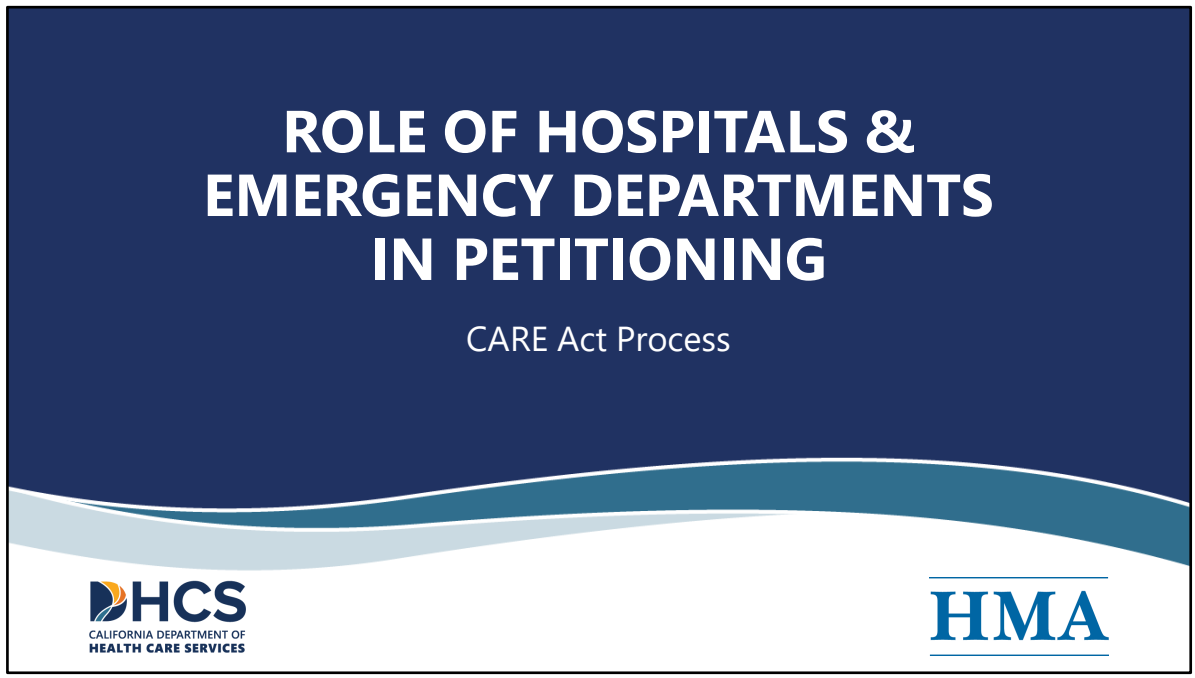
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

HMA

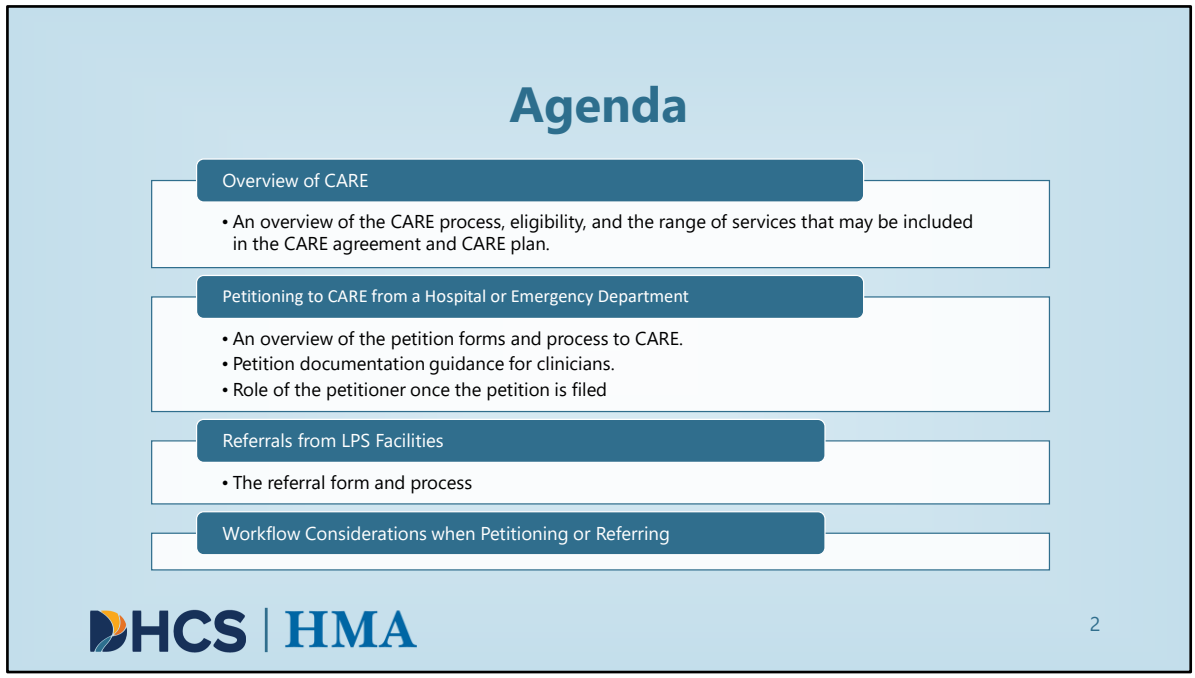
CARE Act Training & Technical Assistance



[Slide Image Description: This cover slide introduces the title and category of this training. It contains the logos for the California Department of Health Care Services and Health Management Associates.]

Disclaimer: This session is presented by Health Management Associates. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, California Department of Health Care Services.

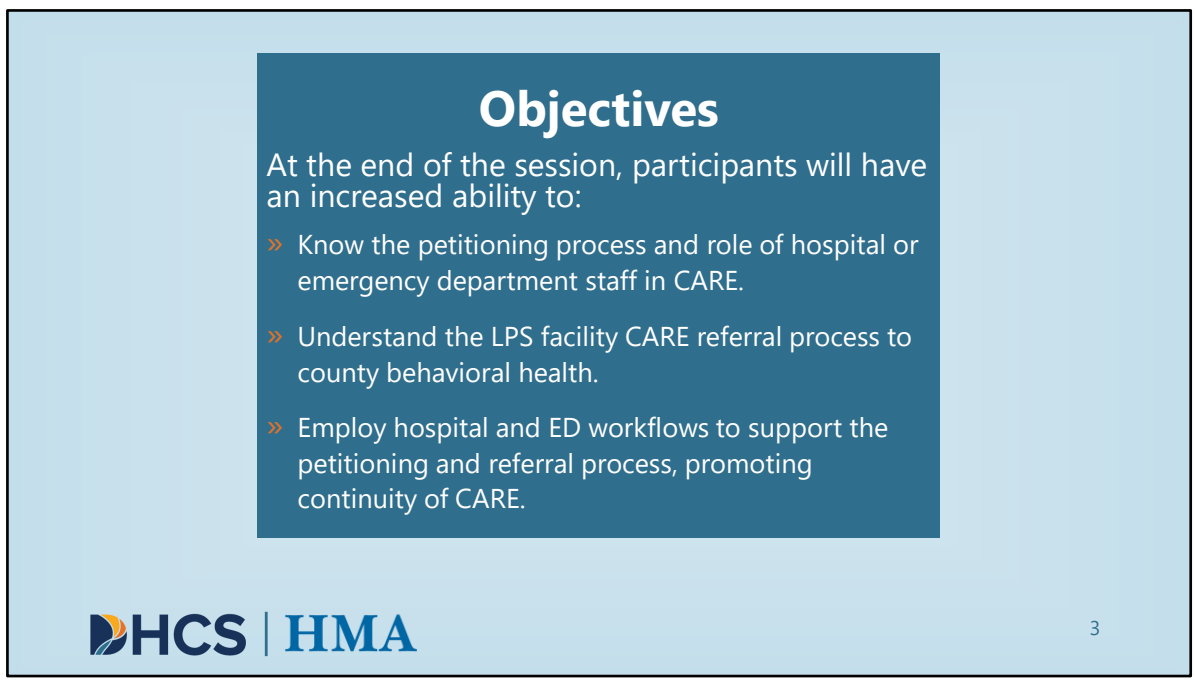
DHCS | HMA



[Slide Image Description: This slide shows the major sections of this training on a light blue background.]

In today's training, we will discuss:

- Overview of CARE:
    - Describe the purpose of CARE, including who it helps and why it was created.
    - An overview of the CARE process, eligibility, and the range of services included in the CARE agreement and CARE plan.
- Petitioning and Referring to CARE
    - An overview of the petition and referral process to CARE.
    - Provide recommendations for hospitals and emergency rooms engaging in the CARE petitioning process.



[Slide Image Description: This slide shows the learning objectives for this training with a light blue background.]

At the end of the session, participants will have an increased ability to:

- Know the petitioning process and role of hospital or emergency department staff in CARE.
- Understand the LPS facility CARE referral process to county behavioral health.
- Employ hospital and ED workflows to support the petitioning and referral process, promoting continuity of CARE.

Presenters

DEBORAH ROSE, PSYD

Principal
Health Management Associates

LAURA COLLINS, LICSW

Managing Principal
Health Management Associates

DHCS | HMA

4

[Slide Image Description: This slide includes images of the presenters of this training on a light blue background.]

