		OFFICE SPECIALIST II
CMO	OFFICE SPECIALIST III	Filled		OFFICE SPECIALIST III
CMO	PROGRAM MANAGER II U	Filled		PROGRAM MANAGER II U
CMO	SOCIAL SERVICES SPECIALIST	Vacant		SOCIAL SERVICES SPECIALIST
CMO Count	**9**		**0**	**9**
Finance	ASSOC. MANAGEMENT ANALYST	Vacant		ASSOC. MANAGEMENT ANALYST
Finance	REVENUE DEV. SPECIALIST I	Vacant		REVENUE DEV. SPECIALIST I
Finance	REVENUE DEV. SPECIALIST I	Vacant		REVENUE DEV. SPECIALIST I
Finance	SENIOR SYSTEMS ANALYST	Vacant		SENIOR SYSTEMS ANALYST
Finance Count	**4**		**0**	**4**
Fire	APPARATUS OPERATOR	Filled	APPARATUS OPERATOR	
Fire	APPARATUS OPERATOR	Filled	APPARATUS OPERATOR	
Fire	APPARATUS OPERATOR	Filled	APPARATUS OPERATOR	
Fire	ASSC MGT ANLY	Filled		ASSC MGT ANLY
Fire	FIRE CAPTII 40	Filled		FIRE CAPTII 40
Fire	FIRE CAPTII 40	Filled	FIRE CAPTII 40	
Fire	FIRE CAPTII 40	Filled	FIRE CAPTII 40	
Fire	FIRE CAPTII 40	Filled	FIRE CAPTII 40	
Fire	FIRE INSPECTOR	Vacant		FIRE INSPECTOR
Fire	FIRE MARSHAL	Vacant		FIRE MARSHAL
Fire	FIREFIGHTER	Filled	FIREFIGHTER	
Fire	FIREFIGHTER	Filled	FIREFIGHTER	
Fire	FIREFIGHTER	Filled	FIREFIGHTER	
Fire	PROGRAM MANAGER II	Filled		PROGRAM MANAGER II
Fire Count	**14**		**9**	**5**
HHCS	BEHAVIORAL HLTH CLIN II	Filled		BEHAVIORAL HLTH CLIN II
HHCS	BEHAVIORAL HLTH CLIN II	Filled		BEHAVIORAL HLTH CLIN II
HHCS	COM HEALTH WORKER SPEC	Filled		COM HEALTH WORKER SPEC
HHCS	COM SERVICE SPEC II	Filled		COM SERVICE SPEC II
HHCS	COM SERVICE SPEC III	Filled		COM SERVICE SPEC III
HHCS	MENTAL HEALTH PROGRAM SUPV	Filled		MENTAL HEALTH PROGRAM SUPV
HHCS	SR COMMNTY HEALTH SPECIALIST	Filled		SR COMMNTY HEALTH SPECIALIST
HHCS	VECTOR CONTROL TECHNICIAN	Filled		VECTOR CONTROL TECHNICIAN
HHCS	ASST MGMT ANALYST	Vacant		ASST MGMT ANALYST
HHCS	BEHAVIORAL HLTH CLIN I	Vacant		BEHAVIORAL HLTH CLIN I
HHCS	BEHAVIORAL HLTH CLIN I	Vacant		BEHAVIORAL HLTH CLIN I

