Milwaukee Community Intervention Task Force

Report of Findings and Recommendations for 2023

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Executive Summary

The Community Intervention Task Force (CITF) was formed in 2021 at the request of the common council with the intent of exploring alternative responses to incidents initiated through citizen contact with the 911 system. Specifically, the CITF was charged with developing a plan to address calls that don't pose a threat to public safety with trained unarmed responders in concert with diverse governmental and non-governmental service providers that exist in the Milwaukee community.

The CITF held several meetings and heard from diverse stakeholders that represented a wide variety of service providers, including the two current 911-based response agencies: the Milwaukee Fire Department and the Milwaukee Police Department. In the summer and fall of 2022, an analysis that primarily included the responses of the MPD was completed by the Law Enforcement Action Partnership (LEAP) that identified several potential calls for service that would be feasible for diversion, looked at several other responder programs and completed time, fiscal and response analysis.

The review identified a limited call set of approximately 30,500 responses in 2021 from the MPD (21,000) and the MFD (9,500) that met the criteria set forth by the common council. However, the departments found it difficult to further isolate which calls in the LEAP report could be attended to by an alternative responder, as the current dispatching and record-keeping systems do not offer additional subcategorization necessary to separate the important characteristics of the incidents, and a manual review of 30,000 incidents falls outside of the scope of either department. Additionally, the city's 911 system is in a transitional state, moving from an antiquated and separate police and fire system to a new integrated system shared between the two departments. Any immediate modifications to the current system while in this transitional period would be unwise.

The committee suggests utilizing the existing department assets and incorporating an academic evaluator as a partner to identify the sub-characteristics of responses with a behavioral health nexus, evaluate phone-based triage and develop training for future responders based on community need. To achieve the goal set forth by the common council, the task force provided a 2023-2024 calendar reflective of the operational realities of the wide variety of key stakeholders involved. No single city agency rises to the top as a clear home for an alternative responder workforce, so the task force presents some key considerations for the Fire, Health, and Police Departments and suggests a hybrid model capitalizing on the strengths of each agency.

Finally, a supplemental report is presented speaking to the scope, capacities, and skills of a sample of the diverse grouping of community agencies currently in the Milwaukee area. The sub-categorization of the focus incidents by the evaluator and the current 911 response agencies will serve to optimize the training of future responders and best match the services that currently exist in the city with the agencies and providers best suited to provide culturally competent and situationally relevant services to Milwaukee residents during the times when they need them most.

Findings:

The Community Intervention Task Force established that the diverse stakeholders, professional responsibilities, and experiences of its members identified multiple views, benefits, drawbacks, and opportunities present in our current 911-based response system. There does not exist one single clear path forward that could function within the confines of our current 911 dispatch, Emergency Medical Service (EMS), law enforcement, and social service delivery systems, which are currently poorly connected. Milwaukee's current political, geographic, and local and federal legal structures also add a layer of complexity to the problem presented to the task force. Instead of a singular plan to move forward to operationalize a response unit, the task force proposes a collaborative and academic-led period of evaluation of some identified calls for service over a dedicated period. Stated individually, the task force presented the following report that supports the following three key findings.

1. 911 calls with a behavioral health nexus and low acuity call for service, although poorly defined, do present a space for non-law enforcement and non-EMS response.
2. The MFD and MPD identified a limited call set that could be attended to by a paraprofessional in an Alternate Response Model (ARM). MPDs Community Service Officer (CSO) and the MFDs Alternative Response Vehicle (ARV) could be used to evaluate the selected call types (Table 1).
3. To operationalize a program, the proposed timetable (Table 3) would be adhered to through the close of the 2024 calendar year. The critical tasks, time points and initial partners indicated on the table would serve to address the shortcomings of the first finding, utilizing existing city resources.

Proposal – Vision

Vision: Utilize existing first responder resources to perform an evaluation of low acuity response calls that could be serviced by an alternate responder and would provide longitudinal benefit to citizens utilizing evidence-based/evidence-informed interventions.

Proposed Beta Project

The Taskforce proposes facilitating interdepartmental cooperation and dedicating the appropriate financial resources to fund a third-party evaluator. Utilizing the existing 911 response resources of the MFD and the MPD, specifically the MPDs Community Service Officer position and the MFDs Alternative Response Vehicle, the departments shall use these two units to respond to a limited set of call types during the third and fourth quarters of 2023. Under the guidance and direction of a funded evaluation project, the two agencies would respond to an estimated 15,000 calls during a beta test period. While holding the current response constant, the evaluator would work ahead of and closely with the two departments to achieve the following short-term goals to address the first finding.

1. Identify reporting methodology and platform (Cognito, Qualtrics, etc.) that would be appropriate for an alternative responder, taking into account existing privacy requirements (HITECH) and information necessary for the resolution of caller complaints.
2. Evaluate Impact Connect as a referral platform to connect customers/clients to services and track the resolution/completion of referrals.
3. Identify the current gaps in response for the existing two agencies.
4. Develop expectations for response times, scene times, problem resolutions, and necessary supplementary resources.

5. Evaluation of a two-responder, city-wide model for the MPDs CSO program compared to the one-responder, the district-based model currently in use.
6. Identify, illuminate and propose solutions to programming issues that inhibit service delivery to customers, or reduce the efficacy of solutions offered by responders.
7. Evaluate customer satisfaction with services offered by providers.
8. Develop a "Toolkit" for future training that identifies what training and tools are needed for the pilot to "resolve" patient issues as opposed to relocating patients to medical centers or leaving them in the current environment.
9. Monitor the development of the Department of Emergency Communications and provide recommendations for integrating alternative response triage questions into the system.
10. Provide recommendations for a pilot to begin in 2024 to include the training, staffing, and deployment of an alternative responder agency based on the findings.
11. Provide recommendations for education and other interventions that reduce the utilization of 911 as a first-tier resource for indicated incidents.
12. Begin to evaluate the appropriate integration of other community-based prevention and response assets based on findings.

The public health model of prevention serves as a valuable vocabulary tool to further define and specify the types of activities that occur at different levels as well as identify appropriate target audiences, geographies, and goals for activities. The model also provides a tool to focus discussions and identify realistic objectives for initiatives and place them in the appropriate temporal position in a longitudinal program. Based on the current state of the system and resources available, the CITF recommends that a responder program focuses on Secondary and Tertiary prevention activities.

Primary – Primary prevention includes things like education and public-facing marketing and education. Discussions of massive public-facing education are premature and would likely lead to oversaturation and over-utilization of the program before it had time to develop effective and efficient response modalities. The authors' recommendation is to delay substantial primary prevention activities until 2025, with discussions facilitated by program leadership and evaluation staff. The operationalization of primary prevention activities would also be an appropriate and valuable position for a community panel and additional subject matter experts.