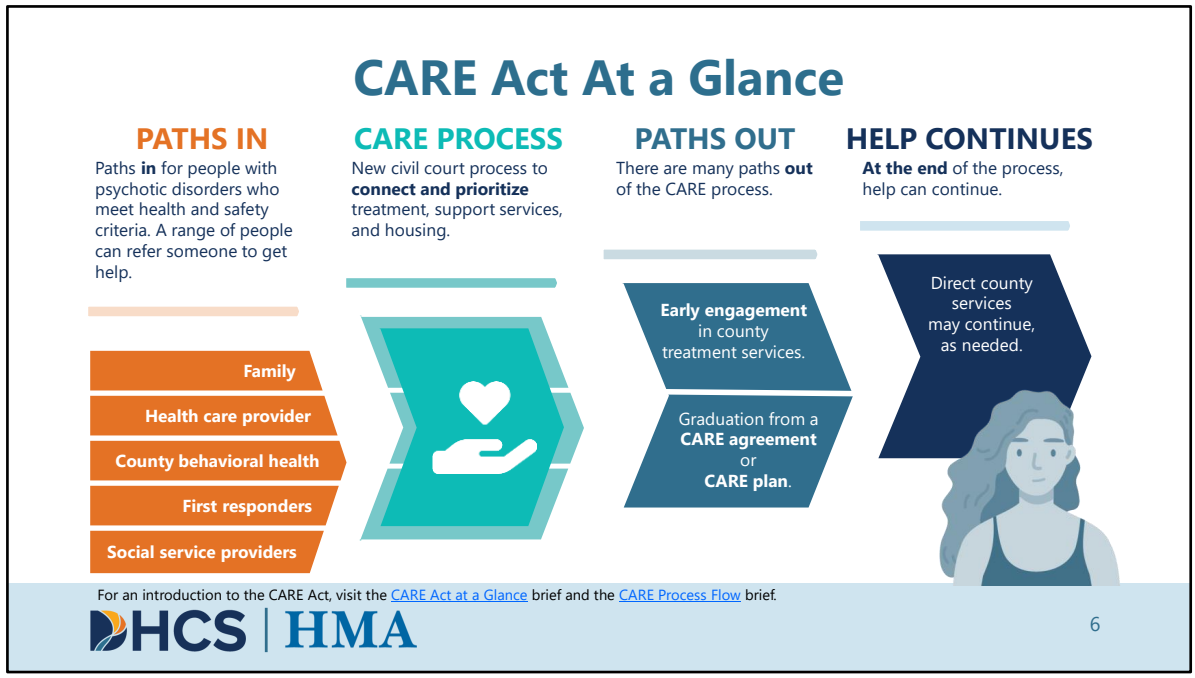
Deborah Rose, PsyD, from Health Management Associates is a licensed clinical psychologist with a history of designing and scaling new initiatives in behavioral health services. She has extensive experience working with social service agencies, behavioral health centers, care coordination, supported housing, and services for unhoused populations. Dr. Rose has broad clinical experience with a variety of underserved populations in human services and has held executive leadership positions in community-based agencies and carceral settings. Earlier in her career, Dr. Rose oversaw Kendra's Law, an Assisted Outpatient Treatment (AOT) program in New York City. She was also Deputy Director of Behavioral Health across the Rikers Island jail system. She has strived to improve access to and delivery of person-centered services for adults living with mental illness, substance use disorders, and co-occurring conditions.

Laura Collins, from Health Management Associates, is a licensed clinical social worker with 25 years of experience in psychiatry and across the behavioral health continuum, with extensive knowledge of, and involvement with civil and forensic processes for persons with mental illness. She has worked both on the ground and at the

administrative/systems-level in the crisis, acute care and outpatient spheres. Laura also understands the housing and community support needs of this complex population, having worked at all-levels to support success and independence for this population.

[Slide Image Description: This is a section divider slide to indicate a major section of this training.]

In this first section, we will provide an overview of CARE, including its purpose, who it helps, and why it was created. We will also detail the CARE process, eligibility, petitioning, and the range of services included in the CARE agreement and CARE plan.



[Slide Image Description: This slide shows the CARE Act at a glance with an icon image of an individual and a heart hovering over a hand.]

The CARE Act creates a new pathway to deliver mental health and substance use disorder services to a subset of Californians with the most complex behavioral health conditions who too often suffer in homelessness or incarceration without treatment.

The CARE Act is more than just a process: it is a way to connect individuals to services in their communities. There are many paths in, and there are individualized paths out. Each path begins when someone files a petition, which means that the petitioner believes someone is eligible and would benefit from additional support. In this process, that individual is referred to as the "respondent," or the person being connected to services. You could know them as a patient or client.

The goal is to give personalized support that someone would benefit from. Think of how hospitals and emergency departments could help an individual get on a path to receive help.

For an introduction to the CARE Act, visit the CARE Act at a Glance brief and the CARE

Process Flow brief.

---

1. Paths in:
    - There are several potential people who can start the process in for people with schizophrenia spectrum and other psychotic disorders who meet health and safety criteria. A range of people can refer someone to get help.
    - Those that can "petition" for an individual to be considered for CARE Act services include:
        - Family member (parent, spouse, sibling, child or grandparent).
        - Health care provider.
        - County behavioral health.
        - First responders.
        - Social service providers

2. CARE process:
    - The CARE process is a new civil court process to connect and prioritize treatment, support services, and housing.
    - The three main paths to services triggered by a petition include voluntary engagement with services, the CARE agreement, and the CARE plan. All these paths essentially connect the individual with treatment, services, and support.
    - Voluntary engagement:
        - The individual engages early with county behavioral health (BH) and accepts services voluntarily. In which, services and supports can be provided outside of the CARE process.
    - The CARE agreement:
        - Treatment, services, and supports take place within the CARE process.
        - All parties are in agreement on the treatment and services that support the recovery of the CARE participant.
        - A CARE agreement is approved by the court.
    - Finally, the CARE Plan:
        - Treatment, services, and supports again take place within the CARE process.
        - In this case, if parties were not able to reach an agreement, the court will adopt elements of the parties' proposed plan(s) into a CARE plan that supports the recovery of the CARE participant.
    - The key here is that all of this is triggered by that initial referral, or petition. By referring or petitioning someone to CARE, a wide net is cast to engage them in services.

1. Paths out:
    - There are many paths out of the CARE process.
        - Early on in the court process, the county BH agency will attempt to engage the individual in treatment services. At this point, it may be possible to divert the respondent from the CARE process through this engagement.
        - Other paths out of the CARE process can include a graduation from a CARE agreement or CARE plan.
2. Help continues:
    - At the end of the process, help can continue.
    - Direct county services may continue, as needed.

https://care-act.org/resource/the-care-act-at-a-glance/
https://care-act.org/resource/the-care-process-flow-to-treatment-housing-and-support/

[Slide Image Description: This slide shows 10 boxes that depict ways the CARE model can help.]

The CARE Act process aims to serve as an upstream intervention and support for individuals with schizophrenia spectrum or other psychotic disorders, which may assist in preventing hospitalizations, incarcerations, and Lanterman–Petris–Short (LPS) conservatorships.

Leveraging the state's investments in behavioral health and homelessness prevention, CARE ensures access to comprehensive and wraparound treatment, housing, and other services and supports to promote stabilization and recovery. CARE adds another option in the continuum of care, with the goal of helping individuals stabilize, move toward recovery, and thrive in community-based settings.

CARE includes the following approaches to support the success of eligible respondents:

- Trauma-informed outreach and engagement – behavioral health teams are being strategic and creative in locating and engaging respondents into their services, meeting the client "where they are at," and often starting with providing resources and meeting immediate needs to build rapport and trust.

- Wraparound services and coordination, multidisciplinary model of care – teams are typically considering the Assertive Community Treatment (ACT) or Full Service Partnership (FSP) model of care.
    - Linkage to other services, including CalAIM programs such as Enhanced Care Management (ECM) and Community Supports.
- Housing that ideally includes additional supports, which may include behavioral health services, case management, substance use disorder services, and peer support.
- Medications as a part of the comprehensive behavioral health services.
- Peer Recovery Supports may be an important part of an individual's recovery, with mutuality, mentorship, and coaching. In addition, many CARE teams are incorporating peer support into both their behavioral health teams and homeless outreach teams, which have been found to contribute to engagement efforts.
- Overall, the CARE Act uplifts the tenets of the recovery model, in that:
    - All components of the CARE agreement and CARE plan must be individualized to the respondent's needs and preferences.
    - CARE speaks to the development of a psychiatric advanced directive that outlines the respondent's treatment and personal preferences. These can be utilized in moments of crisis and also inform ongoing treatment planning.
    - CARE speaks to the volunteer supporter role – a person who is approved by the respondent to support the respondent in expressing their preferences, choices, and decisions.
- Please note that the CARE Act adds an element of county accountability to provide the services outlined in the CARE agreement and plan.
- CARE is the least restrictive alternative to conservatorship.

CARE Eligibility Criteria

All of the following:

- Aged 18 years+.
- Experiencing a serious mental disorder and has a diagnosis of schizophrenia spectrum or other psychotic disorders.
- Severe and persistent symptoms, interfering with daily functioning.
- Not stabilized with ongoing voluntary treatment.
- Participation in CARE is the least restrictive alternative.
- Will likely benefit from participating in a CARE plan or CARE agreement.

At least one of the following:

- Unlikely to survive safely in the community without supervision, and condition is substantially deteriorating.
- Intervention needed to prevent relapse or deterioration.

For more information, visit the CARE Act Eligibility Criteria Fact Sheet, the Eligibility in Practice training materials, and California Welfare and Institutions Code (W&I Code) section 5972.

DHCS | HMA

8

[Slide Image Description: This slide shows an image of a checklist with a person and a description of CARE Act eligibility criteria.]

The CARE Act stipulates eligibility, and we have that list up here. While it is good to have the eligibility in mind, the petitioner is not responsible for proving diagnosis. Rather, the petitioner should focus on documenting what you observe of someone and consider how they might benefit from the CARE process.

