

EVIDENCE-BASED PRACTICE TRAINING, TECHNICAL ASSISTANCE, FIDELITY MONITORING AND DATA COLLECTION POLICY MANUAL

Assertive Community Treatment, Forensic Assertive
Community Treatment, Coordinated Specialty Care for First
Episode Psychosis, and Individual Placement and Support
Supported Employment

April 2026

TABLE OF CONTENTS

Introduction	4
What is in This Manual?	5
Centers of Excellence	6
Foundational Medi-Cal and BHSA Requirements for Counties Implementing ACT, FACT, CSC and IPS.....	7
County Consultations with COEs.....	7
Oversight of ACT, FACT, CSC, and IPS Practitioners.....	9
County Implementation Timeline	10
Assertive Community Treatment (ACT).....	14
ACT Training Requirements.....	15
Tracking Training Status.....	16
Training Exemptions	17
Fidelity Monitoring	17
Probationary Fidelity Period	19
ACT in Rural Areas.....	20
Tracking Fidelity Monitoring Status.....	20
Data Collection.....	20
Technical Assistance.....	21
Forensic ACT (FACT).....	22
FACT Training Requirements.....	23
Fidelity Monitoring for FACT.....	24
Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP).....	24
CSC Training Requirements.....	25
Tracking Training Status.....	27
Training Exemptions	28
Fidelity Monitoring	28
Probationary Fidelity Period	30
CSC in Rural Areas.....	31

Tracking Fidelity Monitoring Status.....	32
Data Collection.....	32
Technical Assistance.....	33
Individual Placement and Support (IPS) Supported Employment.....	33
IPS Training Requirements.....	34
Tracking Training Status.....	36
Training Exemptions.....	37
Fidelity Monitoring.....	37
Probationary Fidelity Period.....	39
IPS in Rural Areas.....	40
Fidelity Action Planning.....	41
Tracking Fidelity Monitoring Status.....	41
Data Collection.....	41
Technical Assistance.....	42

INTRODUCTION

The Department of Health Care Services (DHCS) is committed to increasing access to and strengthening the continuum of community-based behavioral health services for Californians living with significant behavioral health needs. Central to this effort is the implementation of evidence-based practices (EBPs) that have been shown to improve health outcomes for individuals living with mental health conditions and/or substance use disorders (SUDs).

As part of the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) initiative, mental health plans (MHPs), Drug Medi-Cal Organized Delivery System (DMC-ODS) counties, and Drug Medi-Cal (DMC) programs have the option to cover Assertive Community Treatment (ACT), Forensic ACT (FACT), Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP), and/or Individual Placement and Support (IPS) Supported Employment under Medi-Cal as bundled services with unique billing codes and monthly bundled rates.^{1,2} In addition, implementation of ACT, FACT, CSC and IPS is required as part of Full Service Partnership (FSP) and Early Intervention (EI) programs pursuant to the Behavioral Health Services Act (BHSA).^{3,4}

¹ In December 2024, CMS approved SPAs [24-0042](#), [24-0051](#), and [SPA 24-0052](#), establishing Assertive Community Treatment (ACT), Forensic ACT (FACT), Coordinated Specialty Care (CSC) for First Episode Psychosis, Clubhouse Services, Individual Placement and Support (IPS) Supported Employment and Enhanced Community Health Worker (ECHW) Services as covered Medi-Cal services, effective January 1, 2025. Counties have the option to offer some or all of these EBPs at any time in any combination. Additional Medi-Cal coverage and payment guidance for these EBPs is available in BHINs [25-009](#) and [25-028](#) or subsequent guidance.

² Historically, counties were able to claim many “unbundled” components of ACT, FACT, CSC, and IPS under Medi-Cal, but did not have the option to utilize dedicated procedure codes and comprehensive monthly rates. Under BH-CONNECT, counties have the option to be paid for these services at a monthly rate.

³ ACT, FACT and IPS must be implemented as part of FSP programs. CSC must be implemented as part of EI programs. See the [BHSA Policy Manual](#) for information about BHSA requirements.

⁴ State law permits counties with a population of less than 200,000 to request exemptions from offering ACT, FACT and/or IPS in their FSP programs under the BHSA. More information is available in the [BHSA Policy Manual](#). Counties that receive FSP EBP exemptions are not required to meet any of the training, technical assistance, fidelity monitoring and data collection requirements established in this manual for the respective EBPs.

This manual establishes training, technical assistance, fidelity monitoring and data collection requirements for counties⁵ and county-operated and county-contracted behavioral health practitioners to implement ACT, FACT, CSC and IPS under Medi-Cal and the BHSA.⁶

The requirements in this manual apply to services billed to Medi-Cal and services delivered through FSP and EI programs. This manual provides requirements for ACT, FACT, CSC and IPS in addition to requirements in [BHIN 25-009](#) or subsequent guidance and in the [BHSA Policy Manual](#), and operational and practice guidance available in the EBP Policy Guide.

DHCS' goal is to ensure each EBP is delivered consistent with evidence-based standards and improves outcomes and quality of life among Californians living with significant behavioral health needs.

What is in This Manual?

This manual establishes training, technical assistance, fidelity monitoring, and data collection requirements for delivering ACT, FACT, CSC and IPS with fidelity to the evidence-based models. The following sections include:

- » An overview of the role of Centers of Excellence (COEs) established by DHCS in providing training, technical assistance, fidelity monitoring, and data collection for counties and behavioral health practitioners;
- » A review of foundational requirements for counties to deliver ACT, FACT, CSC and IPS under the BHSA and as optional Medi-Cal services; and
- » Specific requirements related to implementing ACT, FACT, CSC and IPS, including:
 - Training requirements for behavioral health practitioners;
 - Fidelity monitoring requirements, including information about the fidelity tools COEs will use to determine if ACT, FACT, CSC and IPS practitioners are delivering services with fidelity to the evidence-based models, the

⁵ "County" is used throughout this guide to be inclusive of the county behavioral health agencies that are responsible for Medi-Cal specialty behavioral health services and county FSP programs.

⁶ DHCS is authorized to implement, interpret, or make specific the terms of the BH-CONNECT waiver and the BHSA, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or other similar instructions, without taking further regulatory action. (Welf. & Inst. Code, §§ 5963.05, 14184.102, subd. (d), and 14184.400, subd. (c).)

fidelity assessment process, and specific fidelity thresholds required to achieve and maintain Fidelity Designation;

- Technical assistance opportunities for counties and ACT, FACT, CSC and IPS practitioners; and
- Data collection requirements for ACT, FACT, CSC and IPS practitioners to ensure services are improving the health and wellbeing of Californians living with significant behavioral health needs.

Please contact BH-CONNECT@dhcs.ca.gov with any questions related to these EBPs and the information provided in this manual.

CENTERS OF EXCELLENCE

DHCS has contracted with Centers of Excellence (COEs) to provide training, technical assistance, fidelity monitoring and data collection support for ACT, FACT, CSC and IPS:⁷

- » **ACT and FACT:** The Public Mental Health Partnership (PMHP) at the UCLA Semel Institute for Neuroscience and Human Behavior
- » **CSC:** Early Psychosis Intervention California (EPI-CAL)
- » **IPS:** The IPS Employment Center

COE resources are available free of charge to counties and county-operated and county-contracted behavioral health practitioners that serve the Medi-Cal and uninsured populations.⁸ The [DHCS COE Resource Hub](#) website will direct counties and behavioral health practitioners to the training, technical assistance and fidelity monitoring materials for each EBP.

Together, training, technical assistance, fidelity monitoring, and data collection requirements ensure counties and practitioners meet requirements for each EBP to deliver high-quality, evidence-based care.

⁷ DHCS also contracted with COEs to support implementation of Clubhouse Services, Multisystemic Therapy (MST), Functional Family Therapy (FFT), Parent-Child Interaction Therapy (PCIT), and High Fidelity Wraparound (HFW). Additional information on Clubhouse Services is available in [BHIN 25-009](#) or subsequent guidance. Guidance on MST, FFT, PCIT and HFW is forthcoming.

⁸ DHCS will communicate to stakeholders and may adjust guidance if at any time DHCS is no longer able to make COE resources available free of charge.

Foundational Medi-Cal and BHSA Requirements for Counties Implementing ACT, FACT, CSC and IPS

Counties must meet foundational requirements to deliver ACT, FACT, CSC and IPS consistent with Medi-Cal (if opting in) and BHSA policy. Foundational requirements are detailed in sections below, and include:

- » Completing county consultations with the respective COEs for ACT and FACT, CSC and IPS;
- » Ensuring practitioners meet specified training, technical assistance, fidelity monitoring, and data collection requirements; and
- » Meeting specified implementation milestones for ACT, FACT, CSC and IPS to demonstrate services are delivered with fidelity to the evidence-based models.

County Consultations with COEs

Counties are required to offer ACT, FACT, CSC and IPS under the BHSA. In addition, counties may opt to cover one or more of these EBPs as bundled Medi-Cal services with monthly bundled rates.

Counties are required to participate in consultations with the respective COEs for ACT and FACT, CSC and IPS to establish and/or expand these EBPs consistent with BHSA and, where applicable, Medi-Cal requirements. All counties are required to complete consultations with the CSC COE. Counties without BHSA FSP exemption(s) must also complete consultations with the ACT and FACT and IPS COEs.

