



CARE

(Community Assistance, Recovery and Empowerment) Act

California Health & Human Services Agency
Person Centered. Equity Focused. Data Driven.

CARE Act Working Group Meeting

August 27, 2025

California Health & Human Services Agency

Person Centered. Equity Focused. Data Driven.



Welcome and Introductions

Agenda

1. Welcome and Opening Remarks
2. Annual Report Overview – Presentation and Response Panel
3. Implementation and Training and Technical Assistance Updates
4. Lunch
5. Featured Topic: Role of Peers in the CARE Act
6. Role of Health Plans in the CARE Act and Opportunities for Coordination
7. Updates on CARE Subject Matter Expert Focus Groups
8. Closing Thoughts
9. Public Comment

Working Group Members

Amber Irvine

Beau Hennemann

Bill Stewart

Brenda Grealish

Dr. Brian Hurley

Dr. Clayton Chau

Deb Roth

Harold Turner

Herb Hatanaka

Ian Kemmer

Ivan Bhardwaj

Jennifer Bender

Jenny Bayardo

Jerry May (Meagan Subers)

Jodi Nerell

Dr. Katherine Warburton

Kent Boes

Keris Myrick

Ketra Carter

Khatera Aslami

Lauren Rettagliata

Hon. Maria Hernandez

Mark Salazar

Nichole Zaragoza-Smith

Roberto Herrera

Ruben Imperial

Ruqayya Ahmad

Salena Chow

Hon. Scott Herin

Stephanie Welch

Stephanie Regular

Susan Holt

Tawny Macedo

Tim Lutz

New Members

- Khatera A. Tamplen
- Hon. Scott Herin



Virtual Meeting Guidelines

- Meeting is being recorded
- American Sign Language interpretation in pinned video
- Live captioning link provided in chat

Working Group Members

- Mute/Unmute works for members and policy partners.
- Stay ON MUTE when not speaking and use the “raise hand feature” if you have a question or comment.
- Please turn on your camera as you are comfortable

MEMBERS OF THE PUBLIC will be invited to participate during public comment period

Working Group Overview – Operations

- The Working Group will meet quarterly during the implementation of the CARE Act through December 31, 2026.
- Working Group meetings will be a mix of in person and virtual, with in person meetings held primarily in Sacramento, but at times possibly in other locations throughout California.
- Working group members are expected to attend 75% of meetings each year, with the option of sending a delegate for the remainder.
- All meetings of the Working Group shall be open to the public and subject to Bagley-Keene Open Meeting Act requirements.

Working Group Agreements

- Be present and curious.
- Respect each other's expertise and time and participate fully.
- Encourage different opinions and be respectful of disagreements.
- Be accountable to your fellow group members and practice patience and persistence – we can't solve everything in a single conversation or meeting, but we need to remain solution focused.
- Assume Positive Intent: Trust that people are doing the best they can.

Recap of May Meeting

- Featured Topic: The Role of Public Guardians and Public Conservators in CARE Implementation
- The Alameda CARE Team Approach
- CARE Act Respondent's Counsel
- Implementation and Training and Technical Assistance Updates
- Updates on CARE Act Working Group Ad Hoc Groups

Upcoming CARE Working Group Meetings

- November 19, 2025 in Los Angeles
 - Westin Bonaventure, collocated with Judicial Council's Beyond the Bench Conference

DATA COLLECTION & REPORTING UPDATE

CARE Act Working Group

August 27, 2025

Agenda



Annual Report Findings: Q3 2023-Q1 2024 data and Key Takeaways

Policy in Action: CARE Act Legislative Updates

Update on Statewide Data Collection and Reporting (Quarter 1, 2025)

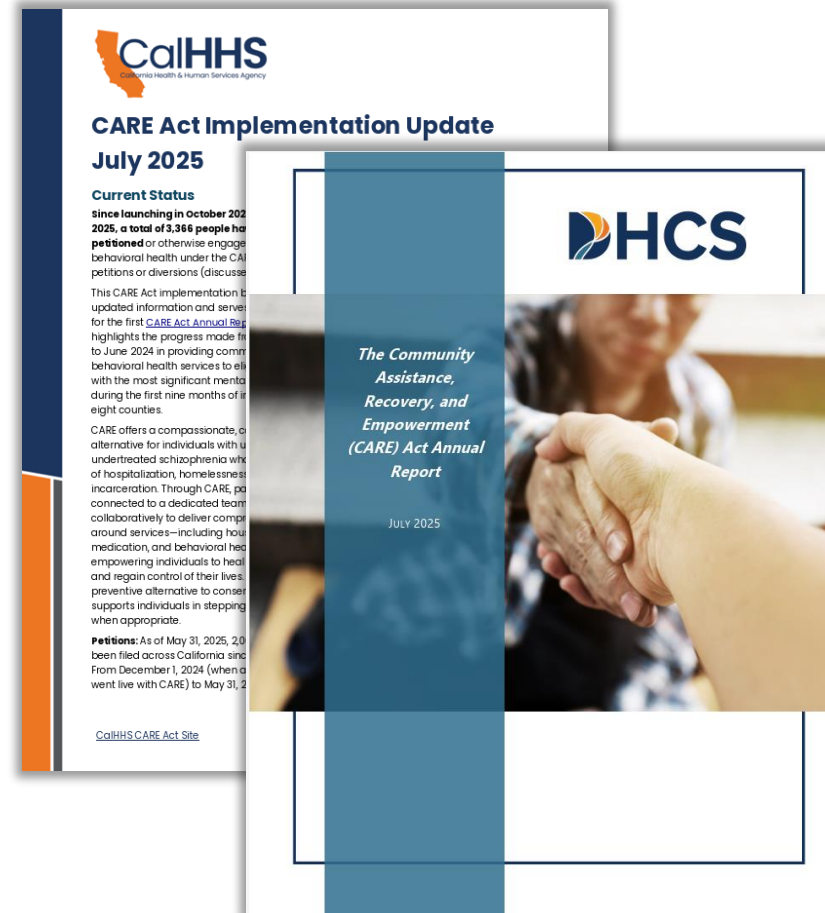
Data Collection and Reporting Resource Review

Annual Report Findings (Q3 2023-Q1 2024 data)

CARE Act Annual Report & Implementation Update

The July 2025 CARE Act Annual Report released data about the first 9 months of implementation, including key takeaways and opportunities to leverage findings.

Accompanying CalHHS Implementation Update.



For more information, see [CARE Act Annual Report & CARE Act Implementation Update – July 2025](#).

Objectives of the Annual Report

Overall objective of the Annual Report is to:

- ✓ Provide an overview of early CARE Act implementation
- ✓ Identify opportunities for program enhancement.

Insight into...



Volume of CARE petitions through civil courts.

Flow of CARE respondents sent to county BH agencies.

Characteristics of CARE respondents.

Services and supports accessed among those with a CARE agreement or plan (i.e., CARE participants).

County BH agencies' capacity to meet CARE participants' needs.

County provision of services to elective clients, who voluntarily engage in services and supports outside court jurisdiction.

CARE Act Annual Report Data

The first CARE Act Annual Report leverages data in accordance with the CARE Act Data Dictionary 1.0.

Data Sources

- Judicial Council (JC) aggregated data from county CARE courts.
- County BH agency individual-level data on CARE respondents served by counties.

Timeframe

- First nine months, or first three reporting periods, of CARE implementation (October 1, 2023- June 30, 2024).

Population

- Cohort 1 counties (Glenn, Orange, Riverside, San Diego, Stanislaus, and Tuolumne counties, and the City and County of San Francisco) and Los Angeles County.

Volume of CARE Petitions Through Courts

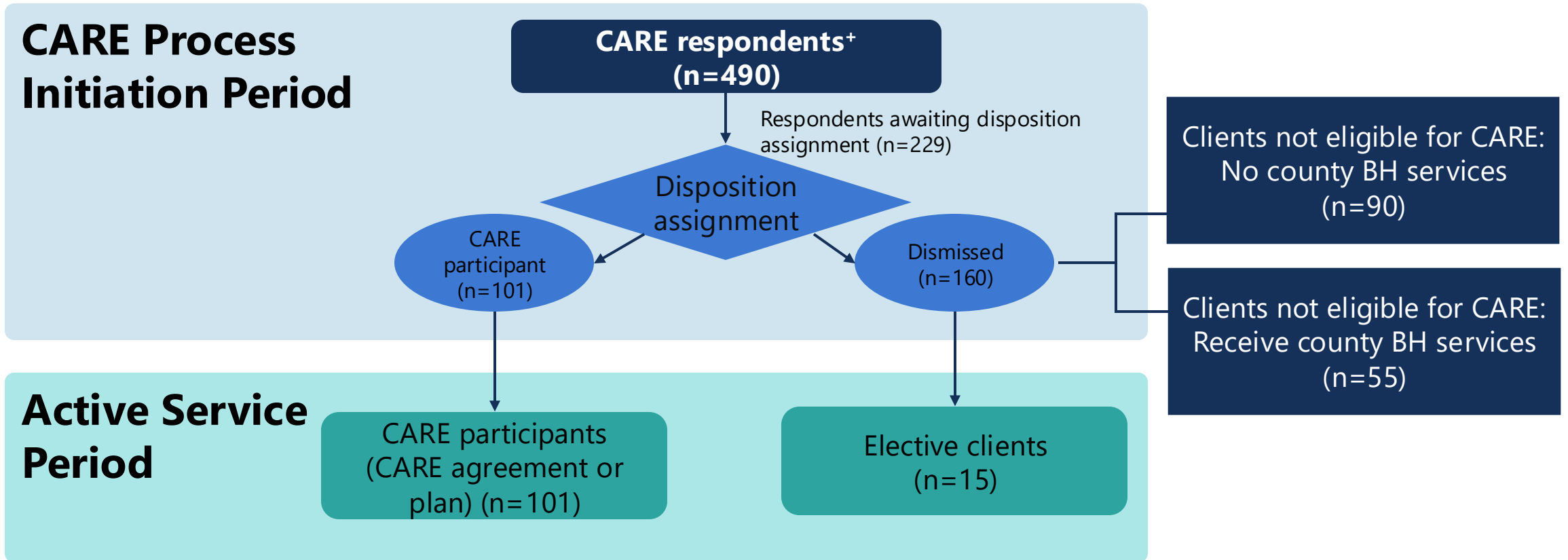
556 CARE petitions were filed over the first nine months of CARE implementation.

- 101 (18%) resulted in an approved CARE agreement or ordered CARE plan.
- 217 (39%) were dismissed by the courts, including 15 petitions that resulted in elective clients.

782 total hearings were held, including 403 initial CARE appearances.