CARE eligibility criteria is defined as:

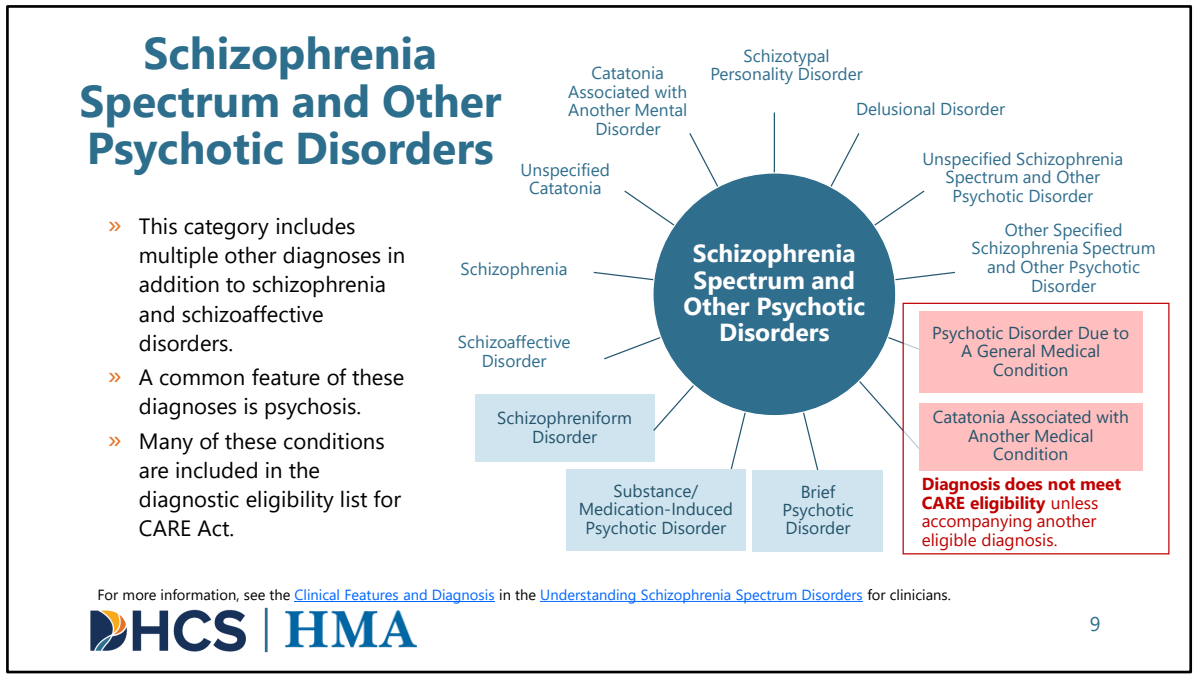
- The person is 18 years of age or older.
- The person is currently experiencing a severe mental disorder, as defined in California Welfare and Institutions Code (W&I Code) section 5600.3, paragraph (2), subdivision(b), and has a diagnosis identified in the disorder class schizophrenia spectrum and other psychotic disorders, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (which we will go into next).
    - This section does not establish respondent eligibility based upon a psychotic disorder that is due to a medical condition or is not primarily psychiatric in

nature, including but not limited to, physical health conditions such as traumatic brain injury, autism, dementia, or neurologic conditions.
    - A person who has a current diagnosis of substance use disorder, as defined in California Health and Safety Code (H&S Code) section 1374.72, paragraph (2), subdivision (a), but who does not meet the required criteria in this section shall not qualify for the CARE process.
- The person is not clinically stabilized in ongoing voluntary treatment.
- Participation in a CARE plan or CARE agreement would be the least restrictive alternative necessary to ensure the person's recovery and stability.
- It is likely that the person will benefit from participation in a CARE plan or CARE agreement.

At least one of the following is true:
- The person is unlikely to survive safely in the community without supervision, and the person's condition is substantially deteriorating.
- The person is in need of services and supports in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or others, as defined in W&I Code section 5150.

For more information, visit the CARE Act Eligibility Criteria Fact Sheet, the Eligibility in Practice training materials, and California Welfare and Institutions Code (W&I Code) section 5972.

https://care-act.org/resource/care-act-eligibility-criteria-fact-sheet/
https://care-act.org/training-material/care-act-eligibility-in-practice/
https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=5972.&lawCode=WIC



[Slide Image Description: This slide shows a circle with arrows listing schizophrenia spectrum and other psychotic disorders.]

When we are thinking about eligibility of course it's helpful to better understand the qualifying diagnoses. This slide shows that array of diagnoses that are eligible – specifically schizophrenia spectrum and other psychotic disorders that are defined in the Diagnostic and Statistical Manual of Mental Disorders (also known as the DSM-5) that includes this grouping of diagnoses that essentially have psychotic features. However each has somewhat different diagnostic criteria.

Not all the diagnoses in this chapter of the DSM-5 are eligible for CARE. The two that are not eligible are psychotic disorder due to a general medical condition or catatonia associated with a medical condition. These diagnoses must be accompanying another eligible diagnosis to meet criteria for the CARE process.

There are other conditions where someone might experience psychosis that are not contained in this chapter (e.g., such as bipolar disorder or depression with psychotic features). Even though these mood disorders may feature psychotic symptoms, they are not currently eligible diagnoses.

Keep in mind that having an eligible diagnosis is just one of the eligibility criteria for CARE. For example, someone diagnosed with brief psychotic disorder, schizophreniform disorder (often associated with early diagnosis), or substance-induced psychotic disorder would also have to meet eligibility criteria related to the "severity in degree and persistent duration" of their symptoms as well.

For more information, see the Clinical Features and Diagnosis in the Understanding Schizophrenia Spectrum Disorders for clinicians.

https://care-act.org/training-material/clinical-features-and-diagnosis-understanding-schizophrenia-spectrum-disorders-series/
https://care-act.org/training-material/series-understanding-schizophrenia-spectrum-disorders/

[Slide Image Description: This is a section divider slide to indicate a major section of this training.]

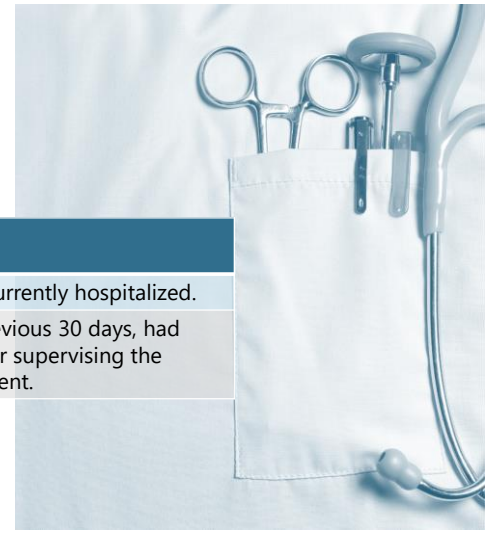
In this section, we will provide an overview of the petition and referral process to CARE, as well as recommendations for hospitals and emergency rooms engaging in the CARE petitioning process.

Who Can Petition?

Hospitals and emergency department staff are among eligible petitioners.

Eligible Petitioner	Includes designee?	Timing
Director of a hospital	Yes	The individual is currently hospitalized.
Licensed behavioral health professional	Yes	Currently, or in previous 30 days, had been involved in or supervising the individual's treatment.

"Designee" includes individuals at the organization who have been identified by the director to complete the petition.



For more information, visit CARE Act Resources For Petitioners. For a complete list of eligible petitioners see this FAQ and refer to W&I Code section 5974.

DHCS | HMA

11

[Slide Image Description: This slide shows an image of a clinician's shirt pocket and includes information about eligible petitioners.]

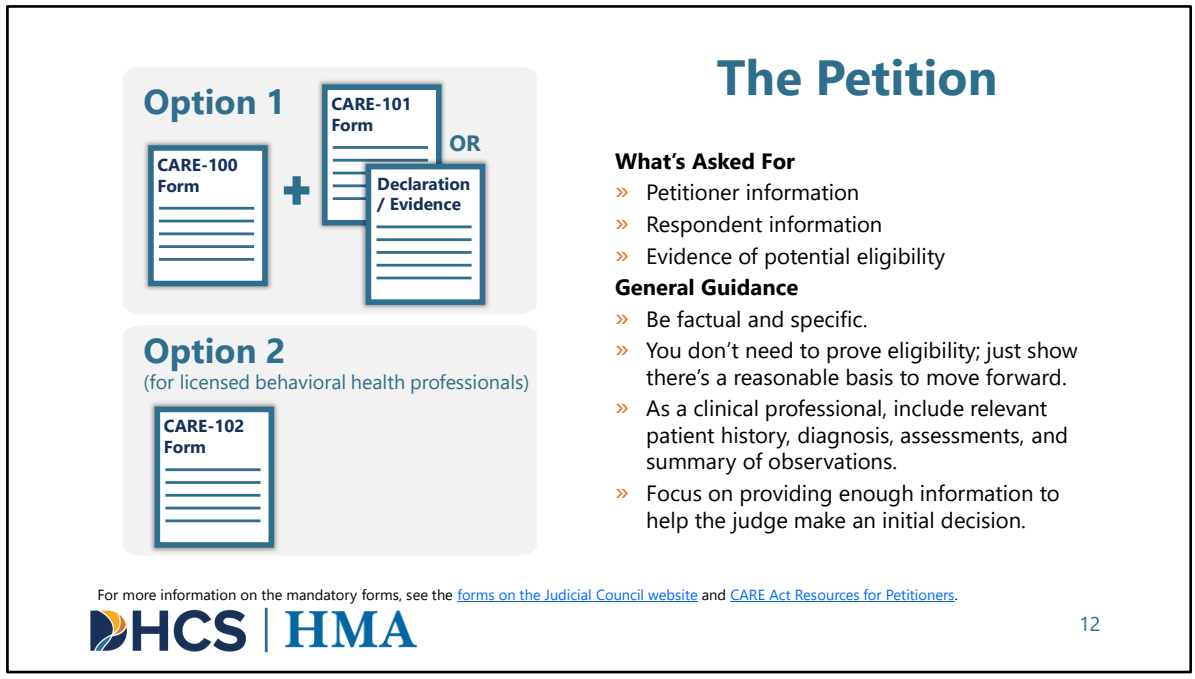
A petitioner could include lay individuals like a family member, roommate, or the individual themselves. A petition can also be filed by a number of system partners, which includes hospitals and emergency department staff.

- The director of a hospital (or designee) in which the respondent is hospitalized.
- A licensed behavioral health professional (or designee) currently, or in previous 30 days had been, involved in respondent's treatment.

Both of these petitioners include a "designee," or individuals at the organization who have been identified by the director to complete the petition. A "designee" of the director of a hospital could, for example, include a psychiatrist, social worker, or other treatment team member.

Keep in mind that petitioners can partner with other petitioners to complete the petition. For example, if a first responder (another eligible petitioner) is completing the petition, hospital staff could help complete additional documentation (which we will discuss in a moment).

For more information, visit CARE Act Resources For Petitioners. For a complete list of eligible petitioners see this FAQ and refer to W&I Code section 5974.



[Slide Image Description: This slide describes the options for petitioning and includes four images representing CARE-100 form, CARE-101 form, declaration/evidence, and CARE-102 form.]

The purpose of this petition is not to prove everything up front—but to give the judge enough information to decide whether the case should move forward. Based on what's submitted, the judge may either dismiss the petition or ask the county BH agency to investigate further.