Secondary – Secondary prevention activities are those that focus on subgroups that are identified to be at risk for an adverse outcome. While resources exist in the broader community space, at-risk populations often underutilize these resources or are unaware of their existence. Secondary prevention activities are similar to holding cases, with a CITF responder having the capability to do an in-home, face-to-face check-up and preempt issues. These cases should be evaluated and referred to CITF leadership to identify frequent utilizers or resources, high volume utilizers (those with complex cases that are easily managed), and targeted community responses following an incident (similar to MFD's project focus or 414-life community canvases). This supplemental work serves to increase community visibility, potentially reduce future calls, and reserve critical resources for those in the most acute need, by performing a focused assessment and redirection of those likely to use services in the future.

Tertiary- Tertiary prevention describes the actual responses that a CITF staff person would respond to secondary to a 911 call. In these cases, the perceived emergency has already occurred, and a citizen has accessed the system seeking the "low friction" solution. In these responses, the CITF staff seek to identify, address and potentially rectify the issue for which they were called. In cases where the responder discovers an indecent of higher acuity, they utilize the existing dispatch system to elevate the incident to a higher level of service. In cases where the responder can rectify the citizen's need, responders should be given the ability to do so, utilizing

applicable technology such as a city-issued mobile phone, mobile laptop with an air card for reporting, and knowledge of relevant resources for the caller or customer to utilize. Several service calls such as property transfers do not present a problem to fix, but instead, provide an opportunity to simply address a perceived urgent need that requires an impartial third party. Finally, the lowest acuity response is the identification capacity, where the only need may be data collection on an individual or location for further evaluation, follow-up, or monitoring, should a situation intensify or change categorically.

Non-Goals & Goals with pilot call set.

Finding #1 speaks to the inconsistent definition of terms like "crisis" and the methodologies used to capture how behavioral health intersects with MFD and MPD operations, as well as the interactions that the two departments have with Milwaukee's homeless populations. The MFD's EMS responsibilities and the legal and statutory power granted to the MPD under Chapter 51 highlights the fact that the goals of a community responder program are not to replace existing critical response capacity. The LEAP report identified that less than 5% end in emergency detention, indicating a large, but poorly categorized group of sub-acute 911-initiated incidents (LEAP, 2022, p 25). A "sub-acute" crisis definition is necessary to create appropriate dispatch questions, design training, and policies, and establish citizen expectations when calling for service. The Beta and Pilot methodology will identify characters of sub-acute incidents, as well as the tools necessary to address them without law enforcement or pharmacological intervention.

911 calls for service with a strong behavioral health component are typically services by Crisis Assessment Response Team (CART). MPD partners with the Behavioral Health Division (BHD) to staff CART which is a team consisting of a clinician from the County and an officer. The team only assesses adults experiencing a possible psychiatric crisis. CART focuses on voluntary options: stabilization on the scene, referrals to other mental health resources, and mental health assessments for prisoners in custody. The dispatch or utilization of CART may be based on an officer's impression of the situation after their arrival or a dispatcher's impression of the situation based on the information received over the phone. CART teams currently work until midnight and respond to incidents that may be questionable or approach this definition, or when their unique scope of service is known to a family.

In situations where voluntary stabilization options are feasible or realistic, MPD has a Standard Operating Procedure as it relates to MPDs responsibility for Emergency Detention (Wis. Stat 51.15(1)) that allows MPD to take a person into custody if they believe they are mentally ill, drug dependent, or developmentally disabled; unable or unwilling to cooperate with voluntary treatment; *and* that taking a person into custody is the least restrictive alternative appropriate to the person's needs. Additionally, the individual must evidence *any* of the following:

1. A substantial probability of physical harm to himself/herself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm.
2. A substantial probability of physical harm to others as manifested by evidence of recent homicidal or other violent behavior on his/her part, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt or threat to do serious physical harm on his/her part.
3. A substantial probability of physical impairment or injury to himself/herself or other individuals due to impaired judgment, as manifested by evidence of a recent act or omission.

4. Behavior manifested by a recent act or omission that, due to mental illness he/she is unable to satisfy basic needs for nourishment, medical care, shelter, or safety without prompt and adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness

The necessary components of Chapter 51 previously stated the law enforcement definition of a behavioral health crisis, which is currently utilized in the servicing of 911 calls. When a possibility for taking a person into custody exists, calls for services are serviced by a law enforcement professional, with CART responding to near or sub-acute incidents. As these systems currently function and serve as a necessary tool when Chapter 51 is appropriate, it is not a goal of this report to alter the currently functional CART model, nor is it within the current state of Chapter 51 for a -non-law-enforcement person to facilitate the process of involuntary treatment for high-acuity situation meeting the above definition.

For the Milwaukee Police Department and the Milwaukee Fire Department, the data collection portion in 2023 will provide a better understanding of what pre-response questions, assessments, and triage need to occur at the dispatch level. These will serve to differentiate the necessity of a CART response and predict if Chapter 51 would be necessary. Data collection will also identify the prevalence of these types of responses to right-size an alternate response, including the supplemental voluntary options that would be most valuable to an alternate responder as well as the appropriate procedures to engage a community member with these resources.

MFD Paramedics utilize the Milwaukee County OEM Patient Restraint Practice Guideline to determine when a patient may be in "crisis" defined as *"patients demonstrating behavior which represents a clear risk of harm and danger to themselves or others; usually the result of acute intoxication, overdose, or mental health crisis" (*OEM-EMS*, 2022).* Following failed attempts at de-escalation and suicide evaluation, these patients are often either physically or chemically restrained. Paramedics and EMTs also co-respond with MPD when protective custody under Chapter 51 or Chapter 55 may be appropriate, such as in cases where adult protective services are appropriate (OEM-EMS, 2022). EMS responses for Opioid overdose patients require immediate attention to support their respiratory drive, typically through the administration of Naloxone or manual airway support with a Bag Valve Mask or a manual airway adjunct (OEM-EMS, 2022). Current MFD reporting practices capture when clinical skills are performed, such as administering a drug or ventilating a patient, not when a specific policy is used. Identifying the frequency and appropriateness of incident types when de-escalation was used, when a co-response wasn't or wasn't necessary for Chapter 51 or Chapter 55, or when an overdose did not require respiratory or pharmacological support is not current practice. EMS reports are also clinical medical documents that are not readily available to members of the public without redaction to remove any information that could, either alone or in combination, be used to identify a specific individual (HHS, 2022).

Emergency medical technicians from Bell and Curtis Ambulance companies as well as the MFD currently respond to sub-acute incidents categorized through the emergency medical dispatch system as psychological or suicidal in nature, without a critical life safety component. Current guidelines service these as co-responses with law enforcement. Over a dozen response codes exist that specify the severity of each situation as well as the presence of lethal means and the current behavior of the patient. A recent analysis revealed that several of these incidents are brought to a resolution without EMS intervention or assessment. However, without patient contact, the existing records do not speak to the tools used by the caller or on-scene law enforcement to bring these incidents to a close. Finally, the

current Milwaukee County EMS Hospital destination and transport policy does not permit EMS transport to the Milwaukee Mental Health Emergency Center (MHEC) by any Milwaukee County EMS provider (OEM,2022).

