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In 2023, the University of California Davis Fire Department (UCDFD) developed a unique service to create wellness in the collegiate campus community through a mobile community response program. This program is called Health34. The vision is to be a model organization through innovative delivery of services that will enhance campus community well-being.

Health34 accomplishes this vision by performing two major services: navigating clients to resources and bridging care until resource acquisition. Health34 provides crisis avoidance through layperson counseling and navigation to resources. The program is a mobile service navigation unit that responds to any person in their time of need. The resource navigation addresses housing, basic needs, mental health, education resources, social support, and transportation. The program serves all members of the campus community, including students, staff, and visitors. It has some foundations in mobile crisis response, but actively engages the community at a point prior to crisis with a novel crisis avoidance model. We are not aware of another mobile campus response program that takes the stance of crisis avoidance.

Health34 is operational twenty-four hours a day, seven days a week, including holidays and weekends. The community accesses Health34 via a 7-digit phone number. Health34 is staffed with a paramedic provider (H34 provider) and an EMT partner. The EMT partner has several roles. The client-facing roles include answering the phone when the provider is not available and guiding clients to resources. Administrative roles include documentation, driving, equipment checks, and restocking.

Jack Fagan, NREMT, is a Senior Student EMT for the University of California – Davis Fire Department and has been serving in this role since March of 2023. He has been a member of the Health34 team since its inception and organizes Student EMT trainings. In addition to his work at the fire department, he is a 4th-year Cognitive Science Major with a computational emphasis. **Lisa Mills, MD** is the Medical Director for the University of California – Davis Fire Department since 2018. In this role, she refined the vision for an intrepid mobile community response service and brought this to implementation as Health 34. She continues to oversee and develop the operational guidelines for Health 34. She is also a member of the JCEMS Editorial Board.

For Health34, the EMT partner is a member of the UCDFD Student EMT (SEMT) program. The SEMT program consists of UC Davis students who are also licensed EMTs and employed by UCDFD. Prior to the launch of Health34, the SEMT work included event standby, health education, and teaching in the UCDFD AHA training center.

With the launch of Health34, the job scope of the SEMTs increased to include the role of Health34 EMT partner. This scope was novel and required training. The program has been operational for one year. With the anticipation of training another group of SEMTs, the effectiveness of the training protocol was evaluated. This paper will discuss the steps the Fire Department took to train SEMTs to fulfill a role on the Health34 team and critically appraise the effectiveness of the training.

Logistics

The vaccine clinic administered its first vaccine in February 2021. The clinic was open seven days per week from 8:30 AM to 4 PM with a 45-minute midday closure. Vaccinator shifts were broken into 3.5-hour morning shifts and 3.25-hour afternoon shifts. An online shift scheduling program was established for open sign-up.

The clinic required a large space to accommodate the staff and the patient group while maintaining the requisite 6 feet of personal space required for social distancing. The campus was closed for in-person instruction and research beginning in March 2020, leaving the large UCD Activities and Recreation Center ballroom available for the clinic. Parking, usually pay by hour or permit, was made unrestricted and free to all patients during the vaccination clinic.

Training Overview

SEMT training was multifaceted, placing emphasis on crisis de-escalation, safety, resource navigation, and logistical functions. These training sessions were accomplished in a way that reinforced our standard operating guidelines.

The goal of SEMT training was to train skills and standard operating guidelines. In order to train these skills, SEMT training was broken down into three major steps: conceptual presentations, interactive experiential training with a collaborator from another mobile health service, and on the job administrative training under the supervision of

the H34 provider.

Conceptual Presentations

The conceptual presentation stage of training was broken into two presentations created by the H34 providers, and a virtual presentation by a collaborator from a mobile crisis unit. The first presentation provided an overview of the program's goals and mechanics. The objective was for SEMTs to understand the purpose of the program, the need in the community, and the expected delivery method of the services.

The second presentation introduced the SEMTs to the concept of lay counseling support through theoretical foundations. During this presentation, specific implementation strategies were not provided. This is left to later practical stages of training. The focus areas included open-ended questions, asymmetry, empathetic reflection, bias, and other miscellaneous communication strategies. The goal was to enable the SEMT to actively engage with the client in a supportive fashion.

The presentation then introduced SEMTs to the concept of asymmetry under which SEMTs should minimize sharing information about their own personal experiences or thoughts. A key point stressed by the presentation was that this form of communication can be challenging because it differs from standard interpersonal communication. The importance of this intentional communication is to leave space for the client to share their experience without limitation of the perceived boundaries of societal standards. This model enhances the perception of a nonjudgmental space in which to receive support.

Empathic reflection was another strategy the presentation introduced. The goal is to not convey understanding or judgment but, instead, to reflect back the language used by the client while prompting them to further explain their perspective. Empathetic reflection encourages further reflection in a non-judgmental environment. The presentation addressed attitudes and biases, and how, even unconsciously, these attitudes can conflict with empathy, compromising the trust between the client and provider. Strategies to counter bias were introduced.