Consultations for ACT, FACT, CSC and IPS must be completed no later than June 30, 2026. Counties must submit a COE Engagement Initiation Form (EIF) on the [DHCS COE Resource Hub](#) website to initiate county consultations with the COEs.⁹

⁹ Counties may submit one or more EIFs to initiate county consultations with the COEs at any time. The EIF is used for ACT, FACT, CSC, IPS, Clubhouse Services, MST, FFT and PCIT. There is no deadline to submit an EIF for a county consultation with the Clubhouse Services, MST, FFT and PCIT COEs.

County consultations must occur:

- » Within three months of the EBP effective date indicated on the county's letter of commitment to cover the EBP under Medi-Cal;¹⁰ and/or
- » No later than June 30, 2026, if the county does not opt to cover the service under Medi-Cal before this date. Counties must submit EIFs for ACT, FACT, CSC and IPS no later than March 31, 2026 to ensure consultations are complete by June 30, 2026.

Consultations will be held virtually in individual or small group settings and will be used to cover topics that may include, but are not limited to:

- » County-specific implementation timelines for each EBP;
- » County-specific resources available to establish and/or expand ACT, FACT, CSC and IPS programs;
- » The anticipated provider network in a county to deliver each EBP;¹¹
- » The anticipated number of individuals in a county that may be eligible for each EBP;
- » Referral sources to identify individuals who may be eligible for each EBP;
- » Prior authorization (as applicable) and enrollment processes for each EBP;
- » Training, technical assistance and data collection requirements for each EBP;
- » Adaptations for rural areas; and
- » Other county-specific concerns to ensure EBPs meet the unique needs of the individuals they serve.

Counties may have additional follow-up consultations with COEs at any time after the initial consultations to continue discussing county-specific implementation considerations.

¹⁰ Counties may submit a letter of commitment to cover one or more EBPs under Medi-Cal at any time, using the process described in [BHIN 25-009](#) or subsequent guidance and on the [DHCS BH-CONNECT](#) website. Counties may also submit letters of commitment to cover EBPs under Medi-Cal after completing an initial COE consultation.

¹¹ As part of county consultations and ongoing technical assistance, counties must provide COEs with information about behavioral health practitioners delivering each EBP in the county. Counties must also notify the respective COE when a new team of practitioners is established to ensure COEs can appropriately engage practitioners in required training and fidelity monitoring activities.

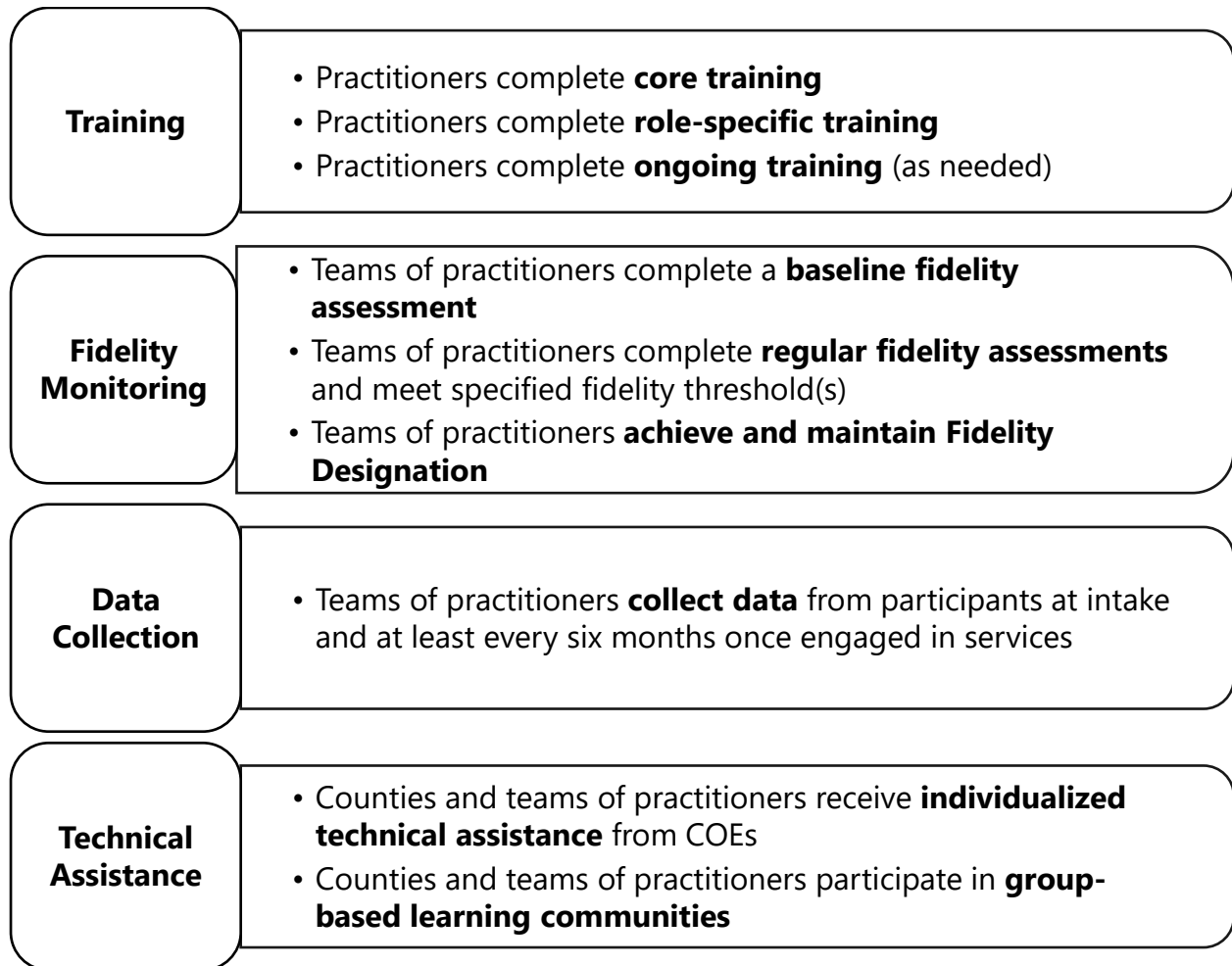
Oversight of ACT, FACT, CSC, and IPS Practitioners

Counties must ensure all teams of behavioral health practitioners delivering ACT, FACT, CSC and/or IPS practitioners meet the training, technical assistance, fidelity monitoring, and data collection requirements in this manual. Training, technical assistance, fidelity monitoring and data collection requirements are the same for all practitioners delivering each EBP, whether they are delivering services as part of FSP or EI programs or as bundled Medi-Cal services.

To ensure practitioners delivering EBPs meet the specified training, technical assistance, fidelity monitoring and data collection requirements, counties must share information about their network of practitioners delivering EBPs with the respective COEs on an ongoing basis. This includes providing COEs with information about new and existing teams of practitioners delivering EBPs during the county consultation process, and alerting COEs when a new team of practitioners are established (defined as a team that has been staffed and is beginning to deliver and be paid for services) or when a team is no longer delivering services.

Training, technical assistance, fidelity monitoring and data collection requirements for each EBP are summarized in Figure 1 and are detailed in the subsequent chapters of this manual.

Figure 1. Overview of Training, Fidelity Monitoring, Data Collection and Technical Assistance Requirements for ACT, FACT, CSC and IPS



County Implementation Timeline

As described above, under the BHSA counties are required to implement ACT, FACT, CSC and IPS. In addition, counties have the option to implement ACT, FACT, CSC and/or IPS as bundled Medi-Cal services.¹² **All counties – regardless of whether they opt in**

¹² BHPs and DMC programs may submit a letter of commitment to cover one or more EBPs under Medi-Cal at any time, using the process described in [BHIN 25-009](#) or subsequent guidance and on the [DHCS BH-CONNECT](#) website. Counties may opt to implement one or more EBPs as a bundled Medi-Cal service at any time.

to cover EBPs as bundled Medi-Cal services – must meet specific implementation milestones to demonstrate compliance with BHSA requirements.¹³

These milestones were established to ensure counties administer high-quality ACT, FACT, CSC and IPS programs while recognizing it takes time and resources to hire staff, train practitioners, and ensure programs are operating with fidelity to the evidence-based models.

Counties must:

- » Submit COE EIFs for ACT, FACT, CSC and IPS no later than **March 31, 2026;**
- » Complete county consultations with the ACT and FACT, CSC and IPS COEs, as described in the “County Consultations with COEs” section of this chapter, and begin establishing ACT, FACT, CSC and IPS teams no later than **June 30, 2026;**¹⁴
- » Ensure a projected number of teams¹⁵ delivering each EBP complete a baseline fidelity assessment and receive Baseline Fidelity Designation no later than **December 31, 2027;**¹⁶
- » Ensure a projected number of teams delivering each EBP complete a first fidelity assessment and achieve Minimum Fidelity Designation no later than **June 30, 2028;**¹⁷ and

¹³ Counties that have received FSP EBP exemptions are not required to meet the training, technical assistance, fidelity monitoring or data collection requirements described in this manual for those EBPs.

¹⁴ An “established” team reflects a group of practitioners that has been staffed according to the standards of the EBP and is beginning to deliver and be paid for services delivered to individuals living with behavioral health needs. A “team” is a multidisciplinary group of practitioners that are delivering services to a specified caseload of members and participating in fidelity assessments; the structure and size of a team may shift over time, including as a result of staff turnover.

