Community Assistance, Recovery & Empowerment (CARE) Act Working Group Meeting Minutes February 12, 2025

Working Group Members in Attendance:

- **Amber Irvine**, San Diego County Behavioral Health
- **Beau Hennemann**, RVP of Local Engagement & Plan Performance, Anthem
- **Brenda Grealish**, Executive Officer, Council on Criminal Justice and Behavioral Health
- **Dr. Brian Hurley**, Medical Director, Substance Abuse Prevention and Control (SAPC), Los Angeles Dept of Public Health
- **Deb Roth**, Disability Rights California
- **Harold Turner,** Executive Director, NAMI Urban Los Angeles
- **Ivan Bhardwaj,** Chief, Medi-Cal Behavioral Health – Policy Division, DHCS
- **Jill Nielsen**, Deputy Director of Programs, Department of Disability and Aging Services, San Francisco Human Services Agency
- **Jodi Nerell**, Director of Local Mental Health Engagement, Sutter (greater Sacramento)
- **Dr. Katherine Warburton,** Chief Medical Officer, California Department of State Hospitals
- **Lauren Rettagliata**, Family Member and Co-Author of *Housing That Heals*
- **Hon. Maria Hernandez**, Assistant Presiding Judge, Superior Court of Orange County
- **Mark Salazar**, CEO, Mental Health Association of San Francisco
- **Stephanie Welch**, Deputy Secretary of Behavioral Health, CalHHS
- **Xóchitl Rodriguez Murillo**, Deputy Secretary, Minority Veterans Affairs, CalVet
- **Zach Olmstead**, Chief Deputy Director, Department of Housing and Community Development

Working Group Members in Attendance Online:

- **Charlene Depner,** Director, Center for Families, Children & The Courts, Judicial Council of California
- **Ian Kemmer**, Director of Behavioral Health with the Orange County Health Care Agency
- **Jenny Bayardo**, Executive Officer, California Behavioral Health Planning Council
- **Jerry May**, San Jose Fire Department, Local 230
- **Keris Myrick**, Person with Lived Experience of Schizophrenia Diagnosis
- **Ketra Carter**, Director, Homelessness Strategies and Solutions Department
- **Lorin Kline,** Director of Advocacy, Legal Aid Association of California
- **Meagan Subers**, California Professional Firefighters
- **Ruqayya Ahmad**, Policy Manager, CPHEN
- **Susan Holt**, Behavioral Health Director and Public Guardian, Fresno County

Working Group Members Not in Attendance:

- **Bill Stewart**, San Diego County Behavioral Health Advisory Board, Chair
- **Dr. Clayton Chau**, National Healthcare and Housing Advisors
- **Dhakshike Wickrema,** Deputy Secretary of Homelessness, Cal BCSH
- **Herb Hatanaka,** Executive Director, Special Services for Groups

- **Ruben Imperial**, Director, Stanislaus County Behavioral Health and Recovery Services
- **Tim Lutz**, Director of Health Services, Sacramento County
- **Sarah Jarman**, Director of Homelessness Strategies and Solutions, City of San Diego

1. Welcome and Introductions

Karen Linkins, Principal, Desert Vista Consulting, welcomed the CARE Act Working Group (WG) members, both those present in person and those who joined online.

Linkins acknowledged that this was the first meeting after the election and for all to extend grace, stay focused on supporting the most vulnerable, and move forward with purpose. She also acknowledged the absence of the Working Group members in the Los Angeles area that could not attend due to the recent wildfires.

Linkins reminded the group to speak slowly for the ASL interpreters. She reviewed virtual meeting guidelines for the members who joined via Zoom and members of the public. She also reviewed essential operations information for the Working Group. She shared the dates for upcoming meetings and encouraged members to submit agenda item suggestions for future meetings.

Deputy Secretary Stephanie Welch acknowledged that this was the first meeting since CARE launched in all counties.

Linkins asked all new members to introduce themselves briefly, beginning with Jill Nielsen, Brenda Grealish, and Ruben Imperial. Mark Salazar, CEO, Mental Health Association of San Francisco, joined the meeting late and introduced himself when he arrived. Also later in the meeting, Linkins welcomed Ian Kemmer, Director of Behavioral Health with the Orange County Health Care Agency, explaining that he will be replacing Dr. Veronica Kelley on the Working Group, as she has now taken a new position in the county.

Deputy Secretary Welch spoke to the importance of the perspective these new members bring to the Working Group as people who are working in the field.