The third presentation was delivered on a virtual platform. The facilitator was an experienced provider from a mobile crisis unit in a different region that uses similar methods to H34. This training session discussed de-escalation and safety. The presenter drew on experience to help the SEMTs synthesize the theoretical information through case examples and discussion.

In summary, the presentations formed a foundation for the principles of lay counseling and support. The goal of this training stage was to create a conceptual framework to support experiential training.

Experiential Interactive Training

Next, the SEMTs began experiential training. The in-person training environment provided an opportunity for SEMTs to observe a strong implementation of the conceptual training applied by an experienced provider on calls. The SEMTs participated in client interaction in a graduated role. After each call, the provider conducted a debrief which was structured by the provider and intended to explicitly acknowledge the tools employed in the interaction and discuss the foundation for their use. The focus was justification of actions and pertinent feedback on topics, interaction style, and word choice. This training stage also provided the SEMTs with an opportunity to ask questions about the practical aspects of lay counseling and support.

Lastly, the SEMTs completed the University of California standard safety driver training allowing them to operate the Health34 van.

Administrative Tasks

Administrative task training occurred on the job. During the first few shifts that an SEMT had, when the Health34 team was not responding to calls, the H34 provider instructed the SEMT on tasks including note-taking, answering the phone, campus resources, on-shift expectations, and documentation. The H34 provider presented each the ideal interaction flow for a phone call.

The flow begins with getting the caller's name, and determining if the caller's request. The SEMT should gather demographics, contact information, and location. Then in consultation with the H34 provider, the client is notified of an estimated arrival time.

Documentation training included the expected data to collect, including student ID number, location of call, chief complaints, resource utilization and service navigation. The role of the SEMT is to collect during a client interaction to allow the H34 provider to focus on the client.

SEMTs were assigned daily maintenance roles. They perform vehicle inspections, cleanings, and restockings. Instructions regarding the checklist and location of supplies for restocking were provided.

Lessons Learned

Overall, the training was successful at conveying the process and vision for H34 and client interaction. That being said, there are some places where the efficacy of the training can improve.

One improvement would be conducting in-person group training. In-person group training would have given the

SEMTs the additional opportunity to perform supervised role play to demonstrate skills with phone calls and in person client interactions. The virtual platform was not effective for role play. In person training would also provide the opportunity for feedback and allow repeated attempts.

Video examples of aspirational client interactions would have enhanced the SEMT's understanding of layperson counseling and support. These videos could be integrated into virtual or asynchronous training.

A further improvement would be to create written standard operating guidelines as reference charts. The high volume of information in the training could not be integrated into practice immediately. To enhance consistent practice and promote retention of key information, documentation of processes and procedures was necessary. This gives the SEMTs the opportunity to familiarize themselves with the information and perform more consistent work.

Conclusion

With the genesis of Health34, the UC Davis Fire Department had to greatly expand the knowledge and skill set of its SEMTs to accommodate the increase in job scope. To do this, it created a multistage training program meant to provide foundations in lay counseling techniques, a knowledge of new Health34 procedures, and an awareness of local resources. This paper has outlined the structure of our training process and detailed some of the lessons we learned undertaking this first-of-its-kind program in the campus community.

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to continued care whenever possible. As such, we encourage other collegiate EMS programs to likewise seek longitudinal partnership with primary care and urgent care providers at their institutions' student health centers or other nearby healthcare institutions.

Limitations: At the time of publication, we have not yet received a formal response from a representative at the Engemann student health center about formally implementing a direct referral program for patients we respond to on shift experiencing a mental health crisis but we remain open to partnership and continue to explore other community-based options for referrals to continued mental health care. While EMSC already has a working relationship with a Health Promotion Specialist at Engemann who advises us about crisis de-escalation on shift and wellness practices for our student EMTs, we believe there remains a gap in the transfer of care between the immediate mental health services we provide on shift and longer-term mental health treatment offered at Engemann. Expanding our partnership with Engemann to include direct referrals for patients experiencing a mental health crisis would better address the upstream factors leading to the emergent situation. As EMSC and other collegiate EMS programs become more deeply integrated into university's emergency response systems, collaboration both within and between existing institutions is necessary to develop proactive solutions to best promote the health and safety of the students these institutions serve.

3. Community Partnerships

Collegiate EMS programs can assist in expanding awareness of existing resources through building partnerships with the university's mental health programs, local mental health clinics, and on-campus, student-run organizations. Once mental health resources are identified for a broad array of student populations, covering various combinations of SDOH, collegiate EMS programs can package these resources into small infographics, brochures, etc. that may be handed out to all patients during calls. Furthermore, after the standardized screening in step 1, the EMS provider may have a better understanding of which specific mental ailment(s) the patient may be suffering from. At this point, the provider may be able to provide more specific, premade resources to the patient so they are able to seek treatment beyond the short-term treatment that the provider offers.