CARE Respondents Connected to County BH



+ 497 total CARE petitions, representing 490 unique CARE respondents, were received by county BH agencies

Note: The average length of time from petition to disposition was between 2-3 months.

Origin of CARE Petitions

CARE Petition



334
(68.2%)

Personal petition (e.g., spouse, domestic partner, or family member of respondent; person who lives with respondent)



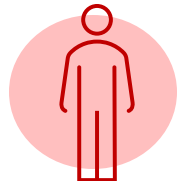
107
(21.8%)

System partner petition (e.g., Director of hospital, licensed BH professional treating client, public guardian, or conservator)



34
(6.9%)

Petition from first responder, mobile crisis team, outreach worker

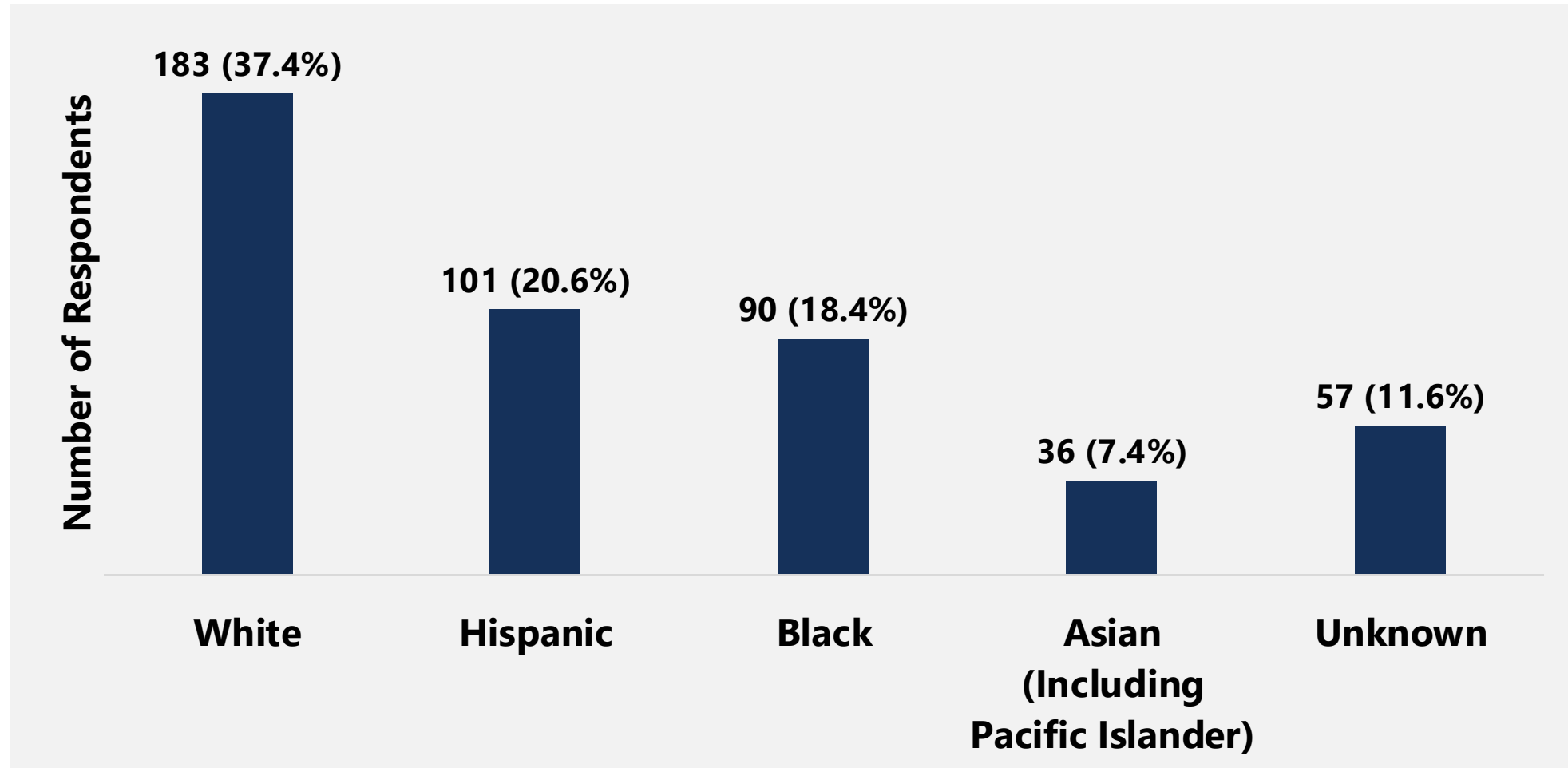


14
(2.9%)

Self-petition by respondent

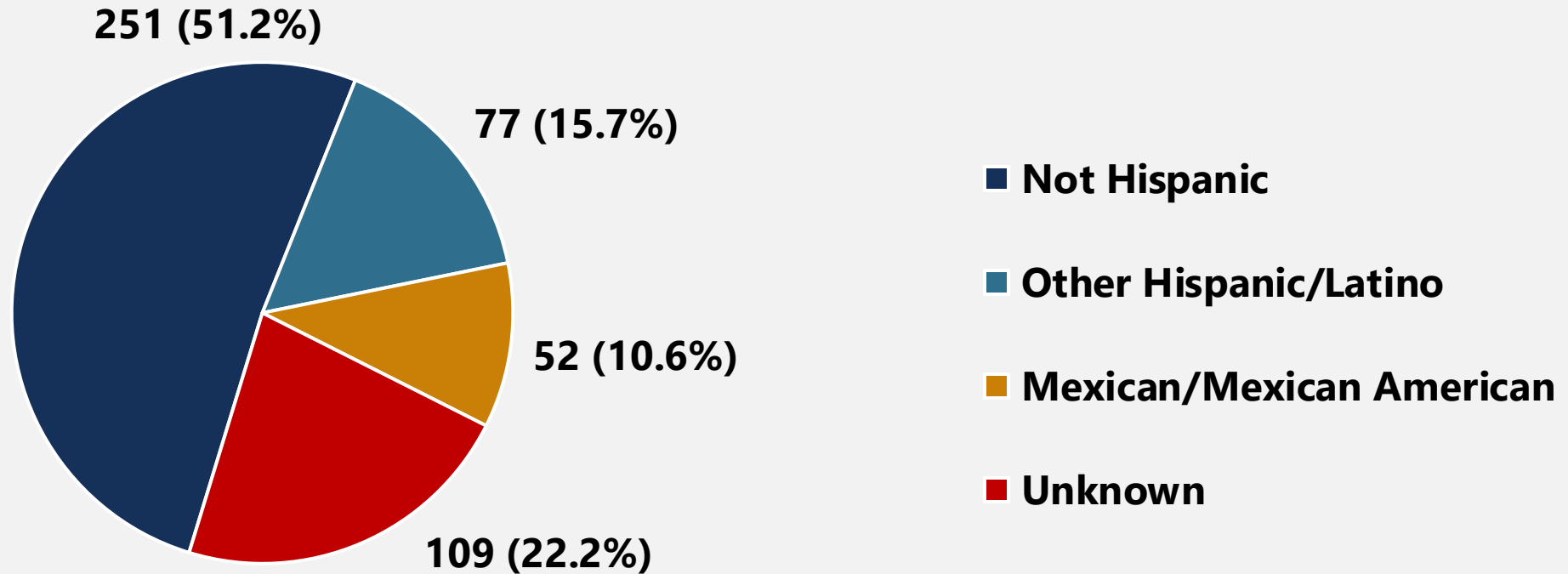
Total CARE Respondents (n=490)