The petition doesn't need to be exhaustive. It should include what you know and have observed—enough to reasonably believe the person may meet the CARE criteria.

There are two different ways to file a petition, depending on who you are and what information you have. We'll touch on Option 1 but today we are focusing on Option 2, as those petitioning from the hospital or emergency department will likely fall under the category of the licensed behavioral professional. In both options they will ask for information about the petitioner, information about the respondent (such as how to contact them and any language or accessibility accommodation that may be useful). The bulk of these forms focus on capturing information related to the individual's potential eligibility.

Option 1: General Petition Process (For Most Petitioners)

You would use this path if you're not a licensed behavioral health professional (but still an eligible petitioner). In this case, you may be a first responder who was involved in referring someone to the emergency department. Option 1 would also be an option that family members consider when meeting with emergency department staff, who may be discharging the patient and wants to provide options to families about petitioning for CARE.

Option 1 includes the **CARE-100** form, that asks the petitioner to explain their observation in their own words. Again, for today's training this is for non-clinicians interacting with an ED or hospital, who in this case could be first responders or family members.

With **Option 1,** the petitioner must include *one* of the following to support the petition:

- **CARE-101 form**: A declaration from a licensed behavioral health professional who has either examined the person in the last 60 days or has tried multiple times. They must believe the person may meet CARE eligibility criteria. The family member or first responder may reach out to this individual to provide the additional clinical information included in the CARE-101.
- **OR other documentation**: Evidence that the person has had at least two intensive treatments, one within the last 60 days. This could include hospital discharge papers or a signed declaration from someone with direct knowledge of the hospitalizations. If the petitioner has knowledge, the declaration of two 5250s can be included directly on the CARE-100. Otherwise, that information can be attached to the petition.

Option 2 is the more streamlined process for Licensed Behavioral Health (BH) Professionals

As a licensed BH professional, either working in the ED or hospital, you may use this path.

- In this case you would fill out the **CARE-102** form. This combines both the petition and the declaration from the licensed behavioral health professional into one document.
- Like the CARE-100 and CARE-101, it allows you to describe what you know in terms of the patient's history, diagnosis, including current assessments, plus what you have observed and why you believe the person may be eligible for CARE. Often, if the patient also has a recent history of psychiatric hospitalizations, the ED or hospital staff may choose to include this with the CARE-102 responses, to bolster the petition.

Reminder:

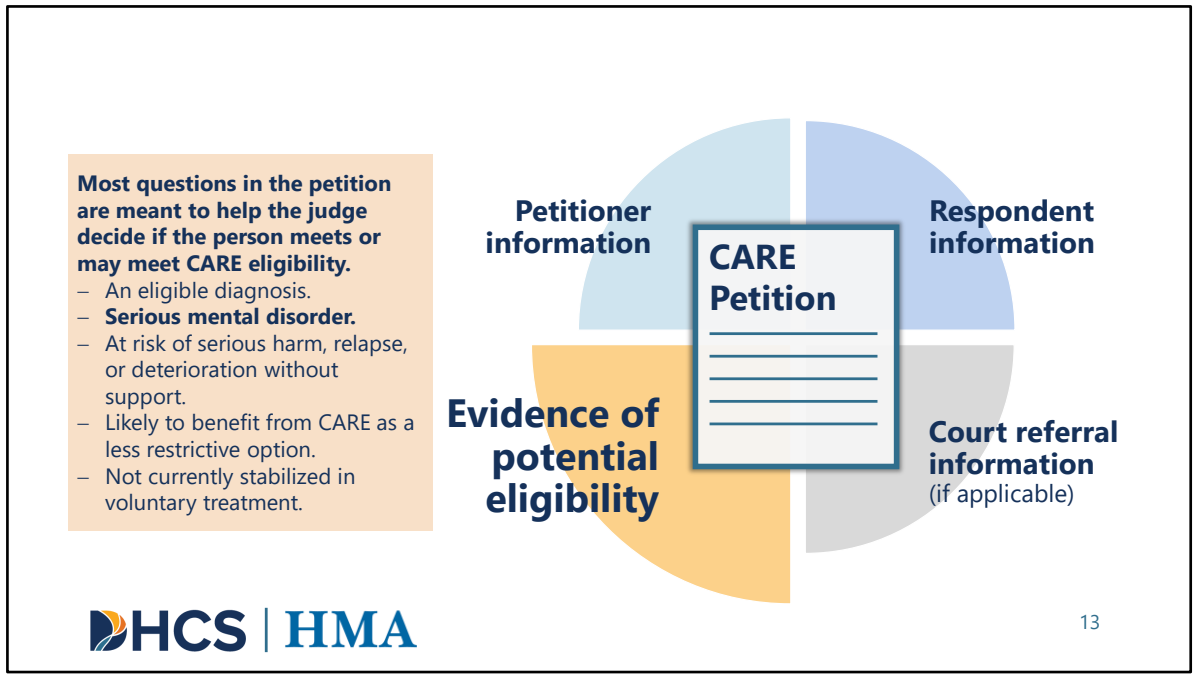
Regardless of which option you use, the key is to provide enough detail for the judge to decide whether the case should proceed—not to prove everything. If the judge believes there's a reasonable basis, they may request more information or begin the formal CARE

process. Just document what you know, and keep the focus on what you've personally seen or learned.

As hospital and emergency department staff, it's important to understand that the petition isn't a test about getting it "right or wrong." It's about providing what you observe and know and documenting this information in response to the questions. You only need to have a reasonable belief that the individual qualifies for CARE. The judge has broad discretion when reviewing your petition when conducting the initial (prima facie) review of the petition.

For more information on the mandatory forms, see the forms on the Judicial Council website and CARE Act Resources for Petitioners.

http://www.selfhelp.courts.ca.gov/CARE-Act/forms
https://care-act.org/library/petitioners/



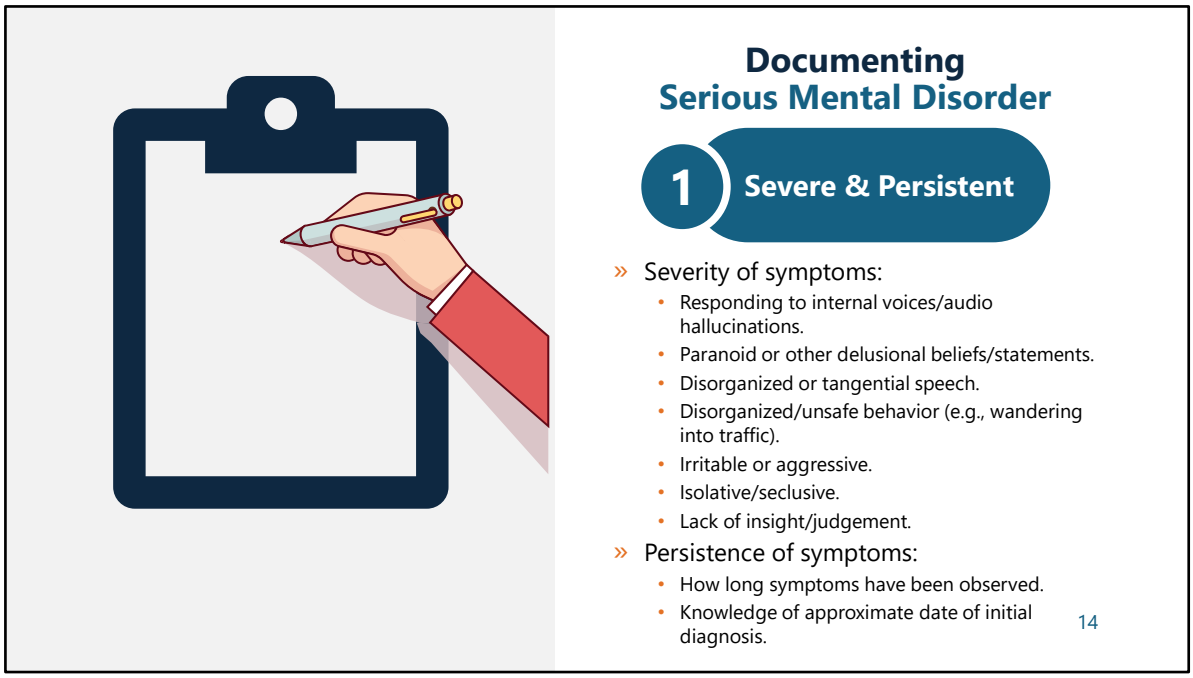
[Slide Image Description: This slide includes an image representing a CARE petition, with a focus on evidence of potential eligibility.]

Most questions in the petition are meant to help the judge decide if the person meets or **may meet CARE eligibility.** I'll be speaking to one aspect specifically – **serious mental disorder**, but please note the additional criteria you will be asked to document:

- An eligible diagnosis – even if it's provisional or historical.
- At risk of harm or deterioration without support.
- They are likely to benefit from CARE as a less restrictive option.
- And importantly, that the individual may **still be eligible** even if they are currently enrolled in outpatient treatment but **not stabilized**.

As a behavioral health professional, you can provide additional clinical information, insights, and details that will help determine eligibility.

As a reminder, you don't need to provide exhaustive information, just enough for the judge to determine the person may be eligible. And keep in mind that the respondent will receive a copy of the petition.



[Slide Image Description: This slide describes what you can include to show that symptoms are severe and persistent.]