Summary of Position Reduction List for FY 2027 FY 2028 Biennial Budget

Department	Original Proposed Reduction (Classification)	Filled/Vacant	Proposed Allocation to Sales & Use Tax	Revised Reduction After Sales & Use Tax Application
HHCS	BEHAVIORAL HLTH CLIN I	Vacant		BEHAVIORAL HLTH CLIN I
HHCS	BEHAVIORAL HLTH CLIN II	Vacant		BEHAVIORAL HLTH CLIN II
HHCS	BEHAVIORAL HLTH CLIN II	Vacant		BEHAVIORAL HLTH CLIN II
HHCS	BEHAVIORAL HLTH CLIN II	Vacant		BEHAVIORAL HLTH CLIN II
HHCS	BEHAVIORAL HLTH CLIN II	Vacant		BEHAVIORAL HLTH CLIN II
HHCS	BEHAVIORAL HLTH CLIN II	Vacant		BEHAVIORAL HLTH CLIN II
HHCS	BEHAVIORAL HLTH CLIN II	Vacant		BEHAVIORAL HLTH CLIN II
HHCS	BEHAVIORAL HLTH CLIN II	Vacant		BEHAVIORAL HLTH CLIN II
HHCS	BEHAVIORAL HLTH CLIN II	Vacant		BEHAVIORAL HLTH CLIN II
HHCS	COM HEALTH WORKER SPEC	Vacant		COM HEALTH WORKER SPEC
HHCS	COM SERVICE SPEC II	Vacant		COM SERVICE SPEC II
HHCS	COM SERVICE SPEC II	Vacant		COM SERVICE SPEC II
HHCS	EPIDEMIOLOGIST	Vacant		EPIDEMIOLOGIST
HHCS	HEALTH EDUCATOR	Vacant		HEALTH EDUCATOR
HHCS	HEALTH SVCS PROGRAM SPCLST	Vacant		HEALTH SVCS PROGRAM SPCLST
HHCS	MENTAL HEALTH CLINICAL SUPV	Vacant		MENTAL HEALTH CLINICAL SUPV
HHCS	MENTAL HEALTH NURSE	Vacant		MENTAL HEALTH NURSE
HHCS	MENTAL HEALTH NURSE	Vacant		MENTAL HEALTH NURSE
HHCS	MENTAL HEALTH NURSE	Vacant		MENTAL HEALTH NURSE
HHCS	MENTAL HEALTH NURSE	Vacant		MENTAL HEALTH NURSE
HHCS	MENTAL HEALTH PROGRAM SUPV	Vacant		MENTAL HEALTH PROGRAM SUPV
HHCS	OFFICE SPECIALIST II	Vacant		OFFICE SPECIALIST II
HHCS	OFFICE SPECIALIST II	Vacant		OFFICE SPECIALIST II
HHCS	OFFICE SPECIALIST II	Vacant		OFFICE SPECIALIST II
HHCS	OFFICE SPECIALIST II	Vacant		OFFICE SPECIALIST II
HHCS	OFFICE SPECIALIST II	Vacant		OFFICE SPECIALIST II
HHCS	OFFICE SPECIALIST III	Vacant		OFFICE SPECIALIST III
HHCS	PROGRAM MANAGER II	Vacant		PROGRAM MANAGER II
HHCS	PSYCHIATRIST	Vacant		PSYCHIATRIST
HHCS	PUBLIC HEALTH NURSE	Vacant		PUBLIC HEALTH NURSE
HHCS	SENIOR BEHAVIORAL HLTH CLINC	Vacant		SENIOR BEHAVIORAL HLTH CLINC
HHCS	SOCIAL SERVICES SPECIALIST	Vacant		SOCIAL SERVICES SPECIALIST
HHCS	SR. COMMNTY DEV. PROJ COORDINATOR	Vacant		SR. COMMNTY DEV. PROJ COORDINATOR
HHCS	VECTOR CONTROL TECHNICIAN	Vacant		VECTOR CONTROL TECHNICIAN
HHCS Count	**45**		**0**	**45**
HR	ASSOCIATE HR ANALYST	Vacant		ASSOCIATE HR ANALYST
HR	OCCUPATIONAL HLTH/SAFTY SPEC	Vacant		OCCUPATIONAL HLTH/SAFTY SPEC
HR Count	**2**		**0**	**2**
IT	APP. PROGRAM ANALYST II	Vacant		APP. PROGRAM ANALYST II
IT	CUST. SVCS. SPECIALIST III	Vacant		CUST. SVCS. SPECIALIST III
IT	PROGRAM MANAGER II	Vacant		PROGRAM MANAGER II
IT	SR. INFO. SYSTEMS SPECIALIST	Vacant		SR. INFO. SYSTEMS SPECIALIST
IT Count	**4**		**0**	**4**