CARE Respondents: Race



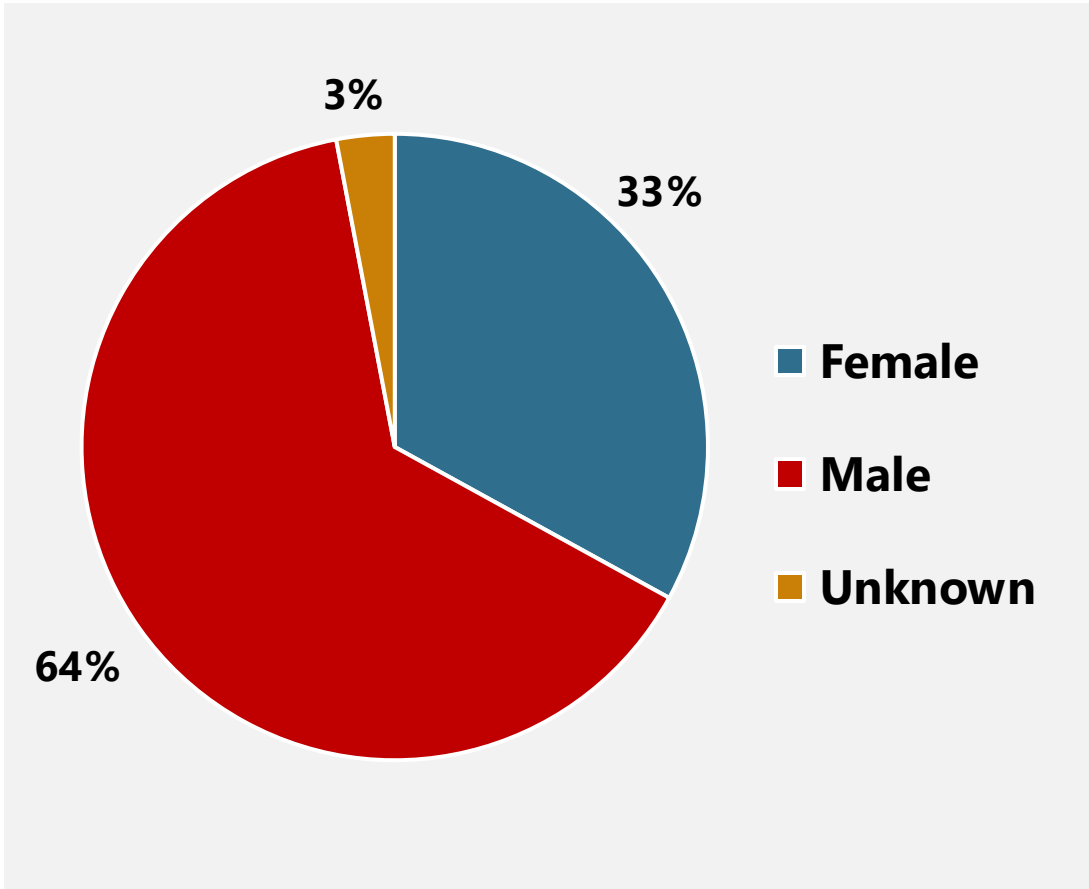
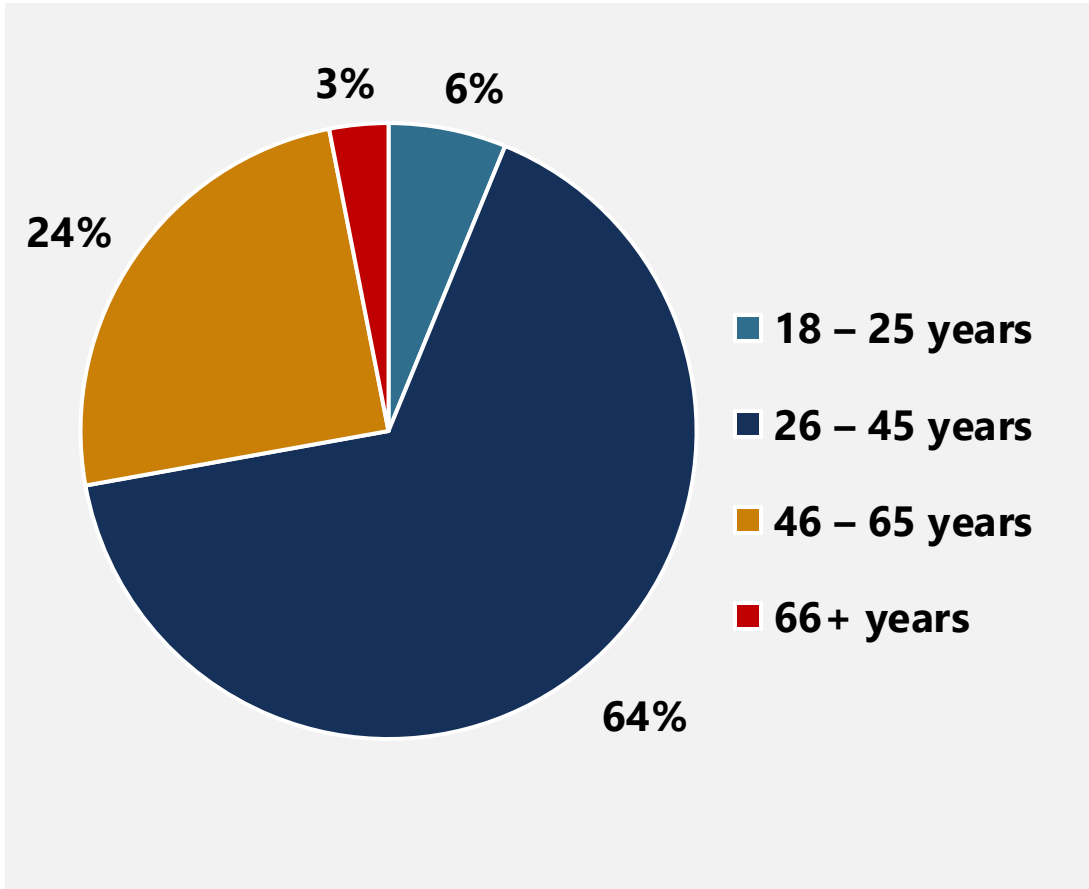
Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool | Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024; Prepared by the California Department of Health Care Services. Note: Respondents may identify as more than one race and may be included in more than one category. The sum of respondents by race will not equal the total number of respondents.

CARE Respondents: Ethnicity



Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool | Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.

CARE Respondents: Age and Sex



Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool | Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.

CARE Respondents: Employment, Insurance, and Housing

Employment Status

7% Unpaid workforce

60% "Other"

Insurance Status

51% Medi-Cal Enrollees

6% Medicare Beneficiaries

43% Unknown

Housing or Living Situation

(At time of Petitioning)

41% Permanently Housed

16% Institutionally Housed

8% Temporarily Housed

30% Unhoused

3% Unknown

Time to First Disposition Assignment

Of the 261 CARE respondents with a petition disposition, the average number of days from petition to first disposition was 75.6 calendar days, or approximately 2.5 months (range: 8 – 253 days). 85 percent of respondents took 31 or more days to have a petition disposition assigned.

Respondent Group	Time from CARE Petition to First Disposition Assignment (in Calendar Days)			
	Mean	Min	Max	Std. Dev.
All CARE Respondents with Assigned Disposition (n=261)	75.6	8	253	43.9
CARE participants (CARE agreements and CARE plans) (n=101)	79.3	8	253	47.3
Dismissed (including elective clients) (n=160)	73.2	16	235	41.5

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool | Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024.

CARE Services and Supports Accessed Over First Nine Months

Access to Specialized Programs

Over three quarters (76%) accessed a specialized program for individuals with serious mental disorders (e.g., Assertive Community Treatment or Full-Service Partnership).



Program	CARE Participants (CARE Agreements + Plans) (n=101) with Specialized Program Access n(%)
Specialized Program - Any	76 (76.2%)
(Assertive Community Treatment (ACT)) ⁺	48 (47.8%)
(Full-Service Partnership (FSP))	31 (30.0%)

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool | Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.

Service and Support Access

Most received mental health treatment services (93%) and stabilizing medications (72%); of those who received medications, 40% received a long-acting injectable.

Service or Support Category	CARE Participants (CARE Agreements + Plans) (n=101) with Service or Support n(%)
Any Mental Health Treatment Service	94 (93.1%)
Stabilizing Medication at Any Time	73 (72.3%)
Any Social Service or Support	61 (60.4%)
Any CalAIM Community Support	16 (15.8%)

* Values are not shown to protect the confidentiality of the individuals summarized in the data. Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool | Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.



Housing Supports

Fifteen percent of CARE participants received a CalAIM housing service or support, and 31 percent received a county, state or federally funded housing service or support.



Housing Service or Support Category	Total CARE Participants (CARE Agreements + Plans) (n=101) with Support n(%)
Any CalAIM Housing Support	15 (14.8%)
Any County, State, or Federally Funded Housing Support (Not CalAIM)	31 (30.7%)

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool | Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.

Receipt of Key Recovery-Supporting Services

63 percent of CARE participants received all three critical services—stabilizing medication, comprehensive psychosocial and community-based treatment, and housing supports—while 28 percent received two of the three, most often a combination of housing supports and psychosocial treatment.

Three Recovery-Supporting Services	Total CARE Participants (CARE Agreements + Plans) (n=101) with Service or Support n(%)
All Three Components	64 (63.4%)
Two of Three Components	28 (27.7%)
One of Three Components	*
No Components	*



*Values are not shown to protect the confidentiality of the individuals summarized in the data.

Note: a CARE participant was counted as having housing supports if they (a) accessed a housing support program (e.g., No Place Like Home, California Housing Accelerator); (b) received a CalAIM community housing support service (i.e., Housing Deposits); or (c) were housed in permanent, temporary, or institutional housing.

Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool | Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services.



Unmet Needs Impacting Community Stability

Housing Challenges

- **28% were unhoused** for at least part of the active service period.
- **12% were temporarily housed.**
- **20% spent a majority of a month in institutional settings** (e.g., jail, prison, psychiatric facility, hospital, long-term or nursing home care facility)

Other Indicators of Unmet Needs*

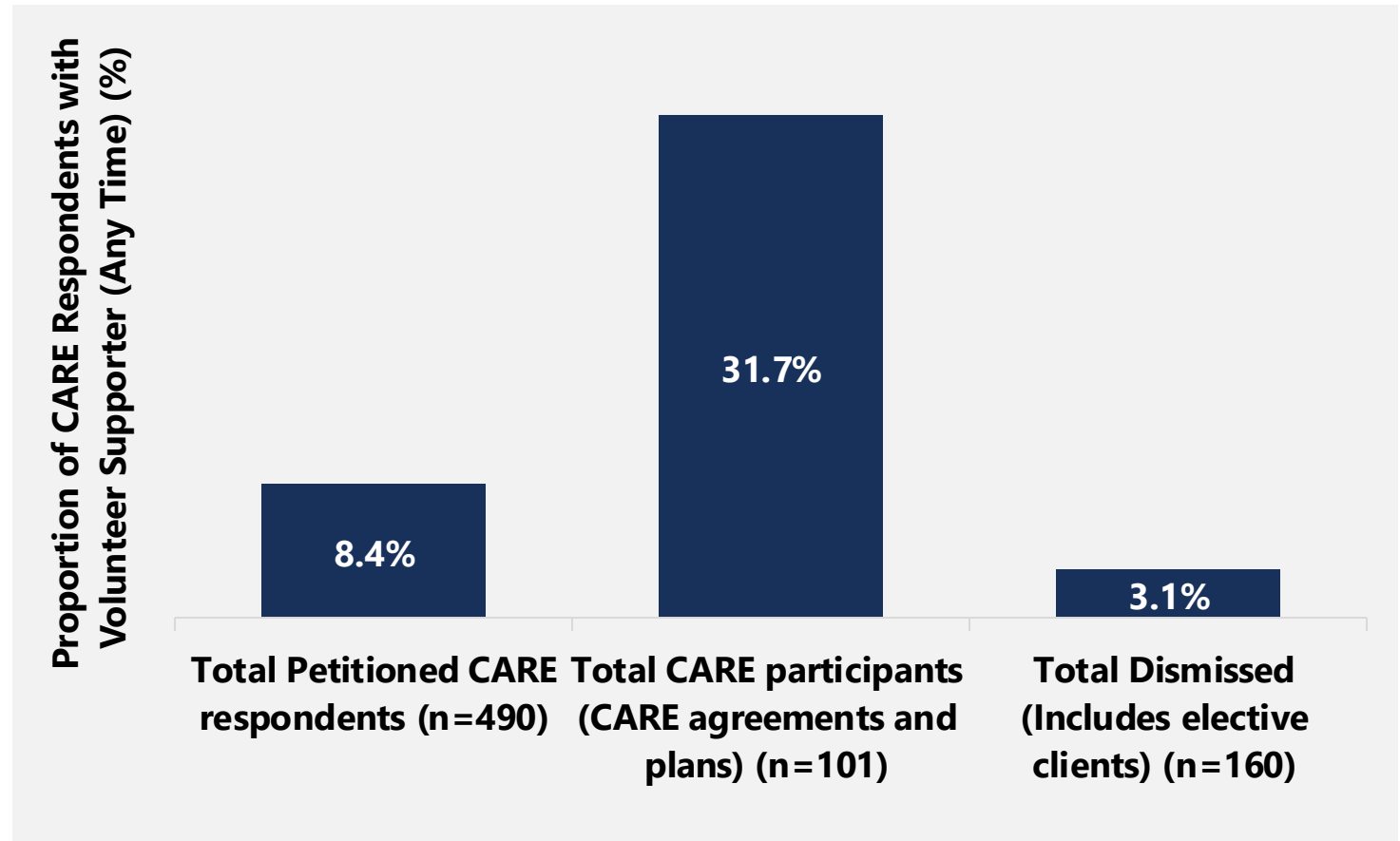
- **25%** had criminal justice involvement.
- **21%** visited an emergency department.
- **20%** had inpatient hospitalizations.
- **20%** experienced LPS holds.