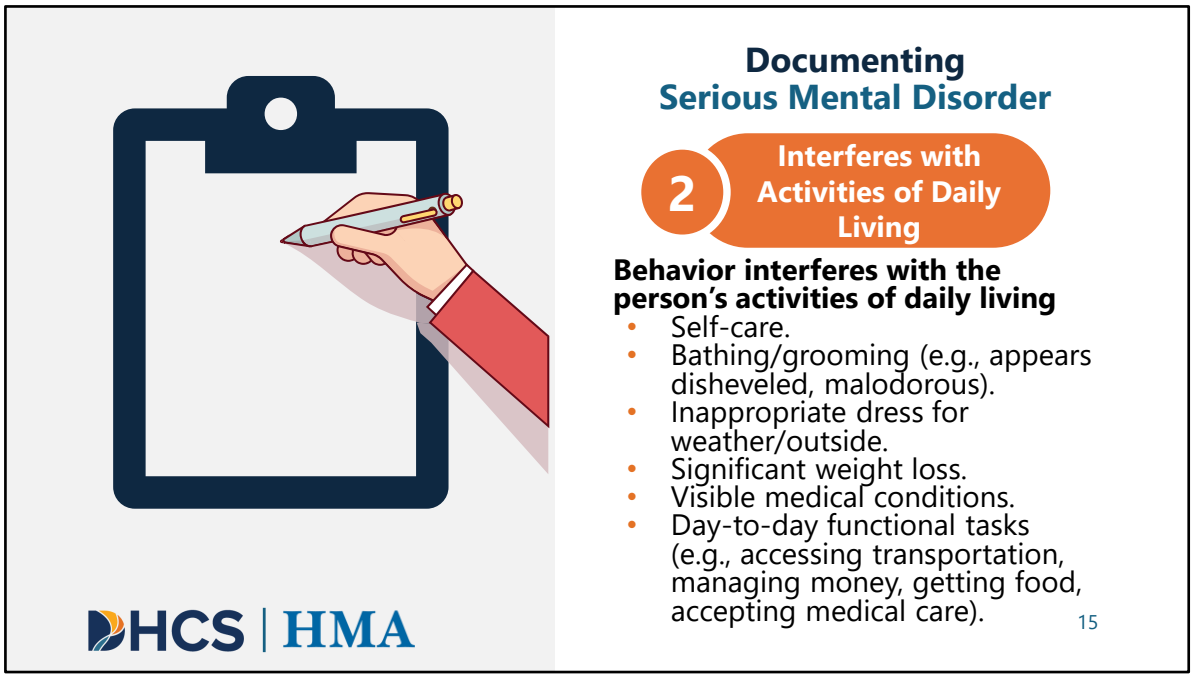
In addition to documenting the patient's diagnosis and the other criteria for CARE eligibility, you will be asked to speak to Serious Mental Disorder, which has 3 components.

The first is noting that the mental disorder is **"severe in degree and persistent in duration**."

- This is where you can speak specifically **to the severity** of the symptoms you are observing.
- You see here examples of some of these symptoms, speech and behaviors you may want to note, including how the illness may be impacting the individual's insight and judgment:
    - Responding to internal voices/audio hallucinations.

- Paranoid or other delusional beliefs/statements.
- Disorganized or tangential speech.
- Disorganized/unsafe behavior (e.g., wandering into traffic).
- Irritable or aggressive.
- Isolative/seclusive.
- Lack of insight/judgement.

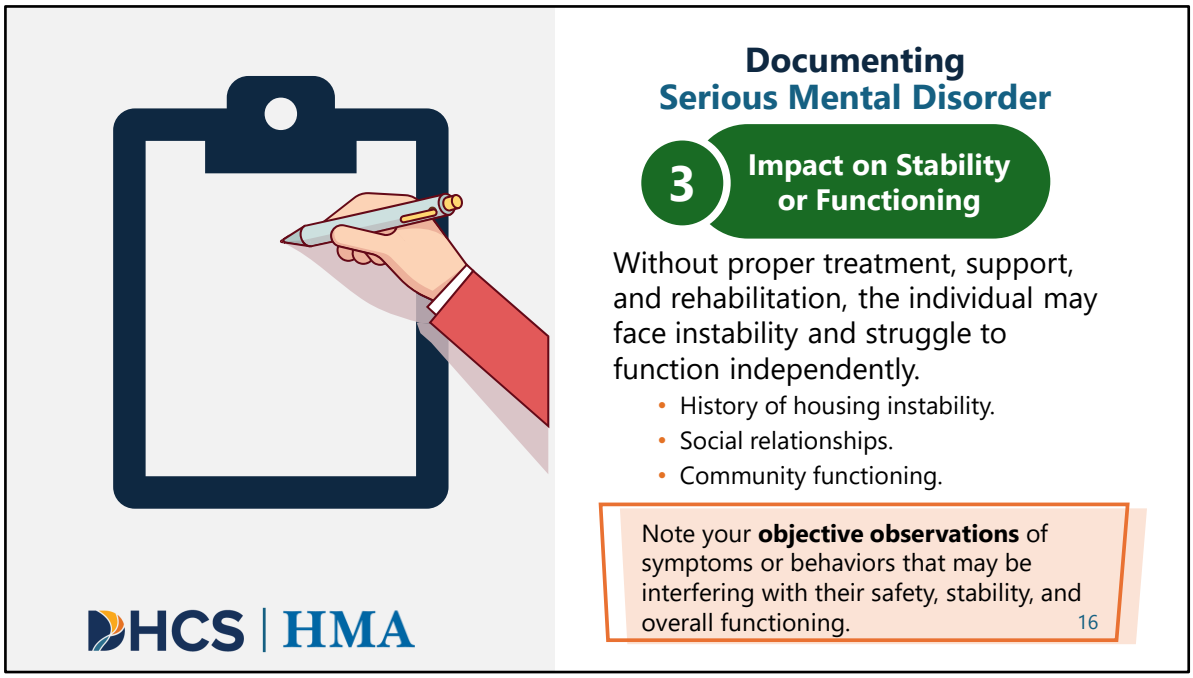
- With regards to the mental disorder being "**persistent in duration**," note
  - How long symptoms have been observed.
  - Knowledge of approximate date of initial diagnosis**.**



[Slide Image Description: This slide describes what you can include to document that symptoms interfere with daily living.]

The **second** area that supports the assertion of Serious Mental Disorder is behavior that is interfering with the individual's Activities of Daily Living or ADL's. Some key examples of how you might document this are noted here, related to **self-care and day-to-day functional tasks:**

- Self-care.
- Bathing/grooming (e.g., appears disheveled, malodorous).
- Inappropriate dress for weather/outside.
- Significant weight loss.
- Visible medical conditions.
- Day-to-day functional tasks (e.g., accessing transportation, managing money, getting food, accepting medical care).



[Slide Image Description: This slide describes what you can include to document that symptoms impact stability or functioning.]

The **third** supporting assertion is that without treatment, support, and rehabilitation, the individual will not be able to maintain stability or independent functioning.

Consider the following:

- History of housing instability.
- Social relationships.
- Community functioning.

Note your **objective observations** of symptoms or behaviors that may be interfering with their safety, stability, and overall functioning.

Petitioner's Role After Petition is Filed

- The original petitioner should be present and can make a statement at the initial appearance.
  - Many courts allow remote appearances.
- Original petitioners are replaced by county BH during the initial appearance, so would not be required to be present ongoing.

DHCS | HMA

17

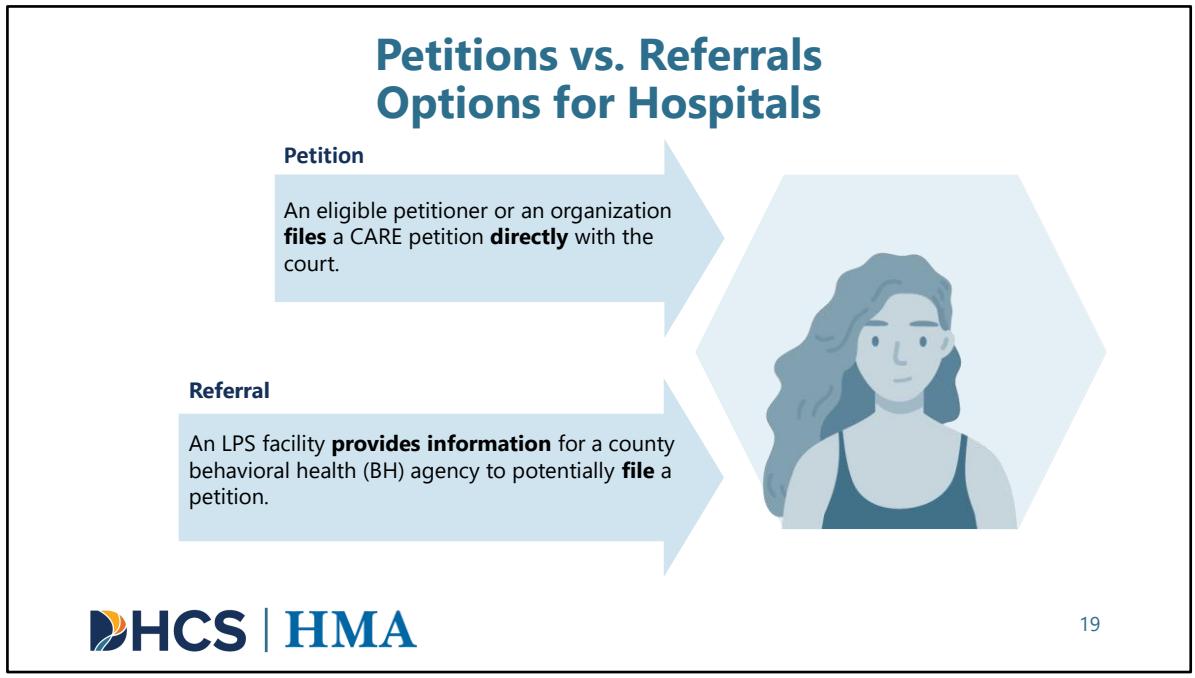
[Slide Image Description: This slide contains a picture of scales, representing the court process that occurs after a petition is filed.]

Let's talk about the petitioner's role after the petition is filed.

- The original petitioner from the hospital or ED should be present and can make a statement at the initial appearance. Please note that thus far, many courts are allowing remote appearances.
- During the initial appearance, the court will replace the original petitioners with county BH, who will from then on be considered the petitioner. After that point, the original petitioner would not be required to attend future hearings. In some counties we are hearing that the court works to efficiently replace the original petitioner with the county, knowing that a court appearance may pose a burden on hospital and ED staff.

[Slide Image Description: This is a section divider slide to indicate a major section of this training.]

In this section, we will provide an overview of the LPS Facility Referrals to CARE.



[Slide Image Description: This slide shows two arrows pointing at a silhouette representing a person and describes a petition and a referral.]

Certain hospitals or facilities also have the option to refer individuals to CARE, rather than petition. Let's discuss the difference between the two.

- In the case of the **petition**
  - The eligible petitioner or an organization **files** a CARE petition **directly** with the court.
  - County BH steps in as a petitioner at the initial appearance hearing.