Emergency Medical Dispatch (EMD), the dispatch triage system used by the MFD (which will also be used by the Department of Emergency Communications (DEC), does not have a categorization for homelessness. Drug overdoses of all kinds, including stimulants, depressants, over-the-counter medications, and accidental asymptomatic overdoses, are categorized in the overdose/poisoning incident category. As EMS research is typically focused on incidents that produce high rates of morbidity and mortality, additional surveillance would be necessary to isolate incidents of homelessness as well as sub-acute overdose responses where an alternative resource would have been appropriate and would have saved a response from both the police and EMS, whether at the paramedic or EMT service level.

Additional information specific to resources necessary to mitigate the aforementioned calls for service and better evaluate patient disposition would be identified in Q3 and Q4 of 2023 and further tested for efficacy and customer satisfaction through a pilot, as well as by endorsing an evaluator to work collaboratively with both departments to investigate a methodology to reliably investigate the response and longitudinal outcomes of the thousands of incidents that exist between both departments.

Considerations for a host department

The academic approach of rigorously refining and revising hypotheses or groups of hypotheses is important in this space. It's well established that there is no one clear answer or evaluation methodology to identify a host agency for this project. The City of Milwaukee as well as Milwaukee County have more than a dozen large specialty agencies that offer unique strengths and resources that are used to execute their missions and evaluate their efficacy. It is impossible to measure two departments with the same metrics and timely tools to evaluate caller satisfaction with emergency responses or services that are non-existent and require substantial human capital to combat normally low survey response rates. In spaces where two or more departments' operations of mission may overlap, there are often different metrics or operational priorities that may seem like duplication to a novice but represent an operational need or specialty to the experienced observer. Instead of a "best" solution, what follows is a S.W.O.T. analysis with considerations for each department, considering that the desired outcome is not a result that an emergency responder would typically produce, but instead, a response that addresses and provides for a need, that may be more complex or temporally demanding that the emergency space of training provides for, or where a citizen "emergency" definition does match that of existing 911 responders. A mixed-model approach would see a leader begin the pilot phase in a non-fire or police city office and budget (possibly under DOA).

MFD:

S: Geographically locations firehouses, can fit vehicles (transit vans), currently sharing houses with Bell/ Curtis, hundreds of "ride-along" per year, familiarity with evaluation & academic research, registered as an HCO, familiar with Business Associate Agreement (BAA) process, MIH structure/ CP training, CP training directly aligns, "handoff" well established in operational culture, existing infrastructure for rapidly evaluating patient satisfaction, and longitudinal patient follow-up (hospital-based only).

W: EMS transporting requirements for "Patients", several programs already in use in Community Paramedicine space, Medical assessment training is four months (EMT) up to 2 years (Paramedic) to hone assessment skills.

O: potential for financial reimbursement (long history with a billing company filtering billable/non-billable incidents), EMD offers specified classification of incidents, the opportunity for customization of some codes and responses exists, CAD easily adds/integrates specialized units and response packages (available for use during beta)
T: Lowest level of medical response is "EMT", a medical/clinical mindset well-baked into the culture, only specialized staff is experienced in navigating the space between patient care and providing non-medical services in an emergent fashion.

MHD:

S: Multiple clinical and programming disciplines; registered as an HCO; existing BAAs with several agencies already; experienced in "multidiscipline" approach; existing clinic infrastructure; existing connections with some county services and programs; OVP has good community connections; limited scope AODA, homeless/housing programs exist (may be specific to a program/grant).
W: low volume response capacity experience; no existing automatic dispatch integration; clinical locations poorly suited for rapid vehicle response and associated maintenance/deployment; no 911-emergency-response authority; not currently equipped with technology for rapid field reporting
O: Clinics and programs have several "fixes" in-house (may be specific to a program/grant); multiple taxonomies for billing exist; an epidemiology team exists in-house; strongest academic connections across multiple disciplines.

T: Limited call set is a much larger response volume than any current program; Several key staff and programs (MHD & OVP) are built into grants that have specific requirements, or sunsets.

MPD:

S: Limited Call Set is a small percentage of the current volume, current PSAP currently receives all calls for service, 24/7/365 working hours, and the current staff is familiar with CART as a resource.
W: Dispatch system poorly automated for this use case, district model response model not sufficient for an entire response division/implications of a city-wide model unknown, CSO recruiting and hiring is challenging/historically understaffed/currently pipelining to officer. CSO job description doesn't reflect proportions of limited call set or associated responsibility, long training loops for the entire department, CSOs not currently equipped with technology for rapid field reporting
O: Opportunity to offer different community service models has political support
T: Adding additional data systems for reporting may have LE implications, hiring individuals with "lived experience" may prove difficult, Non-Law Enforcement reporting requirements and goals unclear, current systems not HIPAA, HITECH compliant, unable to establish BAA (partners may want), as MPD is not a covered entity

Mixed model – Similar to OVP, a mixed model could serve to capitalize on several strengths and weaknesses of the previously mentioned agencies. A CITF leader and program could be hosted within DOA or be an office of the mayor, but physically assigned within the physical structure of an MFD, MPD, or MHD building. CITF responders would receive training and hold the capacity to modify their

secondary prevention responses with specialized supplemental staff from other agencies (UWM, MPD, MFD, DHHS) while retaining their core response capabilities and responsibilities. A mixed responder model could utilize vehicles with responders of mixed disciplines to respond to calls within their specialist skillset and allows for rapid evaluation of responses. Specialized responders from individual agencies could remain in their respective departments' budget, with CITF staff accompanying them to specified calls. MPD's ability to transport to MHEC, MFD's field data collection, and patient follow-up capability, and the Department of Emergency Communication (DEC) dispatching tools could all be combined in new, previously unutilized ways to bring a responder agency together that realizes the strengths of multiple city departments.

Identify limited call set/caseload for pilot

The following represents a brief, general description of the types of calls that would make up the dispatched responses for a limited call set. It's important to remember that the purpose of a pilot is to look at the feasibility and build a well-functioning system, not to address every need at once. Subsequent advancements in the city's dispatch system with further specifications and a well-regulated question set for call takers will make this process better in future phases.

Community Service Officers

The MPDs Community Service Officer (CSO) program was established in August 2016 with the intent to supplement the efforts of officers in the field and to reduce the number of non-emergency calls to which law enforcement members must respond. CSOs are non-sworn members of the MPD and are essential in providing quality service to the residents of Milwaukee. General Duties and Responsibilities CSOs are intended to support the Patrol Bureau and Criminal Investigation Bureau by responding to low-priority and non-emergency calls for service. CSOs also assist with other functions that do not require an officer's response and contribute to the Milwaukee Police Department's mission statement by using effective community engagement to help build sustainable neighborhoods and foster positive community relations.