* About **15%** of data on these events was reported as "unknown," suggesting that these challenges may be even more widespread.

Adoption of PADs and Volunteer Supporters

Psychiatric advance directives (PADs) and volunteer supporters are considered key features of person-centered care for CARE participants.

- No PADs were reported for any CARE participant.
- A third of participants had a volunteer supporter.



Values for Total dismissed petitions are not shown to protect confidentiality of individuals. Data Source: Data gathered from DHCS CARE Act Data Collection and Reporting Tool | Dates represented: October 2023 – June 2024 | Date Downloaded: December 9, 2024. Prepared by the California Department of Health Care Services

Elective Clients

During the first nine months, 15 petitioned CARE-eligible clients were diverted to receive county services and supports outside court jurisdiction, referred to as “elective clients.”



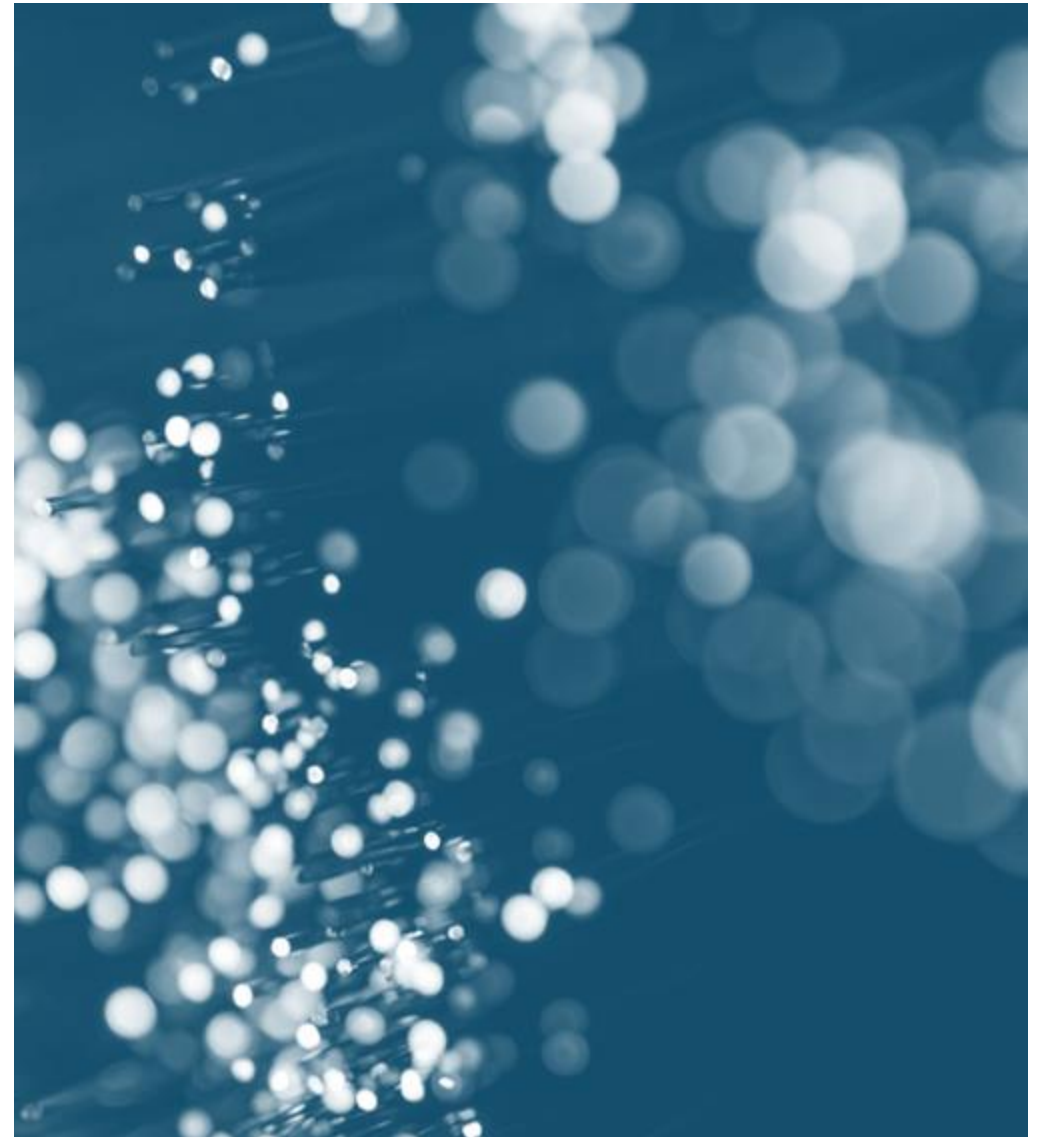
Elective clients received fewer services overall than CARE participants, but also had more data quality issues (e.g., missingness) – likely reflecting inherent challenges with tracking individuals outside the court jurisdiction.

Half the elective clients were enrolled in ACT, but none were engaged in FSP, Early Psychosis Intervention, or Forensic ACT (FACT) services.

Few received all three services and supports foundational to recovery (i.e., stabilizing medications, comprehensive BH services, housing supports).

Data Limitations: Inconsistencies Between County BH and Court Data

- » Discrepancies in County BH and JC reported counts of CARE plans ordered and CARE agreements approved.
- » County BH agencies have been encouraged to work with their CARE courts to identify opportunities to improve coordination and alignment of submitted data.



Data Limitations: Missing and Unknown Data

Missing data from county BH agencies represented less than 1% of all reported data. Non-random missing or unknown data may reflect:

- » The challenges county behavioral health agencies face in tracking individuals outside of court jurisdiction.
- » Sensitivities about reporting certain information (e.g., substance use) due to privacy regulations.



Most common missing data fields were:

- Employment status.
- Presence of a volunteer supporter.
- Type of housing support funding.
- Frequency of secondary substance use.
- Number of arrests.



“Unknown” responses decreased over the reporting periods of CARE Act implementation.

- The most frequent “unknown” values were related to misuse of illegal or controlled substances and diagnosis of substance use disorder.
- There were fewer “unknown” or “unable to answer” responses for CARE participants compared to dismissed CARE respondents.

Key Takeaways & Opportunities: Lessons from the First Nine Months

Key Takeaways

The majority of CARE respondents engaged were males, between ages 26-45, and indicated English as their preferred language. Over a third (37 percent) identified as White, 21 percent identified as Hispanic, 18 percent identified as Black, and 7 percent identified as Asian.

Opportunities to Leverage Findings

- » Increase awareness of CARE Act among system partners and potential petitioners.
- » Expanding outreach and engagement efforts (and data collection) in CARE Act implementation, ensuring equitable access for eligible individuals who may be difficult to reach.



Key Takeaways

The petition process for CARE respondents varies, typically taking 2–3 months from petition to disposition. Like other mental health and substance use care, CARE Act processes take time to build trust and develop person-centered plans.

Opportunities to Leverage Findings

- » Continuing to aid courts, counties, and system partners to optimize and improve CARE Act processes.
- » Expand data collection to include new data on referrals from key system partners to promote access among potentially eligible individuals and outreach and engagement efforts to improve CARE process efficiency.



Key Takeaways

Ongoing housing services and supports are an area of high need, likely compounded by other unmet needs among CARE participants. The proportion of CARE participants with permanent housing increased over the first nine months of CARE implementation (from 46 percent to 56 percent).

Opportunities to Leverage Findings

- » Prioritize housing services and connect participants to federal and state programs supporting housing needs.
- » Promote awareness of programs that offer rental subsidies and housing supports, such as BH-CONNECT and Proposition 1.



Key Takeaways

Nearly two-thirds (63 percent) of CARE participants received the three evidence-based services and supports that provide critical foundations for recovery (i.e., stabilizing medication, comprehensive psychosocial and community-based treatment, and housing supports).

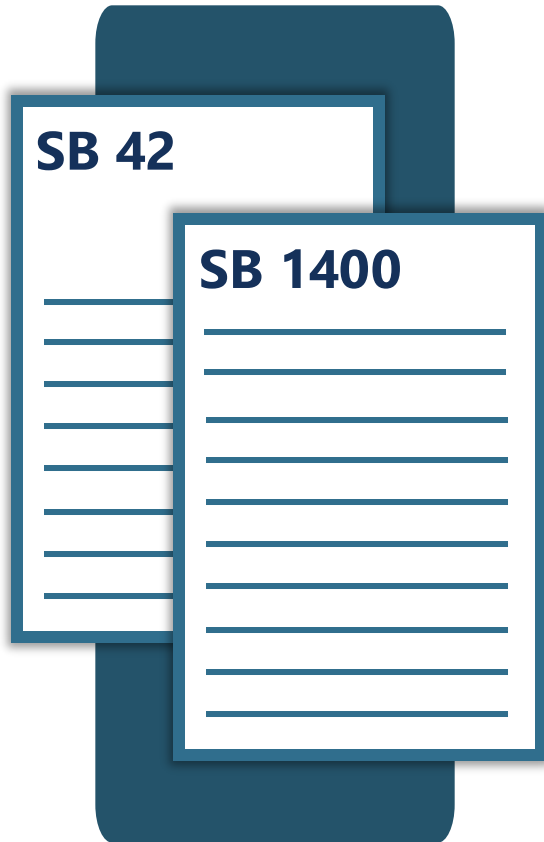
Opportunities to Leverage Findings

- » Expand technical assistance to raise awareness and improve access to all three foundations for recovery.
- » Expand technical assistance to raise awareness and improve access to PADs and volunteer supporters.
- » Continue to address unmet needs that may contribute to undesirable encounters with the criminal justice system, emergency department visits, hospitalizations, and LPS holds.
- » Enhance county data collection to better analyze service access and quality across different disposition groups (e.g., CARE participants vs. elective clients).