- In the case of a **referral**
  - If your hospital is also designated as an LPS facility (we will talk more about what LPS means in a moment), your facility would **provide information** to the county BH agency, who would then proceed with potentially **filing** a petition, based on their assessment of eligibility. Remember that when a referral is made, a petition must be filed to move forward in CARE.

- The CARE Act provides some parameters for these specific, formal referrals.
- County BH can also consider establishing referral processes from referral sources not specified in the statute. For example, nothing precludes counties from establishing a referral process that would allow non-LPS facilities to make a referral to county BH for their consideration.
- Referrals in CARE can facilitate access to services for eligible individuals.

Any eligible petitioner is able to file a petition directly with the court. The addition of specific referrals pathways allows these designated entities another option to instead refer to county BH. There are a few potential benefits to this referral process:

- **Timely Access to Services:** Referrals from facilities ensure that individuals are swiftly directed to BH services that can assess their needs and determine the appropriate interventions, avoiding delays in the process. It can also reduce gaps in care that might occur if an individual is discharged without engagement in place.
- **Improved Outcomes:** By referring individuals to county BH agencies, facilities help ensure that people are evaluated within the right context. This increases the likelihood of appropriate care, leading to better behavioral health outcomes.
- **Streamlined Process:** Facilities that use established referral processes with county BH can ensure that petitions contain the right information needed for the court to make initial eligibility determinations and ensure that the county BH teams can build early engagement and conduct needed assessments.

CARE is a less restrictive alternative that should be considered when assessing someone under an involuntary hold.

Referrals from Involuntary Holds

Eligible facilities can refer individuals under an involuntary hold to county BH for CARE consideration.

- **Timing:** Facility is to make a referral as soon as clinically indicated.
- **County BH Action:** County BH assesses the individual and files a petition within 14 days, if the individual meets or is likely to meet CARE criteria.
- **Involuntary Hold Limitations:** A referral does not allow for an extended hold unless individual meets hold criteria.

For more information about updates in SB 42, see the Senate Bill 42 Amendments brief.

DHCS | HMA

20

[Slide Image Description: This slide has a picture of two women speaking and outlines considerations for referrals from involuntary holds to CARE.]

Again, referrals from LPS-designated facilities are outlined in statute. A facility can refer individuals on an involuntary hold to county BH for CARE consideration.

Let's look at some of the specifics:

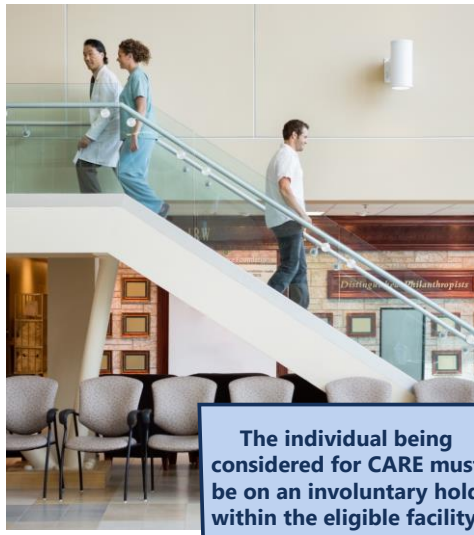
- **Timing**: The facility should make the referral as soon as it's clinically appropriate, usually during discharge planning. We'll talk more about timing shortly, when we discuss hospital workflows.
- **County BH Action**: County BH has 14 business days to assess the individual after receiving the referral. If the individual meets or is likely to meet CARE criteria, county BH will file a petition.
- **Involuntary Hold Limitations**: A referral to CARE does not allow the facility to extend the involuntary hold if the individual no longer meets the criteria for the hold, in order to wait for a county BH assessment.

A CARE referral does not affect the ability of a facility to also make an AOT referral. The key is ensuring coordination with county BH regarding the recommendations.

Since an individual is in an LPS facility and may be eligible for CARE, the facility should consider using the referral option as part of discharge planning. This will enable the facility and county BH to collaborate while BH assesses the individual's situation and, if appropriate, files a petition. However, keep in mind that CARE allows facilities to file a petition directly with the court as well.

This referral pathway was specified in an amendment to the CARE Act in Senate Bill 42. For more information about updates in SB 42, see the Senate Bill 42 Amendments brief.

https://care-act.org/resource/senate-bill-42-amendments/



The individual being considered for CARE must be on an involuntary hold within the eligible facility.

Eligible Facilities

Definition

A facility that provides assessment, evaluation, and crisis intervention, pursuant to W&I Code section 5150(a).

OR

A designated facility as defined in W&I Code section 5008(n):

- A facility that is licensed or certified as a mental health treatment facility or a hospital
- May include a licensed psychiatric hospital, a licensed psychiatric health facility, and a certified crisis stabilization unit

DHCS | HMA

21

[Slide Image Description: This slide has a picture of individuals walking on stairs and outlines facilities eligible for CARE statutory referrals.]

The law defines which facilities can make statutory referrals for CARE. These include one of the following:

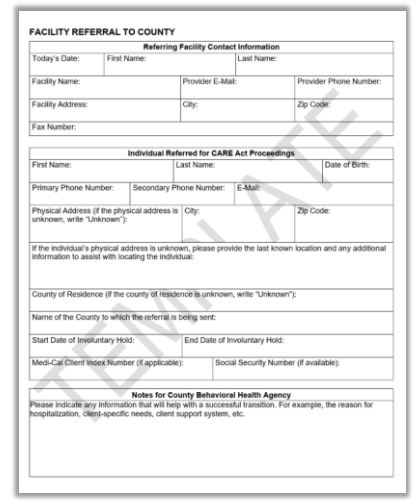
1. **Facilities authorized under W&I Code § 5150(a):** A facility that provides assessment, evaluation, and crisis intervention, pursuant to California Welfare and Institutions Code (W&I Code) section 5150(a) which allows facilities to hold an individual for an evaluation and treatment for up to 72 hours.

2. **Designated Mental Health Treatment Facilities:** A designated facility is one that is licensed or certified as a mental health treatment facility or a hospital, by the State Department of Public Health, (as defined in W&I Code section 5008(n)) which may include:
    - A licensed psychiatric hospital
    - A licensed psychiatric health facility
    - A certified crisis stabilization unit.

Please keep in mind that the individual being considered for CARE must be on an involuntary hold within the eligible facility.

Facility Referral Requirements

- DHCS provided a standard referral form for facilities and encourages its use. LPS-designated facilities must also include a copy of the patient's Model of Care Coordination Plan.
- If facility or county BH develops their own form, the minimum information (if available):
  - Referred individual's name, birthdate, and contact information
  - Medi-Cal Client Index Number (CIN)
  - Social Security Number (SSN)
  - BH professional or their designee's name
  - Facility name and contact information
  - Receiving county BH agency
  - Date of referral
  - Start and end date of involuntary hold
  - Confirmation the referring professional is authorized to make the referral



FACILITY REFERRAL TO COUNTY

Referring Facility Contact Information

Today's Date: | First Name: | Last Name:

Facility Name: | Provider E-Mail: | Provider Phone Number:

Facility Address: | City: | Zip Code:

Fax Number:

Individual Referred for CARE Act Proceedings

First Name: | Last Name: | Date of Birth:

Primary Phone Number: | Secondary Phone Number: | E-Mail:

Physical Address (if the physical address is unknown, write "Unknown"): | City: | Zip Code:

If the individual's physical address is unknown, please provide the last known location and any additional information to assist with locating the individual:

County of Residence (if the county of residence is unknown, write "Unknown"):

Name of the County to which the referral is being sent:

Start Date of Involuntary Hold: | End Date of Involuntary Hold:

Medi-Cal Client Index Number (if applicable): | Social Security Number (if available):

Notes for County Behavioral Health Agency

Please indicate any information that will help with a successful transition. For example, the reason for hospitalization, client-specific needs, client support system, etc.

TEMPLATE

For more information, see Behavioral Health Information Notice 25-012: Facility Referrals to the CARE Act Process and the Facility Referral to County template.

DHCS | HMA

22

[Slide Image Description: This slide lists the referral form components.]

Behavioral Health Information Notice 25-012 provides guidance to counties and facilities on the referral procedures and includes a form for these forms to be used by facilities. Along with this information, facilities must also include a copy of the patient's Model of Care Coordination Plan.

- A facility or a county behavioral health agency may adopt this CARE Act referral form published on the DHCS website or develop and use its own form. DHCS encourages the use of the referral form published on the DHCS website. While facilities are encouraged to use this form when making referrals, county BH is required to accept facility referrals in any form or manner received.
- If facility or county BH develops their own form, the minimum information (if available):
  - Minimum information (if available):
    - Individual's name, date of birth, and contact information (name, phone number, address, and email)

- Medi-Cal Client Index Number (CIN)
- Social Security Number (SSN)
- Behavioral health professional or their designee's name
- Facility name
- Receiving county BH agency
- Date of referral
- Start and end date of involuntary hold

- The facility should include any information that will help with a successful transition through the CARE referral process. For example, the facility may include the reason for hospitalization, client-specific needs, and the client support system.
- They also need to confirm that the licensed BH professional is authorized to make the referral, meaning they:
  - have knowledge of the individual's case
  - have been involved in the individual's treatment during their involuntary hold, and
  - believe that the individual is likely to meet CARE eligibility criteria.

For more information, see Behavioral Health Information Notice 25-012: Facility Referrals to the CARE Act Process and the Facility Referral to County template.

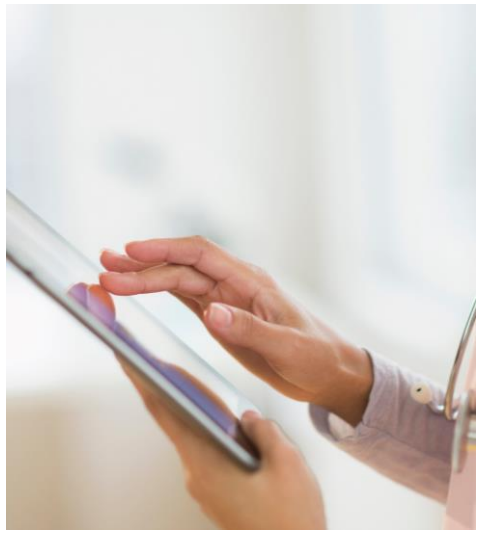
https://www.dhcs.ca.gov/provgovpart/Documents/BHIN-24-039.pdf

https://urldefense.com/v3/__https:/www.dhcs.ca.gov/Documents/BHIN-25-012-CARE-Facility-Referrals.pdf__;!!NwMct28-Ww!LW4Q6OWQ1ILvRhhvdV0zqZxv5D_GwOe6mwO0GyGZJR8AUxu684dRbzytbrKVtCjS0WoxGnMx6ezYEOIMQlaTnE9l_XGRVJo3m2uU$

https://urldefense.com/v3/__https:/www.dhcs.ca.gov/Documents/Facility-Referral-Form-TEMPLATE.pdf__;!!NwMct28-Ww!LW4Q6OWQ1ILvRhhvdV0zqZxv5D_GwOe6mwO0GyGZJR8AUxu684dRbzytbrKVtCjS0WoxGnMx6ezYEOIMQlaTnE9l_XGRVB2cCviA$

[Slide Image Description: This is a section divider slide to indicate a major section of this training.]