Table 1

Call type	Call volume	Median Incident Time (min)	Sample resources
Child Custody (MPD)	756	47	The Benedict Center, Division of Milwaukee Child Protective Services
Cruelty Animal (MPD)	1,021	25.8	Milwaukee Area Domestic Animal Control, Wisconsin Humane Society
Fall-17A (MFD)	2,178	14.1	Department of Aging, Energy Assistance,
Family Trouble (MPD)	2,552	*not provided	Crisis Mobile Team, CMC
Person down/unknown-32B, D (MFD)	6,796	11.3, 11.6	Disability Services Division, Housing Division, Independence First, Milwaukee Center for Independence,
Property Pickup (MPD)	1,073	*not Provided	
Soliciting (MFD)	141	27.5	Franciscan Peacemakers
Vehicle Accident-29B (MFD)	419	14.3	Milwaukee Police Department -

Welfare Citizen (MPD)	15,575	20.8	geriatric crisis services, Department of Aging
Total	30,511		

During Q3 and Q4 of 2023, CSOs shall respond to non-emergency calls for service within the limited call set where there is no known suspect and no indication of risk to the responder, potentially drawing more than 20,000 calls for service from the seven MPD police districts. Based on demand, CSOs may also respond to traffic hazards and resolve them safely or direct the traffic until the hazards have been mitigated. Taking into account the sometimes-unpredictable nature of responses, CSOs are trained to request resources from the dispatcher for civilian injuries, crimes in progress, individuals in a mental health crisis, and potentially hazardous situations, minimizing personal risk and risk to others while being a good witness. They also administer first aid, as necessary until help arrives, to the extent that they have been trained when encountering an injured individual.

In addition to calls for service, CSOs should be assigned to assist members at special events, during community outreach, and in limited administrative functions. The visualization of CSOs and their integration into interdepartmental as well as community culture is essential in providing experience with procedures, as well as a firm understanding of when to triage a situation to a higher level of service. Specific reporting responsibilities already exist as a part of the CSO job requirement, but additional technical support (web-enabled field-based laptops, cell phones) would be necessary to add efficiency to the position and evaluate record-keeping tools and referral tools.

Alternative Response Vehicle

The MFDs Alternative Response Vehicle (ARV) was a model used as an investigatory tool by alderman Witkowski several years ago. The program utilized an SUV to respond to dedicated incidents. The existing MFD computer-aided dispatch system allows for the prioritization of certain vehicles by vehicle type or specialty; producing a situation where certain coded incidents are dispatched first to certain vehicles. The ARV is staffed by 2-4 people, depending on the mission, and is utilized for rapid response to EMS incidents that do not have the potential to escalate to the 4-6 responders necessary to complete advanced cardiac life support procedures.

The recategorization of incidents to a new responder model requires the approval of the medical director, and sometimes the Department of Health Services (DHS) EMS division. New responses are evaluated for adverse outcomes that may increase patient morbidity and mortality, or cause unnecessary harm to patients. Very specifically, the ARV can not be used to transport patients, as it does not meet the requirement set forth by DHS (DHS 110.04(4), 256.01(2)). Selected incidents are always those with low percentages of advanced life support and basic life support interventions that result in transport.

For Q3 and Q4 of 2023, the proposed staffing model would be two EMTs and possibly the evaluation of a single EMT and a community responder as permitted by DHS (DHS 110.50(1)(f))The evaluator would be asked to work in concert with medical direction to monitor patient outcomes, collect information on interventions and assessments and possibly participate in continuous quality improvement efforts.

In addition to the response capacity, the MFD would agree to use its training center capacity to provide EMS training for the evaluator and facilitate supplemental responder training, and assist MPD and the evaluator with identifying and selecting IT materials that meet the HHS requirements.

Key stakeholders for pilot

MFD and MPD remain primary stakeholders in as much as these two agencies current response capacity, dispatch integration, and experience with 24x7x365 response modalities currently function within our existing 911 system capacities. DHHS currently provides the most comprehensive and widest array of social support services in the county, while UW-Milwaukee has a long history of providing academic support, impartiality, and rigor to program evaluation and delivery of industry-supported practices. The limited call set is currently serviced to the MFD via the departments' respective dispatch centers, soon to be combined into a singular Department of Emergency Communications. In addition to these key stakeholders, The Department of Employee relations will play an important role in identifying, validating, and assisting in the selection of a program administrator, the City Attorney's office will assist in navigating legal agreements and protecting the city from unnecessary liability, and full support from purchasing will be required to acquire the physical operational materials for a response program. With the better categorization of incidents, community partners can be engaged following a pilot to ensure that the appropriate linkages exist to match the right citizens with the right agency or resources in a timely fashion with high fidelity. A sample of the diverse offerings, capabilities, and limitations of our community partners is provided as a companion to this document.

The proposed model retains communications with the two premier high-acuity responders in the space and ensures that a CITF responder is aware of the types of situations that require these specialized responders to take additional measures to protect individuals and put them in locations where acute specialized care can occur, or a more appropriate long-term solution can be evaluated.

Milwaukee County DHHS retains several programs that, could serve as resources to an alternative responder. The Crisis Mobile Team, geriatric psychiatric crisis intervention and stabilization services, the Community Consultation Team (CCT), Children's Mobile Crisis Team (CMC), Community Linkage and Stabilization Program (CLASP), and Team Connect are but a small sample of the resources already available at the county level. While the county and the community at large recognize the value of these programs, access, staffing and coordination continue to challenge comprehensive service delivery to the neediest populations. A 911-based responder model, coupled with comprehensive healthcare system access could address several of the challenges highlighted in the County's redesign report ((Milwaukee County, 2021).

Among the multiple area institutions of higher learning, the University of Wisconsin – Milwaukee (UWM) has a long history of academic partnership and expertise in evaluating existing programming, serving as subject matter experts, and developing new programming reflective of the innovation and evidence being developed in the diverse fields represented by the University's multiple colleges.

The City of Milwaukee is in the process of bringing a Department of Emergency Communication online. Every 911 call originates in the dispatch centers of the Milwaukee Police Department and the Milwaukee fire department and will funnel to and through this new agency in 2023. Every call identified in the limited call set is currently serviced by MPD and/or MFD dispatch. After the onboarding of the DEC, it will be imperative to develop a methodology to continue to appropriately categorize calls for service into the response categories above, and work to revise the evaluation process that is reflective of the entire system. The conventional metrics for dispatch center efficacy include call handling time

and wait times, while a more comprehensive methodology, to be considered in a future state following the pilot, includes call fidelity (how well does the dispatch category match the scene the responders found on arrival) and a quality control/quality improvement metric. Fully taking into account that not every 911 caller provides accurate information, the pilot would also include a quality control portion to identify the rate at which the appropriate resources are being dispatched for the appropriate emergency.

In looking to monitor the fidelity, and efficacy of connections to community resources, the CITF recommends partnering with Milwaukee County to onboard the Impact Connect web-based service referral and tracking platform. The LEAP report speaks to the ability to mine data from the existing Record Management Platforms of the MPD, however, the current platforms are not linked to the data systems of hospitals, social service agencies, or community-based organizations. Poor communications and interoperability across agencies is a common complaint levied by agencies and providers alike, so deliberate strides should be made during the beta phase of the project to evaluate the efficacy of a purpose-built tool to overcome this deficit.