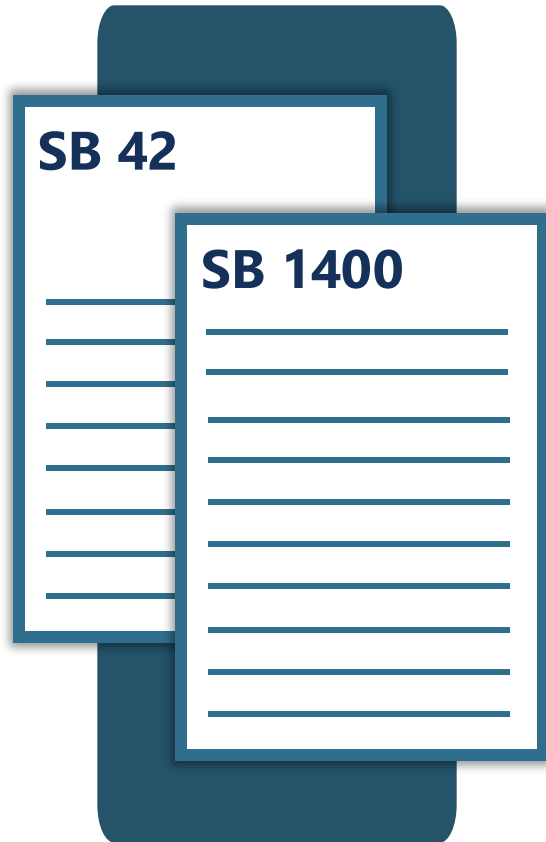
Policy in Action: CARE Act Legislative Updates

Legislative Updates



- » [Senate Bill \(SB\) 42](#): Amended provisions of the CARE Act, including referrals by facilities to County BH, communication between courts, alternatives to conservatorship, changes to CARE procedures, as well as collaboration on system performance.
 - Referral data from facilities to be included in the Annual CARE Act Report ([SB 42 Brief here](#)).
- » [Senate Bill \(SB\) 1400](#)*: Amended provisions of the Penal Code related to CARE referrals of individuals deemed incompetent to stand trial. Additionally, it amends provisions to expand reporting requirements related to CARE inquires, referrals, and petitioned individuals ([SB 1400 Brief here](#)).

Legislative Updates



- » Per SB 1400, DHCS is required to include the additional data elements in its annual CARE Act report, beginning in 2026. These include:
 - Outreach and engagement to petitioned and referred individuals.
 - Services provided during early stages of the CARE process.
 - County recommendations and court actions.
 - System referrals and inquiries made to County BH agencies.
- » **Effective January 1, 2025**, counties are expected to report on the expanded data requirements.

Most Recent Data



CARE Act Implementation Update July 2025

- [CARE Act Implementation Update - July 2025](#) -- On CalHHS CARE site

CARE Act Trial Court Data

As of the July 2025 reporting period (please note data are subject to change):

- **2,421** cumulative petitions filed
 - **206** petitions were filed in July 2025
- **1,331** active petitions
- **514** CARE agreements
 - **55** CARE agreements were approved in July 2025
- **14** CARE plans



CARE Act Independent Evaluation

CARE ACT WORKING GROUP
AUGUST 2025



Today's Presentation

Goal: To provide an overview of the independent evaluation, and describe the data types

Agenda:

- Highlight IE's goals and research questions
- Describe the data sources and value of each type of data
- Describe high-level differences between HMA's role and RAND's role in the CARE Act

Meet the RAND Evaluation Leadership Team



Melissa
Labriola, PhD
Co-PI



Stephanie
Holliday, PhD
Co-PI



Rachel Burns,
MPH
Quantitative
Analyst



Nicole Eberhart,
PhD
Co-PI



Amy Shearer, PhD
Evaluation
Methodologist



Wendy Hawkins,
MPP
Project Manager



Goals of RAND's CARE Evaluation

- Evaluate the program implementation, outcomes, and impact
- Document lessons learned related to the CARE Act model and policies
- Make recommendations for ongoing implementation of the CARE Act

CARE Evaluation Logic Model – Draft 5-13-24

Evaluation Questions	Strategies & Activities	Implementation Outcomes	Key Outcomes
Implementation: 1. How prepared were counties to implement the CARE Act model? 2. How was CARE implemented? 3. What factors might be impacting the effectiveness of CARE?	Individual-level - Participation in CARE process: - Petition/Initiation - Engagement - Court process and development of CARE plan - Service connection - Service delivery - Engagement of advocates, including peers, family, and volunteer supporters	Individual-level - Number and description of individuals on different pathways: - Elective clients - Voluntary CARE agreement status - Ordered CARE plan status - Developed - Accessed - Shared - Adhered to - Psychiatric Advanced Directive status	Community Assistance, Recovery and Empowerment: <u>3-legged stool:</u> ↑ Engagement in services ↑ Medication stabilization ↑ Safe, stable, preferred housing ↑ Personal recovery (CHIME framework): - Connectedness, - Hope, - Identity, - Meaning and purpose, - Empowerment ↑ Achievement of personal CARE goals ↑ Meaningful work or community engagement –e.g., employment, volunteering, caring for others or enrollment in education ↓ ED use ↓ Hospitalizations ↓ Arrests and incarceration ↓ LPS and probate conservatorships • Equity/disparities in above outcomes
Community Assistance, Recovery and Empowerment: 4. Did CARE participants increase their engagement in needed services? 5. Was access to services equitable? 6. Did CARE participants experience increased mental illness recovery and empowerment? 7. Were recovery and empowerment outcomes experienced equitably?	System-level - County workflows to support CARE implementation - System coordination and linkage, including County BH, Public Defenders, Courts, and County Counsel - Data collection and sharing - Accountability levers	System-level ↑ Coordination between County BH, Public Defenders, Courts, and County Counsel - Barriers and facilitators to implementation - Availability of appropriate services - County accountability (e.g., claims, fines and sanctions) • Equity/disparities in above outcomes	

Evaluation Questions and Data Sources

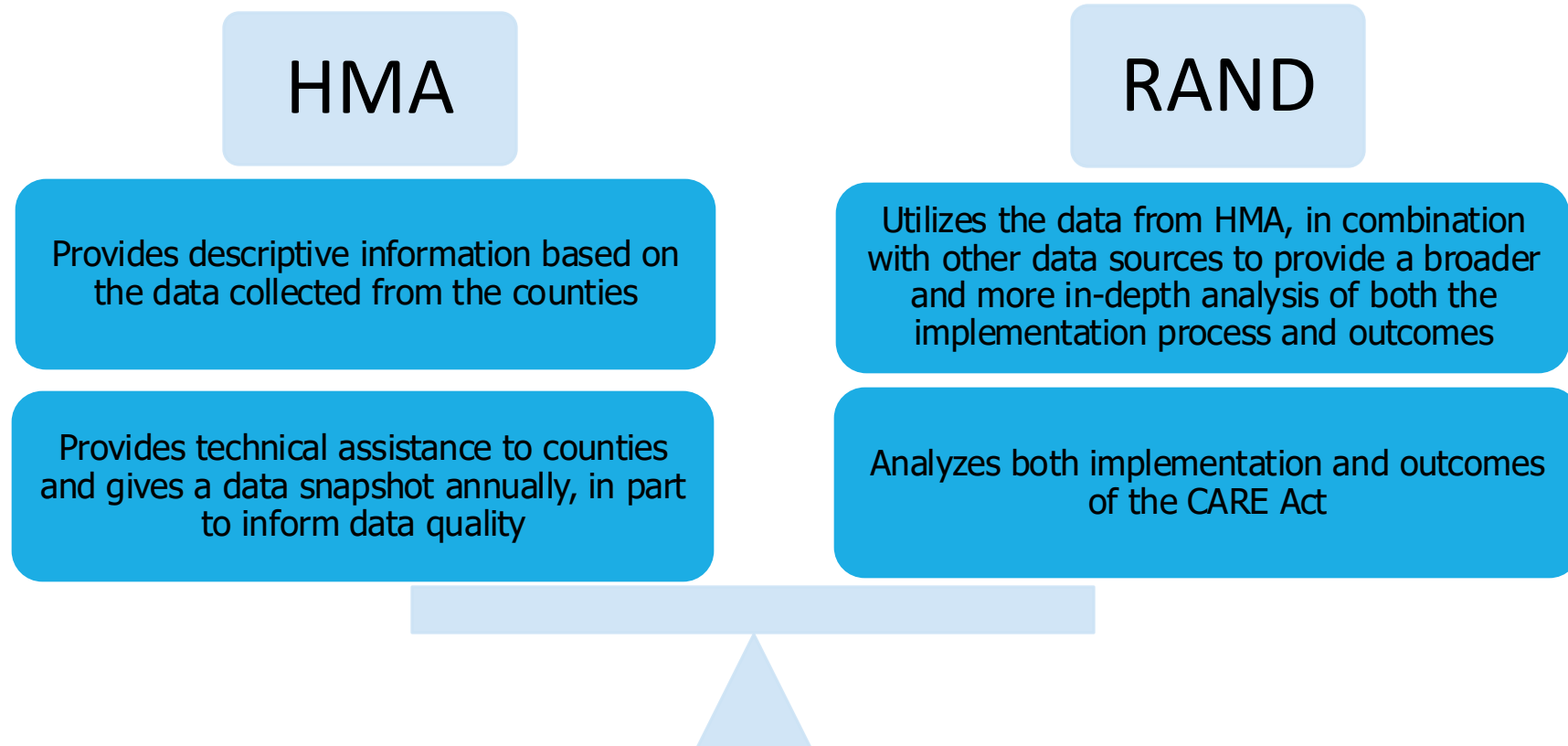
		Implementation Partner Interviews	CARE Participant Interviews	Petitioner Interviews	CARE Participant Survey	Administrative Data
Process Evaluation	Q1. How prepared were counties to implement the CARE Act model?	X	X	X		X
	Q2. How was CARE implemented?	X	X	X	X	X
	Q3. What factors might be impacting the effectiveness of CARE?	X	X	X	X	X
Outcome Evaluation	Q4. Did CARE participants increase their engagement in needed services?	X	X	X	X	X
	Q5. Did CARE participants experience increased mental illness recovery and empowerment?	X	X	X	X	X

Data Collection & Analysis

Data Type	HMA	RAND
Data Dictionary 2.0	Oversees collection of data elements for Data Dictionary and puts together annual report based on Data Dictionary, which describes the CARE Act	Provide descriptive and statistical analyses highlighting disparities and populations served
Existing Administrative Data including MediCal claims, HCAI, DSH, homelessness data, DOJ	Not collecting or analyzing	Analyzed by RAND for IE to understand characteristics of individuals served and services received beyond data shared in Data Dictionary
Qualitative Data - Staff Interviews - Respondent Interviews - Petitioner Interviews	Not collecting or analyzing	Conducted by RAND for IE to gain in-depth understanding of county experiences implementing CARE Act from perspective of multiple stakeholders
Respondent and Petitioner Survey	Not collecting or analyzing	Conducted by RAND for IE to elevate the voices of individuals served and understand how CARE is benefitting them

How does RAND's Independent Evaluation differ from HMA's reporting?

