HIGH FIDELITY WRAPAROUND (HFW) POLICY MANUAL

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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)[1] 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, counties[2] are required to cover High Fidelity Wraparound (HFW)[3] under Medi-Cal as an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service[4], in accordance with this Policy Manual and the accompanying BHIN 26-XXX, or subsequent guidance. In addition, counties are

[1] As defined by the Agency for Healthcare Research and Quality, an EBP is a way of providing health care that is guided by a thoughtful integration of the best available scientific knowledge with clinical expertise. This approach allows the practitioner to critically assess research data, clinical guidelines, and other information resources in order to correctly identify the clinical problem, apply the most high-quality intervention, and re-evaluate the outcome for future improvement.

[2] "County" is used throughout this guide to be inclusive of county mental health plans (MHPs) and integrated plans that deliver SMHS, as well as county behavioral health agencies that administer FSP programs.

[3] HFW is covered through the Specialty Mental Health (SMHS) delivery system. For purposes of this Policy Manual, BHP refers to the entity that covers SMHS and is not intended to reference Drug Medi-Cal Organized Delivery System (DMC-ODS) benefits or plans. The Drug Medi-Cal State Plan program is also not included in the definition of BHP.

[4] 42 C.F.R. Part 441, Subpart B; 42 U.S.C. §§1396a(a)(43) and 1396d(r)

required to implement HFW as part of Full Service Partnership (FSP) programs pursuant to the Behavioral Health Services Act (BHSA).[5,6]

Core policy and compliance requirements for the implementation of HFW under Medi-Cal is available in BHIN 26-XXX, or subsequent guidance, and **this Policy Manual provides additional, operational guidance for counties and behavioral health practitioners to implement HFW (Section 1) *as well as* training, fidelity monitoring, and data collection requirements (Section 2) to comply with Medi-Cal and the BHSA.[7]**

DHCS' goal is to ensure counties and providers deliver HFW consistent with evidence-based standards (as outlined in the CA Wraparound Standards, see details in "Overview of HFW" section below) and improves outcomes and quality of life among youth in California living with significant behavioral health needs.

What is in This Policy Manual?

This manual provides information about current evidence and national and state standards (see "Overview of HFW" section).

This manual is divided into two distinct sections.[8] Section 1 of this manual includes the following information on service provision:

- Medi-Cal coverage of HFW and HFW under BHSA;
- Evidence-based service criteria for HFW;

[5] See the BHSA Policy Manual for information about BHSA requirements.

[6] HFW provided under FSP programs must meet all of the same standards as HFW delivered under Medi-Cal. Hereafter, references to "Medi-Cal HFW" apply to FSP/BHSA (see Section B.4.3 in the BHT Policy Manual for more information on alignment of HFW in FSP and Medi-Cal).

[7] DHCS is authorized to implement, interpret, or make specific the CalAIM terms and conditions 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 and 14184.102, subd. (d))

[8] DHCS guidance for other BH-CONNECT evidence-based practices (EBPs) is issued via two policy documents (EBP Policy Guide; and EBP Training, Technical Assistance, Fidelity Monitoring, and Data Collection Policy Manual), in addition to a BHIN. To ensure that stakeholders receive comprehensive guidance for HFW under Medi-Cal and BHSA in advance of the July 1, 2026, DHCS is releasing one manual combining the elements above alongside a HFW BHIN.

- HFW team structure, roles, and key functions; and
- HFW treatment intensity and duration.

Section 2 of this manual establishes training, technical assistance, fidelity monitoring, and data collection requirements for delivering HFW with fidelity to the national evidence-based model and CA Wraparound Standards by covering the following:

- The role of Center of Excellence (COE) established by DHCS in providing training, technical assistance, fidelity monitoring, and data collection for counties and behavioral health practitioners;
- The foundational requirements for counties to deliver HFW under Medi-Cal and BHSA, including information about County BHP and HFW Provider implementation timelines, the fidelity tools the COE will use to determine if HFW providers are delivering services with fidelity to the evidence-based model, and specific fidelity thresholds required to achieve and maintain Fidelity Designation;
- HFW training requirements;
- Fidelity monitoring requirements;
- Data collection requirements to confirm services are improving the health and wellbeing of youth in California living with significant behavioral health needs; and
- Technical assistance opportunities.

This Policy Manual is based on available research and evidence for HFW and was developed in partnership with state and national experts and key implementation partners and stakeholders. The manual is intended to reflect the diversity of California's county-based behavioral health system and, where appropriate, accounts for needed flexibilities to provide HFW in geographically isolated areas that are disproportionately affected by workforce challenges or other limitations. DHCS may periodically update this Policy Manual to align with evolving evidence and national practice standards.

Please contact BH-CONNECT@dhcs.ca.gov with any questions related to HFW and this Policy Manual.

SECTION 1 – OPERATIONAL GUIDANCE FOR HFW SERVICE PROVISION

Overview of HFW

HFW is a team-based, family-centered[9] service for children and youth living with serious mental health or behavioral challenges. HFW is an intervention designed to help the youth stay at home with their families/caregivers, in school, and in the community. HFW is also designed to help the youth's family, caregivers, and natural supports understand the youth's needs and learn how to support them in navigating complex mental health and/or behavioral challenges. HFW is not a prescribed set of services but instead organizes a collaborative planning process that brings together the youth and family/caregivers, natural supports, and involved providers to develop and carry out an individualized plan.[10]

Although wraparound services have been available in California for decades, studies have shown that certain practices garner the best outcomes for youth.[11] The work of the National Wraparound Initiative (NWI) has been to gather those practices into standards that are required by the evidence-based model, which is called "high fidelity" because it adheres to the evidence-based practice standards. As outlined in the CA Wraparound Standards,[12] HFW is delivered in accordance with ten principles of the National Wraparound Initiative (NWI) via four phases. Through these principles, HFW includes a family-centered, "anything necessary" approach to care for youth. HFW combines team-based intensive care coordination and facilitation with individualized and home- and

[9] For the purposes of this Policy Manual, "family" is defined as anyone who is providing care and supervision for the youth.

[10] For information on natural supports, see ACL 25-47/BHIN 25-027.

[11] Youth participating in HFW have demonstrated improved outcomes including, improved behavior, mental health functioning, and reduced school absences and suspensions (National Wraparound Initiative (2017); Bruns (2008)). HFW is also linked to cost savings through reduced emergency room and inpatient psychiatric visits (Olsen et al. (2021); Smith et al. (2019)). In order to achieve these outcomes, the HFW program must have staff trained in HFW, outcomes monitoring, and demonstrated adherence to fidelity standards in line with the CA Wraparound Standards (see Section 2 of this manual).

[12] The CA Wraparound Standards align with the NWI HFW model. See ACL 27-47/BHIN 25-047.

community-based mental health services and supports tailored to meet the individualized needs of the youth. Many youth who benefit from HFW are often involved in multiple child-serving systems, like child welfare and/or juvenile probation.

As noted in BHIN 26-XXX, the Child and Family Team (CFT) is an integral part of HFW. A CFT consists of a group of people (i.e., family, community, a youth's therapist, social worker, probation officer, Tribes when applicable,[13] and practitioners from across the System of Care[14]) who support the youth and family to develop and implement an individualized plan of care. The youth and family[15] are active members of the CFT and serve a key role to identify other CFT members.[16] All youth receiving HFW shall have a CFT, regardless of whether they are involved in the child welfare and/or juvenile probation system. When a youth who receives HFW has an existing CFT, the HFW staff become part of the CFT, so there is only one team for the youth inclusive of the formal support systems a youth may need.[17]

The team works together to integrate required services and supports into a plan of care (incorporating information from the youth's Child Adolescent Needs and Strengths (CANS) assessment) that aligns with the youth and family's goals and values, using individualized, strengths-based planning.[18,19] Hereafter throughout this Policy Manual,

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[13] See ACL 22-73 for guidance on including Tribes in CFTs.