Citizens are the final and perhaps most important stakeholder in the alternative responder process, however accurate tools to measure the fidelity and satisfaction from 911 services are sparse and often focused on a specific part of the system. For example, expeditious handling of a 911 call at the dispatch level may neglect to collect the appropriate information for appropriate services, and rapidly transporting cardiac arrest patients from a scene may tax resources at a local hospital. It's worthwhile to note that system-specific evaluation metrics may categorize a measure as a positive outcome that is less than favorable to the caller, but beneficial to a system provider. The MFD recently onboarded a model where a random subset of 911 callers are contacted and surveyed within 7 days of the 911 call, which produced response rates well above standard survey tools, maintained patient privacy, and provided the ability to link responses to otherwise confidential patient information. The authors recommend a similar tool be used to recruit representative samples of service users, evaluate system efficacy, evaluate innovation projects and serve as a judge of the quality and fidelity of the services provided by alternative responders.

Training/referral needs for initial call set

As a necessary modification from current responses from emergency providers, the alternative responders training will be focused on identifying and accessing a stable resolution to sub-acute, non-emergent issues that are nonetheless urgent for the requestor. The LEAP report outlines some minimums for training to appropriately equip personnel to respond to a variety of incidents while maintaining responder and citizen safety. For the beta phase, it's well understood that the existing CSO and MFD staff already have this training, however, it may prove valuable to supplement these responders with training in motivational interviewing and supplemental documenting training to ensure accurate data collection. Both MFD ARV members and CSO will require some supplemental training on accessing and directing callers to existing community resources commonly requested or utilized in the initial call set.

The LEAP report highlights the importance of radio communications, basics of scene assessment for law enforcement and EMS, situational awareness, and basic life support activities such as CPR and the administration of naloxone. Supplemental training that dedicated responders will need to operate effectively will be a mix of familiarity with resources and processes currently available in the region and several items suggested in the LEAP report. Potential training topics could include;

- Understand how calls come in through different phone numbers, how call-takers screen those calls, and the information they provide when dispatching to those calls
- Initiate safe and effective interactions and motivational interviewing

- Recognize the symptoms of a range of low, medium, and high mental health conditions
- Training on substance use (both drug and alcohol)
- Basic medical instruction (CPR, Emergency medical responder, airway support, etc.)
- Conflict resolution and restorative justice
- Cultural competency/understanding of marginalized groups (sex workers, individuals with autism spectrum disorders, BIPOC, and members of the LGBTQIA+)
- Recognizing the signs of trauma and domestic violence, providing trauma-informed care to victims and witnesses in the aftermath of a violent act, and preventing retaliation
- Elderly, youth, and families involved in custody disputes
- Connecting community members in need with key community resources

The 2021 Report on International Crisis Response Team Trainings (Reach Out Response Network, 2021) describes the training duration and components of several responder programs across North America and the UK. The report supports the notion of a hybrid training process where classroom instruction is supported with field-based training and continuing education through employment. Approximately 40 hours of classroom training supplemented by several weeks of field-based training seems to be the median for the highlighted programs. A Milwaukee-based model would need to be supplemented by focused training in resource navigation as well as additional areas of importance identified by the evaluator during the beta phase in 2023. The report also offers additional suggestions for supervisory and managerial training.

Logistics

For the initial phase of the program in Q3 and Q4 of 2023, the authors recommend that the existing infrastructure of the MFD and the MPD be utilized to house the CSOs and ARVs. The two departments also have shared training infrastructure and accommodations for vehicles and fuel. Initial investments for the beta phase will also include IT investments for supplemental reporting software and referral software previously mentioned. Some duplicate reporting will likely take place in the initial phases as record-keeping methodologies are explored, and supplemental work with partner agencies identifies the necessary contents necessary for proper enrollment, referral, and service delivery.

In preparation for a Pilot in 2024, the authors note that housing 6-8 teams daily for 24-hour service delivery may require some financial investment and deliberate considerations. MPD has experience housing clinicians as a part of the CART team while the MFD houses ambulances and staff from Bell and Curtis in select firehouses currently. These are familiar with housing other responders within their facilities serves as a benefit, but the entirety of the City and County of Milwaukee real-estate options should be evaluated to account for locating responders in proximate locations to maximize their operability and minimize the response times to incidents. A more in-depth analysis of the frequency and temporal demands of the limited call set may reveal the optimal location for responders.

It's also important to reflect on the temporal demands that an alternate response may levy on the selected call types. For the LEAP report, median times are used to discuss the most common response times a citizen would experience, however, alternative responses may produce more in-depth conversations, more deliberate efforts to address an issue, or citizen transports to an alternate location producing longer scene times that previously experienced by MFD or MPD. As producing more longitudinal solutions for 911 callers is currently outside of the scope of either agency, the practical application of this needs additional research.

Alternative responder agencies across the world utilize a variety of different vehicles to attend to the diverse needs of their 911 callers. Vehicle selection should be a combination of maximum

intended use and appropriateness for climate and responses. MPD uses a variety of vehicles to achieve its mission, but there are minimal considerations for the storage of supplemental equipment. At the other end of the spectrum, the MFDs all-hazards mission denotes vehicles that are optimized for storage, often at the cost of supplemental passenger seating. All-wheel-drive-equipped vans seem to be a happy medium, and the Ford Transit Express model has commonly available modification packages that can be used to install a small desk and chair in the rear with additional storage for equipment and literature while still offering an additional seat. A full-size transit van is a more expensive alternative but offers additional seating and work space with higher clearance for more than one person to move in the rear of eh vehicle.

The beta phase will also serve to inform exactly l how an alternative responder vehicle should be equipped. The capacity for field-level data entry and the safe conveyance of persons are obvious, but the current response system is mute on what types of adjuncts may assist callers. Equipping the vehicle with a printer vs pre-printed pamphlets (to account for multiple languages spoken), providing blankets or basic clothing or hygiene materials for homeless individuals, smoke detectors for residents, or public versions of naloxone kits are highly salient examples of materials that are currently available from community service providers. The time spent in the nets phase will ensure that responders hired and trained in the pilot are properly equipped and trained to provide service and resources that are right-sized and culturally appropriate for the community without unnecessary waste of time and materials that are less likely to be used. These considerations also play a role in vehicle selection and design to ensure that the recommended on-hand quantities of supplies can be appropriately stocked and secured inside of a vehicle, and take temperature into account for both summer and winter operations.

In consideration of the common council's direction that the program "*shall address options for operating alongside, in partnership with, or merging with, other local emergency response programs, including the City-County Trauma Response Initiative, the Milwaukee Opioid Response Initiative, and the Community Paramedic Integrated Mobile Healthcare Program*", several legal considerations need to be made to bring a full alternative responder program to fruition. Collaborative agreements can take the form of memorandums of understanding for simple partnerships, but the transfer of protected health information requires more in-depth work to ensure that federal standards are met, and liability is minimized to the satisfaction of both parties, often resulting in somewhat lengthy negotiations with outside entities. Technology contracting and auditing are also specialized considerations that will need attention. Onboarding student interns as a less-expensive labor source required Agreements with schools and the approval of Program Memos, and supplemental funding in the form of grants require the city and the funder to come to an agreement on the specifics of the funding and provide the labor to develop and submit reports. Finally, the development of new documents for the agency to capture consent of service and referral may not exist in a format or on a platform currently in use by either department. The legal requirements for building a new program are often overlooked and underestimated, but are a necessary component of program development and provide the valuable function of minimizing risk to the city and responders, to the extent capable.