List of Vacant Positions as of 04/03/2026

Department	Position Description	Status
City Attorney	Assistant City Attorney	Vacant
City Attorney	Deputy City Attorney IV	Vacant
City Attorney	Legal Office Supervisor	Vacant
City Attorney	Risk Manager	Vacant
City Attorney Count		4
City Clerk	Assistant City Clerk	Vacant
City Clerk Count		1
CMO	Animal Control Officer	Vacant
CMO	Diversity, Equity, and Inclusion Officer	Vacant
CMO	Economic Development Project Coordinator	Vacant
CMO	Office Specialist II	Vacant
CMO	Senior Management Analyst	Vacant
CMO	Social Services Specialist	Vacant
CMO Count		6
Finance	Accounting Manager	Vacant
Finance	Administrative Secretary	Vacant
Finance	Associate Management Analyst	Vacant
Finance	Deputy Director of Finance	Vacant
Finance	General Services Manager	Vacant
Finance	Revenue Development Specialist I	Vacant
Finance	Revenue Development Specialist I	Vacant
Finance	Senior Systems Analyst	Vacant
Finance	Treasury Manager	Vacant
Finance Count		9
Fire	Administrative Assistant	Vacant
Fire	Fire Captain II	Vacant
Fire	Fire Marshal	Vacant
Fire	Fire Prevention Inspector (Sworn)	Vacant
Fire	Firefighter	Vacant
Fire	Firefighter	Vacant
Fire	Firefighter	Vacant
Fire	Office Specialist II	Vacant
Fire	Paramedic (R)	Vacant
Fire	Paramedic (R)	Vacant
Fire	Paramedic (R)	Vacant
Fire	Paramedic (R)	Vacant
Fire	Paramedic Supervisor I	Vacant
Fire	Paramedic Supervisor I	Vacant
Fire	Paramedic Supervisor I	Vacant
Fire Count		15
HHCS	Assistant Management Analyst	Vacant
HHCS	Assistant Management Analyst	Vacant

List of Vacant Positions as of 04/03/2026

Department	Position Description	Status
HHCS	Associate Management Analyst	Vacant
HHCS	Behavioral Health Clinician I	Vacant
HHCS	Behavioral Health Clinician I	Vacant
HHCS	Behavioral Health Clinician I	Vacant
HHCS	Behavioral Health Clinician II	Vacant
HHCS	Behavioral Health Clinician II	Vacant
HHCS	Behavioral Health Clinician II	Vacant
HHCS	Behavioral Health Clinician II	Vacant
HHCS	Behavioral Health Clinician II	Vacant
HHCS	Behavioral Health Clinician II	Vacant
HHCS	Behavioral Health Clinician II	Vacant
HHCS	Behavioral Health Clinician II	Vacant
HHCS	Behavioral Health Clinician II	Vacant
HHCS	Community Health Worker Specialist	Vacant
HHCS	Community Services Specialist II	Vacant
HHCS	Community Services Specialist II	Vacant
HHCS	Epidemiologist	Vacant
HHCS	Health Educator	Vacant
HHCS	Health Services Program Specialist	Vacant
HHCS	Mealsite Coordinator	Vacant
HHCS	Mental Health Clinical Supervisor	Vacant
HHCS	Mental Health Nurse	Vacant
HHCS	Mental Health Nurse	Vacant
HHCS	Mental Health Nurse	Vacant
HHCS	Mental Health Nurse	Vacant
HHCS	Mental Health Nurse	Vacant
HHCS	Mental Health Program Supervisor	Vacant
HHCS	Mental Health Program Supervisor	Vacant
HHCS	Office Specialist II	Vacant
HHCS	Office Specialist II	Vacant
HHCS	Office Specialist II	Vacant
HHCS	Office Specialist II	Vacant
HHCS	Office Specialist II	Vacant
HHCS	Office Specialist III	Vacant
HHCS	Program Manager II	Vacant
HHCS	Program Manager II	Vacant
HHCS	Psychiatrist	Vacant
HHCS	Psychiatrist	Vacant
HHCS	Public Health Nurse	Vacant
HHCS	Public Health Nurse	Vacant
HHCS	Public Health Nurse	Vacant
HHCS	Senior Behavioral Health Clinician	Vacant
HHCS	Senior Community Development Project Coordinator	Vacant