¹⁵ More information about EBP staffing projections is available in the [BHSA Policy Manual](#).

¹⁶ Baseline fidelity assessments are not full fidelity assessments. They are tailored tools to support providers in understanding gaps to foundational fidelity standards and preparing for the formal fidelity assessment process.

¹⁷ Teams of practitioners may advance more quickly to Full Fidelity Designation if they demonstrate they are operating at a high level of fidelity. For example, if a team receives the score required to receive Full Fidelity Designation after the first fidelity assessment, they will bypass the Minimum Fidelity Designation level and move to a biennial (ACT, FACT, CSC) or triennial (IPS) cadence of ongoing fidelity assessments.

- » Ensure a projected number of teams delivering each EBP complete a second fidelity assessment and achieve Full Fidelity Designation no later than **June 30, 2029**.

Box #1: What is Fidelity Designation?

Fidelity Designation is granted to each team of practitioners delivering an EBP. Fidelity Designation indicates that the team has achieved the required fidelity score for that fidelity assessment.

There are three levels of Fidelity Designation:

- » **Baseline Fidelity Designation** indicates a team has completed their baseline fidelity assessment;
- » **Minimum Fidelity Designation** indicates a team has completed their first fidelity assessment and meets the minimum fidelity score for the EBP; and
- » **Full Fidelity Designation** indicates a team has completed their second fidelity assessment and meets the full fidelity score for the EBP.

All teams of practitioners that complete the baseline fidelity assessment automatically receive Baseline Fidelity Designation. Teams of practitioners that do not receive the score required to pass a subsequent fidelity assessment will enter a probationary period and will not automatically lose their Fidelity Designation, as described in the subsequent chapters of this manual.

All fidelity assessments must be conducted by the respective COEs for ACT, FACT, CSC and IPS. More information about the fidelity tools used, and the specific fidelity scores required to achieve each Fidelity Designation level for each EBP are also described in the subsequent chapters of this manual and summarized in Box 2.

As described in [BHIN 25-009](#) or subsequent guidance, for counties that opt to provide EBPs as bundled Medi-Cal services, teams of behavioral health practitioners must achieve and maintain Fidelity Designation for the county to claim bundled Medi-Cal payment for ACT, FACT, CSC and/or IPS. Counties may claim bundled Medi-Cal payment for ACT, FACT, CSC, and/or IPS for up to nine months before each team completes their baseline fidelity assessment.

Counties that do not opt to provide EBPs as bundled Medi-Cal services must also ensure teams delivering ACT, FACT, CSC and/or IPS achieve and maintain Fidelity Designation.¹⁸ As described in the [BHSA Policy Manual](#), each county must submit staffing projections for each EBP in their 2026 Integrated Plan (IP) submission, and may adjust those projections as part of the 2027 Annual Update (AU) process. Counties are encouraged to consult with COEs to determine staffing projections for each EBP that account for county resources and capacity. Staffing projections will be reviewed by DHCS as part of the IP/AU process.

The projected number of teams identified in the IP/AU for fiscal year 2026-2027 must achieve Baseline, Minimum and Full Fidelity Designation on the timeline specified above. In the IP/AU, counties must also project the number of teams they will staff for each EBP for fiscal years 2027-2028 and 2028-2029. DHCS does not expect all teams established after fiscal year 2026-2027 to achieve Full Fidelity Designation by June 2029; rather, all new teams must progress through the Fidelity Designation levels on the timeline specified in the subsequent sections of this manual. Additional information is in the [BHSA Policy Manual](#).

Counties that are unable to demonstrate that their projected number of teams for fiscal year 2026-2027 meet the fidelity requirements for the respective EBPs as described in this manual must consult with the respective COEs and establish county-specific EBP fidelity plans to meet DHCS' fidelity requirements.

For example, if a county projects that it will establish four ACT teams in fiscal year 2026-2027 but only one ACT team completes a baseline fidelity assessment before December 31, 2027, the county must work with the ACT COE to establish a plan for expanding their ACT program and completing the requisite fidelity assessments for the remaining three teams.¹⁹ If a county projects that it will establish four ACT teams in fiscal year 2026-2027 and four ACT teams complete the baseline fidelity assessment in 2027, but only one ACT team achieves Minimum Fidelity Designation by June 2028, the county must also work with the ACT COE on a county-specific EBP fidelity plan to improve fidelity implementation for the remaining three teams. Counties must be prepared to share their county-specific EBP fidelity plans upon request from DHCS.

¹⁸ Fidelity Designation reflects that the service is being implemented "with fidelity," consistent with requirements in the [BHSA Policy Manual](#).

¹⁹ In some cases, the COE and county may determine that it is appropriate for the county to establish fewer teams than originally projected. While the COE may offer technical assistance to counties and make corresponding recommendations for a county's EBP fidelity plan, DHCS remains responsible for monitoring county compliance with BHSA requirements.

Box #2: Summary of ACT and FACT, CSC and IPS Fidelity Designations

ACT and FACT Fidelity Designations:

- » **Fidelity Tool:** Tool for Measurement of ACT (TMACT)
- » **Baseline Fidelity Designation:** Assess foundational ACT competencies
- » **Minimum Fidelity Designation:** TMACT score of ≥ 3.3
- » **Full Fidelity Designation:** TMACT score of ≥ 3.7

CSC Fidelity Designations:

- » **Fidelity Tool:** First Episode Psychosis Services – Fidelity Scale Version 1.1 (FEPS-FS 1.1)
- » **Baseline Fidelity Designation:** Assess foundational CSC competencies
- » **Minimum Fidelity Designation:** Meet specified CSC competencies
- » **Full Fidelity Designation:** FEPS 1.1 score of ≥ 4 and meet all CSC competencies

IPS Fidelity Designations:

- » **Fidelity Tool:** IPS Fidelity Scale
- » **Baseline Fidelity Designation:** Assess foundational IPS competencies
- » **Minimum Fidelity Designation:** IPS Fidelity Scale score of ≥ 80 and 3 or more on community-based services
- » **Full Fidelity Designation:** IPS Fidelity Scale score of ≥ 100 and 3 or more on community-based services

ASSERTIVE COMMUNITY TREATMENT (ACT)

When implemented with fidelity to the evidence-based model, ACT is one of the most effective treatments for individuals living with complex and significant mental health needs. Teams of behavioral health practitioners delivering ACT under Medi-Cal and/or BHSA must meet training, fidelity monitoring, and data collection requirements described below.

Counties and ACT practitioners must work with PMHP at the UCLA Semel Institute for Neuroscience and Human Behavior (from the point forward, "ACT COE") to meet these requirements. ACT COE resources are available free of charge for counties and ACT practitioners that serve the Medi-Cal and uninsured populations. The ACT COE maintains all ACT and FACT resources, which can be accessed through the [DHCS COE Resource Hub](#) website.

Counties are required to share information about their network of practitioners delivering ACT with the ACT COE on an ongoing basis, which includes providing information about new and existing ACT teams during the county consultation, and alerting the ACT COE when a new team of practitioners is established (defined as a team that has been staffed and is beginning to deliver and be paid for services) or when a team is no longer delivering ACT.

ACT Training Requirements

Every behavioral health practitioner delivering ACT under Medi-Cal or through a FSP program must complete training covering the evidence-based approaches and core practices comprising the ACT service model. Each practitioner must also complete role-based training.^{20,21}

Behavioral health practitioners may begin delivering services on an ACT team prior to completing training. ACT practitioners must complete a total of 20 hours of training each year. The annual training requirement can be met through a combination of foundational and role-based topics listed in Box 3 as well as additional topics available through the ACT COE.²²

Training sequencing and pacing can be flexible.

²⁰ See the [EBP Policy Guide](#) for additional information about roles on ACT teams.

²¹ ACT teams with a caseload of >25% of individuals who meet eligibility criteria for FACT must also complete specialized FACT training. See additional details in the "Forensic ACT" chapter of this manual.

²² The ACT training curricula may change over time. All current training requirements will be specified by the ACT COE.

Box #3: ACT Training Curricula

Foundational Curriculum:

- » Recovery-Oriented Care
- » Trauma-Informed Care
- » Harm Reduction
- » Boundaries and Provider Wellbeing
- » Suicide Assessment and Prevention
- » Motivational Interviewing
- » Cultural Humility and Engagement
- » Safety and De-Escalation

Role-Based Curriculum:

- » Team Lead
- » Peer Specialist
- » Prescriber
- » Nurse
- » Employment Specialist
- » Case Manager
- » Mental Health Clinician
- » Substance Use Disorder Specialist

Tracking Training Status

ACT team leads²³ must maintain an accurate roster of ACT team members and their respective roles on the ACT team as well as their training status. The ACT COE will also maintain a record of the training status of all ACT teams, and send reports to ACT team leads, counties and DHCS with information about ACT teams and their training status. If an ACT team member fails to complete training requirements within the required

²³ All ACT teams must have a designated ACT team lead. The ACT team lead has full clinical, administrative, and supervisory responsibility for the ACT team. Find additional guidance in the [EBP Policy Guide](#).

timelines, the ACT team lead must act promptly to ensure the training requirements are met or replace the team member with a different practitioner.