Evaluation

An academically-based evaluator will work closely with key stakeholders to conduct formative evaluation activities and assess the implementation of the pilot using an established planning and evaluation framework (RE-AIM/PRISM). Business Associate Agreements (BAA) and procedures for secure, HIPAA-compliant data sharing and management will be established. Initial formative evaluation activities will involve the collection of both quantitative and qualitative data to examine selected call types (and identify subcategories), record-keeping options, host agency implications, needed training, and operational logistics. The evaluator will analyze call data and conduct interviews/surveys with key

stakeholders to identify potential implementation barriers and facilitators and inform the pilot implementation and evaluation plan. The evaluator will also work with key stakeholders to create an initial program logic model and process map.

In collaboration with key stakeholders, the evaluator will design a HIPAA-compliant and secure data collection strategy to evaluate the implementation of the pilot in Q3 and Q4 of 2023. This will include collecting call and response data from the Department of Emergency Communication, MPD, and MFD and interviews/surveys with staff at each participating agency, staff from Milwaukee County DHHS, and people that utilize CSO and ARV services. Implementation fidelity, logistical barriers, referrals to services, and opportunities for prevention will be examined. This phase of the evaluation will also test the implementation of both the district (one responder) and citywide (2 responders) deployment of CSOs. Findings will inform decisions about whether and how to proceed beyond the pilot phase, including the optimal program structure, the appropriate call set, and the training required to prepare responders to safely and effectively respond to calls that don't pose a threat to public safety.

Operational modifications

Without specific input from department heads and assistance from multiple city departments including DOA, DPW, CAO, and DER to name a few, it's impossible to specify all of the operational modifications that would be required for MFD and MPD to facilitate a fruitful pilot. The authors also support absorbing a limited number of "cases" from partner agencies to identify, address and remove known triggers and reduce an individual's likelihood of progressing to a crisis state that would require acute law enforcement and or EMS intervention. The authors recommend that a program director explore a multiple-disciplinary responder model, with certain vehicles staffed to account for some specialized tasks. Additionally, the authors suggest an "air traffic controller" position, functioning as an expert navigator of locally specific resources, be available to field responders to facilitate the prompt and accurate dissemination of information and resources to address caller issues in a way currently unrealized by MFD and MPD 911-response staff.

It will be essential to seek input from the city attorney's office to draft and review the documents necessary to establish a BAA with an evaluator, as well as other service providers taking part in the beta to build a system where otherwise protected information can flow smoothly to a trusted third party, without inappropriate breaches in privacy. The City Attorney's Office (CAO) and purchasing will also be integral in developing limited-use agreements with web ware providers such as Impact Connect or Qualtrics which are industry-standard referral tools and data collection/ research tools respectively. MPD has also indicated that CSOs do not have web-enabled mobile computers or city-issued cell phones. New data collection and reporting will likely require the use of dedicated devices compliant with security standards set forth by the US department of health and Human Services, likely functioning on a stand-alone network, likely requiring DPW and ITMD to weigh into either repurpose or identify and acquire new equipment.

Regardless of the amount of education that takes place, the primary means that individuals access care and resources in situations that they perceive to be emergencies is through 911. During Q3 and Q4 of 2024, MPD and MPD CSOs and ARVs respectively will continue to be dispatched through the existing 911 system, which is currently also handling the calls received from the limited call set. Moving to the operational pilot phase in 2024 with a new responder model will require collaboration between the host agency, the evaluator, and the DEC to develop and onboard new dispatcher questions to isolate appropriate calls for a community responder that fall short of the crisis' that are resolved with involuntary detention or chemical restraint.

A handful of government and non-governmental agencies routinely service several individuals in the community who have a history of or are at high risk of having their existing conditions progress into a crisis state, have limited personal or social means, and have frequent low-acuity interactions with emergency responders or are experiencing persistent homelessness. Milwaukee County Department of Health and Human Services houses several of these agencies including the Behavioral Health Division, the Department of Aging, and the Housing Division to name a few. To proactively prevent emergency responses that have the potential to end in hospitalization or detention, it would be a wise investment for an unarmed responder task force to absorb a limited number of cases where face-to-face contact would be beneficial to the long-term well-being and stability. Responders could facilitate basic assessments, and resource navigation and work with other providers to facilitate known adjuncts such as the monitoring of triggers, follow-up after discharge, and facilitating (either through transportation, direct administration, or co-deployment with a skilled provider) long-acting injectable antipsychotics where appropriate.

The LEAP report also extolls the value of Proactive encounters (LEAP, 2022, p.22) with responders attending to issues that present themselves when they are between incidents. In Milwaukee, the most frequent application of this would likely be working with homeless populations, but could also manifest itself as assessment and navigation following minor car accidents and assessments with sex workers to curtail human trafficking. The multiple iterations of a proactive approach are spaces for the program to grow and evaluate efficacy and value in a pilot stage, and can also serve as valuable training opportunities for new responders, as is common with "on the job" or "experiential field training" common in existing response agencies.

In the current emergency responder space, there exist several specialists who have advanced training in disciplines that are valuable to the service but may exceed the ability of the service to train all of their members to an appropriate level of functionality, or the specialized nature of the training would levy demands on the agency that are not feasible when combined with their everyday operations. Based on the results of the beta phase, which would further categorize types and frequency of responses, the authors recommend that response vehicles can offer specialized services by adding skilled providers to a vehicle. The flexibility of adding an EMT to a vehicle allows for some basic biological medical assessment to take place, which a social worker could bring case management and interview skills. A pharmacist or paramedic could administer medications while a counselor could complete post-discharge follow-up or evaluate a client's comfort and progress with another provider. The idea of a single "type" of responder would likely limit the service hours of an alternative response service as well as severely limit the recruiting pool to those who can undergo extensive education and training. The multiple disciplinary models, currently in use with MPDs CART and MFDs Opioid Response initiative, are also the most flexible when considering the best way to integrate community agencies with variable levels of staffing, specialist services, and business hours such as veteran serving agencies, peers in recovery and others with lived experience. The LEAP Report Supports the joint model and points to the city's existing use as a successful example to be built upon (LEAP, 2022, p.19).