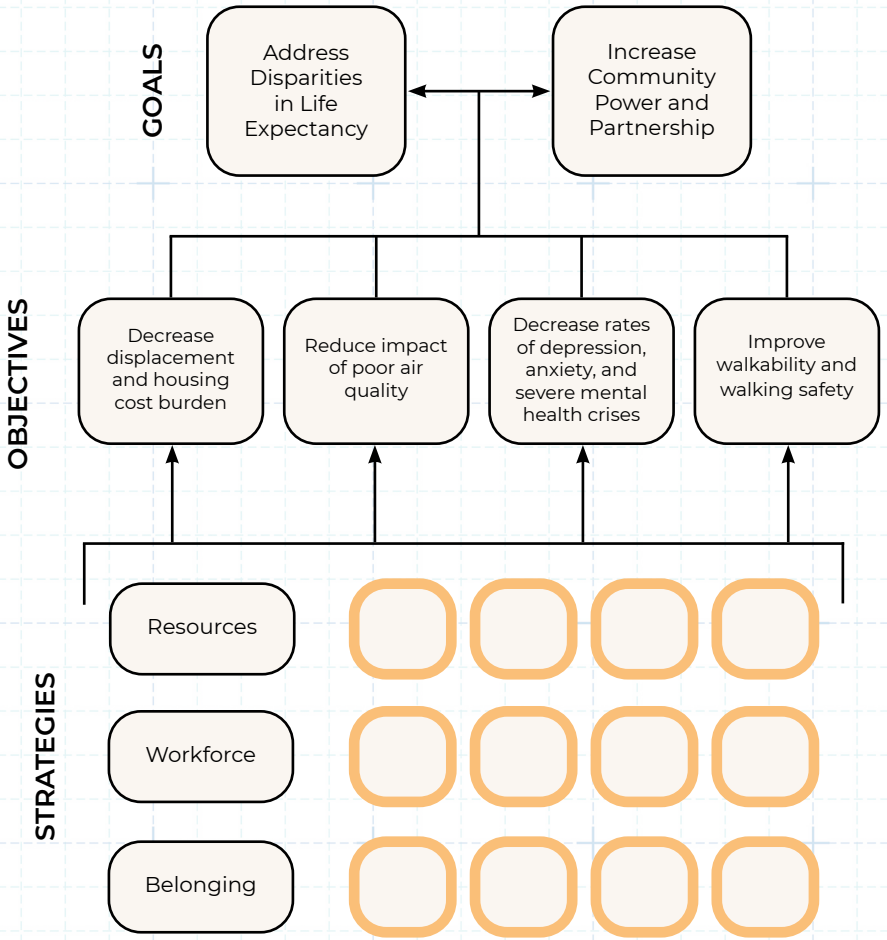
STRATEGIES

When discussing strategies to advance the health topic objectives, three key categories consistently emerged: resources, workforce, and belonging. For strategies to succeed, they must to maximize resources, expand the community-connected health workforce, and foster a sense of belonging. These categories highlight the interconnected nature of the health topics and present an opportunity for City of Berkeley departments and community partners to work together on shared underlying issues.

TABLE 2: Strategy Categories

CATEGORY	DEFINITION
Resources	Maximize state and local resources. Across topics there are opportunities to draw down additional resources and to increase the impact of current funding. In particular, the city could play a key role convening leaders from community organizations to create strategic networks and build capacity to receive funding.
Workforce	Expand the community- connected health workforce. There are a number of new or underutilized reimbursable classifications (community health workers, doulas, violence prevention specialists, etc.) that could serve to improve health and safety through connections outside clinic walls while also creating positive career pathways. However, the value of a community connected workforce is undermined if individuals can't afford to live Berkeley.
Belonging	Foster community connection. Community members believe that Berkeley is thriving when it's a place that fosters community connection —where people are seen, heard, respected,and valued not only when they received services, but by their neighbors and in gathering spaces. It's also more than a personal experience but a public health necessity that strengthens mental health and community resilience.

FIGURE 5: CHIP Goals, Objectives, and Strategies



Improvement Planning

Workgroups identified one strategy in each category to advance in the next three years, laying the groundwork for the implementation part of the cycle. Given funding and policy uncertainty, these ideas reflect current thinking about "how" to improve the overarching goals and health topic objectives in alignment with the principles described above. City staff and community members will need to collaborate to modify this approach based on changing conditions and opportunities and to maintain accountability to each other and this process. See Appendix C for an initial set of potential activities to advance these strategies.