Training Exemptions

ACT team members may request exemptions from one or more required trainings if they can demonstrate they have completed equivalent training in the past 12 months. All training exemption requests are subject to review and approval by the ACT COE on an individual basis. To demonstrate equivalent training, the ACT team member must provide syllabi or other documents that show the content of the training (e.g., slides, readings, etc.) and proof of their completion of the training.

Fidelity Monitoring

Regularly monitoring fidelity to the model is a key component of ACT to ensure members are receiving the best possible care and to identify where improvements can be made.

In counties that opt to cover ACT as a bundled Medi-Cal service, ACT teams must achieve and maintain Fidelity Designation for the county to claim bundled Medi-Cal payment for ACT on an ongoing basis.²⁴ ACT teams established through FSP programs must also achieve and maintain Fidelity Designation to comply with BHSA requirements.

ACT teams must achieve and maintain Fidelity Designation by completing the following steps:

- » **Baseline Fidelity Designation.** ACT teams must complete a baseline fidelity assessment to receive Baseline Fidelity Designation. Baseline fidelity assessments must be completed within nine months of establishing a new ACT team.²⁵ The baseline fidelity assessment assesses if an ACT team meets foundational fidelity requirements and identifies key gaps an ACT team must address before their first fidelity assessment. The ACT COE will conduct baseline fidelity assessments using the Core Components Checklist. The Core Components Checklist includes seven domains of team functioning consistent with the evidence-based ACT model. All ACT teams that complete the baseline fidelity assessment receive Baseline Fidelity Designation.

²⁴ Counties may claim the bundled Medi-Cal rate for ACT for up to nine months before teams of practitioners complete their baseline fidelity assessments. See [BHIN 25-009](#) or subsequent guidance.

²⁵ An “established” team reflects an ACT team that has been staffed and is beginning to deliver and be paid for ACT services delivered to individuals living with behavioral health needs.

- » **Minimum Fidelity Designation.** To move from Baseline Fidelity Designation to Minimum Fidelity Designation, ACT teams must pass²⁶ an in-person fidelity assessment conducted by the ACT COE using the Tool for Measurement of ACT (TMACT).²⁷ The first fidelity assessment must be completed within 15 months of establishing a new ACT team. ACT teams must achieve a TMACT score of 3.3 or higher to pass the first fidelity assessment and receive Minimum Fidelity Designation.
- » **Full Fidelity Designation.** To move from Minimum Fidelity Designation to Full Fidelity Designation, ACT teams must pass a second fidelity assessment conducted by the ACT COE using the TMACT. The second fidelity assessment must be completed within 12 months of the first fidelity assessment. ACT teams must achieve a TMACT score of 3.7 or higher to pass the second fidelity assessment and receive Full Fidelity Designation.
- » **Maintaining Full Fidelity Designation.** To maintain Full Fidelity Designation, ACT teams must pass biennial fidelity assessments to demonstrate they continue to deliver high-quality ACT services. ACT teams must achieve a TMACT score of 3.7 or higher on biennial fidelity assessments to maintain Full Fidelity Designation.

DHCS established this stepwise process to support continued improvement over a multi-year period. The ACT COE will also provide technical assistance tools to help teams advance from Baseline to Full Fidelity Designation.

ACT teams may advance more quickly to Full Fidelity Designation if they demonstrate they are operating at a high level of fidelity. For example, if an ACT team achieves a TMACT score of 3.7 in their first fidelity assessment, they will receive Full Fidelity Designation and move to biennial fidelity assessments (bypassing the Minimum Fidelity Designation level).

All ACT fidelity assessments must be conducted by the ACT COE. ACT teams must coordinate with the ACT COE to ensure fidelity assessments are completed on the required timeline.

²⁶ ACT teams that do not achieve the specified TMACT score to pass a fidelity assessment will enter a probationary period and will not automatically lose their Fidelity Designation, as described below.

²⁷ The [TMACT](#) is a contemporary, standardized ACT evaluation tool used in many states and other countries to assess ACT program fidelity and guide higher quality ACT implementation efforts.

As described in the “County Implementation Timeline” section of the “Foundational Medi-Cal and BHSA Requirements for Counties Implementing ACT, FACT, CSC and IPS” chapter of this manual, the projected number of ACT teams established in counties’ IPs for fiscal year 2026-2027 must achieve Baseline Fidelity Designation by December 31, 2027; Minimum Fidelity Designation by June 30, 2028; and Full Fidelity Designation by June 30, 2029. Counties that are unable to demonstrate that their projected number of teams meet ACT fidelity requirements as described in this manual must consult with the ACT COE and establish a county-specific EBP fidelity plan to meet DHCS’ fidelity requirements. Counties must be prepared to share the county-specific EBP fidelity plan upon request from DHCS.

Probationary Fidelity Period

If an ACT team does not pass a specified fidelity assessment (i.e., does not achieve a TMACT score of 3.3 on their first assessment or a TMACT score of 3.7 on their subsequent assessments), the team will enter a 12-month probationary period.²⁸ During the probationary period, the ACT team will maintain their Baseline, Minimum, or Full Fidelity Designation, depending on what level they reached before entering the probationary period. The ACT team must pass their next fidelity assessment during the 12-month probationary period.

For example, if an ACT team does not achieve a TMACT score of 3.3 during their first fidelity assessment, they must still achieve a TMACT score of 3.7 during their second fidelity assessment. If an ACT team achieves a score of 3.3 on their first assessment but does not achieve a score of 3.7 on their second fidelity assessment, they must complete their third assessment within 12 months of the second assessment and achieve a 3.7 on that fidelity assessment to receive Full Fidelity Designation.

ACT teams that do not pass the required fidelity assessment after their probationary period will lose their Fidelity Designation.²⁹ Teams that lose their Fidelity Designation must work with the ACT COE to determine key fidelity gaps and identify specific steps to

²⁸ There is no probationary period following a baseline fidelity assessment. Baseline fidelity assessments will be assessed based on completion only. All teams that complete a baseline fidelity assessment will receive Baseline Fidelity Designation.

²⁹ On a case-by-case basis, the ACT COE may recommend and DHCS may approve an ACT team to maintain their Fidelity Designation level even if they do not achieve the required fidelity score. In those instances, the ACT team must consult with the ACT COE and establish a team-specific plan to meet fidelity requirements.

re-gain Fidelity Designation. As described in [BHIN 25-009](#) or subsequent guidance, bundled Medi-Cal payment cannot be claimed if a team loses Fidelity Designation.

ACT in Rural Areas

Small counties and rural areas of California that have a lower demand for ACT may not be able to support a full ACT team. In consultation with the ACT COE, ACT providers in these areas may implement ACT team staffing modifications to support a smaller caseload of members while maintaining fidelity to the evidence-based model. For example, an ACT team in a rural area may staff a “small team” of six practitioners, rather than a full-size team of 10 practitioners.³⁰

ACT team staffing adjustments may be appropriate when:

- » Fewer than 60 individuals have a clinical need for ACT in a county or within a one-hour average drive time from the ACT provider’s location; or
- » In other scenarios upon recommendation by the ACT COE (e.g., establishing a new ACT team that will grow over time, or if the population with a clinical need for ACT only supports one full-size and one modified ACT team).

When staffing adjustments are made, ACT teams will be assessed by the ACT COE using a modified TMACT, in which select TMACT items are scaled based on the team size and caseload. ACT teams must still achieve a score of 3.3 or higher on the modified TMACT to achieve Minimum Fidelity Designation, and a score of 3.7 or higher on the modified TMACT to achieve Full Fidelity Designation.

Tracking Fidelity Monitoring Status

ACT team leads must track the ACT team’s fidelity status and ensure the ACT team undergoes the required fidelity assessments on the cadence described above. The ACT COE will also maintain a record of the fidelity status of all ACT teams, and send reports to ACT team leads, counties, and DHCS with information about fidelity assessments. ACT team leads will also receive reminders from the ACT COE when it is time to schedule their next fidelity assessment.

Data Collection

ACT teams must collect data on member outcomes to ensure ACT is effectively supporting the recovery of participating individuals. The ACT COE has developed a tool

³⁰ See the EBP Policy Guide for additional information on ACT team structure.

that ACT teams must use to collect member outcomes data. The ACT data collection tool is available through the ACT COE.

ACT teams must use the ACT data collection tool at the following intervals:

- » At intake (i.e., when a new individual is enrolled in ACT)
- » At least every six months thereafter
- » At discharge

Any member of the ACT team can collect member outcomes data. All data must be securely submitted through an online portal established by the ACT COE. ACT teams should review member outcomes data on a regular basis to ensure ACT is being delivered effectively and meeting the needs of enrolled individuals.

In addition, the ACT COE will share de-identified, aggregated data with DHCS on a regular cadence to assess the effectiveness of ACT across the state.³¹

Technical Assistance

ACT teams may utilize the ACT COE for individualized and group-based technical assistance on an ongoing basis. Technical assistance is intended to support ACT teams in meeting training, fidelity monitoring and data collection requirements described above and to ensure services meet the needs of the individuals receiving ACT. Technical assistance is also available in individualized and group-based settings for counties to support their county-wide implementation of ACT.

ACT teams and counties may request technical assistance from the ACT COE at any time.