Linkins provided a brief recap of the November 6th Working Group and January Ad Hocs:

- November's Working Group meeting featured a keynote by Dr. Brian Hurley on CARE for individuals with co-occurring disorders. Members received legislative and implementation updates, including details on SB-42 and SB-1400, as well as communications updates from the Neimand Collaborative and San Diego County. Additionally, HMA provided a TTA update.
- Data: HMA provided updates on legislative changes, data dictionary revisions, and county reporting expectations and resources.
- Combined TTA/Comms and Services & Supports: Members heard from Kiran Sahota on the statewide PADs pilot project and from HMA on recent TTA efforts.

2. Featured Topic: Psychiatric Advance Directives (PADs)

Kiran Sahota, MA, President & CEO, Concepts Forward Consulting

Linkins introduced Kiran Sahota.

Sahota presented the following information on Psychiatric Advance Directives (PADs), the multi-county PADs pilot, and the role of PADs in the CARE process:

- Sahota explained three interconnected types of Directives: Psychiatric Advance Directive (PAD), Medical Advance Healthcare Directive (AHCD), and POLST (Physician Orders for Life-Sustaining Treatment).
- A PAD can be a document that transitions with an individual throughout their lifespan.
- Sahota shared that a PAD is voluntary and is a self-directed legal document recognized in 27 states. A PAD is a powerful tool to increase a person's quality of care within mental health, behavioral health and justice-involved settings.
- A "Graduation plan" is a voluntary agreement at the end of CARE to support a participant's successful transition out of the CARE process. Graduation plans aim to facilitate ongoing service access and may include a psychiatric advance directive. It is not court-enforceable or a local government obligation.
- PADs seamlessly integrate across the care continuum, including justice-involved settings (90-day reach-in before release), AOT, FSP, and other services.
- There are two legal parts of a PAD. The first is an Instructive PAD that outlines the clients preferred mental health treatment during a crisis and does not authorize others to make decisions for them. The second is a Proxy PAD which designates a healthcare proxy or agent to make decisions for the client during a mental health crisis if the client is deemed incompetent.
- Hospitals and health facilities must inform patients about PADs and ask if they have one. While some note PADs in discharge plans, they haven't met CMS standards, and PADs aren't yet routine due to limited technical assistance.
- The PADs project Sahota is spearheading is a time-limited, multi-county initiative piloting digital PADs for adults (18+). Participation is voluntary, with counties focusing on different populations.
- The pilot's primary innovation is a digital platform for creating, storing, and sharing PADs. The benefit of a Digital PAD is that it provides efficiency, quality of care and increases care coordination between law enforcement, providers, hospitals, crisis teams, etc.
- Sahota showed a video on how the Digital PAD project is developing: https://www.youtube.com/watch?v=Vs-7Tbt_TGQ
- Sahota discussed potential cost savings benefits of PADs. She highlighted that 25% of the population has a behavioral health condition, with 3% being high utilizers of county services or SMHS. For incarcerated individuals, the cost of one year of mental health services is $120,000.
- PADs Project Phase Two projected cost savings (per total of the eight-counties populations) assuming all SMHS members will have been incarcerated and have had at least one IPU hospitalization at some point in their lives, would be $21,080,136 for one three-day IPU stay.
- Sahota highlighted challenges with PADs, including limited individual use, lack of understanding, and restricted access for first responders and hospital EDs.
- Sahota emphasized that advancing PADs requires training, legislation, and improved accessibility.
- The benefit to PADs is that it reduces hospital and jail recidivism, enhances safety, shortens ED stays, lowers repeat arrests, decreases officer-involved incidents, and improves behavioral health outcomes.

Sahota concluded her presentation and thanked everyone for their time.

Deputy Secretary Stephanie Welch emphasized the importance of action-oriented engagement with the community. She highlighted that PADs were envisioned to support individuals facing repeated hospitalizations and receiving care in settings like jails and emergency departments. Their goal is to help individuals collaborate with their care teams in advance to reduce the trauma of crisis situations. She encouraged the group to explore ways to advance PAD use and understand its impact.

Working Group Discussion

Deputy Secretary Welch and Linkins invited members to share their experiences and challenges with implementing PADs in their county.