TABLE 3: Strategies by Health Topic

	Housing	Environmental Health	Behavioral Health	Community Safety
Resouces	Provide assistance for CBOs to participate in housing-related funding opportunities.	Deepen partnerships between Housing and Community Services and the Office of Energy and Sustainable Development to facilitate the process of creating green residential buildings.	Facilitate regular convenings to improve collaboration and data-sharing between organizations.	Prioritize bike/pedestrian infrastructure investments in areas with the greatest need, based on equity, safety, and community health indicators.
Workforce	Expand youth internship opportunities across educational institutions and CBOS, that support building and renovating housing.	Expand community outreach and implementation of tree-planting initiatives in South and West Berkeley.	Implement targeted hiring initiatives and leverage training programs to ensure representation of priority populations.	Grow the network of alternative responders and violence prevention specialists to strengthen safety and social connection.
Belonging	Enhance outreach, application assistance, and education campaigns to increase participation in Housing Preference application for displaced community members and their families.	Identify regions with frequent air quality related school absences and work with those communities to develop practical solutions.	Train youth mentors and implement evidence-based mental health curricula, with a focus on improving students' sense of safety and belonging.	Increase neighborhood interaction and engagement.

Improvement Planning

Implementation

The implementation of the CHIP, and preparation for the next assessment, will occur across 3 phases over the next 3-5 years. This phased approach establishes accountability and oversight at the beginning with a set of formative steps, then moves to a focus on taking action. Throughout these phases there are reminders to review and revise the approach and to communicate out to stakeholders. Without a clear implementation process, all of the momentum built up during the CHA and CHIP processes can dissipate. The result would be both a lost opportunity to address priority health and equity concerns and also eroded trust among the stakeholders who provided time and good faith effort.

PROCESS

SEPTEMBER 2025 - MARCH 2026

Phase 1: Preparation

- Identify a staff lead and allocate dedicated time for the implementation of each Health Topic Objective.
- Confirm and meet with 4 CSC members to continue their role as stewards of the process, with an emphasis on co-leading the CHIP objectives implementation meetings.
- Hold a planning and design meeting to engage staff from multiple city departments with community stakeholders to think creatively about how to advance the CHIP goals and objectives.
- Put together advisory group for each of the 4 health topics include at least 1 staff member, 1 community organization, 1 community member
- Adequately compensate community members supporting CHIP planning implementation and evaluation.

APRIL 2026 - MARCH 2028

Phase 2: Action

- Schedule a minimum of quarterly meetings with advisory teams.
- Set a regular schedule for reporting back to the community on progress of CHIP objectives (minimum every 6 months).
- Confirm performance measures for each health topic area, people responsible for tracking each measure and build measures into city systems, such as results-based accountability and other departmental metrics.
- Midpoint assessment: review of strategies and measures, government funding and decision making processes, name opportunities to improve collaboration. Share findings with the community.
- Identify new and existing programs that can contribute to addressing health topic objectives.
- Publish annual progress report with progress updates on measures and community power and partnership initiatives.

APRIL 2028 - AUGUST 2028

Phase 3: Refresh

- Identify potential Steering Committee.
- Plan next CHA/CHIP cycle.
- Institutionalize successful efforts and systems changes.
- Confirm and communicate community engagement opportunities for next CHA/CHIP.

Conclusion

The Berkeley Wellness Blueprint is more than a report; it is a commitment to a different way of working together to build a healthier, more equitable city.

It is a starting point, born from the voices and experience of the Berkeley community, that provides a shared direction and a framework for accountability. The overarching goals of closing the staggering gap in life expectancy and building genuine community power will not be achieved by this document alone. Success requires sustained, collective action. The power of this plan will only be unlocked through the dedicated efforts of residents, city staff and officials, and community-based organizations working in partnership.

Call to Action

For Community Members: Stay involved and hold decision- makers accountable. Participate in the public meetings where progress will be reported. Share your experience to help refine these strategies. This is your plan: your continued engagement will ensure it leads to the tangible, lasting change you desire to see in your community.