Our Intervention: Patient Resource Card

As an agency, we implemented a shift data review and classification process in the Spring of 2019 to develop evidence-based quality improvement strategies. The process involved a confidential review of shift employee records to code data by call type, frequency, partner agency dynamics, and extraordinary circumstances. A manual inductive approach was used to analyze and code the aggregated qualitative and quantitative information to identify recurring trends. This data was then used to facilitate actionable decision making in our organization, whether in continued training or mediated debriefs with staff. We rapidly noticed an alarming prevalence of mental health concerns (both chief and secondary) in our call logs. In formal post-shift debriefs, our EMTs often noted a sense of helplessness when attempting to offer further care resources to such patients, only vaguely referencing our student health center and national resources while on scene. EMTs receive very little mandated training on mental health; further, they rarely receive any training at all from employers on local mental health resources for patients. The nature of our collegiate EMS program involves high turnover, which makes changes to foundational protocol more effective than cohort training alone. After implementing a dedicated psychiatric emergencies lecture into our skills training sessions curriculum, we decided to pursue broader protocol reform to ensure a lasting impact on EMT preparedness to handle calls that are psychiatric in nature, whether emergent or not.

Thus, we added a gear item to our oxygen bags, alongside our clipboards and patient care reports: a mental wellness resource card. The card is discreet in size and includes references to campus-specific, community-specific, cost-specific, and national/remote care. Given the nature of the COVID-19 pandemic and its resulting halt of recreational events which

Figure 1: Our most recent card template, revised in Fall 2020 (front)

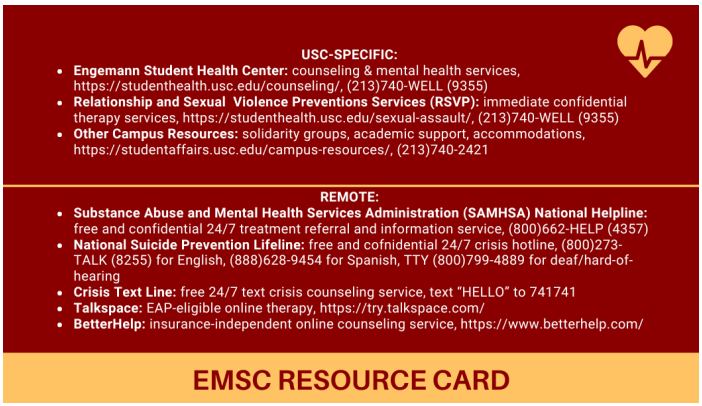
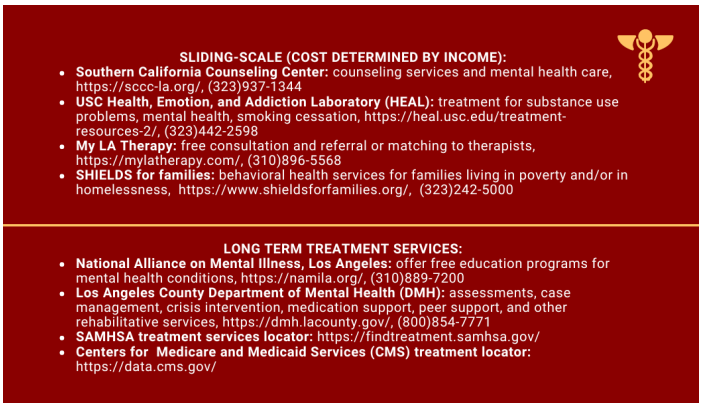


Figure 2: Our most recent card template, revised in Fall 2020 (back)



our organization traditionally staffs, we have not yet received real-time feedback from our community as to the efficacy of the resource card. The card, however, is designed to be reevaluated as necessary by EMSC's Director of Internal Relations (a fairly new role, only proposed in Spring 2019), who is responsible for staff wellness, personnel logistics, and conflict management. As the nature of internal affairs management is vastly different depending on collegiate EMS program size and resource capacity, we recommend organizations seek out a distribution of responsibility (i.e. tasking this to student volunteers versus outsourcing to credentialed professionals) best suited to their own needs.

Limitations: In order to create sustainable partnerships with local resources, we promote going beyond raising awareness to the formation of concrete and fluid partnerships. By working with the university's mental health programs and local mental health clinics, collegiate EMS programs will first identify the most important resources to build awareness about. Then, by working with on-campus, student-run organizations, collegiate EMS programs can provide brief presentations on existing resources. Furthermore, collegiate EMS programs may be able to build websites with tools (such as brief quizzes or surveys) to walk students through which mental health resource(s) may be best for them during a specific crisis. By expanding awareness of such resources through presentations and partnerships with on-campus student-run organizations and personalizing them to the student's needs with quizzes and/or surveys, collegiate EMS programs would be able to greatly demystify the daunting steps required to seek mental health resources.

Conclusion

Prehospital providers work within the community setting and are well positioned to connect medical care with social and community resources. As students themselves, collegiate EMS providers are uniquely situated to acutely understand the social factors impacting their classmates and how to compassionately refer them to relevant community services and resources. By tailoring the proposed intervention to best suit the needs of the receiving demographic, EMS agencies can best equip their staff to respond appropriately and effectively to complex calls, especially those involving mental health complaints.

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