[14] For information on the CA Children's System of Care, see System of Care - California Health & Human Services and ACL 27-47/BHIN 25-047. The Children and Youth System of Care is informed by the implementation of AB 2083, which requires each county to develop and implement an MOU outlining the roles and responsibilities of the various local entities that service children and youth in foster care who have experienced severe trauma.

[15] A youth's caregivers may include, but is not limited to, a biological parent, adoptive parent, foster parent, kinship car giver, legal guardian, or non-residential caregiver (e.g., a non-custodial parent) who shares caregiving responsibilities for the child.

[16] See ACL 25-47/BHIN 25-027, ACL 22-35, and ACL 22-73.

[17] This approach is also key to meet the shared goal across BH-CONNECT, BHSA, and the Children and Youth System of Care of ensuring a one child/youth/one team/one plan for youth in foster care.

[18] See BHIN 25-035.

[19] While the CANS is intended to inform the youth's plan of care, the needs, strengths, and strategies identified in the youth's plan of care are ultimately determined by the youth, family,

the term "HFW team" is used to describe the requirements and roles for the practitioners operating within the context of the CFT. More information on CFTs is outlined in the "Role of Significant Support Persons or Other Collaterals" section below.

HFW is delivered in home- and other community-based settings, and, as necessary, to support continuity of care during transitional periods into and out of inpatient and residential settings. HFW is characterized by the following ten principles:

1. Family Voice and Choice
2. Strengths Based
3. Individualized
4. Natural Supports
5. Community-Based
6. Culturally Respectful and Relevant
7. Team-Based
8. Collaboration
9. Outcome-Based
10. Persistence

HFW includes four phases and associated key activities, with flexibility to align services and supports with youth and family-identified strengths and needs[20]:

- **1: Engagement and Team Preparation** – Initial contact between the HFW team, youth, and family to introduce the HFW process, identify CFT members (if one does not already exist), address immediate needs, and discuss the youth and family's needs and strengths.
- **2: Plan Development** – During this phase, the HFW team develops an individualized plan of care that reflects the child or youth and family's needs, strengths, and strategies to build shared vision among the CFT.
- **3: Implementation** – During this phase, the HFW team implements the individualized plan of care, with each team member undertaking action steps for which they are responsible. The HFW team also meets to review and update the individualized plan of care, crisis and safety plan, and transition plan, gradually shifting responsibility from the HFW team to the family and natural supports.[21]

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and CFT. Additional clinical assessments may also be delivered in the context of HFW (e.g., by youth's therapist) to inform the youth's individualized plan of care.

[20] Walker and Bruns (2008)

[21] Empowering and promoting the long-term resilience of the family and natural support are central to the HFW theory of change.

- **4: Transition** – During this phase, the HFW team meets to prepare the youth and family for transitioning out of HFW, continuing to shift responsibility to the family and natural supports. The HFW team organizes one closing ceremony at the end of HFW, celebrating success to facilitate a positive transition in a way that is meaningful to the child or youth and family.

Medi-Cal Coverage of HFW

DHCS will submit a Medicaid SPA to CMS for authorizing BHPs to provide specified activities with a unique billing code and HFW monthly rate (see BHIN 26-XXX, or subsequent guidance). BHPs have historically provided HFW as an unbundled service using both Medi-Cal, BHSA, and other funding, billing services such as Targeted Case Management (TCM) and Intensive Care Coordination (ICC).

Counties must also deliver or arrange for additional medically necessary SMHS or Drug Medi-Cal (DMC)/Drug Medi-Cal-Organized Delivery System (DMC-ODS) services that are not covered through the HFW monthly rate, and refer a youth to any non-specialty mental health service or Medi-Cal service that a youth needs (services that may be provided by a qualified provider, not just the HFW team). As described in BHIN 26-XXX, BHPs must consider the choice or preferences of Medi-Cal youth and caregivers when a youth is referred to or receiving Medi-Cal HFW services.

Together, the specified activities/service components covered by HFW monthly rate and the individualized array of SMHS and other Medi-Cal services comprise the "Medi-Cal HFW Service Package" outlined in BHIN 26-XXX, or subsequent guidance.

HFW Under the BHSA

In accordance with W&I Code section 5887, counties must begin offering HFW through their FSP programs to individuals up to age 26 effective July 1, 2026. HFW provided under FSP programs must meet all of the same standards as HFW delivered under Medi-Cal. Additional information about BHSA requirements for HFW are in the BHSA Policy Manual.

Evidence-Based Service Criteria for Youth Ages Six Years and Older

Licensed mental health professionals (LMHPs)[22,23] must use the youth's CANS scoring to determine whether HFW is medically necessary and clinically appropriate for each youth referred for HFW. To add certainty in the determination of whether the intense support provided by HFW would correct or ameliorate a mental health condition, and is therefore medically necessary and clinically appropriate for a youth, DHCS is establishing HFW Decision Support Criteria (DSC) for Medi-Cal (which will also be applicable in FSP, as noted above). As noted in BHIN 26-XXX, the HFW DSC is a research-based tool/process intended to support clinical decision-making and statewide consistency in determination of need for HFW and is based on the CANS. The Medi-Cal HFW DSC was developed in partnership with the Praed Foundation, the organization responsible for creation of the CANS and similar HFW DSC used in other states.[24]

CANS is an open domain tool for use in multiple youth-serving systems. CANS assesses the needs and strengths of youth and is a flexible and evolving tool supporting open discussion and collaborative decision-making regarding care coordination and planning, levels of care, services, and placement (if applicable).[25]

HFW DSC and additional clinical needs of the youth and family will inform the clinical determination that HFW is the appropriate service for a member (i.e., that HFW is medically necessary). In limited circumstances, a LMHP may still recommend HFW as medically necessary and clinically appropriate even if a youth does not meet the HFW DSC. DHCS expects that these "edge cases" (e.g., when a youth's CANS domain scores are very close to, but do not fully meet the required ratings outlined in the HFW DSC) in which a LMHP identifies and recommends HFW as a SMHS intervention but the youth does not meet HFW DSC will be limited. Rendering LMHPs must still consider the youth's CANS assessment scoring in the context of the HFW DSC to assess how closely the youth's needs align with DHCS' HFW DSC.

For youth who do not meet the HFW DSC, a rendering LMHP that seeks to recommend this service should also engage the youth, family, and care team in making a clinical

[22] For the purposes of this BHIN, a LMHP is defined on page 2l of Supplement 3 to Attachment 3.1-A of the California Medicaid State Plan.

[23] See BHIN 24-023.

[24] CANS Standard CANS Comprehensive 3.0 (2021)

[25] See BHIN 25-035.

determination of need for HFW. LMHPs may also consider factors such as, but not limited to, utilization of emergency, inpatient, and mobile crisis services and multi-system involvement, to assess clinical need for HFW.

HFW DSC Edge Case Example: Please refer to Figure 3 within BHIN 26-XXX. A youth meets HFW DSC for the Behavioral Emotional Needs CANS domain (3.1) and Risk Behaviors CANS domain (3.2) but does not meet HFW DSC for the Caregiver Needs domain (3.5). The youth recently went to the emergency department on two occasions to address a behavioral health need. When discussing HFW with the family, the caregiver indicates a desire for more support through HFW.

Transition Age Youth and Uninsured Youth in FSP Programs

Transition Age Youth (TAY) may receive HFW under FSP programs if determined clinically appropriate.[26,] Because FSP requirements are derived from Medi-Cal requirements, DHCS requires counties and providers to use CANS, and the HFW DSC, to inform decision-making about the provision of HFW for uninsured youth ages six years old and older in FSP programs. While counties are not required to cover HFW as a Medi-Cal SMHS for Medi-Cal members over 21 years of age, DHCS will require counties and providers to use CANS and apply the DSC when considering whether to recommend HFW for Medi-Cal-enrolled TAY youth ages 21-25 in FSP programs who request to receive HFW.[27,28] HFW DSC requirements apply for determining clinical appropriateness of HFW regardless of whether the service is being provided in Medi-Cal to youth, or adults, or solely under the BHSA.

DHCS will provide additional guidance to clarify whether and how CANS data for uninsured youth, and for Medi-Cal enrolled youth ages 21-25 years old, must be submitted to DHCS.