For Community-Based Organizations: Use this Blueprint as a foundation for partnership and advocacy. Participate actively in the convenings and capacity-building opportunities proposed in the plan to strengthen your networks and access new resources. Support community members to participate and raise their voices. Collaborate with the city to refine and implement the strategies, bringing your expertise to ensure initiatives are culturally responsive and effective.

For City Staff: Champion the objectives of this plan within your department. Proactively identify how the strategies outlined for housing, environmental health, behavioral health, and community safety can be integrated into your team's work plans and metrics. Take the lead in convening stakeholders for creative problem- solving and commit to transparent reporting to build and maintain community trust.

For City Officials: Endorse this Blueprint and use the goals, principles, and objectives to focus citywide attention and resources. Explicitly refer to the Blueprint when making policy and resource decisions and encourage other officials and staff to do the same. Support and participate in the convening of stakeholders to review progress and creatively solve problems, and use your visibility to highlight transparent reporting.

Appendix B: Alignment with Local, State, and National Priorities

	Planning Documents		
Health Topic Objectives	**City/County**	**State**	**National**
Housing	2024 Alameda County 10 Year Housing Plan 2022-2025 Alameda County Community Health Assessment Berkeley Housing Element Update	California Health and Human Services Agency (CalHHS) Program Priorities (2024-2025) California Statewide Housing Plan (2022)	Healthy People 2030 Objectives Department of Housing and Urban Development Strategic Plan (2022-2026) CMS Rescission of Guidance on Health-Related Social Needs (2025)
Environmental Health	General plan EJ Element update (2026) By Climate Action Plan update (2025)	California Department of Public Health Strategic Plan 2025-2030 California State of Public Health Report (2024)	Healthy People 2030 Objectives CDC National Center for Environmental Health Strategic Framework (2024)
Behavioral Health	2022-2025 Alameda County Community Health Assessment Mental Health Services Act (MHSA) Annual Update 2025-2026	California Youth Behavioral Health Initiative California Department of Public Health Strategic Plan 2025-2030 Behavioral Health Services Act Population-Based Prevention Program Guide - Phase 1	Healthy People 2030 Objectives SAMHSA Strategic Plan (2023-2026)
Community Safety	Berkeley Reimagine Public Safety Task Force 2022-2025 Alameda County Community Health Assessment	California Department of Public Health Strategic Plan 2025-2030 California State of Public Health Report (2024) California Violence Intervention and Prevention Program (CalVIP)	Healthy People 2030 Objectives 2022-2026 U.S. Department of Transportation Strategic Plan

Appendix C: Potential Activities & Accountability

The health topic workgroups identified a set of potential implementation activities and policy changes that would advance each strategy. The expectation is not that all of these actions will be taken but rather that city staff and community members will meet during Phase I of Implementation to review and prioritize the activities based on evolving conditions. Additionally, at that point, timelines and performance measures will be set for the prioritized actions. The performance measures will be selected based on alignment with Results-Based Accountability (RBA) measures that HHCS and other city departments are establishing as well as other easy to collect measures that can serve to monitor progress.

Housing				
Strategy	**Activities/Policy Changes**	**Timeline**	**Performance Measures**	**Leads/Responsible Parties**
Resources: Provide assistance for CBOs to participate in housing -related funding opportunities.	• Share learnings from successful housing initiatives (i.e. Co-op model) • Convene housing focused and housing adjacent CBOs to build capacity and provide technical assistance around CalAIM participation • Create a single application for CDBG funding in housing creation, preservation and workforce	*To be filled out during phase 1 of Implementation.*		
Workforce: Expand youth internship opportunities across educational institutions and CBOS, that support building and renovating housing.	• Improve and streamline communication to increase participation around Housing related internships (i.e. councilmember Lunapara's and Mayor Ishii's internships) • Expand internship opportunities to support building and renovating housing • Inventory and collate physical sites and assets being leveraged for housing related workforce development			
Belonging: Enhance outreach and application assistance to increase participation in Housing Preference application for displaced community members and their families.	• Evaluate applications to gauge percent of applicants and awardees who are facing displacement or have been displaced • Collaborate with CBOs working with target community to increase awareness			

