SCALING DYADIC CARE GRANT PROGRAM

Request for Applications Overview, Strategy, and Design

September 2026

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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PART 1: OVERVIEW

1.1 Introduction to the Grant Opportunity

As a part of the Children and Youth Behavioral Health Initiative (CYBHI) the California Department of Health Care Services (DHCS) is launching the Scaling Dyadic Care Grant Program (hereafter "the grant program"), a two-year, statewide investment designed to accelerate the implementation of Medi-Cal dyadic services benefit across California.[1] DHCS is committing approximately $17 million to provide direct funding to Medi-Cal provider organizations and to deliver comprehensive technical assistance (TA) aimed at building, scalable models of dyadic care.

The grant program is structured to support participating providers in developing the clinical, operational, and data infrastructure required to effectively deliver, document, bill for, and sustain dyadic services. This includes strengthening care team integration; establishing standardized workflows; enhancing electronic health records (EHRs) and reporting capabilities; and aligning dyadic services with Medi-Cal reimbursement pathways.

This approach reflects the foundational understanding that successful implementation of dyadic services requires substantial upfront investment, including workforce expansion, training, technical assistance, and care delivery redesign. It also ensures that funded provider service locations are positioned not only to initiate high-quality dyadic services, but to sustain and grow beyond the grant period through reliable Medi-Cal billing, improved operational capacity, and long-term financial viability.[2]

Through this two-year grant period, participating providers will receive structured, hands-on support to establish and operationalize dyadic care services while fully leveraging the Medi-Cal dyadic services benefit to drive long-term financial sustainability. The grant program is intentionally designed to support providers at the practice-level pairing flexible, start-up funding with multi-year, evidence-based technical assistance that strengthens clinical workflows, enhances care team integration, and supports the delivery of trauma-informed dyadic care services for Medi-Cal children and their families.

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[1] The Children and Youth Behavioral Health Initiative (CYBHI) was established pursuant to California Welfare and Institutions Code § 5961. California Welfare and Institutions Code § 5961. The Medi-Cal Dyadic Services Benefit was established through California State Plan Amendment (SPA) 23-0010 and is implemented in accordance with DHCS All Plan Letter (APL) 22-029 (Revised). See SPA 23-0010 Approval and APL 22-029 (Revised).

[2] A service location is defined as a distinct physical clinical site delivering services, a location that typically has its own Medi-Cal enrollment/NPI, a site that operates as a unique care delivery setting, and part of the same legal entity.

The grant structure reflects established best practices from state and federal implementation funding models, incorporating safeguards that balance access, equity, operational feasibility, and fiscal responsibility. The framework ensures providers not only initiate dyadic services, but also build the capacity, infrastructure, and reimbursement understanding necessary to sustain and scale services well beyond the grant period.

The University of California, San Francisco Center for Advancing Dyadic Care in Pediatrics (UCSF CADP) serves as the Technical Assistance Vendor (TA Vendor), in partnership with DHCS and a Third-Party Administrator (TPA), the California Institute for Behavioral Health Solutions (CIBHS) to oversee implementation, provide structured coaching and consultation, and guide statewide adoption of dyadic care services. This coordinated support model ensures that grantees receive consistent, high-quality guidance rooted in national best practices for integrated pediatric behavioral health and Medi-Cal dyadic services benefit implementation.

What is Dyadic Care and Why Does It Matter?

Dyadic care in pediatric primary care is a core strategy for advancing health equity and improving outcomes for California's children, parents, and caregivers. By integrating behavioral health support, developmental screening, and assessment of social and environmental factors directly into routine pediatric visits, dyadic care expands access to preventive and early intervention services, particularly for families who face structural and systemic barriers to care. Population-based dyadic models provide unparallel access to young children and caregivers, two of the most underserved populations in behavioral health care.

Preventive dyadic care mitigates downstream health inequities by addressing the impacts of toxic stress and adverse childhood experiences (ACEs) early in the life course.[3] Integrating behavioral health providers alongside pediatric clinicians enables real-time response to developmental, mental health, and psychosocial concerns. This approach are especially important in California, where gaps in early identification persist and children's preventive care, maternal health, birth equity, and behavioral health integration have been identified as statewide priorities.

This grant program supports scaling the Medi-Cal Dyadic Services Benefit which includes behavioral health well-child visits, comprehensive community support services, psychosocial educational services, and family training for child development. The program reflects the strong connection between dyadic care, preventive service access, and the Medi-Cal transformation goals outlined in DHCS's Comprehensive Quality Strategy.

[3] See DHCS Policy Resources for ACEs Aware.

1.2 Equity-Driven Approach

Equity is a core principle of the Scaling Dyadic Care Grant Program. The program is grounded in the understanding and reflected throughout the Grant Strategy document that dyadic care, when implemented as intended, is itself an equity strategy, strengthening caregiver-child relational health through preventive, family-centered services delivered in trusted primary care settings.