In this section, we will provide an overview of the workflow considerations when petitioning or referring to CARE.



Assessing & Planning for CARE in Hospital/ED Workflows

- Assess for eligibility.
  - Initial clinical assessment by a nurse or social worker.
  - Psychiatric evaluation.
- Discuss the process and decision.
  - Discuss with the treatment team.
  - Include and educate the patient.
- Plan for next steps.
  - Identify a point of contact (and team) to complete the petition/referral.
    - Can pull information from EHR.
    - Consider having patient complete a release of information.
  - Coordinate with county BH contacts.
  - Incorporate into discharge planning.

DHCS | HMA

24

[Slide Image Description: This slide shows an image of a hand typing on a tablet.]

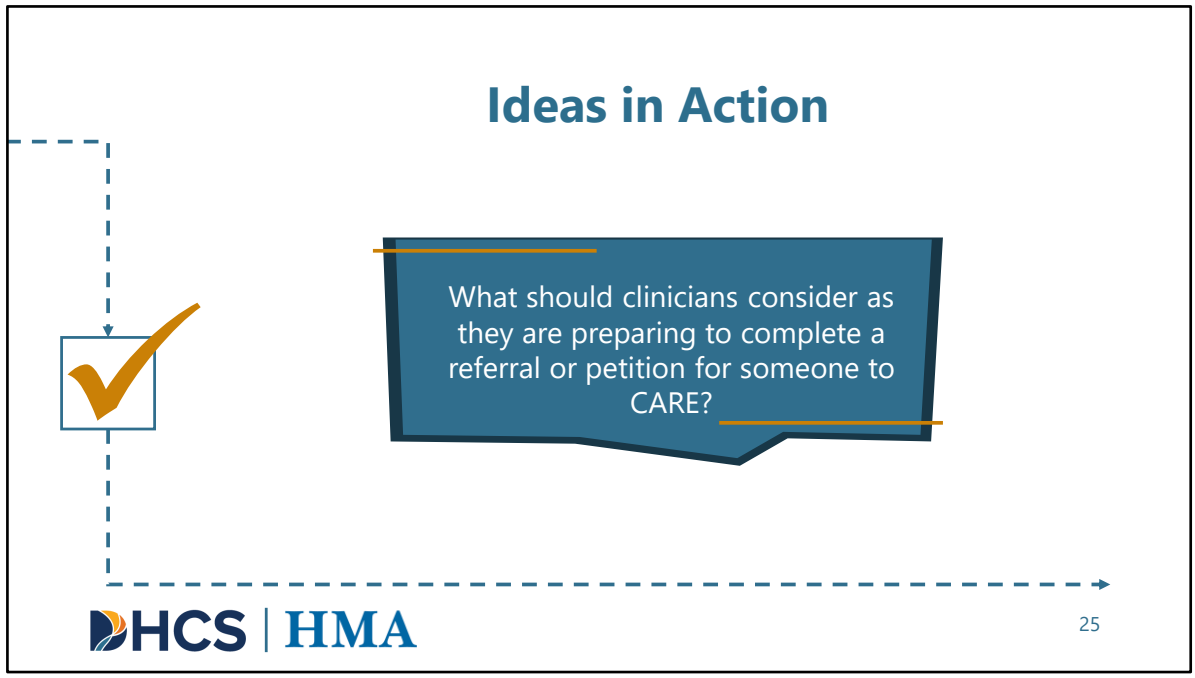
Consider where in your workflows your team can assess whether individuals are eligible for CARE, when you might have these discussions, and what your planning workflows may look like. Based on what we are hearing from counties we some recommendations as to possible workflows.

1. **During the initial assessment or psychiatric evaluation, you can assess for CARE eligibility.**
   - Upon admission to the emergency department or during the admission process for inpatient care, clinicians (such as nurses or social workers) are completing initial assessments that could support evidence of eligibility based on diagnosis, history of hospitalizations, current functionality and safety in the community. This evaluation could happen during an emergency room visit or admission related to a serious mental disorder, but it can also be prompted by a visit or admission related to a physical health concern that is exacerbated by their serious mental disorder.
2. **Discussing the decision to refer or petition to CARE and describing the process.**
   - The decision to refer or petition should be made with the treatment team, or

if you are in the ER, with a supervisor or appropriate team members, according to your hospital's protocols.

- It's also important to include the patient in this discussion, relaying the team's recommendations and answering the patient's questions about the benefits of CARE, including access to additional outpatient support and housing.

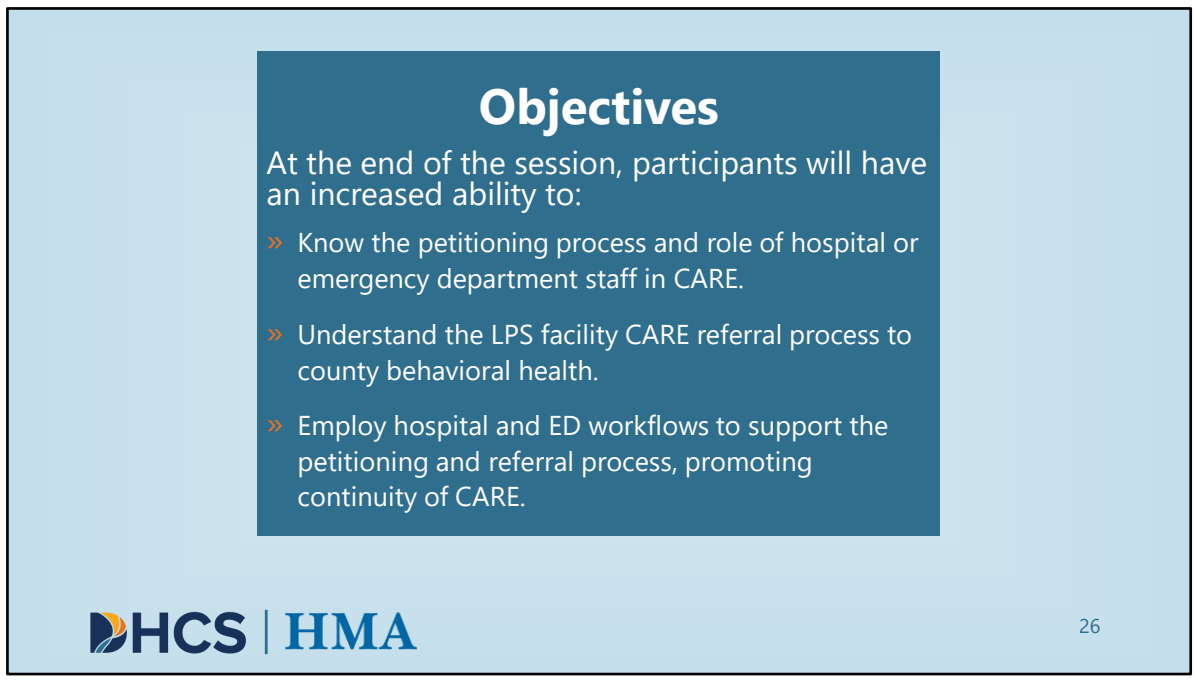
3. **From there, the identified team member works on next steps.**
    - Next steps should include identifying who is completing the referral form or petition; in some cases, it could be a team effort.
        - We have also heard from hospitals that they are pulling content from the electronic health record to populate the referral or petition information.
        - If the patient is agreeable to the referral or petition, having the patient sign releases of information to the recommended treatment and community support providers would certainly support continuity of care, as well as reinforcing the voluntary nature of CARE and the importance of their partnership in the process.
    - Coordinating with county behavioral health sooner than later is also key to supporting a timely response from the county with their own assessment, specifically if it is a CARE referral (which is timebound).
    - Timing is critical—ideally, a referral to CARE should be integrated into the discharge planning process. As many of you know, discharge planning should begin on "day one" of admission. Effective coordination with the court and county BH teams is essential to determine the appropriate timing for initiating this process. These discussions should involve both the treatment team—who assess the patient's readiness for discharge daily—and county BH, who play a key role in ensuring continuity of care.



[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

What should clinicians consider as they are preparing to complete a referral or petition for someone to CARE?

- Take time to discuss before respondent gets a petition to explain your goal in referring them to CARE. Consider who should be a part of that discussion (e.g., psychiatrist, peer, family member if appropriate).
- Gather documentation (e.g., medical records, psychological evaluations) that supports the petition, including observations.
- Familiarize yourself with eligibility criteria, including qualifying diagnosis, but don't get caught up in having to know every detail. You just have to have a reasonable belief that they may qualify.
- Collaborate with others to gather information or complete the referral form or the petition.



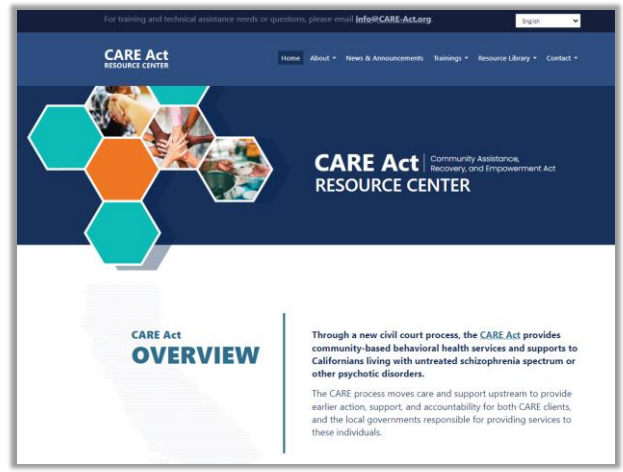
[Slide Image Description: This slide shows the learning objectives for this training with a light blue background.]