RAND and HMA have different purposes related to the CARE Act



Thank you!

Questions:
Melissa Labriola
labriola@rand.org

Judicial Council of California Implementation Update



Trainings, TA, and Resources

Recent Trainings and Technical Assistance:

- Best Practices for CARE Act Proceedings
- Motivational Interviewing
- CARE Act Updated Rules, Forms, and New Standard
- On Demand training for judges with CARE Act court assignments
- Quarterly office hours (July and October)

Upcoming Trainings:

- CARE Act, Serious Mental Illness, and De-escalation Trainings (Sept, Oct, Dec)
- Beyond the Bench Pre-Conference (November)

Resources:

- Judicial Benchguide



TRAINING AND TECHNICAL ASSISTANCE UPDATES

CARE Act Working Group

August 27, 2025

What We've Been Up To

TTA resources and activities since the last Working Group in May include:

- Updated trainings to reflect petitioning form updates.
- 🖥️ New training and panel session on Paths Out of Care.
- 📄 Hosted office hours on IST & LPS referrals.
- 👥 Hosted a panel session on creating a culture of support in CARE.
- 📊 Continued to provide data collection and reporting TTA.
- ❓ Added FAQs on key topics.
- 🖥️ Hosted TA sessions with counties.
- 🖥️ Expanded use of the peer video and dissemination support.



County Post-Implementation Survey Success Stories

01

Client milestones and transformations

A few counties shared positive client outcomes and improved stabilization, including:

- » Transition from homelessness to stable housing.
- » Increased treatment engagement from previously resistant or distrustful individuals.
- » Successful step-downs from LPS conservatorships and MIST proceedings.

02

Cross-system collaboration to improve care coordination and service accessibility

Certain counties highlighted coordination with various stakeholders, including:

- » Improved relationships with courts, public defenders, and county counsel.
- » Partnerships with housing providers.

03

Community and stakeholder engagement highlights

Meaningful engagement and awareness building, resulting in:

- » Increased awareness among service providers, community organizations, and the general public.
- » Increases in petitions being filed.



Training & Technical Assistance Ongoing Needs

County BH noted specific TTA topics and resources to support CARE implementation.



Data Collection & Reporting



Legal Aspects & Legislative Updates



PADs Guidance & Support

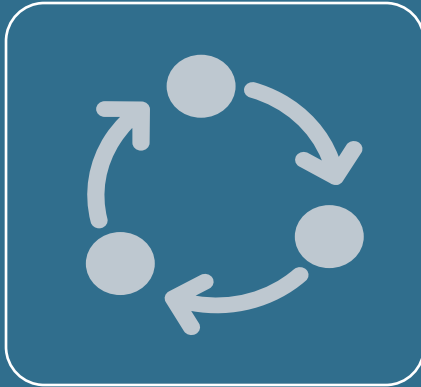


Housing



Billing, Claiming, & Reimbursement

Training Updates in 2025



Update trainings related to:

- Administrative claiming and reimbursement
- Petitioner trainings, such as first responder, hospitals, behavioral health and social service providers, and justice system partners
- Training revisions to reflect legislative updates



Develop “how to” tutorial and short videos

- Navigating claiming resources
- Volunteer supporter role
- CARE graduate video
- Developing PADs in practice
- Supplemental Guide for CARE Act Data Dictionary 2.0

Targeted TA

Briefs & Resources:

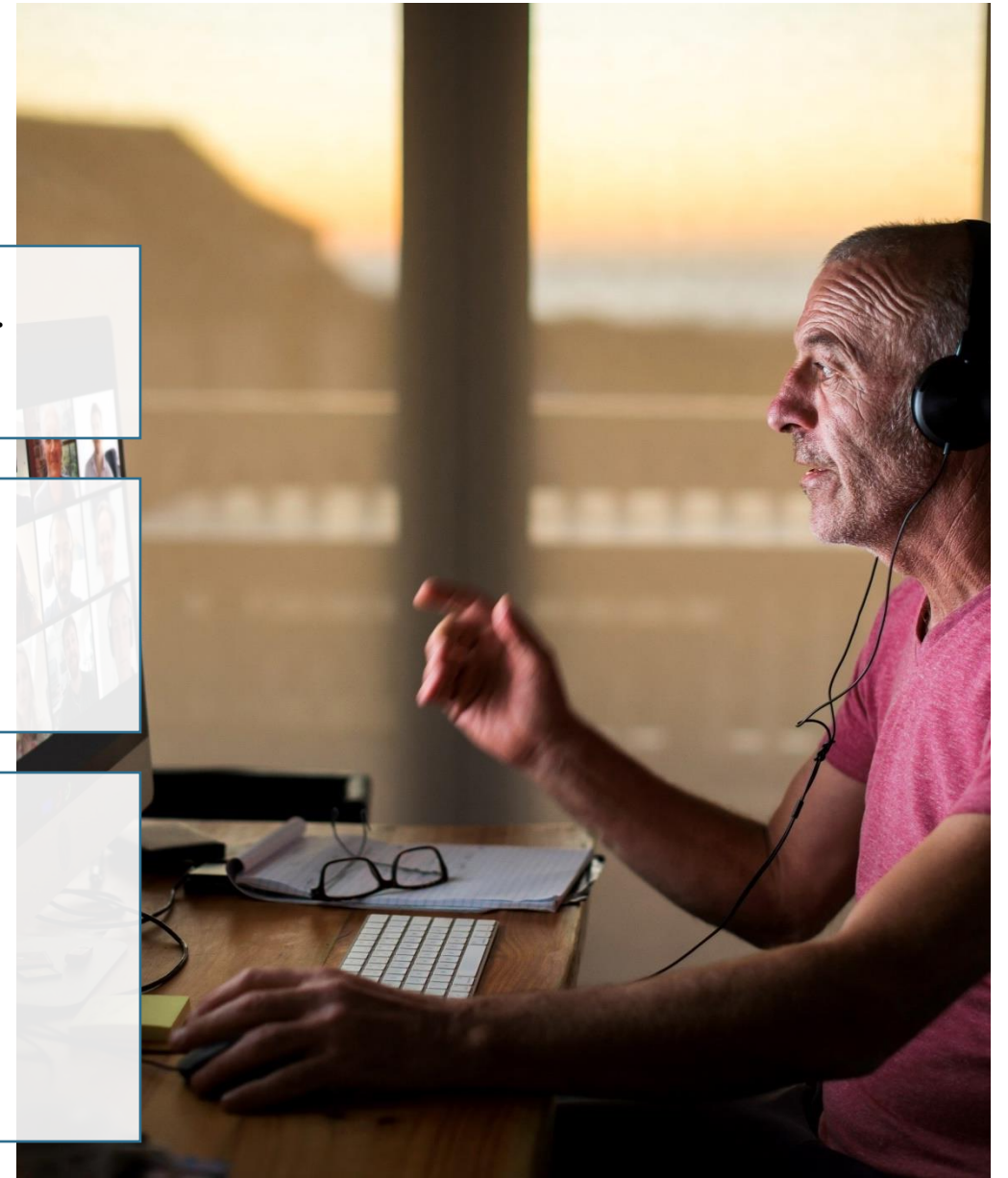
- Legislative updates, PADs, peers in CARE, and eligibility.
- Enhancements to the Communications Toolkit.

County-Focused TA:

- Continued liaison engagement.
- Tailored TA.
- Question triage.

Collaborative & Responsive TA:

- County-to-county sessions (e.g., FSP/ACT integration, PADs, EHRs).
- Proactive outreach based on Implementation Survey results.
- System partner connections (DSH, CDCR, firefighters).



CARE Act Resource Center

» New to the CARE Act?

- View the pinned [training](#) materials and [resources](#).

» Reminders

- 23 languages
- Training and Resource library with advanced search features
- Family Resource Guide
- Volunteer Supporter Toolkit
- Petitioners page
- Upcoming trainings
- FAQs

The screenshot displays the CARE Act Resource Center website. At the top right, a language selection dropdown menu is open, showing 'English' as the selected language, with other options including Arabic, Armenian, Chinese, Dutch, Filipino, and French. The main content area is titled 'New to the CARE Act?' and includes a sub-header 'View these recommended CARE Act Trainings to get started with the basics.' Below this, there are six training material cards arranged in a 2x3 grid. Each card features a blue circular icon with a white 'i', a title, a brief description, and an orange button labeled 'Training Material Details'. The cards are: 'CARE Act 201: The Client's Journey Through the CARE Act', 'CARE Act 202: The CARE Agreement & CARE Plan', 'CARE Act Eligibility in Practice', 'Practical Approaches to Housing for the CARE Act', 'Role of the Family in the CARE Process', and 'Considerations for Petitioning in the CARE Act Process'. Below the grid, there is a search section titled 'Search Training Materials' with filters for 'I am a...' (All Audiences), 'I am looking for...' (Keyword or Phrase), 'Topic' (All Topics), and 'Training Material Types' (All Types). A 'Submit' button and a 'Reset Filter' link are also present. To the right of the search section, there are three detailed training material cards, each with a title, description, and an orange 'Training Material Details' button. The cards are: 'CARE Act 201: The Client's Journey Through the CARE Act', 'CARE Act 202: The CARE Agreement & CARE Plan', and 'CARE Act Eligibility in Practice'.



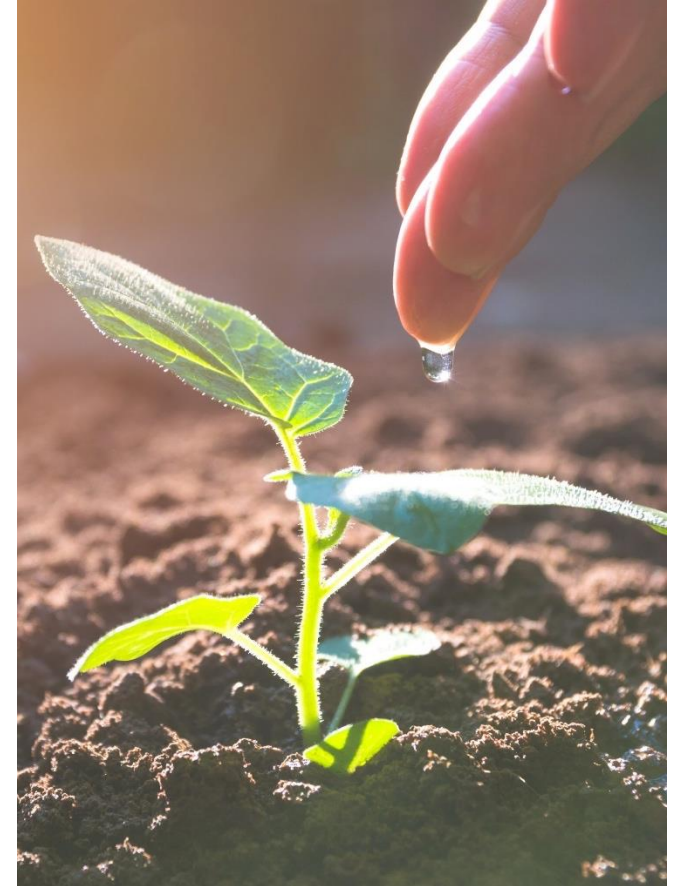
CARE Act Resource Center: Data Collection & Reporting

- » Redesigned [Data Collection and Reporting Resources page](#):
 - Trainings, tools, and resources to support reporting and transition to Data Dictionary 2.0.
 - Supplemental Guide with general and scenario-based guidance.
- » Ongoing bi-weekly data office hours, with special topics.
- » Dedicated CARE Data email inbox. CAREdatateam@healthmanagement.com
- » Training presentations, including a Q1 2025 Data Quality Summary in July 2025.