[26] BHSA eligible children and youth includes TAY and uninsured for FSP programs. BHSA eligible TAY may also receive Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), or FSP Intensive Case Management (ICM) if determined to be clinically and developmentally appropriate by the provider and FSP eligible individual.

[27] CANS is not universally required for Medi-Cal youth 21 years of age or older. Except for nonminor dependents ages 18-21. See BHIN-25-035.

[28] Counties may claim Medi-Cal payment for many components of HFW using existing, unbundled SMHS guidance and procedure codes.

Evidence-Based Service Criteria for Children Age 5 and Under

At the time of publication of this Policy Manual, DHCS has not established HFW DSC for youth ages 0-5 years old. Historically, BHPs have not been required to administer CANS for this age group; consequently, DHCS does not have CANS data with which to develop appropriate DSC. Youth ages 0-5 may receive Medi-Cal covered HFW when the service is deemed medically necessary and recommended by a LMHP acting within their scope of practice and authorized to direct services under the California Medicaid State Plan.

For children ages 0-5, LMHPs should consider but are not limited to the following minimum factors when determining clinical appropriateness of HFW: utilization of emergency services to respond to behavioral health needs, use of inpatient care to address behavioral health needs, use of mobile crisis services; multi-system involvement; and repeated turnover in childcare settings. For children ages 0-5, DHCS does not require that LMHPs employ the HFW CANS DSC for clinical determination of medical necessity for HFW. After BHPs implement updates to CANS policy that include use of the CANS Early Childhood module, DHCS may consider implementing HFW DSC for this age group.

HFW Team Structure

HFW is a multidisciplinary, team-based service. Each youth receiving HFW will have a team that includes both paid supports (HFW provider) and natural supports (such as caregivers or others) selected by the youth and caregivers. The team should prioritize the youth and their caregiver(s)/family at the center of decision-making. For the Indian youth, the team should also include input from the youth's Tribe. The Medi-Cal HFW staff consists of paid supports staffed by the HFW provider that provide key HFW service activities (outlined below) to the youth.

- **A role** is a set of responsibilities on the HFW team that are generally, but not always, assigned to one person.
- **Team functions** (see "HFW Key Functions Required by HFW Teams" section) refer to the core Medi-Cal coverable service activities that are performed as part of the evidence-based model and may be performed by multiple roles on the team.

Team Roles

Within the HFW staffing model, each role does not need to be assigned to a separate individual. One individual may serve in the capacity of two separate roles (i.e., fidelity coach and supervisor). Counties and providers have the flexibility to structure their teams based on local capacity and needs, allowing a single staff member to fulfill

multiple roles, as long as they are adequately trained and supported. However, it is not generally recommended that one staff member hold multiple roles, especially those delivering direct services, for the same youth and family, as this can compromise role clarity and reduce effectiveness.[29] The HFW COE will monitor HFW sites to confirm team configurations enable sites to meet fidelity requirements. The HFW COE can also provide technical assistance on filling team roles when there are workforce challenges or programmatic needs to tailor team roles.

While all roles are required to be made available to all youth, not all youth and their families will benefit from having all roles represented on their team (e.g., a nine-year old youth receiving HFW would not be appropriately paired with a 19-year old youth peer partner). HFW Providers should work with each youth and family to individualize the HFW team based on youth and family choice. While some roles may not be needed for a youth based on their individualized plan of care, a HFW facilitator is required for all youth receiving HFW, as the intervention cannot function without a designated facilitator.

[29] The HFW COE will work with providers and gather information that will inform staffing needs and tailored approaches for meeting the fidelity standards via the Training and Technical Assistance Needs Assessment (TTNA). See Section 2 of this manual.

Figure 1 outlines HFW team role descriptions for direct and indirect service staff, as well as potential practitioner types for each role. Direct service staff work directly with the youth and family as part of the CFT and indirect service staff support the direct service staff in offering high quality and high fidelity care.

Figure 1.a. HFW Team Role Descriptions and Practitioner Types: Direct Service Staff

HFW Team Role	High-Level Description Role	Practitioner Type(s)[30]
Facilitator	Serves as the care coordinator and central guide of the HFW process, by facilitating development of the individualized plan of care and coordinating and monitoring its implementation. Ensures the HFW process reflects the family's voice, culture, strengths, needs, and goals.	Other Qualified Provider (OQP), clinical trainee, or Licensed Practitioner of the Healing Arts (LPHA)
Caregiver/ Parent Peer Partner	Builds trusting, peer-to-peer relationships with parents and caregivers, helping them navigate complex systems, prepare for team meetings, strengthen family bonds, and find sustainable support.	OQP or Peer Support Specialist[31]
Family Specialist	Serves as the family's primary behavioral support partner, working in coordination with the youth's therapist and	OQP

[30] Figure 1 outlines practitioner types that DHCS anticipates will assume each of the HFW team roles, practicing at top of scope of their respective licensures and certifications. However, as described above, individual staff may hold multiple roles, so practitioner types and licensure may vary across each role (this is not an exclusive list of allowable practitioner types).

[31] See "Caregiver/Parent Peer Partner and Youth Peer Partner Practitioner Requirements" section for additional details on peer partner requirements.

HFW Team Role	High-Level Description Role	Practitioner Type(s)[30]
	the CFT to support the youth and caregiver(s) in achieving their goals.[32]	
Youth Peer Partner (must be claimed separately from the HFW monthly rate)[33]	Plays a distinct and complementary role to the family specialist within the HFW team, prioritizing emotional support, peer connection, and advocacy for the youth. The youth peer partner ensures that the child or youth's lived experience is recognized, their voice is heard, and their autonomy is respected throughout service delivery.	OQP or Peer Support Specialist[34]

[32] For information on the differences between the Caregiver/Parent Peer Partner and Family Specialist, please refer to the CA Wraparound Standards.

[33] See BHIN 26-XXX.

[34] See "Caregiver/Parent Peer Partner and Youth Peer Partner Practitioner Requirements" section for additional details on peer partner requirements.

Figure 1.b. HFW Team Role Descriptions and Practitioner Types: Indirect Staff

HFW Team Role	High-Level Description Role	Practitioner Type(s)[35]
Supervisor	Ensures that the team follows HFW process with fidelity while role-modeling strengths-based and outcome-focused practices through hiring, onboarding, and Continuous Quality Improvement (CQI). Responsible for the recruitment, selection, training, and management of the members of the HFW team who provide direct services to youth and families. Works with members of the team, but not necessarily directly with the youth and their family except during formal HFW team meetings.	OQP or LPHA
Clinician	Supervises and mentors Associate Clinicians as they pursue licensure and provides clinical consultation and oversight across the HFW team, ensuring that interventions are trauma-informed, strengths-based, and culturally respectful and relevant. Supports non-clinical staff in providing engagement and clinical consultation to possible intensive interventions	Licensed SMHS practitioner (Licensed Psychologist, LCSW, LPCC, LMFT)

[35] Figure 1 outlines practitioner types that DHCS anticipates will assume each of the HFW team roles, practicing at top of scope of their respective licensures and certifications. However, as described above, individual staff may hold multiple roles, so practitioner types and licensure may vary across each role (this is not an exclusive list of allowable practitioner types).

HFW Team Role	High-Level Description Role	Practitioner Type(s)[35]
	(e.g., crisis management), and assessments for youth and families. Works with the HFW supervisor, who assures that the staff are timely and collaborative. Both the licensed clinician and the HFW supervisor are present for HFW team oversight; they help to ensure adequate training and play an important role in fidelity monitoring.	
Fidelity Coach	As noted above, team members like the supervisor play a role in coaching the team to deliver HFW with fidelity. While the fidelity coach can be a supportive role between the COE and the HFW team, the coach does not replace the functions of the COE, nor the Fidelity Designation and training requirements described in subsequent sections. Through observation and consultation, helps staff deepen their understanding of the HFW philosophy, phases, and principles. Fidelity coaches build a competent workforce through guided skill development and ongoing professional improvement.	OQP
Community Developer	Supports the HFW team in identifying and facilitating coordination of community resources, including low- or no-cost resources (e.g., recreational programs, neighborhood, and civic organizations). Supports referral	OQP

HFW Team Role	High-Level Description Role	Practitioner Type(s)[35]
	processes through conducting outreach to providers, family members, counties, MCPs, county child welfare agencies, Tribes, and others.	