For ACT, technical assistance will include synchronous and asynchronous virtual resources on topics that include but are not limited to:

- » Overview of the ACT model (ACT 101 and Setting the Foundation for Fidelity)
- » Organizational Readiness for ACT: Predictors of Implementation Success
- » The Multi-Disciplinary Team: Foundational Infrastructure for ACT
- » Maximizing ACT Service Array for Program Effectiveness
- » Collaborative Team-Based Care in ACT

³¹ Some data collected by ACT teams will be used by DHCS to determine if members receiving ACT demonstrate improved health outcomes as part of the Access, Reform and Outcomes Incentive Program. More information about the Access, Reform and Outcomes Incentive Program is available on the [DHCS BH-CONNECT website](#).

- » Outreach and Engagement in ACT: A Persistent and Committed Approach
- » Daily Clinical Management in ACT
- » Person-Centered Care in ACT: Addressing Client Preferences & Supporting Self-Determination
- » ACT Transitions in Care
- » Sustaining Continuous Quality Improvement in ACT
- » Delivery of ACT for Co-Occurring Conditions

Individual and group-based technical assistance opportunities (e.g., virtual learning communities, consultations) and tailored technical assistance topics will also be available. The ACT COE may also recommend specific technical assistance opportunities following completion of a fidelity assessment for continuous quality improvement.

As described in the “County Consultations with COEs” section of the “Foundational Medi-Cal and BHSR Requirements for Counties Implementing ACT, FACT, CSC and IPS” chapter of this manual, counties are required to participate in at least one county consultation with the ACT COE to establish and/or expand their ACT program.

Additional technical assistance is optional for counties.

FORENSIC ACT (FACT)

FACT adapts the evidence-based ACT model to address the needs of members who are also involved with the criminal justice system. When implemented with fidelity, FACT can not only improve members’ mental health outcomes but also reduce barriers to reintegration back into the community.

DHCS expects that in most cases, FACT teams will be ACT teams that serve some individuals with criminal justice system involvement. In some cases, there may be “FACT-only” teams with a caseload of individuals that all meet the service criteria for FACT. All ACT teams for which at least 25% of their caseload meet service criteria for FACT must meet enhanced training and fidelity monitoring requirements to ensure they can meet the specialized needs of those individuals. In addition, FACT teams should include at least one practitioner with lived experience with the criminal justice system.³²

³² More information about FACT team structures are in the EBP Policy Guide. “Lived experience” with the criminal justice system may include previous arrests, convictions, incarceration, or

All FACT practitioners must meet the training, fidelity monitoring, and data collection requirements described in the “Assertive Community Treatment” chapter of this manual and meet the FACT-specific program requirements described below.

The ACT COE will support counties and practitioners in meeting requirements for both ACT and FACT.

FACT Training Requirements

Behavioral health practitioners may begin delivering services on a FACT team³³ prior to completing training. FACT practitioners must complete 20 hours of training each year as described in the “Assertive Community Treatment” chapter of this manual. As part of the 20 hours of annual training, FACT practitioners must complete a FACT-specific training curriculum. Examples of FACT-specific trainings are listed in Box 4.³⁴ The FACT training curricula should be completed within the first year of delivering FACT, but may be completed on a longer timeline if needed.

Box #4: FACT Training Curricula

- » Reducing Recidivism: Understanding and Addressing the Factors that Contribute to Re-Arrest
- » Justice System Navigation
- » Mass Incarceration, Criminal Justice and Mental Health: A Racial Equity Perspective
- » Cross-Systems Collaboration: Supporting Mandated Clients
- » First Person Perspectives: From Incarceration to Recovery
- » SPECTRM: Sensitizing Providers to the Effects of Incarceration on Treatment

supervision by the courts or probation. Teams that do not have access to a staff member with lived experience in the criminal justice system may be eligible to achieve Fidelity Designation for FACT by meeting training requirements only. Teams will be evaluated on an individual basis during the fidelity process.

³³ Defined as an ACT team for which at least 25% of their caseload meets service criteria for FACT. Service criteria for FACT are in the [EBP Policy Guide](#).

³⁴ The FACT training curricula may change over time. All current training requirements will be specified by the ACT COE.

Fidelity Monitoring for FACT

FACT teams must meet the same fidelity monitoring requirements as ACT teams. In addition to the TMACT assessment, FACT teams will also be assessed on two fidelity items from the Rochester Forensic Assertive Community Treatment (R-FACT)³⁵ model:

- » Information-Sharing Authorization; and
- » Criminal Justice Collaboration.

COORDINATED SPECIALTY CARE (CSC) FOR FIRST EPISODE PSYCHOSIS (FEP)

CSC is an evidence-based, community-based service that supports individuals in their recovery after an initial episode of psychosis or experience of early psychotic symptoms. When delivered with fidelity, CSC has been shown to reduce psychiatric hospitalizations, emergency department use, residential treatment placements, and substance use, and improve overall quality of life. Teams of behavioral health practitioners delivering CSC must meet training, fidelity monitoring, and data collection requirements described below.

Counties and CSC practitioners must work with EPI-CAL (from this point forward, “CSC COE”) to meet these requirements. CSC COE resources are available free of charge for counties and CSC practitioners that serve the Medi-Cal and uninsured populations. The CSC COE maintains all CSC resources, which can be accessed through the [DHCS COE Resource Hub](#) website.

Counties are required to share information about their network of practitioners delivering CSC with the CSC COE on an ongoing basis, which includes providing information about new and existing CSC teams during the county consultation, and alerting the CSC COE when a new team of practitioners is established (defined as a team that has been staffed and is beginning to deliver and be paid for services) or when a team is no longer delivering CSC.

³⁵ The R-FACT model is an evidence-based adaptation of the ACT model designed to reduce recidivism and improve behavioral health outcomes among justice-involved adults with serious mental illness. It focuses on addressing criminogenic risk factors by collaborating with criminal justice partners to promote effective problem solving.

CSC Training Requirements

Every behavioral health practitioner delivering CSC under Medi-Cal or through an EI program must complete training in the evidence-based CSC model. Trainings include foundational and role-based trainings offered in didactic and small group experiential modalities.³⁶

Behavioral health practitioners may begin delivering services on a CSC team prior to completing training, as long as they complete required training within one year of hire.³⁷ An overview of the CSC training curricula is in Box 5 and 6.³⁸ The CSC training curricula comprises approximately 40 training hours.

After the initial 40 training hours, the CSC COE may require some practitioners (e.g., the CSC team lead) to participate in 1-2 ongoing training hours per week to achieve proficiency in utilizing new tools, skills, or best practices. If the curriculum for a specific role is updated, CSC practitioners must also complete any new trainings within six months of the update. The CSC COE may also require ongoing training hours and/or technical assistance for a CSC team following completion of a fidelity assessment. This may include small group experiential training in key areas of the CSC model (e.g. assessment, individual therapy).

³⁶ See the [EBP Policy Guide](#) for additional information about roles on CSC teams.

³⁷ If a CSC team is delayed in establishing the Beehive system for data collection, practitioners may receive additional time from the COE to complete the Beehive curriculum.

³⁸ The CSC training curricula may change over time. All current training requirements will be specified by the CSC COE.

Box #5 CSC Training Criteria

Foundational Curriculum:

- » Overview of EPI-CAL
- » Overview of CSC
- » Introduction to Psychosis
- » Impact of Structural Inequities in CSC
- » Roles on the CSC Team
- » Peer Support
- » CSC Service Flow
- » Supports in CSC
- » Crisis Considerations in FEP Care

Role-Based Curriculum:

- » Clinic Coordinator/ Administrator
- » Team Lead
- » Education/Employment Specialist or Occupational Therapist
- » Peer Support Specialist
- » Family Specialist
- » Clinician/Therapist
- » Case Manager
- » Physician/Physician Assistant/Nurse Practitioner/Nurse
- » Clinic Leadership

Box #6 CSC Training Criteria (cont.)

Beehive Curriculum:

- » Peer Support Specialist
- » Family Specialist
- » Clinician/Therapist
- » Case Manager
- » Physician/Physician Assistant/Nurse Practitioner/Nurse
- » Clinic Leadership
- » Introduction to Data Collection Using Beehive
- » How to Use Individual-Level Data in Care
- » Explore Data Collected in Your Clinic
- » Outcomes Assessment Training
- » How to Use the Beehive Application on a Tablet
- » Program Administrator Trainings

Tracking Training Status

CSC team leads³⁹ must maintain an accurate roster of CSC team members and their respective roles on the CSC team as well as their training status. The CSC COE will also maintain a record of the training status of all CSC teams, and send reports to CSC team leads, counties, and DHCS with information about CSC teams and their training status. If a CSC team member fails to complete training requirements within the required timelines, the CSC team lead must act promptly to ensure the training requirements are met or replace the team member with a different practitioner.

The CSC COE will assess training completion on an ongoing basis. Training completion will be formally assessed at the first fidelity assessment and all fidelity assessments thereafter. For all practitioners that have been in their roles for less than one year at the point of a fidelity assessment, completion of training requirements will be prorated (for

³⁹ All CSC teams must have a designated team lead. The CSC team lead has full clinical, administrative, and supervisory responsibility for the CSC team. Find additional guidance in the [EBP Policy Guide](#).

example, a practitioner that was hired six months prior to a fidelity assessment needs to have 50% of required training completed by the time of the fidelity assessment).

Training Exemptions

CSC practitioners who have completed training through EPI-CAL within the past three years are not required to re-take all required training. However, the CSC COE may require practitioners previously trained by EPI-CAL to complete up to five additional training hours in areas not previously covered.