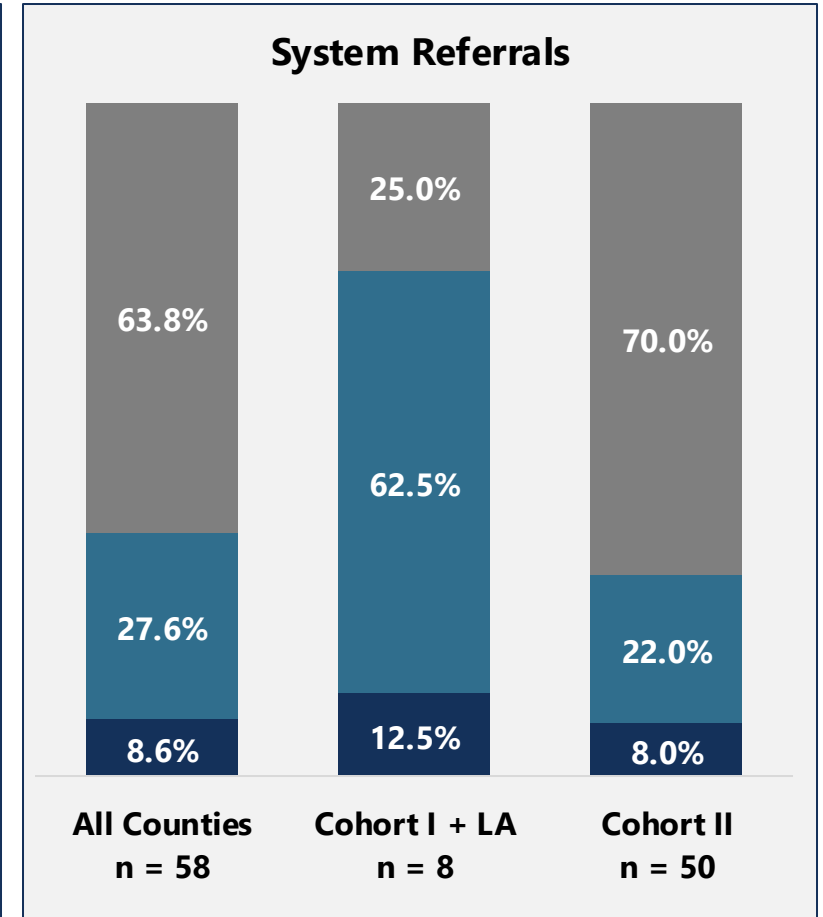
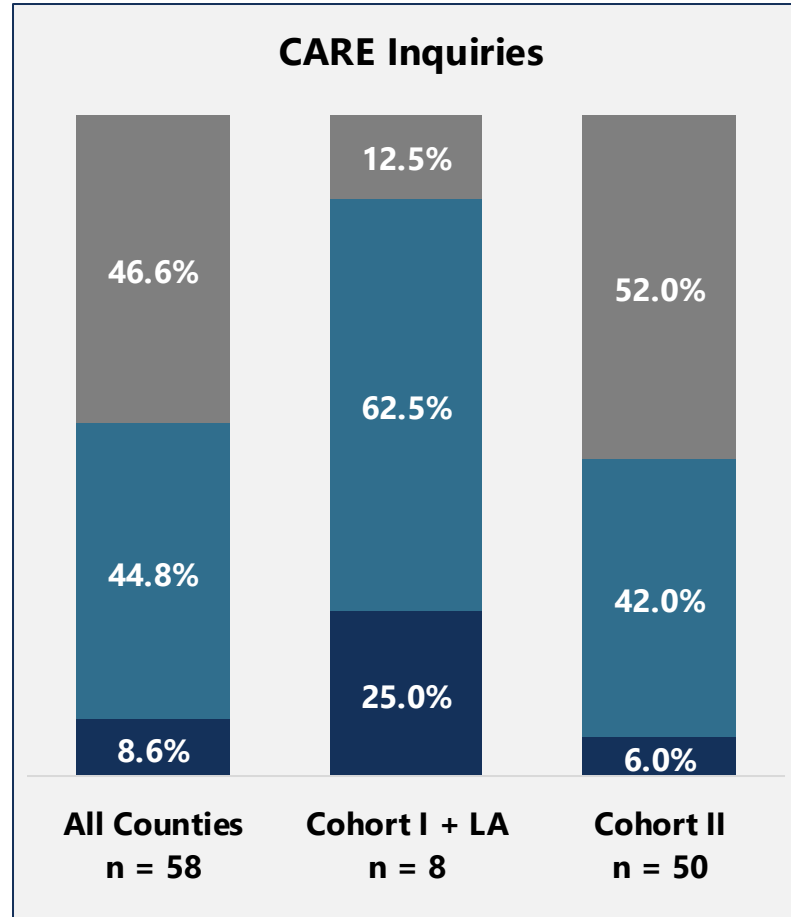
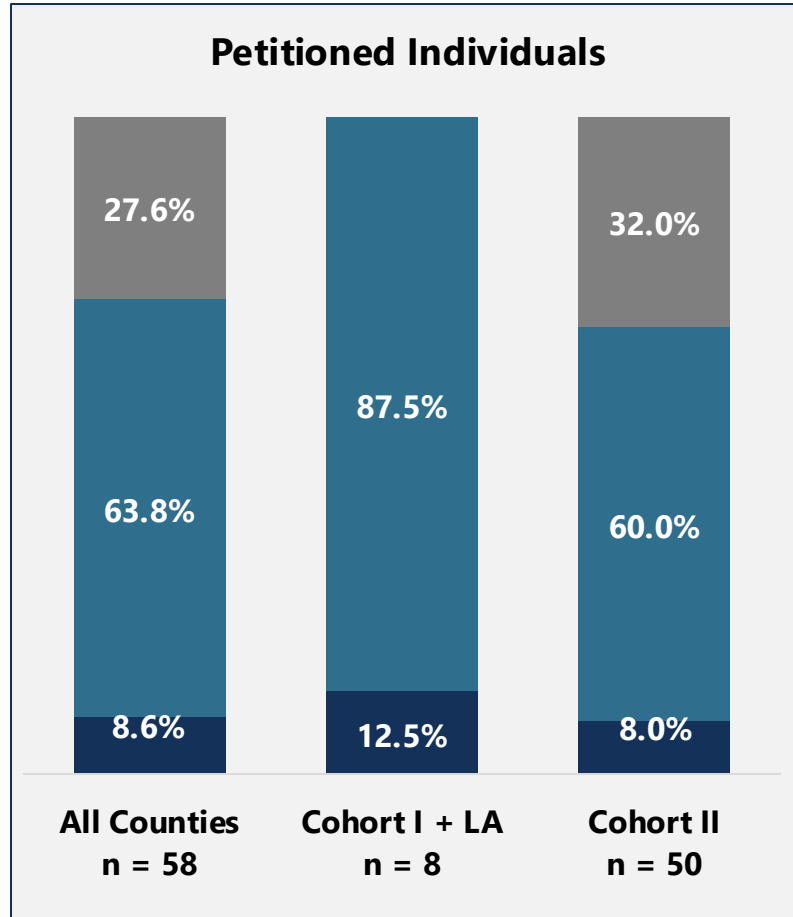
Update on Statewide Data Collection and Reporting

Reported CARE Data: Statewide Implementation

- » Beginning in Q1 2025, counties are required to submit data on three separate modules, in alignment with CARE Act Data Dictionary 2.0:
 - Petitioned individuals
 - CARE inquiries, and
 - System referrals
- » Prior to Q1 2025, counties were only required to submit petitioned individual data.
- » **Looking forward:** The expanded Data Dictionary 2.0 will allow for a more robust assessment of CARE Act implementation. The next slide summarizes the status of early CARE Act reporting in accordance with Data Dictionary 2.0.



Q1 2025: Status of Reporting by DD 2.0 Module



 Counties with No Data to Report  Counties with Reported Data  County Data Excluded (Unanalyzable, Rejected, Requires Resubmission)

Quality Assurance Process

Supporting timely submissions

- Communication to data teams on timeline for submission (initial and frequent reminders)
- On demand 1:1 with data teams

Supporting complete, accurate, and reasonable submissions

- Bi-weekly Office Hours (built on proactive questions from counties submitted via CARE Data Team Inbox or HMA TTA liaisons)
- QA Reports to request county corrections of deficiencies
- Regularly updated Supplemental Guide with scenarios

Supporting Court and County BH data alignment

- Encouragement for County BH agencies to work with their courts to identify opportunities to improve alignment.
- Sharing of County BH agency data contacts with JC so they can promote coordination.

Opportunities to Improve Data Quality

Assign data to
correct reporting
month

Use of correct
county codes

Missing/
unanswered data
fields

Accurate reporting
of CARE status

Validate value codes
within accepted
ranges

Accurate use of
standardized
reporting templates

Timeliness of
quarterly data
submissions

Questions?