So after today's session, let's revisit our learning objectives for today, in that you should have an increased ability to:

- Know the petitioning process and role of hospital or emergency department staff in CARE.
- Understand the LPS facility CARE referral process to county behavioral health.
- Employ hospital and ED workflows to support the petitioning and referral process, promoting continuity of CARE.

CARE Act Resource Center

- Resources:
  - Resources for Petitioners
  - Training and Resource library
  - County Directory
  - Frequently Asked Questions
- Ways to contact:
  - Listserv
  - Technical assistance (TA) request form
  - Data TA request form
  - Stakeholder feedback form
  - Email: info@CARE-Act.org



DHCS | HMA

27

[Slide Image Description: This slide shows a screenshot of the CARE Act Resource Center website, along with a QR code to scan and access the website.]

The CARE Act Resource Center is where you can find resources and also find ways to request training and technical assistance (TTA) or communicate.

- Resources:
  - We have consolidated resources for petitioners, where you can find how-to videos, fact sheets, and other helpful materials.
  - Training and Resource library:
    - We post all trainings to the CARE Act Resource Center; these include trainings that we have done live and also trainings that we record and are available asynchronously. The training materials include a video (with captions available) and a PDF of the slides and talking points that are tagged for accessibility.
    - We also post resources that have been created both by the TTA team and other useful links created by the Judicial Council of California (JC), California Health and Human Services (CalHHS), and other groups (e.g., Office of State Public Defender [OSPD]).

- County Directory: On the CARE Act County Website Directory page, we include links to Self-Help Centers (which can provide legal information and resources to people without a lawyer), links to NAMI, and county-specific links (including county CARE websites created by county BH and by courts in counties).
- FAQs: We frequently add FAQs to the Resource Center based off questions that come up during trainings, through TA requests, and other avenues. There is an option to search and filter FAQs by topic.

- Ways to contact:
  - Listserv
  - TA request form
  - Data TA request form
  - Stakeholder feedback form
  - Email: info@CARE-Act.org

https://care-act.org/library/petitioners/
https://care-act.org/trainings/training-materials-all/
https://care-act.org/library/resources/
https://care-act.org/library/county-website-directory/
https://care-act.org/library/faqs/
https://care-act.us11.list-manage.com/subscribe?u=8ec8c1129c78ce744084103db&id=cbd28f0a2e
https://docs.google.com/forms/d/e/1FAIpQLSfPsaYxPzsE8GYjPRxgGqs5c8AuGTG8Ez_XpWOvrJYQYnJHow/viewform
https://docs.google.com/forms/d/e/1FAIpQLSeqgKj1SJRZhY_OEBhHCYRFghyJL7P3uDR0SGpxF5tMOsv_pw/viewform
https://docs.google.com/forms/d/e/1FAIpQLSf7uSJXEvsH1F-qAVNkng_SEjIgZT9hSbK6kbFEGGgfOPmOhQ/viewform

Learn about Trauma-Informed Care

Definition

- Trauma-informed care is a set of principles that promote a culture of safety, empowerment, and well-being.

Why

- Individuals with schizophrenia spectrum and other psychotic disorders, as well as other mental health conditions, are likely to have experienced trauma.
- It is important to approach individuals with compassion and humility and to consider the whole person.

For more information on trauma-informed care and implications for the CARE Act, see the series for behavioral health (1, 2, 3) or volunteer supporters (1, 2, 3). Also, see the training on implicit bias.

DHCS | HMA

28

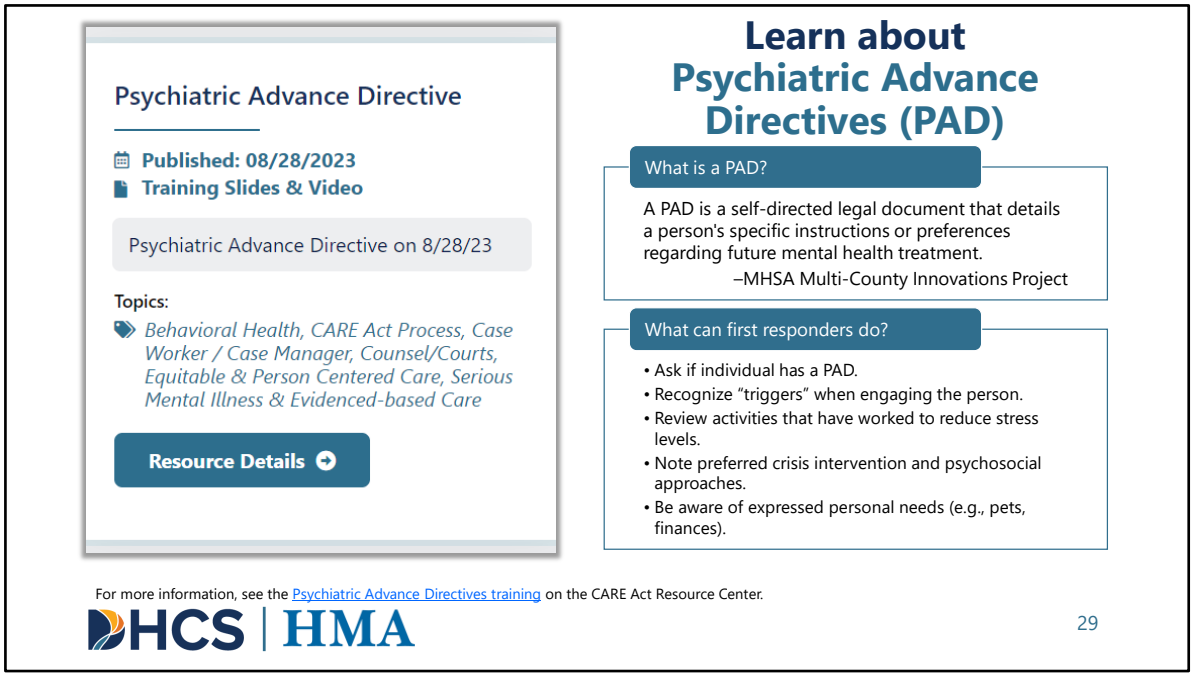
[Slide Image Description: This slide shows an image of an individual putting their arm around another individual's shoulder. The definition and description of trauma-informed care are listed.]

Trauma-informed care is another topic that would be a great next step to learning more. We have two series on trauma-informed care, including three modules for a volunteer supporter (which is more of a lay audience) and then one meant for county BH and courts/counsel, which has a training specifically on mitigating bias. Both series could be helpful for you.

For more information on trauma-informed care and implications for the CARE Act, see the series for behavioral health (1, 2, 3) or volunteer supporters (1, 2, 3). Also see the training on implicit bias.

https://care-act.org/training-material/part-1-trauma-informed-care-tic-organizational-considerations-for-behavioral-health-agencies/
https://care-act.org/training-material/part-2-incorporating-trauma-informed-care-into-

the-care-process-for-behavioral-health-agencies/
https://care-act.org/training-material/part-3-workforce-sustainability-with-trauma-informed-care-for-behavioral-health-agencies/
https://care-act.org/training-material/part-1-foundations-of-trauma-informed-care-tic/
https://care-act.org/training-material/part-2-goals-and-principles-of-trauma-informed-care-tic/
https://care-act.org/training-material/part-3-applying-trauma-informed-care-tic-as-a-volunteer-supporter/
https://care-act.org/training-material/addressing-implicit-bias-for-behavioral-health-agencies/



[Slide Image Description: This slides shows an image of the Psychiatric Advance Directive (PAD) training resource with a detailed description of the background, purpose, and use of PADs.]

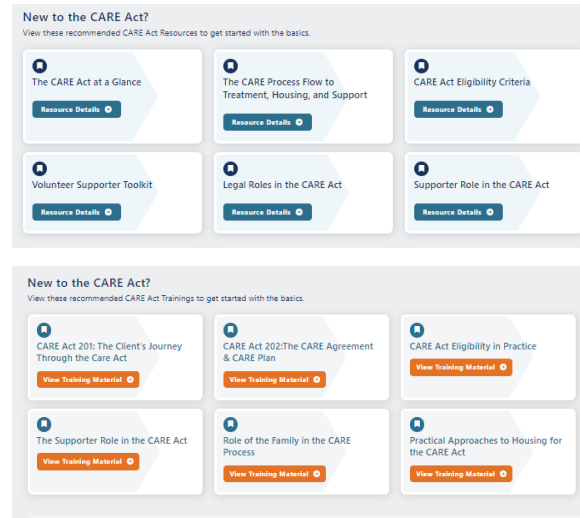
The last training I wanted to highlight was about psychiatric advance directives (PADs). It can be helpful for you to know what a PAD is, how it is used, and what you can ask for when you are working with someone in a hospital or ED. Hospital staff can certainly support – with the patient - the development of a patient's PAD while they are clinically improving and close to discharge.

For more information on PADs, please see the Psychiatric Advance Directives training on the CARE Act Resource Center.

https://care-act.org/training-material/psychiatric-advance-directives/

Available Trainings and Resources

- Recordings and decks of live trainings, as well as asynchronous prerecorded trainings on many CARE process topics.
- Resources, fact sheets, toolkits, and FAQs.
- Recommended foundational CARE Act trainings and resources to get started with the basics.



[Slide Image Description: This slide shows a screenshot of the CARE Act Resource Center website, highlighting key trainings and resources for individuals that are new to the CARE Act.]

The CARE Act Resource Center training library includes recordings and decks of all live trainings, as well as asynchronous pre-recorded trainings. Topics include the CARE Act process, volunteer supporters, legal roles, housing, eligibility criteria, role of the family, role of the peer, data collection and reporting, and more. The new design also highlights foundational trainings and resources for those new to learning about the CARE process.

The CARE Act Resource Center resource library includes resources, fact sheets, toolkits, and FAQs, as well as links to other resources on CalHHS, DHCS, or JC's CARE websites.

[Slide Image Description: This slide shows the CARE Act Resource Center website and the email address.]

We are here to support you and provide you with those opportunities to connect and hear about implementing the CARE Act. The website is **CARE-Act.org,** and our email address is **info@CARE-Act.org.**