- Susan Holt acknowledged the complexities in developing a technical solution. She shared that Fresno is focused on piloting PADs for individuals on conservatorship and the unhoused population. Holt reiterated Fresno's commitment to the pilot and future expansion of PADs.
- Ian Kemmer echoed Holt's points, emphasizing continued progress on implementing PADs. He said Orange County has long focused on the unhoused population and remains committed to advancing these efforts.
- Amber Irvine shared that San Diego integrates PADs into CARE status reviews and graduation planning, completing three so far for CARE participants. Wallet cards help indicate PADs, and providers hold copies. She expressed support for an electronic system and said she hopes to adopt it in San Diego.
- Hon. Hernandez emphasized that while PADs are encouraged in Orange County, trust and relationships take time to build. Clinicians play a key role, as self-help resources alone may not be effective. She stressed the importance of ongoing encouragement and integrating PADs into CARE early, rather than waiting until graduation planning.
- Amber Irvine praised Orange County for being an early CARE pilot county and highlighted its strong peer support team. She noted their enthusiasm for helping facilitate PADs through partnerships, enhancing implementation efforts.
- Sahota emphasized the importance of trust in completing PADs and noted the value of peer support specialists in the process.
- Dr. Katherine Warburton noted that many patients are unhoused and would be ideal candidates for PADs. She questioned why clinicians aren't already facilitating PADs and explored what changes might be needed to enable their involvement.
- Sahota explained that a legal change is needed to allow clinicians to sign PADs, as current probate law restricts them from doing so due to concerns about coercion and loss of capacity. She suggested exploring alternatives, such as involving a notary for capacity-related decisions while allowing clinicians to document treatment preferences.

Linkins asked Meagan Subers and Jerry May about the typical awareness of PADs among first responders in California and how education on PADs for them could be improved.

- Subers noted that from her perspective, there is limited awareness among first responders about enrolling individuals in PADs. A representative from CPFA is involved in a PADs working group to address this and make the process more familiar for first responders.
- May shared that PADs implementation in Santa Clara County faces challenges with stakeholder engagement and funding. First responders, including San Jose Fire and Police, are largely unaware of PADs, and budget constraints hinder progress.

Linkins invited additional comments from group members.

- Jodi Nerell raised concerns about reaching the 22% of individuals with SMI who are outside the specialty mental health system and lack peer support. She suggested integrating PADs into training for community health workers (CHWs) and peer support specialists. Additionally, she inquired about how PADs specifically reduce inpatient admissions and readmissions.

Sahota addressed Nerell's question on reaching the 22%, explaining that the digital form allows anyone to fill it out independently, with two signatures required, in the interest of maximizing accessibility of the tool. Regarding curriculum, Sahota explained that there's no reason why the training for peer support specialists can't be expanded to include PADs. CalMHSA offers a training program, and Sahota encourages PADs to be part of that curriculum, not just for peer support specialists, but for mental health associates or other workers. Sahota discussed the link between PADs and outcomes, stating that they aim to test this in the pilot counties.

- Judge Hernandez noted that while the court can't assist in drafting, they can add materials and resources to their Hub through JCC, and are happy to help with referrals and share more publications on the Hub.
- Brenda Grealish suggested integrating PADs into county planning, mobile crisis teams, and Behavioral Health Services Act transformation. She recommended involving Medi-Cal managed care plans in pre-release and care planning, as well as connecting with the statewide mental health program and CDCR's reintegration teams. She also advised reaching out to probation chiefs, sheriff's associations, and local law enforcement to promote PADs as a prevention strategy. Lastly, she emphasized involving commercial plans, especially for early psychosis intervention, where PADs could be helpful.
- Ruqayya Ahmad said that CPEHN supported expanding PADs for empowering individuals in crises and emphasized their role in prevention and early intervention. She asked if a judge or CARE Court could override the content of a PAD and whether PADs would be integrated into electronic health records with safeguards, allowing providers to access them.

Sahota responded that PADs can be downloaded as PDFs with consent. Testing will be limited, with plans to work with local hospitals and law enforcement through MOUs for training. Widespread access isn't possible yet, so hospitals will receive instruction on adding PADs to client files. Judge Hernandez added that the court does not have the authority to override the content of a PAD.

Deputy Secretary Welch acknowledged the need for more training and further research to make thoughtful recommendations. She asked about the next stage of the project in the pilot counties, wondering if they are conducting research that could offer insights and opportunities for collaboration.

Sahota expressed gratitude to Orange County for providing upfront funding to develop the technology, which allowed them to create a user-friendly, electronic version of the PAD, which will be rolled out starting July 1st, 2025. This will include training facilitators, law enforcement, hospitals, and crisis teams across 8 counties. Vignettes are being created to address common questions, like the court's authority over PADs. The focus will be on training, information use, and access in these 8 counties due to capacity limitations.

- Judge Hernandez clarified that the court cannot order a PAD. Within the CARE setting, the court will not override a PAD, and participation will remain voluntary.

Sahota agreed with Judge Hernandez, stressing that the PAD process is 100% voluntary.

- Deb Roth thanked Sahota for promoting PADs and highlighted the need for clarity on what happens after a PAD is created, particularly regarding the obligations of providers

and law enforcement. She asked if there is any legislation planned for this year to address these issues. Roth stressed the need for more collaboration, expressing concern that PADs should remain as strong as other advanced healthcare directives, which are regulated in the probate code to protect people's rights.