Caregiver/Parent Peer and Youth Peer Partner Practitioner Requirements

As California continues to build capacity for certified Peer Support Specialists, individuals serving in the role of caregiver/parent peer partner and youth peer partner on the HFW team may be certified as Medi-Cal Peer Support Specialists or meet Medi-Cal requirements for Other Qualified Providers. All caregiver/parent and youth peer partners must be employed by a HFW provider site meeting HFW Fidelity Designation (see details in Section 2) and, like all HFW team members, must meet statewide HFW COE training requirements within established timelines.

DHCS recognizes that currently not all caregiver/parent and youth peer partners are certified by Medi-Cal as Peer Support Specialists. DHCS is reviewing the requirements to be certified as a Medi-Cal Peer Support Specialist and is considering the development of separate Medi-Cal certification tracks for these HFW team members. DHCS may update this guidance in the future to require Medi-Cal Peer Support Specialist certification for these individuals.

For details on HFW team claiming for support provided by youth peer partners, which must be claimed separately from the HFW monthly rate, please refer to BHIN 26-XXX, or subsequent guidance.

Key Functions Required of HFW Teams

In alignment with the CA Wraparound Standards, every HFW team under Medi-Cal and BHSA must make available team functions as described in BHIN 26-XXX. Each is discussed in more detail below.

Please refer to BHIN 26-XXX for definitions of the Medi-Cal SMHS service components, as described in California's Medicaid State Plan, under which the team functions described here are covered.

HFW Facilitation and Care Coordination, Care Planning and Documentation

All HFW teams have a designated HFW facilitator. Facilitation of the HFW team is essential to ensure teams are working collaboratively to best support the youth's needs. The HFW facilitator:

- Works with the youth and family to identify CFT members and facilitates HFW team meetings;
- Facilitates the team in development and implementation the youth/family's HFW plan of care;

- Coordinates the development of crisis and safety plans that reflect family-driven, proactive, and reactive strategies;
- Works with the youth and their caregiver(s) to be prepared to manage their own care plan at transition; and
- Ensures all team members are focused on helping the youth achieve their goals, including through leading regular team meetings.

CANS Updates

The HFW team should continuously identify the youth and family's strengths and needs and develop, update, and provide care based on the youth and family's individualized plan of care. Throughout HFW service delivery, the HFW team uses the CANS as one of the tools that support communication and identification of necessary services based on the priorities of the youth and family with the CFT. Each youth's CANS must be updated as necessary throughout the duration of the youth's engagement in HFW and consistent with BHIN-25-035.

Crisis Support and Safety Planning

In addition to the individualized plan of care, the HFW team develops a safety plan that identifies safety needs, risks factors for a crisis, and proactive strategies to avert and respond to crisis, while at the same time ensuring access to 24/7 **telephonic** crisis response by the HFW team as a backup. The HFW team may also choose to provide in-person crisis intervention as needed and appropriate; however, this may not always be possible, so telephonic crisis response, along with other available crisis services, should be considered in the safety plan. As part of this safety plan, the HFW team should discuss the youth and family's preference for mobile crisis response (see section below, on coordinating with crisis service providers).

Counties must ensure crisis services are available to youth participating in HFW and their families. For details on when crisis services must be claimed separately from the HFW monthly rate, please refer to BHIN 26-XXX, or subsequent guidance.

Strength Based Psychoeducation and Psychosocial Skills Coaching for the Youth

Psychoeducation can help youth in HFW recognize the symptoms of their behavioral health condition to prevent and manage or reduce such symptoms. Psychoeducation

may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment needs of the youth (see "Role of Significant Support Persons or Other Collaterals" section below).

The family specialist is the HFW team member primarily responsible for psychoeducation and psychosocial skills coaching. The family specialist:

- Works with the youth providing support, enhancing connections in community and school environments that build on or develop strengths, and developing functional coping skills to reinforce treatment goals;
- Supports parents/caregivers to avoid or navigate crisis escalation patterns;
- Delivers therapeutic and rehabilitative interventions that improve communication, emotional control, and family interactions.

Note: The youth peer partner plays a distinct and complementary role to the family specialist within the HFW team, prioritizing emotional support, peer connection, and advocacy. In contrast, the family specialist focuses on behavior strategies, skill-building, and strengthening natural supports and community connections. See additional information on the role of the youth peer partner in the "Youth Peer Support" section below.

Parent/Caregiver Peer Support

Peer support is a key component of the HFW model. Parent/caregiver peer partners have firsthand experience in navigating systems such as child welfare, juvenile probation, or behavioral health services, and understand the challenges and emotions caregivers face when caring for a youth in HFW. Parent/caregiver peer partners provide valuable guidance, empathy, and support. Parent/caregiver peer partners are key advocates for family-focused care, ensuring that parents/caregivers have a voice in decision-making. The parent/caregiver peer partner:

- Directly supports and engages parents/caregivers new to the HFW process by building their understanding of how to engage with the CFT, as well as by identifying shared values and experiences that they have in common with the parent/caregiver involved in HFW;
- Collaborates with the family specialist to support parents/caregivers in understanding their youth's behaviors and trying new approaches to caregiving.

Parent/caregiver peer support is integral to ensuring HFW delivery is youth and family-driven;

- Supports caregivers in preparation for CFT meetings and contributes to team planning and implementation of an individualized care plan alongside caregivers.

Youth Peer Support *(Must be claimed separately from the HFW monthly rate)*

Youth may also benefit from receiving peer support from young adults who have directly experienced involvement in systems like child welfare, juvenile probation, or behavioral health services. Youth peer partners bring their knowledge and insights from navigating these systems to support and empower youth in HFW in educational skill building, engagement, and therapeutic services. Through receiving peer support, youth may be better able to identify and express their needs, advocate for their rights, and engage actively in their behavioral health treatment. Not all youth will need or want the support of a youth peer partner in their HFW team, especially for young children with which youth peers are not an age-appropriate pairing.

Referrals and Coordination

To deliver HFW to fidelity, HFW teams are expected to coordinate and provide referrals and linkages to physical, behavioral, social services and supports across the Children and Youth System of Care to connect the youth to comprehensive, individualized treatment based on each member's needs. There are also a wide range of other services and supports that may complement a HFW team in providing comprehensive support across the Children and Youth System of Care. The community developer is expected to establish, maintain and expand relationships with local community organizations and healthcare providers to create referral networks to refer youth to appropriate local and state resources and services, which may include:

- Family Services
- Medi-Cal Services
- Emergency Services
- Housing Agencies/Shelter Systems
- Social Services
- School Services

- Self-Help/Peer-Run Services
- Permanency Support Services
- Independent Living Centers
- Regional Centers
- Other Culturally Informed Services and Supports

Care Transition Support[36]

During the Transition Phase of HFW, it is especially important that the HFW team plan for the range of supports and care coordination needs that persist beyond HFW as a glidepath towards improved functioning in the community. The CFT:

- Meets to prepare the youth and family for transitioning out of HFW, continuing to shift responsibility to the family and natural supports; and
- Organizes one closing ceremony at the end of HFW, celebrating success to facilitate a positive transition in a way that is meaningful to the youth and family.

Role of Significant Support Persons or Other Collaterals

HFW uses a team approach to address complex needs across systems. It is not solely focused on providing services, but also bringing together community-based supports, natural supports (i.e., individuals and resources who are not connected with formal systems and are accessible to a youth and family through normal means, i.e., friends, neighbors, relatives, and community groups), relevant system representatives, and professionals to create a cohesive, individualized plan through the CFT process. For information on natural supports and CFTs, see ACL 25-47/BHIN 25-027.