Large urban areas also experience a unique condition referred to as resource specificity. The diversity of the area may give birth to resources that are unique or specifically targeted to a specific demographic group. While these resources can offer amazing services, an individual with different demographic characteristics may not be eligible for service by the same agency as a peer in the same situation. Resources availability by maternal status, military status, gender identity, income level ethnicity, residential geography, and even past encounters with the criminal justice system are just a few of the qualifiers that may qualify or disqualify a person for services. The diversity of services available in an urban setting makes it near impossible for a potential recipient to ever have perfect knowledge of the resources and systems that are or are not available to her/him and are equally as likely to produce frustration with the complexity of system navigation or a mismatch between individual

and service provider producing a less than optimal or failed outcome. To combat this the authors, recommend that an alternative responder service deliberately work to seek or develop an Air Traffic Controller, who has a mastery of information about the resources and relative accessibility of the system and can serve as a reference to responders at an incident as well as the system at large when identifying gaps and both service and public awareness.

2024

Table 2, located in the appendix, provides a brief overview of the significant events that would occur in 2023 and 2024 to bring a full responder program to fruition. The previous sections provide brief descriptions and considerations for the beta phase of a program to occur in 2023. 2024 would be the first fully-supported budget year for a full program and include the application of the lessons learned from the 6-month beta phase as well as more formalized hiring and training. To ensure that physical goods arrive in time for 2024 utilization, it will likely be necessary to secure and order said goods (vehicles, computers, software, etc.) in the preceding year. It would also be necessary to work with DER to identify and select an agency head in 2023 to better facilitate the genesis of the new agency and navigate the remainder of the tasks necessary for the alternative response agency and operationalize the findings of the evaluator.

The calendar and budget year of 2024 would begin with a preliminary report of findings from the evaluator. 2024 will also be a better place to understand the implications and capabilities of a new dispatch system. The spring of 2024 will also be the earliest feasible time to begin recruiting additional response staff, in cooperation with the Department of Employee Relations (DER). Only after staff has been selected could training begin and would likely run through the summer of 2024. It's worthwhile to note that the summer of 2024 will also see Milwaukee hosting the Republican National Convention, which will place a large resource demand on every city department in the months and weeks leading up to the convention.

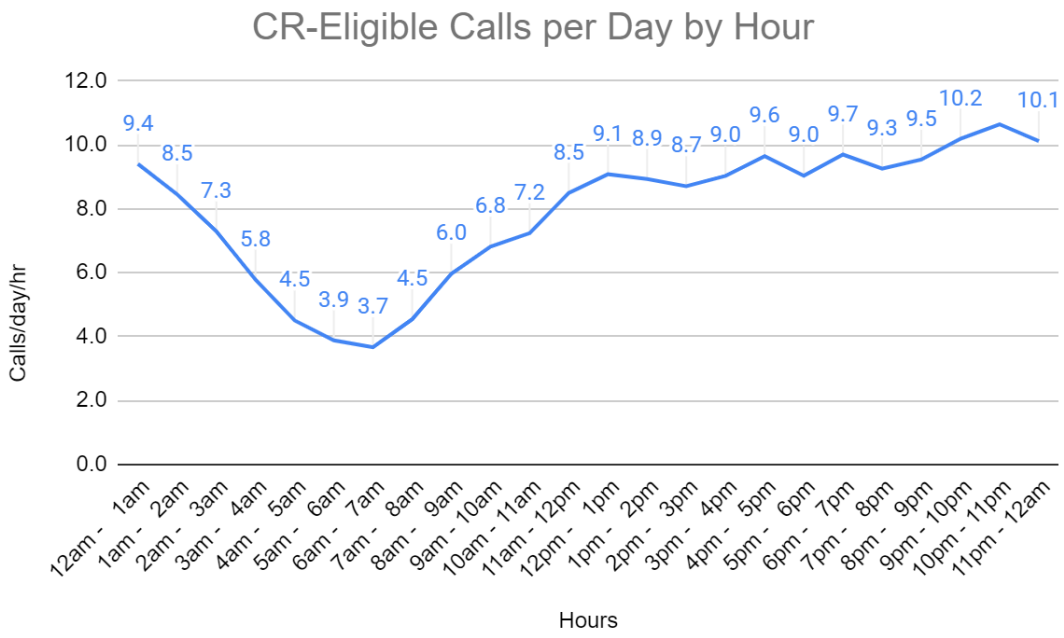
It's unknown if the supply chain issues from 2021 and 2022 will continue to affect large purchases in 2024, but budgetary and contacting timelines and considerations will play a role in the acquisition of vehicles and technology necessary for the full mobilization of an alternative responder agency. Coupled with facility modifications to house the responders, and dispatch integrations the first half of 2024 will be filled with the task of upscaling and preparing the responders to take the information learned from the pilot and operationalizing said information in response to the emergent demands of citizens.

The DEC, as the single nerve center of the city's first response system, will play a pivotal role in ensuring appropriate service is routed to citizens. It's difficult to accurately predict what integration of a third service, or a supplement would integrate into the current dispatch system. Current call-taker training and the triage systems in place do not collect adequate information without adding to the time burden of the existing staff. 2024 will also see additional discussions and the development of call-taking and triage models that are optimized for City of Milwaukee resources while meeting the time expectations of 911 callers. This period is also appropriate to begin to evaluate the routing of 911 calls to more appropriate destinations, as well as appropriate and relevant community education specific to available resources while keeping resource specificity and health literacy in mind.

Due to the functional realities of standing up an entirely new city service, it's unlikely to see sizable numbers of alternative responders functioning independently before the second half of 2024. The large volume of incidents in the sample call set denotes a deliberate and comprehensive approach necessary to ensure that citizens receive prompt and humanitarian service that addresses their needs without the unnecessary escalation of services from MFD or MPD. The limited call set stands to produce a daily average of 84 incidents, supporting the LEAP recommendation of 56 total providers with a

starting staff of 28, broken into 14 teams working alternating 8-hour schedules 7-days a week and providing 24-hour coverage across three shifts; 6am-2pm (3 teams), 2pm-10pm (4 teams) and 10pm-6am (3 teams) as highlighted in figure 1.

Figure 1



Shift:	6am-2pm	2pm-10 pm	10pm-6am
Teams (total responders)	3 Teams (6 responders)	4 Teams (8 responders)	3 Teams (6 responders)

The authors find the LEAP budget estimated to be a close proximation of the 6-month and full annual costs of operating a responder agency, with some exceptions. The table below uses the MPD CSO salary and staffing levels as a basis, excluding fringes. It's also difficult to estimate the extended costs of dispatcher training, as it's currently unknown what the capacity of the new system is, as well as the ability to offer supplemental staffing. The technology costs will include both hardware and software or Webware in the form of annual subscription services, which as a supplement offer a level of technology security that is desirable in this operational space.