- Keris Myrick emphasized the importance of peer support in using PADs, similar to the success of wellness recovery action plans (WRAP) in California. She also highlighted the value of research showing that PADs can reduce coercive care and costly hospitalizations when implemented correctly.
- Beau Hennemann suggested working with MCPs through ECM and using performance metrics, like the palliative care model. He also highlighted the need for a more efficient way to integrate PADs into EMRs and HIEs. Lastly, he asked about challenges in the pilot counties, particularly the extra steps required in urgent situations with limited resources.

Deputy Secretary Welch emphasized the role of the Working Group in advancing PADs, ensuring individuals in crisis have their wishes considered. She highlighted the need for action-oriented problem-solving and community-driven solutions.

3. CARE Implementation Updates Panel

Secretary Kim Johnson, CalHHS
Stakeholders and Working Group Members

Deputy Secretary Welch introduced Kim Johnson, CalHHS Secretary.

Secretary Johnson expressed gratitude for the group's efforts in supporting CARE implementation statewide. With a background in social services and community work, she emphasized her commitment to improving behavioral health access and addressing homelessness. She said she looks forward to listening, collaborating, and breaking down barriers to better serve communities.

Deputy Secretary Welch highlighted the need to expand petition sources. Cohort 1 data revealed a lack of petitions from hospitals, behavioral health providers, and first responders. She said that efforts are underway to increase awareness among system partners, and today, two partners will share their experiences using the petition process to access the CARE Act.

Linkins introduced Camille Rose, LCSW, Supervising Psychiatric Social Worker, California Department of Corrections and Rehabilitation (CDCR), Division of Adult Parole Operations (DAPO), Behavioral Health Reintegration (BHR), San Diego County and Dana Meeks, Manager of Clinical and Psychological Services, Sutter Health, Alta Bates Summit Medical Center, Herrick Campus.

Linkins invited Rose and Meeks to share their history with CARE, their experience serving this population, the number of petitions they have filed, and their overall experience with the process.

- Rose introduced herself as a representative of DAPO, working alongside parole agents to support individuals released from California State prisons. She shared that their first CARE petition was filed about a year ago, with significant support from San Diego

County's CARE clinicians. Their training and responsiveness have been crucial in addressing the needs of this high-risk population, which has historically struggled to access services.

- Rose emphasized the importance of filing petitions for individuals with urgent needs who cannot navigate traditional systems due to their severe symptoms. She said that in San Diego, CARE clinicians collaborate with parole agents to locate and engage clients, overcoming barriers such as transportation and communication challenges. So far, her department has filed around 10 petitions and also follows up on cases initiated while individuals are in custody or hospitalized.
- Meeks said that she oversees crisis and behavioral health services at Alta Bates, which includes one of Northern California's few acute psychiatric units. They serve high-risk patients, many of whom meet CARE criteria due to frequent hospitalizations and justice system involvement.
- Meeks emphasized that hospitals are crucial in identifying patients at high risk for rehospitalization. She shared that since November, Sutter has filed about eight petitions, starting in San Francisco and later in Alameda County. The process has required significant collaboration and adjustments. She said that switching the language they use from "CARE Court" to "CARE Act" has helped reduce the intimidation people feel about the process.
- Meeks shared that Sutter has been pleased to see counties contract with housing and FSP teams to serve CARE participants, meeting the expectation for better access to resources to reduce rehospitalization and retraumatization.
- Rose shared a success story about a client on supervised parole, who had severe mental illness, medical issues, and was often re-arrested due to his inability to charge his GPS tracking device. After a petition was filed, San Diego's CARE team quickly stepped in, housing him and providing medical and mental health care. While the client still faces challenges, such as walking away from programs, his quality of life has significantly improved. He's less vulnerable, no longer living on the streets, and has a much better support system, with the CARE team providing coordination between jail, parole agents, and housing.

Deputy Secretary Welch asked Meeks to provide more examples of challenges that the group could explore and work on solving together.

- Meeks discussed the challenge of balancing conservatorship and CARE processes in Alameda County. She explained that temporary conservatorship is sometimes needed to stabilize individuals before they are ready to transition to CARE, though this approach faces some resistance from the county.
- Meeks shared the success story of a patient with frequent hospitalizations and homelessness. After the Sutter team filed a CARE petition, the county CARE team provided the patient with a phone, prioritized housing, and secured an alternative placement when the initial housing provided was unsuitable.

Deputy Secretary Welch highlighted the group's evolving understanding of the CARE process and the implementation landscape at the local level, noting that early discussions focused on how to stabilize individuals experiencing homelessness before housing. She questioned the assumption she often hears that someone must be stable enough for outpatient services before entering CARE, emphasizing the need to explore safe, comfortable engagement methods to meet the needs of respondents between petition filing and the first court hearing.