CSC practitioners not previously trained by EPI-CAL may also request exemptions from one or more required trainings if they can demonstrate they have completed equivalent training in the past 12 months. All training exemption requests are subject to review and approval by the CSC COE on an individual basis. To demonstrate equivalent training, the CSC team member must provide syllabi or other documents that show the content of the training (e.g., slides, readings, etc.) and proof of their completion of the training.

Fidelity Monitoring

Regularly monitoring fidelity is a key component of CSC to ensure members are receiving the best possible care and to identify where improvements can be made.

In counties that opt to cover CSC as a bundled Medi-Cal service, CSC teams must achieve and maintain Fidelity Designation for the county to claim bundled Medi-Cal payment for CSC on an ongoing basis.⁴⁰ CSC teams established through EI programs must also achieve and maintain Fidelity Designation to comply with BHSA requirements.

CSC teams must achieve and maintain Fidelity Designation by completing the following steps:

- » **Baseline Fidelity Designation.** CSC teams must complete a baseline fidelity assessment to receive Baseline Fidelity Designation. The baseline fidelity assessment must be completed within nine months of establishing a new CSC team.⁴¹ The baseline fidelity assessment assesses if a CSC team meets foundational fidelity requirements and identifies key gaps a CSC team must address before their first fidelity assessment. The CSC COE will conduct baseline

⁴⁰ Counties may claim the bundled Medi-Cal rate for CSC for up to nine months before teams of practitioners complete their baseline fidelity assessments. See [BHIN 25-009](#) or subsequent guidance.

⁴¹ An “established” team reflects a CSC team that has been staffed and is beginning to deliver and be paid for CSC services delivered to individuals living with behavioral health needs.

fidelity assessments through a structured interview with the CSC team lead. The structured interview will review eight fidelity areas aligned with the First Episode Psychosis Services – Fidelity Scale Version 1.1 (FEPS-FS 1.1).⁴² All CSC teams that complete the baseline fidelity assessment receive Baseline Fidelity Designation.

- » **Minimum Fidelity Designation.** To move from Baseline Fidelity Designation to Minimum Fidelity Designation, CSC teams must pass their first fidelity assessment conducted by the CSC COE.⁴³ The first fidelity assessment must be completed within 15 months of establishing a new CSC team. CSC teams must demonstrate all the competencies assessed in the baseline fidelity assessment, must have completed required training, and must have implemented processes to collect and evaluate outcomes data and assess member feedback to pass the first fidelity assessment and receive Minimum Fidelity Designation.
- » **Full Fidelity Designation.** To move from Minimum Fidelity Designation to Full Fidelity Designation, CSC teams must pass a second fidelity assessment conducted by the CSC COE. The second fidelity assessment must be completed within 12 months of the first fidelity assessment. CSC teams must achieve a mean FEPS-FS 1.1 score of 4 or higher and continue to demonstrate all CSC competencies assessed in previous assessments to pass the second fidelity assessment and receive Full Fidelity Designation.
- » **Maintaining Full Fidelity Designation.** To maintain Full Fidelity Designation, CSC teams must pass biennial fidelity assessments to demonstrate they continue to deliver high-quality CSC services. CSC teams must achieve a mean FEPS-FS 1.1 score of 4 or higher and continue to demonstrate all CSC competencies on biennial fidelity assessments to maintain Full Fidelity Designation.

DHCS established this stepwise process to support continued improvement over a multi-year period. The CSC COE will also provide technical assistance tools to help teams advance from Baseline to Full Fidelity Designation.

CSC teams that previously completed a fidelity assessment with EPI-CAL may be exempt from one or more Fidelity Designation levels. CSC teams that received a mean FEPS-FS 1.1 score of 4 or higher through EPI-CAL will receive Full Fidelity Designation and must

⁴² The FEPS-FS is a widely used scale to assess the degree to which mental health teams deliver evidence-based care to individuals receiving a first episode of psychosis.

⁴³ CSC teams that do not meet the specified requirements to pass a fidelity assessment will enter a probationary period and will not automatically lose their Fidelity Designation, as described below.

complete their next fidelity assessment within two years of their previous assessment. In the next assessment, the CSC team must achieve a mean FEPS-FS 1.1 score of 4 or higher and demonstrate all CSC competencies to maintain Full Fidelity Designation.

CSC teams that previously met the requirements of the baseline fidelity assessment will receive Baseline Fidelity Designation. Teams must complete required training and implement processes to collect and evaluate outcomes data and assess member feedback within six months to move from Baseline Fidelity Designation to Minimum Fidelity Designation.

All CSC fidelity assessments must be conducted by the CSC COE. CSC teams must coordinate with the CSC COE to ensure fidelity assessments are completed on the required timeline.

As described in the “County Implementation Timeline” section of the “Foundational Medi-Cal and BHSA Requirements for Counties Implementing ACT, FACT, CSC and IPS” chapter of this manual, the projected number of CSC teams established in counties’ IPs for fiscal year 2026-2027 must achieve Baseline Fidelity Designation by December 31, 2027; Minimum Fidelity Designation by June 30, 2028; and Full Fidelity Designation by June 30, 2029. Counties that are unable to demonstrate that their projected number of teams meet CSC fidelity requirements as described in this manual must consult with the CSC COE and establish a county-specific EBP fidelity plan to meet DHCS’ fidelity requirements. Counties must be prepared to share the county-specific EBP fidelity plan upon request from DHCS.

Probationary Fidelity Period

If a CSC team does not pass a specified fidelity assessment, the team will enter a 12-month probationary period.⁴⁴ During the probationary period, the CSC team will maintain their Baseline, Minimum, or Full Fidelity Designation, depending on what level they reached before entering the probationary period. The CSC team must pass their next fidelity assessment during the 12-month probationary period.

For example, if a CSC team does not pass their first fidelity assessment, they must still achieve a mean FEPS-FS 1.1 score of 4 or higher and demonstrate all CSC competencies during their second fidelity assessment. If a CSC team passes their first assessment but does not achieve a mean FEPS-FS 1.1 score of 4 or higher or demonstrate all CSC

⁴⁴ There is no probationary period following a baseline fidelity assessment. Baseline fidelity assessments will be assessed based on completion only. All teams that complete a baseline fidelity assessment will receive Baseline Fidelity Designation.

competencies on their second fidelity assessment, they must complete a third assessment within twelve months of the second assessment and pass that fidelity assessment to receive Full Fidelity Designation.

CSC teams that do not pass the required fidelity assessment after their probationary period will lose their Fidelity Designation.⁴⁵ Teams that lose their Fidelity Designation must work with the CSC COE to determine key fidelity gaps and identify specific steps to re-gain Fidelity Designation. As described in [BHIN 25-009](#) or subsequent guidance, bundled Medi-Cal payment cannot be claimed if a team loses Fidelity Designation.

CSC in Rural Areas

Small counties and rural areas of California that have a lower demand for CSC may not be able to support a full CSC team. In consultation with the CSC COE, CSC providers in these areas may implement CSC team staffing modifications to support a smaller caseload of members while maintaining fidelity to the evidence-based model. For example, a CSC team in a rural area may have practitioners who dedicate fewer hours to delivering CSC or have practitioners who play multiple roles on the CSC team.⁴⁶

CSC team staffing adjustments may be appropriate when:

- » Fewer than 30 individuals have a clinical need for CSC in a county or within a one-hour average drive time from the CSC provider's location; or
- » In other scenarios upon recommendation by the CSC COE (e.g., establishing a new CSC team that will grow over time, or if the population with a clinical need for CSC only supports one full-size and one modified CSC team).

When staffing adjustments are made, the CSC COE will adjust the target caseload and required amount of available data for the first fidelity assessment. CSC teams delivering services in these areas must have a caseload of five individuals (rather than 10) and are not required to have at least one full year of available data to receive Minimum Fidelity Designation. CSC teams must still achieve a score of 4 or higher on the FEPS 1.1 and meet all CSC competencies to achieve Full Fidelity Designation.

⁴⁵ On a case-by-case basis, the CSC COE may recommend and DHCS may approve an CSC team to maintain their Fidelity Designation level even if they do not achieve the required fidelity score. In those instances, the CSC team must consult with the CSC COE and establish a team-specific plan to meet fidelity standards.

⁴⁶ See the EBP Policy Guide for additional information on CSC team structure.

Tracking Fidelity Monitoring Status

CSC team leads must track the CSC team's fidelity status and ensure the CSC team undergoes the required fidelity assessments on the cadence described above. The CSC COE will also maintain a record of the fidelity status of all CSC teams, and send reports to CSC team leads, counties and DHCS with information about fidelity assessments. CSC team leads will also receive reminders from the CSC COE when it is time to schedule their next fidelity assessment.

Data Collection

CSC teams must collect data on member outcomes to ensure CSC is effectively supporting the recovery of participating individuals. Member outcomes must be assessed using the following data collection tools, which are available through the CSC COE:⁴⁷

- » Client Core Assessment Battery (CAB)
- » Primary Support Person CAB
- » Clinician CAB

CSC teams must use the CAB tools at the following intervals:

- » At intake (i.e., when a new individual is enrolled in CSC)
- » At least every six months thereafter

Any member of the CSC team can collect member outcomes data. All data must be securely submitted through an online portal established by the CSC COE. CSC teams should review member outcomes data on a regular basis to ensure CSC is being delivered effectively and meeting the needs of enrolled individuals.