Additional Expectations for HFW Coordination Across the Care Continuum

Crisis Services (Including Mobile Crisis Providers)

Mobile crisis services are critical in the continuum of care for youth receiving HFW. In some instances, HFW providers may also provide mobile crisis services; in other

[36] Transition is defined as the process of moving from formal services and supports to natural supports and out of HFW.

instances, they are expected to coordinate with mobile crisis providers when the need arises. At the youth and family's preference, if the HFW provider also provides mobile crisis services, the HFW team can be the first line of mobile crisis response. Families may also opt to have a separate entity as the mobile crisis provider (and any other crisis service provider) at their preference, and in all instances the HFW team must remain coordinated with other crisis teams.

Inpatient and Psychiatric Residential Treatment Facilities (PRTFs)

Continuity with a member's HFW team is essential when a member is admitted to a short-term inpatient[37] stay. Whenever possible, if a youth is receiving HFW, the team should be closely involved in hospital admissions and discharges for purposes of care coordination. HFW teams coordinate with inpatient providers to support discharge planning.

When a member is admitted to an inpatient setting or PRTF, HFW teams:

- Help familiarize the inpatient hospital physician/residential treatment team with the youth's care plan;
- Advocate for and support the member during their hospital stay;
- Communicate and coordinate with family members or CFT;
- Work with the inpatient hospital discharge staff to help formulate the member's discharge plan; and
- Support the member on the day of discharge and within the week following discharge to help transition them back to their community or to another level of care and provide any needed follow-up care to help decrease the likelihood of readmission to the hospital.

Short-Term Residential Therapeutic Programs (STRTPs), Community Treatment Facilities (CTFs), and Children's Crisis Residential Programs (CCRPs)

For youth needing care in an STRTP, CTF, or CCRP, ongoing coordination by the HFW facilitator and HFW team may be delivered to youth throughout the stay and to support the youth's transition home. For youth entering an STRTP, CTF, or CCRP with an existing

[37] Inpatient hospital settings include general acute care hospitals, acute care hospitals, and psychiatric health facilities.

HFW team/provider, continued receipt of HFW from the same HFW team can support continuity of care.

Youth and caregivers cannot be required to accept HFW provided by the same organization that provides inpatient, PRTF, CTF, CCRP, or STRTP services; BHPs must be able to offer at least one alternative provider. See BHIN 26-XXX for details.

Enhanced Care Management (ECM)

National research indicates that youth with intensive behavioral health needs use physical health services at a higher intensity level than children in Medicaid without intensive BH needs, and many live with chronic conditions. For members with intensive physical health coordination needs, ECM can be particularly important in providing linkages and ensuring access to physical health services while a member is also receiving higher-intensity behavioral health services. Examples of ECM Population of Focus criteria that MCPs/BHPs and other referral partners may use to identify youth who need both HFW and ECM include, but are not limited to: pregnant or are postpartum youth (through 12 month postpartum period); youth enrolled in California Children's Services (CCS); youth at risk for avoidable hospitalization or use; and/or youth experiencing homelessness. As described in BHIN 26-XXX, HFW teams must coordinate with ECM providers to ensure the services are complementary and not duplicative.

Following the launch of the new Medi-Cal HFW payment model in July 2026, DHCS will continue to evaluate the concurrent provision policy and service utilization across SMHS and MCP care management and coordination programs and may provide technical assistance in the future to support providers/MCP/counties.[38]

California Children's Services (CCS)

Youth enrolled in CCS qualify for medical case management in addition to diagnostic and treatment services.[39] Some youth with both a significant behavioral health need and a CCS qualifying condition may benefit from the enhanced support of HFW. For example, HFW may be appropriate in instances where the family is sustainably navigating the physical health needs of a youth, but requests support to address

[38] See the ECM Policy Guide for additional information on overlap of ECM with other programs.

[39] See the CCS Program Overview for additional information.

behavioral health needs. HFW teams should consult closely with CCS care managers in establishing and updating the individualized plan of care.

Juvenile Justice Settings

It is important that youth in juvenile justice settings who received HFW prior to their incarceration continue HFW in the post-release period if needed. It is also important that youth who may meet criteria for HFW are assessed to identify whether HFW is medically necessary and clinically appropriate in the post-release period. Under the CalAIM Justice Involved Reentry initiative, BHPs and correctional facilities are required to work in partnership to facilitate behavioral health links, which includes professional to professional clinical handoffs.[40] Youth who are identified as needing BHP services will qualify for SMHS and receive a behavioral health link.

HFW Treatment Intensity and Duration

HFW teams are expected to provide at least one contact or encounter per month, and beyond this, as many contacts as needed to support a youth's recovery. The number of contacts per member may vary over the course of their engagement in HFW. In some instances, a youth may interact with their HFW team every day in a month. The COE will monitor appropriate engagement to determine whether HFW provider sites provide the service to fidelity. For details on requirements for claiming the HFW monthly rate, please refer to BHIN 26-XXX, or subsequent guidance.

HFW Services Provided by Telehealth

Telehealth can support delivery of HFW by strengthening access to HFW team members and promoting continuity of care. Telehealth can be used to increase access to HFW; however, in-person contacts between a member and their HFW team are an essential component of the evidence-based model.

[40] Under the CalAIM Justice Involved Reentry initiative, behavioral health links facilitate the initiation or continuation of behavioral health treatment once individuals are released to the community.

SECTION 2 – TRAINING, TECHNICAL ASSISTANCE, FIDELITY MONITORING, AND DATA COLLECTION REQUIREMENTS

Center of Excellence

DHCS has contracted with a HFW Center of Excellence (COE), the Resource Center for Family-Focused Practice (RCFFP) at UC Davis, to provide training, technical assistance, fidelity monitoring, and data collection for HFW statewide.[41]

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.[42] 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.

Alignment of Fidelity Standards and Processes Across Medi-Cal, FFPSA Part IV Aftercare, and the Immediate Needs Program

[41] DHCS also contracted with COEs to support implementation of Multisystemic Therapy (MST), Functional Family Therapy (FFT), Parent-Child Interaction Therapy (PCIT), and Clubhouse Services. Additional information on these EBPs is available in BHIN 25-XXX and BHIN 25-009 or subsequent guidance.

[42] 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.

In July 2025, the California Department of Social Services (CDSS) and DHCS issued ACL 25-47/BHIN 25-027, which established the statewide minimum standards (the CA Wraparound Standards) to be certified to provide family-based aftercare services for foster youth discharged from congregate care or out-of-state placements, in compliance with the FFPSA. Family-based after care services in California require provision of services pursuant to the California Wraparound Standards.

Fidelity Designation for HFW in Medi-Cal and under BHSA builds on the family-based aftercare certification process through the California High Fidelity Wraparound County Plan Approval and Provider Certification Portal (hereafter, "the Portal").[43] The Portal includes two components for family-based aftercare certification: 1) a County Plan Approval submission completed jointly by Behavioral Health, Child Welfare, and Probation; and 2) a Provider Certification submission completed by each provider agency.

Provider agencies are not required to be family-based aftercare providers to be Medi-Cal HFW providers. However, DHCS and CDSS have chosen to align these initial requirements and use of the Portal, so that the process of becoming an aftercare provider will prepare a provider for Baseline Fidelity Designation in Medi-Cal and under BHSA. Please refer to the additional description of Fidelity Designation requirements outlined in the "County BHP and HFW Provider Implementation Timelines" section below.

As described in ACL 25-47/BHIN 25-027, the Immediate Needs (IN) Program pursuant to WIC Section 16562 will offer a range of coordinated services and support for youth in foster care, as a component of the CDSS Tiered Rate Structure outlined in WIC Section 11461(h). HFW will be a core component of the IN Program, and requirements for the IN program will build on requirements for Medi-Cal/BHSA HFW that are described in BHIN 26-XXX, or in subsequent guidance, and in this Policy Manual.[44]

[43] The Portal is distinct from the BHSA Integrated Plan Portal through which counties must submit a three-year Integrated Plan and a budget, beginning with Fiscal Years (FY) 2026-2029 (July 1, 2026 – June 30, 2029).

[44] Medi-Cal HFW providers are not required to become certified IN providers. Refer to forthcoming joint guidance from CDSS and DHCS on the IN Program for details.