Deputy Secretary Welch invited input from other system partners and counties, seeking insights on challenges and experiences similar to those discussed.

- Dr. Warburton highlighted the challenge of discharge planning at state hospitals, as most patients come through the criminal legal system. She noted the rising number of individuals deemed incompetent to stand trial, often arrested due to being unsheltered and untreated. After being stabilized on medication, many have charges dropped and return to the same conditions that they were experiencing at the time of their arrest. To address this, the Department of State Hospitals began filing CARE petitions for this population, coordinating with both criminal and civil courts. With about 55 petitions filed, their early observations suggest promise in breaking the cycle of criminalization.
- Kemmer shared that Orange County trained its jail reentry and outreach teams to file CARE petitions, helping break the cycle of re-incarceration. This has improved engagement with hard-to-reach individuals, showing success since November.
- Holt shared that Fresno County, as a Cohort 2 county, is focused on widespread education. She highlighted a recent state hospital petition as a great opportunity for CARE coordination and relationship-building. Regardless of court outcomes, these efforts help bridge system gaps and improve service connections.
- Brenda Grealish from the California Council on Justice and Behavioral Health, highlighted the immense efforts underway to support individuals in reentry and emphasized two key challenges: a lack of specialized expertise and workforce gaps in serving the SMI population. She stressed the need for trained clinical and support staff across all care levels, from independent living to institutional settings. Additionally, she underscored the importance of a full housing continuum to match individual needs.

Deputy Secretary Welch asked system partners for suggestions on how to make the CARE petition filing process easier for health, hospital, and criminal justice systems, while ensuring the criteria are still met. She acknowledged that navigating the process has been challenging and that the state continues to seek ways to improve it.

- Nerell highlighted the need for standardized petition filing methods, especially for facilities accepting patients from multiple counties. She stressed the importance of E-filing access and simplifying the fee waiver process. Additionally, she noted the strain that petitioning places on inpatient settings, particularly EDs, with multiple competing tasks. To improve efficiency, she recommended involving other roles in petition filing, like peer supports and community health workers, while ensuring proper training and supervision.
- Meeks discussed how her team collaborated with Alameda County to streamline the filing process by having the Behavioral Health Director sign and file petitions, bypassing the investigatory period and avoiding the need for treatment teams to appear at hearings. This has made the process faster and more efficient. However, in other counties, the process is longer and more complicated. Meeks suggested creating a standardized system across counties, where facilities provide necessary information and counties handle the filing.
- Rose agreed with the need for e-filing, noting that in San Diego, petitions must be walked or mailed in. She emphasized that front-loading the effort with the petition reduces ongoing issues like arrests and hospitalizations, and seeing results over time helps her team stay motivated.

Deputy Secretary Welch asked Meeks if the Alameda County system uses the SB42 referral process or if they complete the petition themselves.

- Meeks explained that they complete the petition and send it to the county. The Behavioral Health Director then signs it, and county counsel files it, bypassing the investigatory period. This process is done in partnership, but it's not a referral; they've only filed petitions so far.

Irvine asked Meeks if the individuals for whom they complete the petitions and send to Behavioral Health are agreeing to the referral or the petition being filed and participating in the process.

- Meeks shared that some patients aren't ready to engage due to symptoms like paranoia, but they hope the patient will come around. While no one has refused, engagement improves as patients stabilize, especially when practical support, like a phone or favorite food, is provided by county CARE teams.

Members continued discussion of process challenges and potential improvements:

- Irvine highlighted the challenge of coordinating between systems, noting that while filing petitions electronically would help, courts require physical submissions. She emphasized the intensive collaboration needed across systems, but frustrations arise due to differing guidelines and workflows. She shared an example of a man caught in a cycle of probation and incarceration, where systems often work counterproductively despite everyone's best efforts.
- Salena Chao, COO of the Judicial Council, highlighted the complexity of creating a standardized process for e-filing due to differing court systems and modernization timelines. Efforts are underway to explore alternative platforms that could interface with case management systems. She emphasized the Judicial Council's ongoing collaboration with criminal justice and IT teams to address these challenges.
- Lauren Rettagliata thanked May for sharing insights into the experiences of first responders and suggested streamlining the process for first responders to quickly pass information to the Behavioral Health Director. She proposed working with crisis teams to help bridge the gap between law enforcement and behavioral health, as some officers are hesitant to get involved.
- Grealish suggested creating an inventory of challenges to address through work groups and developing a technical assistance product with best practices. She emphasized the importance of workforce development, a full continuum of care, and engagement incentives, like rewards, to improve participation among respondents. She said that simple strategies can be very effective in boosting engagement.

Deputy Secretary Welch highlighted the potential of contingency management to support individuals, especially those with opioid use disorder. She wrapped up the discussion and called for a lunch break.