In addition, the CSC COE will share de-identified, aggregated data with DHCS on a regular cadence to assess the effectiveness of CSC across the state.⁴⁸

⁴⁷ The CSC COE may make California-specific adjustments to the survey tools depending on member and team needs.

⁴⁸ Some data collected by CSC teams will be used by DHCS to determine if members receiving CSC demonstrate improved health outcomes as part of the Access, Reform and Outcomes Incentive Program. More information about the Access, Reform and Outcomes Incentive Program is available on the [DHCS BH-CONNECT website](#).

Technical Assistance

CSC teams may utilize the CSC COE for individualized and group-based technical assistance on an ongoing basis. All CSC teams are encouraged to participate in virtual meetings with the CSC COE on a regular basis. All CSC teams will also be assigned a liaison who supports the team in achieving Fidelity Designation. New and developing CSC teams (i.e., teams that have not yet completed a fidelity assessment) are encouraged to attend meetings with the CSC COE and their liaison at least monthly, while teams that have received Minimum or Full Fidelity Designation are encouraged to attend meetings at least quarterly. The CSC COE may also recommend specific technical assistance opportunities following completion of a fidelity assessment to support continuous quality improvement.

Technical assistance is also available in individualized and group-based settings for counties to support their county-wide implementation of CSC. As described in the “County Consultations with COEs” section of the “Requirements for ACT, FACT, CSC, and IPS Programs” chapter of this manual, counties required to participate in at least one county consultation with the CSC COE to establish and/or expand their CSC programs. Additional technical assistance is optional for counties.

CSC teams and counties may request technical assistance from the CSC COE at any time.

INDIVIDUAL PLACEMENT AND SUPPORT (IPS) SUPPORTED EMPLOYMENT

For individuals living with significant behavioral health needs, employment is tied to improved self-esteem, community inclusion, and overall quality of life, as well as reductions in homelessness and criminal justice system involvement. All behavioral health practitioners delivering IPS under Medi-Cal and/or BHSA must meet training, fidelity monitoring, and data collection requirements described below.⁴⁹

Counties and IPS practitioners must work with the IPS Employment Center (from this point forward, “IPS COE”) to meet these requirements. IPS COE resources are available free of charge for counties and IPS practitioners that serve the Medi-Cal and uninsured

⁴⁹ The IPS requirements described in this manual apply only to IPS programs, not other employment services and supports.

populations. The IPS COE maintains all IPS resources, which can be accessed through the [DHCS COE Resource Hub](#) website.

Counties are required to share information about their network of practitioners delivering IPS with the IPS COE on an ongoing basis, which includes providing information about new and existing IPS teams during the county consultation, and alerting the IPS COE when a new team of practitioners is established (defined as a team that has been staffed and is beginning to deliver and be paid for services) or when a team is no longer delivering IPS.

IPS Training Requirements

Every behavioral health practitioner delivering IPS under Medi-Cal or through a FSP program must complete training in the evidence-based IPS model. IPS training is largely site-based, with a focus on active learning and demonstration. Site-based training is complemented with synchronous and asynchronous virtual training.

Behavioral health practitioners may begin delivering services on an IPS team prior to completing training, as long as the team completes one and a half days of site-based, in-person training with an IPS trainer within six months of starting to deliver IPS.⁵⁰

During the site-based training, the IPS trainer will:

- » Provide a two-hour kick-off meeting that covers the research and principles that underly the effectiveness of IPS and engages learners in accompanying exercises;
- » Conduct a session on how to use the “career profile” and develop active listening skills;
- » Conduct a session on building relationships with employers;
- » Support the IPS team with practicing making employment contacts; and
- » Facilitate training on individualized job searches.

IPS teams are encouraged to also complete two virtual synchronous trainings to help IPS teams support individuals with criminal justice system involvement and provide individualized job supports. The IPS COE may also recommend supplementary virtual asynchronous training, including training on IPS for individuals with co-occurring conditions.

⁵⁰ In most cases, training will occur at the IPS program site. In some cases, IPS trainings may be conducted regionally for multiple IPS teams or virtually. The employment supervisor must participate in the site-based training along with any IPS specialists on the team.

Following the site-based trainings, the IPS trainer will join IPS team meetings twice monthly for the first three months, and once per month for the next three months, to help the team brainstorm how to address different situations using the IPS approach. In addition, during the six-month period after initial site-based training the IPS trainer will meet with the IPS team's employment supervisor⁵¹ at least once per month to review program outcomes and discuss strategies for improvement.

On two different occasions, within three months and six months after the initial site-based training, an IPS trainer will return to the program site to work alongside the IPS team for approximately one day.

Every IPS team must participate in site-based training. However, new employment specialists may be trained by their employment supervisor if the employment supervisor has previously been trained by an IPS trainer.

A summary of IPS training requirements is in Box 7.⁵²

⁵¹ All IPS teams must be supported by an employment supervisor who has full clinical, administrative, and supervisory responsibility for the up to five IPS teams (ten employment specialists). Additional guidance on the IPS team structure can be found in the [EBP Policy Guide](#).

⁵²The IPS training curricula may change over time. All current training requirements will be specified by the IPS COE.

Box #7: IPS Training Requirements

1.5 Day Site-Based Training:

- » Informational Session
- » Career Profile Development
- » Building Relationships with Employers
- » Making Employer Contacts
- » Individualized Job Searches

Virtual Synchronous Trainings:

- » IPS for Individuals with Criminal Justice System Involvement (optional)
- » Individualized Job Supports

Virtual Asynchronous Training:

- » IPS for Co-Occurring Conditions (optional)

Follow-Up Meetings with IPS Trainer:

- » Twice monthly meetings to brainstorm IPS scenarios (months 1-3 after site-based training)
- » Monthly meetings to brainstorm IPS scenarios (months 4-6 after site-based training)
- » Monthly meetings on IPS outcomes and improvement strategies (6 months after site-based training)
- » One-day site visit (3 months after site-based training)
- » One-day site visit (6 months after site-based training)

Tracking Training Status

IPS employment supervisors must maintain an accurate roster of IPS employment specialists in their program and ensure they are trained to deliver IPS. The IPS COE will also maintain a record of the training status of all IPS teams, and send reports to IPS employment supervisors, counties and DHCS with information about IPS teams and their training status. If an employment specialist fails to complete training requirements within the required timelines, the IPS employment supervisor must act promptly to ensure the training requirements are met or replace the team member with a different practitioner.

Training Exemptions

IPS teams may request exemptions from additional IPS training if they have previously received site-based training from an IPS trainer. All training exemption requests are subject to review and approval by the IPS COE on an individual basis. Training exemption requests must include supporting documentation. The IPS COE may require practitioners previously trained to complete additional training hours in subject areas not previously covered.

Fidelity Monitoring

Regularly monitoring fidelity to the model is a key component of IPS to ensure members are receiving the best possible care and to identify where improvements can be made.

In counties that opt to cover IPS as a bundled Medi-Cal service, IPS teams must achieve and maintain Fidelity Designation for the county to claim bundled Medi-Cal payment for IPS on an ongoing basis.⁵³ IPS teams established through FSP programs must also achieve and maintain Fidelity Designation to comply with BHSA requirements.

IPS teams must achieve and maintain Fidelity Designation by completing the following steps:

- » **Baseline Fidelity Designation.** IPS teams must complete a baseline fidelity assessment to receive Baseline Fidelity Designation. The baseline fidelity assessment must be completed within nine months of establishing a new IPS team.⁵⁴ The baseline fidelity assessment assesses if an IPS team meets foundational fidelity requirements and identifies program strengths, as well as key gaps an IPS team must address before their first fidelity assessment. The IPS COE will conduct baseline fidelity assessments for IPS through a structured interview process. All IPS teams that complete the baseline fidelity assessment will receive Baseline Fidelity Designation.
- » **Minimum Fidelity Designation.** To move from Baseline Fidelity Designation to Minimum Fidelity Designation, IPS teams must pass a fidelity assessment

⁵³ Counties may claim the bundled Medi-Cal rate for IPS for up to nine months before teams of practitioners complete their baseline fidelity assessments. See [BHIN 25-009](#) or subsequent guidance.

⁵⁴ An “established” IPS team reflects an IPS team that has been staffed and is beginning to deliver and be paid for IPS services delivered to individuals living with behavioral health needs.

conducted by the IPS COE using the IPS Fidelity Scale.^{55,56} The first fidelity assessment must be completed within 15 months of establishing a new IPS team. IPS teams must score at least 80 points with a score of 3 or higher on community-based services on the IPS Fidelity Scale to pass the first fidelity assessment and receive Minimum Fidelity Designation.

- » **Full Fidelity Designation.** To move from Minimum Fidelity Designation to Full Fidelity Designation, IPS teams must pass a second fidelity assessment conducted by the IPS COE using the IPS Fidelity Scale. The second fidelity assessment must be completed within 12 months of the first fidelity assessment. IPS teams must score at least 100 points with a score of 3 or higher on community-based services on the IPS Fidelity Scale to pass the second fidelity assessment and receive Full Fidelity Designation.
- » **Maintaining Full Fidelity Designation.** To maintain Full Fidelity Designation, IPS teams must pass triennial fidelity assessment to demonstrate they continue to deliver high-quality IPS services. IPS teams must score at least 100 points with a score of 3 or higher on community-based services to maintain Full Fidelity Designation.⁵⁷ To maintain Full Fidelity Designation, IPS teams must also undergo continuous quality improvement (CQI) reviews conducted by the IPS COE in years in which they do not have formal fidelity assessments to support IPS teams to stay on track to maintain Full Fidelity Designation.⁵⁸ For two consecutive years of CQI reviews, the team must maintain at least a 43% employment rate.