Foundational Medi-Cal and BHSA Requirements for Counties Implementing HFW

Counties must meet foundational requirements to deliver HFW to be able to use Medi-Cal and/or BHSA funding. Foundational requirements are detailed in sections below, and include:

- Completing county consultations with the UC Davis RCFFP;
- Ensuring practitioners meet specified training, technical assistance, fidelity monitoring, and data collection requirements; and
- Meeting specified implementation milestones for HFW so that services are delivered with fidelity to the evidence-based model.

County Consultations with COE

Counties are required to offer HFW under the BHSA. **Counties are required to participate in consultations with the HFW COE** to expand this EBP consistent with Medi-Cal requirements and BHSA.

Counties must submit a COE Engagement Initiation Form (EIF) on the DHCS COE Resource Hub website to initiate county consultations with the COEs. Counties must have an initial consultation meeting with the HFW COE **no later than June 30, 2026**.

In addition to this initial meeting, counties must have a follow-up meeting with the COE. Follow-up meetings must be completed **no later than October 1, 2026.** Meetings may 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 resources available to establish and/or expand HFW, including identifying existing county-operated or contracted practitioners;
- County-specific questions or concerns related to HFW.
- County-specific implementation timelines under BHSA;
- Staffing structure for the teams delivering HFW;
- Training, technical assistance, fidelity monitoring, and data collection requirements for HFW; and

- Adaptations for small and rural counties/areas.

Counties may have additional follow-up consultations with the HFW COE at any time after the two required consultations to receive technical assistance on county-specific implementation considerations.

Oversight of HFW Practitioners

Counties must ensure all behavioral health practitioners delivering HFW 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 HFW, whether they are delivering services as part of FSP programs or as a Medi-Cal service.

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 HFW providers with the COE on an ongoing basis. This includes providing the COE with information about new and existing HFW provider sites (defined in Box 1) during the county consultation process and alerting the COE when a new provider site is established.

Box 1. What are HFW Provider Agencies and Providers Sites?

HFW provider agencies are defined as the legal entity that holds administrative, fiscal, and compliance responsibility for the delivery of HFW services under contract with a county. A provider agency may operate one or more Medi-Cal certified service locations or operational sites.

HFW provider sites are local or regional offices where HFW services are delivered under shared practice-level leadership, supervision, and accountability structures. HFW provider sites are the unit by which HFW fidelity monitoring tools assess programs.

HFW provider sites will generally align with Medi-Cal certified, county-contracted service locations (satellite offices not included) however, billing or contract structure alone does not determine what defines a provider site.

DHCS, in consultation with the COE, retains authority to approve county and/or provider-proposed site definitions to ensure fidelity assessments accurately reflect operational practice oversight and county-level accountability.

Note on HFW provider site serving multiple counties: Where a provider site serves multiple counties, fidelity designation will be based on both the overall site-level performance and the county-level performance within that provider site.

Training, technical assistance, fidelity monitoring, and data collection requirements for HFW are summarized in Figure 2 and are detailed in the subsequent sections of this manual.

Figure 2. Overview of Training, Fidelity Monitoring, Data Collection and Technical Assistance Requirements for HFW

Requirement	Components
Training	» Practitioners complete **core training** » Practitioners complete **role-specific training** » Practitioners complete **ongoing training (as needed)**

Requirement	Components
Fidelity Monitoring	» HFW agencies complete submission in the Portal on behalf of their HFW provider sites (see ACL 25-47/BHIN 25-027) as the **baseline fidelity assessment** » HFW provider sites complete a **Training and Technical Needs Assessment (TTNA)** » HFW provider sites complete **regular fidelity assessments** and meet specified fidelity thresholds » HFW provider sites achieve and **maintain Fidelity Designation**
Data Collection	» HFW provider sites **collect data** from participants at intake and at discharge (or annually, whichever comes first)
Technical Assistance	» Counties and HFW provider sites receive **individualized technical assistance** from COE » Counties and HFW provider sites participate in **group-based learning communities**

County BHP and HFW Provider Implementation Timelines

As described above, under the BHSA, counties are required to implement HFW. **All counties must meet specific implementation milestones to demonstrate compliance with BHSA requirements.**

These milestones were established to ensure counties administer a high-quality HFW program while recognizing it takes time and resources to hire staff, train practitioners, and ensure programs are operating with fidelity to the evidence-based model. The HFW COE will assess Minimum and Full Fidelity using the Wraparound Fidelity Assessment System's Document Assessment and Review Tool (DART; see Figure 5). Figure 3 and Figure 4 below summarize implementation milestones, delineated between county BHPs' role in meeting BHSA and Medi-Cal requirements and HFW providers' role in achieving Fidelity Designation levels. Core county implementation timelines encompass specified dates to demonstrate compliance with BHSA timelines; HFW provider implementation timelines are on a rolling basis. As noted above, provider site Fidelity

Designation for HFW in Medi-Cal and under BHSA builds on the aftercare certification process.

Box 2. What is Fidelity Designation?

Fidelity Designation is granted to each provider site delivering HFW in each county. Fidelity Designation indicates that the provider site has achieved the required fidelity score for that fidelity assessment.

There are three levels of Fidelity Designation:

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

All HFW provider sites that complete the baseline fidelity assessment automatically receive Baseline Fidelity Designation. HFW provider sites 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 sections of this manual.

All fidelity assessments must be conducted by the COE for HFW, the UC Davis RCFFP team. More information about the HFW fidelity tools and process can be found below.

Figure 3. County BHP Implementation Timeline for BHSA and Medi-Cal Requirements

Stage of County BHP Implementation	Requirements
Consultations with COE	» Submit COE EIFs for HFW no later than **March 31, 2026**; » As described in the "County Consultations with COEs" section of this manual o Complete initial meeting with the HFW COE no later than **June 30, 2026** o Complete county consultation with the HFW COE no later than **October 1, 2026**.
Baseline Fidelity Designation	» Complete the county submission in the Portal no later than **July 8, 2026**[45]; » Ensure a projected number of provider sites[46] delivering HFW have received Baseline Fidelity Designation no later than **December 31, 2027**;
TTNA	» County BHPs must also ensure HFW provider sites have completed a TTNA no later than four months after achieving Baseline Fidelity Designation or by **November 8, 2026** for counties sites those providers receiving certification completing the Portal before **July 8, 2026** (please see details on the TTNA in the "Data Collection" section).
Minimum Fidelity Designation	» Ensure a projected number of provider sites delivering HFW have completed first DART and received Minimum Fidelity Designation no later than **June 30, 2028**; and
Full Fidelity Designation	» Ensure a projected number of provider sites delivering HFW have completed second DART and received Full Fidelity Designation no later than **June 30, 2029**.

[45] See ACL 25-47/BHIN 25-027.

[46] Only the projected number of provider sites for FY 2026-2027 in each county's IP must receive Full Fidelity Designation by June 2029. Teams established for FY 2027-2028 and beyond can initiate training and fidelity monitoring on a later timeline.

BHSA Integrated Plan (IP) Staffing Projections

As described in the BHSA Policy Manual, each county must submit staffing projections for HFW in their 2026 IP submission, and may adjust those projections as part of the 2027 Annual Update (AU) process. Counties are encouraged to consult the HFW COE to determine staffing projections for HFW that account for county resources and capacity. Staffing projections will be reviewed by DHCS as part of the IP/AU process.

The projected provider sites identified in the IP/AU for fiscal year 2026-2027 must achieve Baseline, Minimum and Full Fidelity Designation on the timeline specified in Figure 3 above. In the IP/AU, counties must also project the number of provider sites they will staff for HFW for fiscal years 2027-2028 and 2028-2029. DHCS does not expect all provider sites established after fiscal year 2026-2027 to achieve Full Fidelity Designation by June 2029; rather, all new provider sites must progress through the Fidelity Designation levels on the timeline specified in the "Fidelity Monitoring" section of this manual. Additional information is in the BHSA Policy Manual.