4. CARE in Context of the Specialty Behavioral Health System - Working Group Focus for 2025

Deputy Secretary Welch and Ivan Bhardwaj presented on CARE in the context of the specialty behavioral health system.

Deputy Secretary Welch opened the presentation by reflecting on the past two years of CARE implementation. She framed CARE as part of a broader set of complimentary initiatives, focusing primarily on its alignment with Proposition 1 and the BH-CONNECT waiver. She highlighted the following information:

- Much of the early work of CARE implementation focused on process, but the state is now starting to focus on CARE's role in broader behavioral health system transformation.
- The Newsom administration has made broad efforts to transform the state's behavioral health system—from youth mental health and school-based services to crisis response, peer support, and investments in housing, infrastructure, and parity.
- There is strong alignment between CARE and Prop 1 in providing housing, treatment, and support for people with serious mental illness, especially those who are homeless, justice-involved, or at risk of conservatorship. Prop 1 also includes funding for veterans and housing services, reinforcing equity-focused reform.
- Stable housing is crucial for recovery and is a core element of CARE. The CARE process includes the creation of personalized housing plans, which may include options from interim to permanent supportive housing.
- $1.5 billion has been allocated to the Behavioral Health Bridge Housing Program to support CARE participants.
- Under Prop 1, 30% of Behavioral Health Services Act funding is dedicated to housing for individuals with serious behavioral health needs, and $2.2 billion from Prop 1 will fund supportive housing for low-income individuals with behavioral health challenges.
- The ACT and FACT models are the standard for providing the type of intensive support many CARE participants need, though not all participants may require this high level of care.
- BH-CONNECT will help counties implement and expand ACT and FACT and offer services like peer support, therapy, and crisis intervention. For those needing less care, intensive case management will be used after 12 months in CARE.
- Resources from medical and behavioral health services must be integrated into care planning to better support individuals with high needs.

Deputy Secretary Welch turned the presentation to Bhardwaj.

Bhardwaj gave a brief introduction of himself and the role DHCS plays in CARE, then presented on BH-CONNECT:

- There is substantial overlap between the CARE Act and Behavioral Health Transformation, particularly in serving individuals with serious mental illness and substance use disorders. The set of evidence-based practices included in BH-CONNECT align well with these efforts.
- BH-CONNECT is possible through a Section 1115 Demonstration Waiver, which allows flexibility in Medicaid rules for innovative practices, and the State Plan Amendments, which outline California's Medicaid services. Bhardwaj noted recent draft guidance on these services.
- Areas of alignment between CARE and Behavioral Health Transformation include their shared emphasis on models like ACT, FACT, and Coordinated Specialty Care for first episode psychosis—which will now be offered as bundled Medicaid services for the first time in California.

- The success of these initiatives depends on strong implementation, not just policy. To ensure effective implementation, DHCS is working with Health Management Associates on BH-CONNECT to launch Centers of Excellence that provide fidelity monitoring, training, and technical assistance with the goal of helping counties deliver high-quality care through streamlined, accessible support.
- Bhardwaj shared this was the first time publicly naming the organizations supporting BH-CONNECT. While contracts are still being finalized, more partners may be added to meet future needs. Unlike CARE, where HMA led training directly, here HMA serves as the administrative lead—managing contracts, the website, and coordination.
- Centers of Excellence (COEs) like UC Davis will provide hands-on training, mentoring, and fidelity monitoring to ensure counties implement services effectively and consistently. The BH-CONNECT COEs website is live and will expand to include Behavioral Health Transformation. It currently offers draft EBP guidance, policy details, and administrative resources. A new URL is coming soon. He emphasized growing momentum and the goal of helping more counties prepare for implementation.

Deputy Secretary Welch explained that counties opting into ACT early will have greater access to Medi-Cal funding. She stressed that although the Behavioral Health Services Act (BHSA) officially goes into effect July 1, 2026, counties are already shaping how they'll participate, and early engagement offers a smoother transition. While CARE participants might not see immediate changes from BHSA preparation, key groundwork is underway.

Deputy Secretary Welch encouraged the group to familiarize themselves with BHSA/Prop 1 and noted ongoing discussions in the Behavioral Health Task Force, with more to come in the Spring.

Working Group Member Q&A:

Irvine inquired if the State would cover COE costs for intensive EBP training, and how often and where they will be offered.

- Bhardwaj confirmed training and resources will be fully state-funded, with no county costs.

Irvine asked if DHCS or COEs will handle fidelity monitoring and how often audits will occur.

- Bhardwaj stated that, as drafted, counties can claim for the first nine months before the initial fidelity assessment, with ongoing assessments at set intervals, though exact timing is yet to be finalized.
- Serene Olin noted that counties will have their first fidelity review after nine months, with discussions on setting flexible thresholds for payment, fidelity, and improvement.