[CARE-Act.org](https://www.CARE-Act.org) | info@CARE-Act.org

CAREdatateam@healthmanagement.com



Role of Peers in the CARE Act

Representatives from Los Angeles County's Department of Mental Health:

- **Kimberly Manzares-Mora, Peer Certified Specialist**
- **Kristen Ayala, Substance Abuse Disorder Counselor**
- **Dr. Sarah Church-Williams, Program Manager I**
- **Theresa Arredondo, LCSW, Program Manager I**

Role of Health Plans in the CARE Act and Opportunities for Coordination

Beau Hennemann
Anthem Blue Cross

California | Anthem Blue Cross
Medi-Cal Managed Care

Health Plan Programs and Benefits



Core Managed Care Services

- Primary care visits
- Wellness visits
- Vaccines
- Specialist visits
- Behavioral healthcare
- Substance use disorder services
- Prescriptions
- Urgent and emergency care
- Labs and X-rays
- Pregnancy services
- Family planning
- Preventative Services
- ER/Hospital care
- Outpatient Services
- Children's services, including dental and vision care
- Physical and occupational therapy
- Speech and hearing services
- Home healthcare
- Care coordination
- Disease Management for many conditions, such as asthma and diabetes

Benefits for our members

- **Expanded telehealth options:** available with doctors and behavioral health providers, or virtual care through LiveHealth Online when a physician is not available
- **SydneySM Health mobile app:** This app is available to members 24/7 and provides access to benefits, claims information, and ID cards. Members can also use the app to find doctors, set up virtual care visits, track health, and receive important information about their plan.
- **Connecting members with essential resources:** housing, food security, jobs, educational supports, legal aid, and more through FindHelp
- **Doula services:** provided for people during and following pregnancy
- **Ride services** to and from physician appointments and some non-medical trips, such as therapy transportation
- **24/7 NurseLine:** 800-224-0336 (TTY 711)
- **Interpreters and translation:** Customer Care (outside of LA) 800-407-4627 or (inside LA County) 888-285-7801
- **Health education classes and materials**
- **New Baby, New LifeSM:** supports pregnant members and new parents
- **Care management/case management:** supports members with chronic medical and behavioral health conditions
- **Special programs and new benefits:** Enhanced Care Management and Community Supports (ECM/CS), Dyadic services, community health workers (CHW), Street Medicine, Justice-involved population supports

We understand total health is about more than just doctor visits.

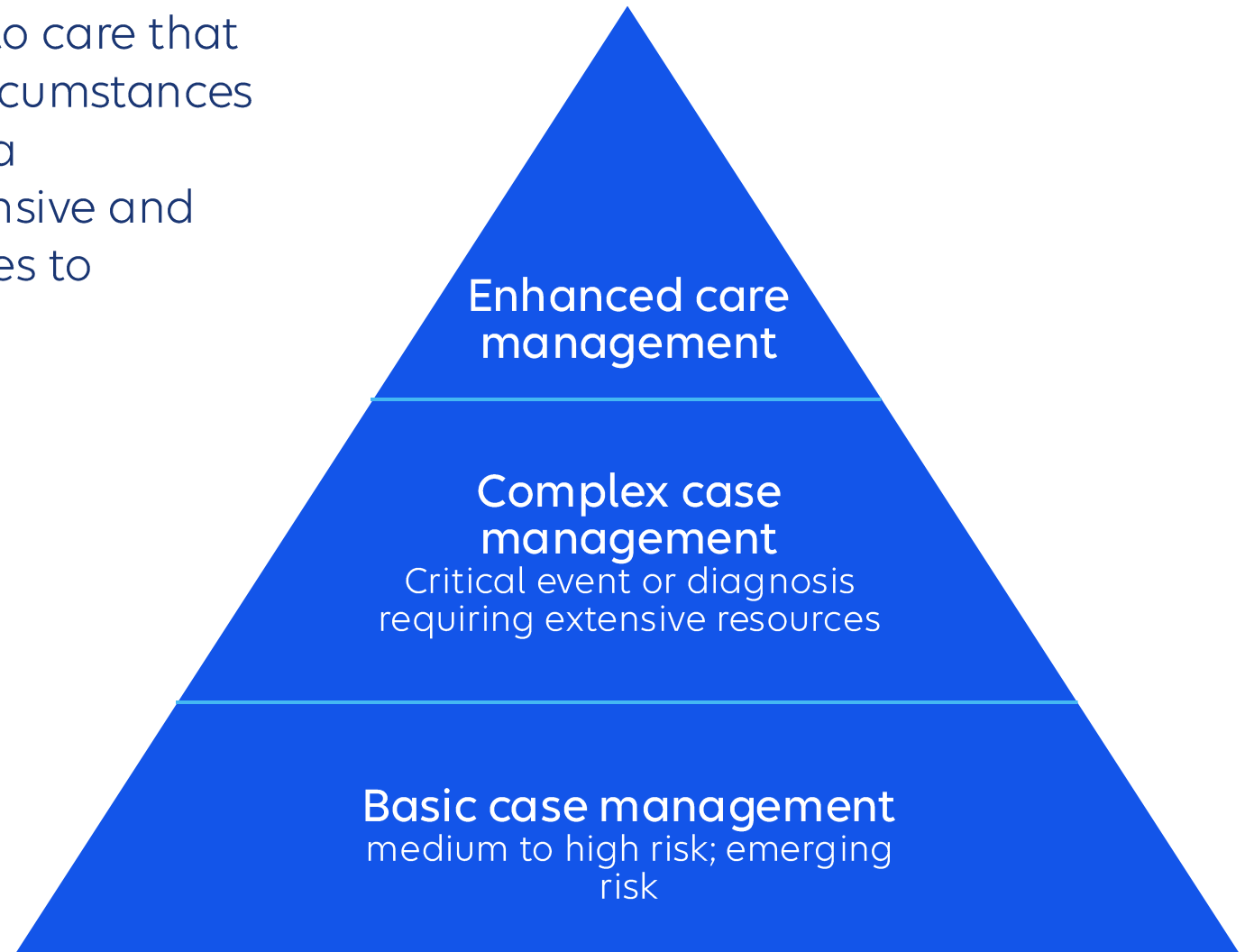
We have specialized teams to support members' well-being from end to end.

What is ECM?

ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of a high-need Medi-Cal member. ECM is a collaborative approach to providing intensive and comprehensive care management services to individuals and families.

Seven core services:

- Outreach/engagement
- Assessment and care planning
- Enhanced coordination
- Health promotion
- Transitional care services
- Member/family supports
- Community supports coordination



Who is eligible for ECM?

ECM population of focus (POF)	Adults	Children and youth
Individuals and families experiencing homelessness	X	X
Individuals at risk for avoidable hospital or ED utilization	X	X
Individuals with serious mental health issues and/or substance use disorder (SUD) needs	X	X
Individuals transitioning from incarceration	X	X
Adults living in the community and at risk for LTC institutionalization	X	
Adult nursing facility residents transitioning to the community	X	
Children and youth enrolled in California Children's Services (CCS)		X
Children and youth involved in child welfare		X
Birth equity population of focus	X	X

Community Supports

Housing/homelessness (four services):

- Housing transition navigation services
- Housing deposits
- Housing tenancy and sustaining
- Day habilitation

Facilities (three services):

- Short-term post-hospitalization housing
- Recuperative care (medical respite)
- Sobering center

In-home supports (two services):

- Respite services (can also be provided in facility setting)
- Personal care and homemaker services

Nursing homes (two services):

- Nursing facility (NF) transition/diversion to assisted living facilities
- Community transition services/NF transition to a home

Constructions (two services):

- Environmental accessibility adaptations (home modifications)
- Asthma remediation

Meals (one service):

- Meals/medically tailored meals

California's bifurcated Medi-Cal Managed Care behavioral health system

Our non-specialty mental health services (NSMHS)

Mental health services provided by licensed professionals (as defined in the Medi-Cal Managed Care provider bulletin) acting within the scope of their license:

- Mental health evaluation and treatment, including individual, group, and family psychotherapy, ABA
- Psychological and neuropsychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for purposes of monitoring drug therapy
- Psychiatric consultation
- Outpatient laboratory, drugs, supplies, and supplements

Note: No approval required for outpatient therapy and psychiatry (required for out-of-network therapy/psychiatry providers only); preapproval required for ABA, psychological/neuropsychological testing.

SMHS — county outpatient:

- Assessment
- Plan development
- Therapy
- Collateral
- Medication support services
- Day treatment intensive
- Day rehabilitation
- Crisis residential treatment
- Adult residential treatment
- Crisis intervention
- Crisis stabilization
- Targeted case management
- Intensive care coordination
- Intensive home-based services
- Therapeutic foster care
- Therapeutic behavioral services

— county inpatient:

- Acute psychiatric inpatient hospital services
- Psychiatric health facility services
- Psychiatric inpatient hospital professional services if the beneficiary is in fee-for-service hospital

Behavioral health eligibility criteria

All members who contact Anthem or the County BH Teams are screened to determine severity of symptoms based on the outcome of the DHCS standardized screening tool:

- If the member scores in the range for **non-specialty mental health** criteria or functional impairments, the member is referred to an Anthem contracted provider for NSMHS.
- If the member scores in the range for the **specialty mental health** criteria or impairments, the member is referred to the MHP County BH team.





Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.

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Updates on CARE Act Subject Matter Expert Focus Groups

Stephanie Welch, MSW, Deputy Secretary of Behavioral Health, CalHHS

Dr. Kate Warburton, State Medical Director, DSH

Karen Linkins, Principal, Desert Vista Consulting

Establish Guidance on a Standard of CARE

- Convene focus groups of researchers, practitioners and court personnel to define:
 - A minimum standard of care for CARE-eligible individuals
 - Best practice guidelines, incorporating both established and emerging practices
- Develop clear recommendations for county eligibility assessments
- Address treatment ambivalence and fluctuating capacity by providing practical clinical strategies and engagement techniques
- Provide guidance on assertive treatment modalities
- Promote integrated care models that treat mental health, substance use disorders, and physical health needs

Provide Recommendations for Reestablishing Centralized State Guidance

- Re-establish dedicated state oversight for the LPS conservatorship system, including an independent ombuds function, including:
 - Promoting accountability for high-quality, comprehensive service delivery not just within LPS treatment, but across the broader continuum of care, including CARE and AOT, and aligned with BHSA and BH-CONNECT.

Continuing Education and Core Competencies for CARE

- Define core competencies for all roles involved in CARE implementation
- Review and evaluate existing training curricula to ensure content is current, accessible, and aligned with CARE standard of care
- Develop new training modules to fill identified gaps
- Offer Continuing Education credits to encourage participation

Closing Thoughts

Stephanie Welch, MSW, Deputy Secretary of Behavioral Health, CalHHS

Next Working Group Meeting:

November 19, 2025 in Los Angeles at
Westin Bonaventure, colocated with
Judicial Council's Beyond the Bench
Conference

Public Comment

Public Comment will be taken on any item on the agenda

There are 3 ways to make comments:

1. In person, please come to designated location
2. Raise hand on zoom to speak. If joining by call-in, press *9 on the phone.
3. We encourage email comment to CAREAct@chhs.ca.gov

NOTE: members of the public who use translating technology will be given **additional time**.

Thank You!

California Health & Human Services Agency
Person Centered. Equity Focused. Data Driven.