Counties that are unable to demonstrate that their projected number of provider sites for fiscal year 2026-2027 meet the fidelity requirements for HFW as described in this Policy Manual must consult with the HFW COE and establish county-specific HFW fidelity plans to meet DHCS' fidelity requirements.

For example, if a county projects that it will establish four HFW provider sites in fiscal year 2026-2027 but only one HFW provider site completes a baseline fidelity assessment before December 31, 2027, the county must work with the HFW COE to establish a plan for expanding their HFW program and completing the requisite fidelity assessments for the remaining three teams.[47] If a county projects that it will establish four HFW provider sites in fiscal year 2026-2027 and four

[47] 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 HFW fidelity plan, DHCS remains responsible for monitoring county compliance with BHSA requirements.

HFW provider sites complete the baseline fidelity assessment in 2027, but only one HFW provider site achieves Minimum Fidelity Designation by June 2028, the county must also work with the HFW COE on a county-specific HFW fidelity plan that it will follow to improve fidelity implementation for the remaining three provider sites. Counties must share their county-specific HFW fidelity plan upon request from DHCS.

Figure 4. HFW Providers Implementation Timeline to Achieve Fidelity Designation Levels (See "Fidelity Monitoring" section for further details)

Stage of HFW Provider Implementation	Requirements
Baseline Fidelity Designation	» **Provider agencies:** Complete submission in the Portal on behalf of their HFW provider sites[48]. Baseline fidelity assessments must be completed **within nine months** of establishing a new HFW provider site. The baseline fidelity assessment assesses if a HFW agency meets foundational fidelity requirements and identifies key gaps a HFW agency must address before provider sites' first fidelity assessments. » **Timeframe:** All HFW agencies and associated provider sites that complete the baseline fidelity assessment receive Baseline Fidelity Designation. To account for onboarding of new providers, HFW provider agencies complete submission in the Portal on behalf of their HFW provider sites on a rolling basis.

[48] See ACL 25-47/BHIN 25-027.

Stage of HFW Provider Implementation	Requirements
	» ***Note:*** Provider agencies pursuing Aftercare certification currently have access to the Portal while all other provider agencies will have access to the Portal effective July 2026.
Minimum Fidelity Designation	» **Provider sites:** To move from Baseline Fidelity Designation to Minimum Fidelity Designation, HFW provider sites must meet fidelity thresholds established by the COE on the DART. HFW provider sites must receive meet or surpass "minimum fidelity thresholds" for six of the seven DART subscales (see details in Figure 5) to pass the first fidelity assessment and receive Minimum Fidelity Designation. » **Timeframe:** The first fidelity assessment must be completed **within 15 months** of establishing a new HFW provider site.
Full Fidelity Designation	» **Provider sites:** To move from Minimum Fidelity Designation to Full Fidelity Designation, HFW provider sites must pass a second fidelity assessment conducted by the HFW COE using the DART. HFW provider sites must meet or surpass "full fidelity thresholds" for six of the seven DART subscales (see details in Figure 5) to pass the second fidelity assessment and receive Full Fidelity Designation. » **Timeframe:** The second fidelity assessment must be completed **within 12 months** of the first fidelity assessment.
Maintaining Full Fidelity Designation	» **Provider sites:** To maintain Full Fidelity Designation, HFW providers must pass annual fidelity assessments to demonstrate they continue to deliver high-quality HFW services. HFW provider sites must meet or surpass "full fidelity thresholds" for six of the seven DART subscales on annual fidelity assessments to maintain Full Fidelity Designation.

Stage of HFW Provider Implementation	Requirements
	» **Timeframe:** Annually.

As described in BHIN 26-XXX, HFW provider sites must achieve and maintain Fidelity Designation for the county to claim the HFW monthly rate. Counties may claim the HFW monthly rate for up to nine months before each HFW agency completes their baseline fidelity assessment.

HFW provider sites must receive meet or surpass "minimum fidelity thresholds" for six of the seven DART subscales outlined in Figure 5 below to pass the first fidelity assessment, receive Minimum Fidelity Designation, and maintain Full Fidelity Designation.

Note: Minimum and Full Fidelity Thresholds represent the score a provider site must meet to achieve Minimum and Full Fidelity Designation, respectively. To develop these thresholds, UC Davis RCFFP and WERT analyzed several states' DART data, scoring criterion, and distribution of scores across youth/families receiving HFW to identify subscales which HFW providers have historically experienced fewer/more challenges meeting. For example, HFW providers have reported challenges with engaging natural and community supports. Subsequently, the minimum score needed to achieve Minimum Fidelity Designation is lower for this item.

Figure 5. DART Subscales and Minimum and Full Fidelity Thresholds

DART Subscales	Brief Description	Minimum Fidelity Thresholds	Full Fidelity Thresholds
Timely Engagement	Facilitator engages family and completes safety plan, family story, first team meeting, plan of care in a timely manner.	40%	60%
Meeting Attendance	Key natural and formal supports are represented at CFT Meetings.	40%	50%
Safety Planning	There is evidence of an up-to-date crisis/safety plan that identifies specific actions and interventions.	40%	50%
Needs-based	Individualized needs statements for youth and family members are included in every plan of care.	50%	80%
Driven by Strengths and Families	An updated inventory of youth, family, and team members' strengths is present and linked to plans of care.	40%	60%
Natural and Community Supports	Natural supports consistently and actively attend and engage in meetings to foster positive connections with family.	20%	40%
Outcomes-Based Process	The team reviews progress towards meeting youth and family needs and updates the plan of care at each meeting.	50%	60%

In addition to the DART, the COE will use two additional tools to assess the needs and strengths of HFW provider sites on an annual basis. **These tools will not impact a HFW provider site's Fidelity Designation but will be used to inform coaching and identify the need for additional training and technical assistance**.

- TTNA: Will inform both the content and delivery of TTA strategies. The TTNA will be completed by HFW provider sites following completion of the Portal and annually thereafter.
- Wraparound Fidelity Index – Short Version (WFI-EZ): Will be administered to caregivers of youth receiving HFW to evaluate their perceptions of the HFW process. The WFI-EZ is a self-report survey that assesses foundational HFW elements; fidelity to HFW; and satisfaction.

HFW Training Requirements

Every behavioral health practitioner delivering HFW under Medi-Cal or through a FSP program must complete training covering the evidence-based approaches and core principles, phases, and practices comprising the HFW service model. Each practitioner must also complete role-based training applicable to their position.

Behavioral health practitioners may begin delivering services on a HFW team prior to completing training, provided they complete required training within established timelines. After completing the Foundational Curriculum, each practitioner must complete 20 hours of continuing education annually.[49,50]

These requirements apply to all practitioners delivering HFW services. Requirements differ for ongoing staff and newly hired staff in order to allow for phased implementation.

Figure 6. HFW Training Curricula

Foundational Curriculum	Role-Based Curriculum
» Orientation to California HFW » HFW 101: Foundations of Fidelity	» HFW Facilitator » Caregiver/Parent Peer Partner

[49] The HFW training curricula and continuing education offerings and requirements may change over time. All current training requirements will be specified by the HFW COE.

[50] Ongoing training must be through COE-sponsored or COE-approved coursework to reinforce HFW principles and practices.

Foundational Curriculum	Role-Based Curriculum
	» Family Specialist » Supervisor » Clinician » Fidelity Coach » Community Developer

Figure 7. Training Requirements by Hire Date

Requirement	Timeline:	Timeline:
Hire Date	**Staff hired before January 1, 2027**	**Staff hired on or after January 1, 2027**
Orientation to California HFW	By April 1, 2027	Within 90 days of hire
HFW 101: Foundations of Fidelity	By July 1, 2027. Provider agencies are responsible for monitoring and documenting completion of HFW 101 for staff hired before January 1, 2027. The HFW COE will not require submission of proof of attendance or process individual exemptions for this group.	Within 6 months of hire
Role-Based Training and Role Refresher Sessions **Note: Must attend the HFW 101 prior to enrolling in role-based courses.*	**Training:** Not required for staff hired before January 1, 2027. Staff hired before January 1, 2027 are required to attend a two-hour live or recorded Role Refresher Session for each role they occupy. Staff must complete this requirement by April 1, 2027.	**Training:** Within 6 months of hire **Role Refresher Session(s):** Not required for staff hired before January 1, 2027.