Deputy Secretary Welch stressed the need for strong support as BH-CONNECT and BHSA changes roll out. She said that counties must leverage these opportunities to develop resources to serve the CARE population.

Grealish noted that a significant portion of the behavioral health workforce expertise now lies in jails, prisons, and state hospitals, but the focus must shift to community-based care.

Working Group Breakout Discussions:

Linkins provided the instructions for break-out group discussions focused on selecting priority issues for the Working Group to address in the remaining meetings of 2025. She assigned members to five break-out groups. After the groups completed their discussions, a representative from each group reported out:

- Group 1 shared that their conversation surfaced several topics for future discussion in the Working Group. They said that success in this system requires more than individual training, it takes coordinated, team-based care. The group discussed launching learning collaboratives to strengthen interventions for this population, not just for behavioral health providers, but also for partners like first responders and jail staff. They said that there is a need for targeted resources for public guardians and conservators to help them use CARE as a diversion or step-down tool. A state-funded, easy-to-access platform could also support emergency and frontline personnel. They suggested that CalAIM's incentive-based payment model could be expanded to support CARE-related services. They said that the Working Group can help by producing clear, user-friendly materials to spread awareness. Their discussion also touched on various other challenges and potential strategies, such as the inability of many frontline workers to file petitions, offering upfront financial incentives for professionals who commit to working with this population, convening navigators for peer learning and support, and the need to create a simple, direct process to move people to CARE from criminal court to make CARE more accessible for justice-involved individuals.
- Group 2 shared that they saw clinical care, housing, and client support as the most pressing topics for the Working Group to focus on. One idea raised was revisiting the AB 1424 form, which collects input from families and hasn't been updated since 2002. They suggested that modernizing it could help streamline the petition process and improve how information is gathered.
- Group 3 highlighted four areas they hoped the Working Group would focus on in upcoming meetings: data, accountability, client support, and housing. In regards to data, the group specified a desire to better define and measure success, including meaningful touchpoints beyond just petition numbers. Regarding accountability, they discussed how the Working Group might recommend mechanisms to hold counties responsible when services aren't available, beyond just fines.
- Group 4 focused their report out primarily on clinical interventions and workforce challenges, including funding, training, and high turnover. They discussed medication, including concerns about using unenforceable tools in a voluntary program. The group also emphasized the importance of relationships, noting that while CARE participants may only be in the program for a year or two, they may remain clients for life. Additionally, the group raised several topics related to housing, such as stigma related to board-and-cares, client preferences for solitude in their living spaces, and the effectiveness of independent living settings with provider support on site. The group stressed the need for better relationships and communication across systems, especially with MCPs, law enforcement, and first responders.
- Group 5 emphasized that clinical interventions must be individualized and that there is no one-size-fits-all approach. Culturally responsive practices are essential, especially with upcoming federal challenges that will affect counties differently. The group also

discussed the need for a standardized e-filing process, while still respecting the autonomy of each county and court.

Linkins thanked everyone for their participation and said that the collected worksheets will be compiled, and participants will receive a follow-up for feedback before the next meeting.

5. Rationale for Recent Changes to the CARE Act Data Dictionary
Representatives of Health Management Associates (HMA)

Deputy Secretary Welch emphasized the importance of quality data to support a full understanding of CARE's implementation and outcomes. She said that since December 2024, nearly 2,500 people have been served in some way as a result of the CARE process. Updates to the Data Dictionary, now in effect as of January 1, 2025, will improve tracking on key metrics that were not previously collected. She explained that CARE reporting required by statute includes DHCS's annual report and RAND's independent evaluation.

Linkins introduced Serene Olin, PhD, Principal, Health Management Associates (HMA).

Olin provided a detailed update on the new changes to the Data Dictionary driven by new legislation (SB 42 and SB 1400), which expanded CARE data reporting requirements, including on CARE referrals and engagement efforts. Olin highlighted key information about the updated requirements:

- Counties were required to begin collecting data in accordance with the updated Data Dictionary on January 1, 2025.
- The major updates from in the new Data Dictionary are focused on tracking individuals who were formally referred to CARE through newly created pathways, including those diverted to county behavioral health services and not petitioned, as well as tracking elective clients, and former participants (tracked for up to 24 months).
- Counties must now track and report additional data related to outreach efforts, services provided during the investigation and engagement period, and reasons for dismissal.
- Reporting has also been expanded to include individuals engaged outside of the formal CARE process, with new data sections on CARE inquiries and pre-petition outreach.
- The updated Data Dictionary is in final approval in Q1 2025. DHCS urges best-effort reporting, with training and support available.

Olin concluded her presentation. There were no questions asked.