DHCS established this stepwise process to support continued improvement over a multi-year period. The IPS COE will also provide technical assistance tools to help teams advance from Baseline to Full Fidelity Designation. IPS teams may advance more quickly to Full Fidelity Designation if they demonstrate they are operating at a high level of fidelity. For example, if an IPS team scores at least 100 points with a score of 3 or higher on community-based services in their first fidelity assessment, they will receive Full

⁵⁵ The [IPS Fidelity Scale](#) translates the 8 principles of IPS into a 25-item fidelity scale that is used to assess the quality of IPS services.

⁵⁶ IPS teams that do not achieve the specified score to pass a fidelity assessment will enter a probationary period and will not automatically lose their Fidelity Designation, as described below.

⁵⁷ Ongoing fidelity assessments may be required on a more frequent cadence (e.g., biennial) if there is a drop in employment outcomes or a change in the team's employment supervisor.

⁵⁸ The CQI review is not scored but is intended to support teams in continuing to deliver high-quality services.

Fidelity Designation and move to triennial fidelity assessments (bypassing the Minimum Fidelity Designation level).

IPS teams that can demonstrate they previously scored at least 100 points on the IPS fidelity scale with a score of 3 or higher on community-based services will receive Full Fidelity Designation and must complete their next fidelity assessment within three years of their previous assessment. In the next assessment, the IPS team must score at least 100 points with a score of 3 or higher on community-based services to maintain Full Fidelity Designation.

All IPS fidelity assessments must be conducted by the IPS COE. IPS teams must coordinate with the IPS COE to ensure fidelity assessments are completed on the required timeline.

As described in the “County Implementation Timeline” section of the “Foundational Medi-Cal and BHSA Requirements for Counties Implementing ACT, FACT, CSC and IPS” chapter of this manual, the projected number of IPS teams established in counties’ IPs for fiscal year 2026-2027 must achieve Baseline Fidelity Designation by December 31, 2027; Minimum Fidelity Designation by June 30, 2028; and Full Fidelity Designation by June 30, 2029. Counties that are unable to demonstrate that their projected number of teams meet IPS fidelity requirements as described in this manual must consult with the IPS COE and establish a county-specific EBP fidelity plan to meet DHCS’ fidelity requirements. Counties must be prepared to share the county-specific EBP fidelity plan upon request from DHCS.

Probationary Fidelity Period

If an IPS team does not pass a specified fidelity assessment (i.e., does not achieve a score of 80 points on their first assessment or a score of 100 points on their subsequent assessments), the team will enter a 12-month probationary period.⁵⁹ During the probationary period, the IPS team will maintain their Baseline, Minimum or Full Fidelity Designation, depending on what level they reached before entering the probationary period. The IPS team must pass their next fidelity assessment during the 12-month probationary period.

For example, if an IPS team does not score at least 80 points on the IPS Fidelity Scale during their first fidelity assessment, they must still score at least 100 points during their

⁵⁹ There is no probationary period following a baseline fidelity assessment. Baseline fidelity assessments will be assessed based on completion only. All teams that complete a baseline fidelity assessment will receive Baseline Fidelity Designation.

second fidelity assessment. If an IPS team scores 80 points on their first assessment but does not score at least 100 points on their second fidelity assessment, they must complete their third assessment within 12 months of the second assessment and score at least 100 points and a 3 or higher on community-based services on that assessment to receive Full Fidelity Designation.

IPS teams that do not pass the required fidelity assessment after their probationary period will lose their Fidelity Designation.⁶⁰ Teams that lose their Fidelity Designation must work with the IPS COE to determine key fidelity gaps and identify specific steps to re-gain Fidelity Designation. As described in [BHIN 25-009](#) or subsequent guidance, bundled Medi-Cal payment cannot be claimed if a team loses Fidelity Designation.

IPS in Rural Areas

Small counties and rural areas of California that have a lower demand for IPS may not be able to support a full IPS team. In consultation with the IPS COE, IPS providers in these areas may implement IPS staffing modifications to support a smaller caseload of members while maintaining fidelity to the evidence-based model. For example, an IPS team in a rural area may staff one employment specialist, rather than two employment specialists.⁶¹

IPS team staffing adjustments may be appropriate when:

- » Fewer than 35 individuals have a clinical need for IPS in a county or within a one-hour average drive time from the IPS provider's location; or
- » In other scenarios upon recommendation by the IPS COE (e.g., establishing a new IPS team that will grow over time, or if the population with a clinical need for IPS only supports one full-size and one modified IPS team).

When staffing adjustments are made, IPS teams are still expected to maintain the same level of fidelity as assessed by the IPS COE. IPS teams must still achieve a score of 80 or higher on the IPS Fidelity Scale to achieve Minimum Fidelity Designation, and a score of 100 or higher on the IPS Fidelity Scale to achieve Full Fidelity Designation.

⁶⁰ On a case-by-case basis, the IPS COE may recommend and DHCS may approve an IPS team to maintain their Fidelity Designation level even if they do not achieve the required fidelity score. In those instances, the IPS team must consult with the IPS COE and establish a team-specific plan to meet fidelity standards.

⁶¹ See the EBP Policy Guide for additional information on IPS team structure.

Fidelity Action Planning

IPS teams are required to develop a written fidelity action plan after each fidelity assessment that includes a list of goals for the IPS team. The employment supervisor must meet with an IPS trainer monthly to review the written fidelity action plan, receive feedback on the plan, and discuss progress on achieving the goals listed the plan. Monthly meetings must occur until the IPS team reaches all of the goals listed in the action plan as determined by the IPS trainer.

Tracking Fidelity Monitoring Status

IPS employment supervisors must track the IPS team's fidelity status and ensure the IPS team undergoes the required fidelity assessments on the cadence described above. The IPS COE will also maintain a record of the fidelity status of all IPS teams and send reports to employment supervisors, counties and DHCS with information about fidelity assessments. Employment supervisors will also receive reminders from the IPS COE when it is time to schedule their next fidelity assessment.

Data Collection

IPS teams must collect data on member outcomes to ensure IPS is effectively supporting the recovery of participating individuals. The IPS COE has developed tools that IPS teams must use to collect member outcomes data. The IPS data collection tools are available through the IPS COE.

IPS teams must use the IPS data collection tool at the following intervals:

- » At intake (i.e., when a new individual is enrolled in IPS)
- » Monthly, to provide updates about employment status, school status, Department of Rehabilitation (DOR) status, and participation level in the IPS program
- » Every six months to capture outcomes related to housing status and quality of life
- » At discharge

Any member of the IPS team can collect member outcomes data. All data must be securely submitted through an online portal established by the IPS COE. IPS teams should review outcomes data on a regular basis, set goals for improvement, and identify where additional training or technical assistance may be needed.

In addition, the IPS COE will share de-identified, aggregated data with DHCS on a regular cadence to assess the effectiveness of IPS across the state.⁶²

Technical Assistance

IPS teams may utilize the IPS COE for individualized and group-based technical assistance on an ongoing basis. Technical assistance is intended to support IPS teams in meeting training, fidelity monitoring and data collection requirements described above and to ensure services meet the needs of the individuals receiving IPS. Technical assistance is also available in individualized and group-based settings for counties to support their county-wide implementation of IPS.

IPS teams and counties may request technical assistance from the IPS COE at any time.

For IPS, technical assistance may include, but is not limited to:

- » Coordination of IPS under Medi-Cal and Vocational Rehabilitation⁶³
- » Support in meeting specific IPS requirements under Medi-Cal⁶⁴
- » Regional trainings
- » Learning community for IPS teams to share best practices
- » Virtual IPS Practice Principles webinars (for new practitioners)
- » Employer relationship webinars (for all practitioners)

The IPS COE may also recommend specific technical assistance opportunities following completion of a fidelity assessment to support continuous quality improvement.

As described in the “County Consultations with COEs” section of the “Foundational Medi-Cal and BHSA Requirements for Counties Implementing ACT, FACT, CSC and IPS” chapter of this manual, counties required to participate in at least one county

⁶² Some data collected by IPS teams will be used by DHCS to determine if members receiving IPS demonstrate improved health outcomes as part of the Access, Reform and Outcomes Incentive Program. More information about the Access, Reform and Outcomes Incentive Program is available on the [DHCS BH-CONNECT website](#).

⁶³ When IPS is available through both Vocational Rehabilitation and Medi-Cal programs in a county, Medi-Cal must serve as the payer of last resort. Additional guidance is in BHIN 25-009 or subsequent guidance.

⁶⁴ Medi-Cal coverage of IPS was authorized through California’s Alternative Benefit Plan (ABP). Counties and IPS providers must meet specific ABP requirements to deliver IPS as a Medi-Cal service as described in [BHIN 25-009](#) or subsequent guidance.

consultation with the IPS COE to establish and/or expand their IPS programs. Additional technical assistance is optional for counties.