Requirement	Timeline:	Timeline:
Continuing Education	20 hours annually beginning July 1, 2027.	20 hours annually following completion of all Foundational training.

Tracking Training Status

HFW provider sites must:

- Ensure all HFW staff meet statewide training requirements within established timelines;
- Maintain an accurate roster of HFW team members and their respective roles on the HFW team as well as their training status;
- Act promptly to ensure the training requirements are met or replace the team member with a different practitioner if a HFW team member fails to complete training requirements within the required timelines;
- Maintain documentation of required training completion within the HFW COE Learning Management System (LMS) and reporting systems; and
- Submit training materials, if applicable, for review by the HFW COE.

The HFW COE will also maintain a record of the training status of all HFW provider sites and send reports to HFW supervisors, counties, and DHCS with information about HFW teams and their training status. For staff hired prior to January 1, 2027, the HFW COE will monitor compliance with HFW requirements at the provider level. The HFW COE will not request individual proof of HFW 101 completion or process exemption requests for these staff. For staff hired after January 1, 2027, training completion and any exemption requests will be reviewed and approved by the COE.

Training Exemptions

All training exemption requests are subject to review and approval by the HFW COE. Exemptions will be offered at the individual level while agencies will be able to obtain approval to deliver provider specific/owned coursework to staff. Exemption requests apply only to staff hired on or after January 1, 2027. Exemptions for role-based training are not available for individual practitioners.

Individual Exemption for Prior Training: HFW team members hired on or after January 1, 2027 may request exemptions from HFW 101 training if they can demonstrate they have completed equivalent training from another training entity within required

timelines (6 months from date of hire). To demonstrate equivalent training, the HFW team members must provide proof of training completion, training materials (agenda, slides, participant guides) demonstrating instructional hours meet minimum requirements) and Learning Objectives (LOs) demonstrating equivalent training requirements. Only training formally approved by the COE may be counted toward compliance. Approval applies only to the individual staff member and does not constitute curriculum approval for future use.

Provider-Level Curriculum Approval: Provider organizations may request approval to use their own curriculum to satisfy statewide requirements (both HFW 101 and Role-Based courses). To demonstrate alignment with statewide requirements, the provider must submit curriculum materials (training guides, slides, learning objectives, agendas). Approval is contingent upon alignment with COE HFW Foundational materials (HFW principles and phases) and minimum instructional hour requirements. The HFW COE will establish a standardized submission and review process for provider-level curriculum approval. If approved, provider staff will not be required to submit individual exemption requests.

Fidelity Monitoring

Regularly monitoring fidelity to the model is a key component of HFW to ensure youth receive the best possible care and to identify where improvements can be made.

HFW provider sites must achieve and maintain Fidelity Designation for the county to claim bundled Medi-Cal payment for HFW on an ongoing basis.[28] HFW provider sites established through FSP programs must also achieve and maintain Fidelity Designation to comply with BHSA requirements.

HFW provider sites must achieve and maintain Fidelity Designation by completing the steps outlined in Figure 4 above.

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

HFW providers may advance more quickly to Full Fidelity Designation if they demonstrate they are operating at a high level of fidelity. For example, if a HFW provider achieves “full fidelity thresholds” for six of the seven DART subscales in their first fidelity assessment, they will receive Full Fidelity Designation and move to annual fidelity assessments (bypassing the Minimum Fidelity Designation level).

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

As described in the "County BHP and HFW Provider Implementation Timelines" section of the "Foundational Medi-Cal and BHSA Requirements for Counties Implementing HFW" section of this manual, HFW provider sites established in counties' 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 provider sites meet fidelity requirements for HFW as described in this manual must consult with the HFW COE and establish and comply with a county-specific HFW fidelity plan to meet DHCS' fidelity requirements. Counties must share the county-specific HFW fidelity plan upon request from DHCS.

Probationary Fidelity Period

If a HFW provider site does not pass a specified fidelity assessment (i.e., Minimum or Full Fidelity for the DART), the provider site will enter a 12-month probationary period. During that period, the HFW provider site will maintain their current fidelity designation but must pass their next fidelity assessment.[51] The HFW provider site will be offered an interim DART review 6 months after entering the probationary period to help them achieve their respective Fidelity Designation within the 12-month probationary period.

HFW provider sites that do not pass the required fidelity assessment after their probationary period will lose their Fidelity Designation.[52] HFW provider sites that lose their Fidelity Designation must work with the COE to determine key fidelity gaps and identify specific steps to re-gain Fidelity Designation. As describe. n , the HFW monthly rate cannot be claimed if a HFW provider site loses Fidelity Designation. To minimize the chances that a provider will lose their fidelity designation, the COE will use

[51] 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.

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

the WFI-EZ and TTNA tools to help inform training and technical assistance for those on probation.

HFW in Rural Areas

Small counties and rural areas of California that have a lower demand for HFW may be more likely to have HFW teams with individual practitioners supporting multiple roles, and/or individuals who provide other behavioral health services in addition to their roles on the HFW team. The HFW COE will work with HFW provider sites to ensure staffing models meet fidelity requirements (see "HFW Team Structure" section). DHCS will not modify required fidelity scores for small counties and rural areas.

Tracking Fidelity Monitoring Status

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

Fidelity data for all HFW provider sites will be tracked using the University of Washington Wraparound Evaluation and Research Team (WERT) WrapStat, which is a web-based, HIPAA-compliant platform that each provider uses to upload their documents for fidelity review. Both providers and the COE will use WrapStat to track progress towards fidelity thresholds, and the COE will monitor data within the system to identify training and technical assistance needs within and across provider organizations.

Data Collection

HFW provider sites must collect data on member outcomes to ensure HFW is effective. The HFW COE will require every HFW provider site to use WrapStat. The WrapStat is used to collect member outcomes data, including data from the DART, WFI-EZ, and additional questions within WrapStat.

HFW provider sites must use the WrapStat at the following intervals:

- At intake (i.e., when a new member initiates HFW)
- At the end of HFW service provision, or annually, whichever is sooner

Any member of the HFW team who has access to WrapStat can collect member outcomes data.

To complement data collected by HFW provider sites, the COE will also engage with caregivers of youth receiving HFW to complete the WFI-EZ annually from a representative sample of youth enrolled for a certain timeframe (e.g., between 3 and 15 months).

HFW provider sites should review member outcomes data on a regular basis to ensure HFW is being delivered effectively and meeting the needs of youth.

In addition, the HFW COE will share de-identified, aggregated data with DHCS on a regular cadence to assess the effectiveness of HFW statewide.[53]

Technical Assistance

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

HFW provider sites and counties may request technical assistance from the HFW COE at any time. Technical assistance will include synchronous and asynchronous virtual resources supporting improvement in the corresponding DART domain, including:

- Timely Engagement
- Meeting Attendance and Team Participation
- Safety Planning
- Needs-Based Planning
- Strengths-Based Practice
- Natural and Community Supports

[53] Some data collected by HFW teams will be used by DHCS to determine if members receiving HFW 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.

- Outcomes-Based Process

Each technical assistance module includes structured TA to assess current practice and identify strengths and gaps, along with improvement planning support to develop targeted, measurable strategies aligned with fidelity standards. Modules also include direct training delivery by the COE, as well as access to practical tools and resources to support implementation and sustained improvement.

Individual and group-based technical assistance opportunities (e.g., virtual learning communities, consultations) and tailored technical assistance topics will also be available. The HFW 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 BHSA Requirements for Counties Implementing HFW" section of this manual, counties are required to participate in at least two county consultations/meetings with the HFW COE to establish and/or expand their HFW program under Medi-Cal and FSP. Counties are also required to share information about their network of practitioners delivering HFW with the HFW COE on an ongoing basis, which includes providing information about new and existing HFW provider sites during the county consultation, and alerting the HFW COE when a new provider site is established (defined as a team that has been staffed and is beginning to deliver and be paid for services). Additional technical assistance is optional for counties.