6. Communications Strategies and Telling the Story of CARE
Representatives of Neimand Collaborative

Linkins introduced representatives from the Neimand Collaborative, a communications firm working with CalHHS on CARE Act messaging.

Sarah Hutchinson, President, and Karolyn Cooper, Vice President of Research, presented learnings from a December Neimand Strategy Lab online focus group aimed at improving CARE communication strategies and supporting county outreach. The feedback collected through the focus group will help refine CARE messaging as implementation progresses. Hutchinson and Cooper shared key highlights:

- 23 participants took part in the focus group, including county staff, advocates, court officials, and providers.
- Participants expressed strong support for CARE's potential despite perceived challenges.
- The session surfaced awareness gaps and questions about voluntariness, court processes, and resources.
- Participant feedback highlighted that clear, people-focused communication is key to addressing concerns. Additionally, messaging that acknowledges doubts among stakeholders fosters increased trust and openness to collaboration.
- Messaging resonated with participants when centered on better client outcomes, with personal stories helping make CARE tangible.
- Distinguishing CARE from other courts is crucial, and communication on the court process should meet stakeholders at their level of understanding.
- Improved technical communication remains vital for successful implementation.

Cooper highlighted key barriers to greater support for CARE among stakeholders, including challenges related to court navigation, low awareness, resource concerns, and confusion about eligibility and process requirements. Recommendations that emerged from the Neimand Strategy Lab feedback include:

- Simplifying processes and clarifying goals could improve engagement among key system partners.
- Messaging tests found "CARE as a pathway to safety and services" to be the most effective framing of its value.
- Clear petition guidance, success stories, and tools to address negative perceptions are needed to broaden support and stakeholder engagement.
- Collaboration, flexibility, and sustained outreach remain essential.

Hutchinson and Cooper concluded their presentation.

Deputy Secretary Welch expressed the need for actionable next steps and stronger messaging on CARE's impact. She acknowledged challenges in countering opposing narratives and the difficulties surrounding sharing client stories, including privacy concerns and the fact that long-term success stories are still emerging.

Hutchinson shared that revised messaging and a communications plan are ready for use. She emphasized the importance of progress stories over success stories, as small, real-life examples help stakeholders see CARE's impact and build connections.

Deputy Secretary Welch outlined the need for everyone involved in the CARE process to share their progress stories. While the client's experience is central, it's also important for roles like public defenders and patient rights advocates to share how CARE has helped those they've worked with for years. These stories can guide improvements in the program. She also acknowledged the complexity of the process and suggested gathering feedback from Cohort 2 counties to understand their challenges better.

Working Group members shared suggestions:

- Grealish highlighted that comprehensive services are essential but challenging to deliver, especially given the infrastructure needed. She stressed the importance of incremental progress and acknowledged the barriers faced by the community. She also

suggested close coordination with housing experts to ensure specialized support for this population.

- Sahota stressed the importance of in-person meetings, particularly for smaller counties. She pointed out that face-to-face interactions help establish relationships, which in turn facilitate better communication and collaboration. While virtual meetings are useful, in-person gatherings strengthen connections and drive progress.
- Laura Collins from HMA noted that while in-person convenings were held, they focused more on sharing than structured learning. Now, HMA prioritizes virtual office hours, trainings, and open forums to stay engaged with all Cohort 2 counties, addressing challenges through regular communication.
- Nielsen emphasized the need for targeted messaging for Social Services partners, especially Adult Protective Services, to better align with CARE Court. She highlighted that public guardians and conservators would benefit from being included in Centers on Excellence and evidence-based practices. Nielsen suggested incorporating conservatorship into the broader behavioral health transformation and sharing success stories alongside the negative media coverage.

7. Public Comment

Linkins opened the Public Comment period and requested that participants limit their comments to 2 minutes. She explained that comments can be made verbally in person or via Zoom and in writing in the Zoom chat or via email.

- Terri introduced herself as an SUD counselor working with one of the therapists at the Wellness Center in San Bernardino County, which used to be an interim shelter and is now a 90-day program located in Victorville. She said that they are working to support participants with severe mental health challenges, including delusions. She noted that resources are scarce in the high desert and said they are curious about how CARE may be able to help the individuals they serve, as they feel they have no other programs in the area to connect their clients to for ongoing support. They recently discovered CARE Court through a recommendation from the City of Victorville.

Deputy Secretary Welch encouraged Terri to reach out via the CARE email address for additional information and support.

9. Adjourn

Linkins thanked all attendees and shared the dates of upcoming meetings.

Upcoming Working Group Meetings
May 21, 2025: 10:00-3:00 pm
August 27, 2025: 10:00-3:00 pm
November 19, 2025: 10:00-3:00 pm