Appendix C: Potential Activities & Accountability (cont)

Environmental Health				
Strategy	**Activities/Policy Changes**	**Timeline**	**Performance Measures**	**Leads/Responsible Parties**
Resources: Strengthen partnerships to facilitate the process of creating green residential buildings.	• Collaborate with the Office of Energy and Sustainable Development to implement Section 4.1 of the Berkeley Existing Buildings Electrification Strategy to transition existing residential buildings into green buildings • Work with developers contracted for new residential buildings to ensure they run on green energy	*To be filled out during phase 1 of Implementation.*		
Workforce: Expand community outreach and implementation of tree-planting initiatives in South and West Berkeley.	• Work with Parks and Recreation Department, recruit community members to discuss and decide how to reach more people with existing tree planting initiatives			
Belonging: Identify regions with frequent air quality related school absences and work with those communities to develop practical solutions.	• Cross-reference absenteeism data with poor air quality data to identify regional clusters impacted by exposure to poor air quality • Create an advisory board/steering committee consisting of residents and communities in the identified regions to discuss how to move forward with reducing impacts of poor air quality			

Appendix C: Potential Activities & Accountability (cont)

Behavioral Health				
Strategy	**Activities/Policy Changes**	**Timeline**	**Performance Measures**	**Leads/Responsible Parties**
Resources: Facilitate regular convenings, service alignment, and data-sharing related to behavioral health services with measurable improvements in cross-organizational collaboration.	• Identify a coordinator to revive the School-Linked Health Program model. • Map all organizations providing BH and adjacent services. • Develop a charter for the collaborative group.	*To be filled out during phase 1 of Implementation.*		
Workforce: Implement targeted hiring initiatives and leverage training programs to ensure representation of priority populations in the behavioral health workforce.	• Form direct partnerships with community colleges, local cultural organizations and faith-based groups to create a pipeline for job applicants. • Create structured, paid internship or apprenticeship programs.			
Belonging: Train youth mentors and implement evidence-based mental health curricula, with a focus on improving students' sense of safety and belonging.	• Launch a targeted recruitment campaign for mentors within specific neighborhoods and cultural communities. • Organize structured, low-pressure events to allow potential mentors and mentees to interact • Form a committee of students, teachers, and school counselors to review and select an evidence-based mental health curriculum			

Appendix C: Potential Activities & Accountability (cont)

Community Safety				
Strategy	**Activities/Policy Changes**	**Timeline**	**Performance Measures**	**Leads/Responsible Parties**
Resources: Prioritize bike/pedestrian infrastructure investments in areas with the greatest need, based on equity, safety, and community health indicators.	• Convene cross-sector stakeholders in priority neighborhoods • Map revenue streams to support improved bike/ped safety and develop set of revenue recommendations • Identify aligned strategies in the General Plan update (2026) • Engage Reimagining Public Safety Task Force	*To be filled out during phase 1 of Implementation.*		
Workforce: Grow the network of alternative responders and violence prevention specialists to strengthen safety and social connection.	• Provide housing assistance and support to violence prevention specialists • Create training and placement pipeline for community-connected workforce (CHWs, alternative responders, etc.) with BHS and BCC • Designate city point person to coordinate community-connected workforce • Expand school-area safety measures (crossing guards and pedestrian lamps)			
Belonging: Increase neighborhood interaction and engagement.	• Reduce cost and process for block parties • Make use of public facilities easier and cheaper • Identify neighborhood "captains" who would get modest benefits from the city and be a local organizer and source of information • Set policy regarding encampments within 500 feet of schools			

CoB CHIP Priority: Behavioral Health

A proposed Objective: Increase awareness about, with the hope of Decreasing, rates of depression, anxiety and severe mental health crises in CoB

Proposed Measure

Increase awareness of the rate of suicide deaths, self-harm emergency visits, and drug-related overdoses in City of Berkeley to help guide development of prevention strategies

Possible Metrics

- Community & Youth Engagement: # of youth trained in mental health curriculum (e.g., peer mentors at Berkeley High School clinic).
- Community Partnership & Governance: # of community partners convened under BHSA funding for behavioral health outcome reporting.
- System Collaboration & Data Sharing: increase availability of sharable data.