Table 2

First-Year Budget Estimate

	6-month	Annual
Personnel cost	**$124,600**	**$1,355,704**
Responder cost (28@$39,518)	$0	$ 1,106,504
Management cost	$124,600	$249,200
Equipment cost	**$38,000**	**$296,920**
Office space	$10,000	$20,000

Vehicle purchase (8-10)		$234,920
Vehicle gas/maintenance	$2,800	$14,000
Technology purchase	$11,200	$11,200
Uniforms		$2,800
Misc. Supplies/software	$14,000	$14,000
Training cost	**$6,000**	**$31,000**
Training space	$0	$0
External trainer		$25,000
Internal trainer cost	$4,000	$4,000
Training supplies	$2,000	$2,000
Total cost	**$825,200**	**$1,683,624**

Risks/ Issues

A complete report should also briefly acknowledge the risks associated with developing and implementing an alternative responder agency for the City of Milwaukee. While not exhaustive, it's important to consider that there are manageable, but real, upstart costs to bring a new program from inception to operation in a short timeframe. The City of Milwaukee dispatch system, currently and for the foreseeable future, is the primary means by which citizens access emergency services. An alternative responder program must integrate into a new system that is yet to be released and will require additional training and support for dispatchers. Both the Milwaukee Police Department, the Milwaukee Fire, and both existing dispatch centers have experienced difficulties recruiting and retaining employees through their respective training programs for the past several years. It's poorly understood what modifications in the job description, advertising, or operational duties would be necessary to optimize recruiting, or what effect that would have on a new responder agency.

Developmentally, a new agency will also require an intricate patchwork of support from several governmental and non-governmental agencies as well as community stakeholders, academic institutions, suppliers, and other parties. These diverse stakeholders may all have competing interests, priorities, and goals that can simultaneously support shared goals but appear to be in opposition to each other. The potential for professional grammar, competing priorities, and mission creep are very real for a project like this and leaders should be keenly aware of the implications of inadequate cooperation dan the need to compromise to achieve the mission and/or the need to pivot when new realities present themselves.

Operationally, a certain amount of liability from unforeseen events has always existed for both the police and fire departments in their provision of services. These same risks will likely be extended to alternate responders, however since the calls already exist in the system, it's unlikely that the number of untoward events will exceed the current number seen in the police and fire departments. For a system with the volume that Milwaukee has, the occasional but unavoidable scenario of inaccurate dispatching will be something that responders will have to be content with. Based on the limited call set, even 99% accurate dispatching would see one inaccurate call every operational hour for 40 hours (based on ~57 incidents/day).

Discussion of service provider capacity, evaluation, and feedback need to consider stakeholder capacity to complete referrals, as well as resource specificity (*the tendency of large municipalities to have resources dedicated to or restricted by subgroups such as veterans and LGBTQ populations or demographic characteristics such as age, race, or ethnicity*). Milwaukee has a very different racial,

governmental, political, social, and financial makeup that will impact the distribution of resources, incidents, responses, and completion of referrals, so the ability to judge their relative efficacy with a sample call set, ahead of actual implementation would prove challenging. Taking this into account, any program would have a long period of growing pains until it reached full maturity.

The two-stage proposal presented here provides the option for key stakeholders to see and experience what a Milwaukee-specific program could be, reasonably estimate the associated costs, and identify attainable outcomes. The sample call set volume of more than 30,000 incidents per year combined with the intricacies of Milwaukee's existing systems demands a dedicated staff person to manage the upstart of a system that can adequately serve a population larger than most of Milwaukee's suburbs. The utilization of existing resources also provides the ability to walk away from the pilot with minimal investment or consider how existing resources could be used to bring a full program to scale over several years. Finally, it's important to note that this is a companion document to the LEAP report, as well as the referenced items. The impartial evaluation of any program for its merits should be completed by an impartial third party after the development of an accurate hypothesis that can be rigorously tested on a representative sample of incidents.

The authors do support the inception and development of a functional alternative response model as a supplement to the existing services offered by the MFD and MPD. The resulting service has the potential to dramatically alter the city's service landscape in some unique ways. It should be noted that in the pursuit of this "different" model all parties involved will be required to release existing expectations, preconceived notions, and anecdotes to allow a new service and product to blossom and grow into a service that meets its primary goals of providing professional and comprehensive services to the residents and visitors of Milwaukee.

Appendix

Covered Entities and Business Associates:

The HIPAA Rules apply to covered entities and business associates. Individuals, organizations, and agencies that meet the definition of a covered entity under HIPAA must comply with the Rules' requirements to protect the privacy and security of health information and must provide individuals with certain rights with respect to their health information. If a covered entity engages a business associate to help it carry out its healthcare activities and functions, the covered entity must have a written business associate contract or other arrangements with the business associate that establishes specifically what the business associate has been engaged to do and requires the business associate to comply with the Rules' requirements to protect the privacy and security of protected health information. In addition to these contractual obligations, business associates are directly liable for compliance with certain provisions of the HIPAA Rules.

A Covered Entity is one of the following: A health care provider, a health care plan, or a clearing house.

A "business associate" is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of or provides services to, a covered entity. A member of the covered entity's workforce is not a business associate. A covered healthcare provider, health plan, or healthcare clearinghouse can be a business associate of another covered entity. The Privacy Rule lists some of the functions or activities, as well as the particular services, that make a person or entity a business associate if the activity or service involves the use or disclosure of protected health information. The types of functions or activities that may make a person or entity a business associate include payment or health care operations activities, as well as other functions or activities regulated by the Administrative Simplification Rules.

Business associate functions and activities include: claims processing or administration; data analysis, processing or administration; utilization review; quality assurance; billing; benefit management; practice management; and repricing. Business associate services are: legal; actuarial; accounting; consulting; data aggregation; management; administrative; accreditation; and financial. See the definition of "business associate" at 45 CFR 160.103.

Table 2

	2023												2024											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Findings/Recommendations																								
PSH Meeting 2/16/2023, 3/9/2023		02/16/23	03/19/23																					
COMMON COUNCIL 2/28/2023, 3/21/2023		02/28/23	03/21/23																					
Identify Host Dept.			Discussions with dept heads																					
2024 budget request materials distributed to city departments			Host department add to budget												Host department budget									
2024 budget requests due from city departments to Budget Office					5/9/2023																			
Beta with CSOs					Evaluate selected call types, current, record-keeping options, host agency implications, needed training, operational logistics, goals/non-goals, prevention, etc.																			
Discussions with DER (job desc., director search, etc.)						Director discussion, Job description, employee implications (employee hx, etc.)							Review, revisions											
Engage with evaluator > mindful of academic calendar/ contracting						Academic 3rd party (privacy), training, QC/QI, referrals systems, systems fidelity, opportunities for prevention, etc.								Contract with Evaluator					Evaluation, QC, QI, problem-solving evaluation, supplemental stakeholder/partner evaluation.					
Special funds for director?								Director implications, chain of command, etc. will depend greatly on host department.																
Special funds for purchasing?								Lead time for contracting; vehicles, laptops, reporting software, facility modification, etc.																
Proposed 2024 Budget Presented																								
Committee Hearings, amendments 2024 Proposed Budget																								
Budget Adoption																								
DER (posting, hiring)													Budget Year 2024											
Buildout (logistics)													System testing, facility integrations, vehicle modification, training on equipment											
Engage w/ CAO &										Contracts, Purchasing				Contracts, MOU's ETC.										
Training															In-house vs. contracted SME training, Hybrid Training									
Pilot																			Response to limited call set, rotating call set for further evaluation, planning for 2025					
	Legislative Deadline/process						Transitional Items				New Agency													

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