UCSF CADP's equity framework draws on principles from child development, liberation psychology, multicultural and community psychology, and trauma-informed healthcare. This framework emphasizes interconnected systems, practice transformation, contextualized care, and community-rooted solutions that address structural inequities while empowering families as active partners in care. Guided by the Brooks' PETAL framework (**P**rioritize health equity, **E**ngage the community, **T**arget health disparities, **A**ct on the data, and **L**earn and improve) the program supports organizations across California in implementing dyadic care with a central focus on diversity, equity, inclusion, accessibility, and belonging.[4] This approach aligns with the program's broader goals of expanding equitable access to dyadic services, addressing disparities in early childhood behavioral health, and ensuring sustainable, community-responsive models of care statewide.

Equity in Outreach and Applicant Selection

Outreach will prioritize geographically diverse providers—serving populations of focus, with communications established to be accessible and culturally responsive.

Final award selection will utilize predetermined allocation methodologies and objective thresholds established in the RFA to support balanced geographic distribution and prevent overconcentration of funding within a single region or delivery system type.

The review process also incorporates a County Equity and Need Composite Index (See Section 3.4) using standardized, publicly available county-level indicators related to:

- Pediatric Medi-Cal enrollment
- California Health Places Index (HPI) scores[5]

[4] Brooks D, Douglas M, Aggarwal N, Prabhakaran S, Holden K, Mack D. Developing a framework for integrating health equity into the learning health system. Learn Health Sys. 2017; 1:e10029. https://doi.org/10.1002/lrh2.10029.

[5] The California Healthy Places Index (HPI) is an evidence-based health equity tool that combines neighborhood-level data on social, economic, environmental, and community conditions associated with life expectancy and health outcomes. HPI scores are commonly used by California agencies to identify communities experiencing the greatest health inequities and to inform equitable resource allocation and investment decisions. See Healthy Places Index (HPI).

County indicators will be standardized using statewide quartile methodologies when feasible, to support equitable comparison across counties of varying size and resource levels.

The application scoring methodology also includes an Equity and Community Impact domain (see Section 3.4) assessing applicant efforts to address health disparities, serve high-need populations, and advance health equity within pediatric care delivery. Equity questions incorporate elements of Brooks et al.'s PETAL framework, including how applicants prioritize health equity, engage communities in quality improvement, target and address disparities, act on data, and demonstrate ongoing learning and improvement.

The scoring methodology also includes a Workforce Development Incentive Adjustment (see Section 3.4) recognizing applicants in behavioral health workforce shortage regions, those that demonstrate investment in workforce pipeline development, such as trainee placements, clinical supervision, and those that have partnerships with academic or workforce training programs.

Together, the geographic allocation methodology, County Composite Index, and Workforce Development Incentive Adjustment support transparent, objective, and equity-centered funding decisions aligned with statewide pediatric behavioral health priorities.

Equity in Monitoring

Equity is integrated into the monitoring framework through both quantitative and qualitative review processes. In addition to tracking demographic and utilization data to assess equitable reach of dyadic services, the TA Vendor applies a relationship-based oversight approach that considers provider context, capacity, and community needs when evaluating performance. Data collection will incorporate both qualitative and quantitative methods, avoiding reductionistic approaches, and insights will be shared with grantees and through family consumer engagement to collaboratively inform ongoing efforts.

1.3 Population of Focus

Young Children and Families

While the Medi-Cal Dyadic Services benefit may be delivered to eligible children and youth across the pediatric age spectrum (ages 0–20), this program prioritizes implementation efforts focused on children ages 0-5 and their parents or caregivers. Early childhood represents a critical period for brain development, attachment, social-emotional growth, and the identification of developmental and behavioral health

concerns. Young children also have the highest frequency of recommended well-child visits, creating repeated opportunities to engage families, provide preventive services, and integrate dyadic care into routine pediatric care delivery.

By focusing on children ages 0–5, the program seeks to maximize opportunities for prevention and early intervention while establishing sustainable clinical workflows, staffing models, and billing practices that can ultimately be expanded to serve broader pediatric populations. Lessons learned through this grant program are intended to inform future expansion and adaptation of dyadic care models across broader pediatric populations and age groups.

Priority Populations for Equity Advancement

Within this primary population of focus, the grant program advances health equity by reducing disparities through targeted outreach, community engagement, and tailored support for providers serving diverse populations. Grant funding and technical assistance will prioritize organizations serving:

- Young children, and especially those in Black, Indigenous, and People of Color (BIPOC) communities
- Children and youth with developmental disabilities or behavioral health concerns
- Families facing social drivers of health (SDOH) concerns or at-risk for systems involvement
- Families of children with complex needs
- LGBTQIA+ communities
- Rural and under-resourced regions
- Lower-income families
- Pregnant and postpartum individuals

By focusing on prevention in the earliest years, the grant program shifts care from individualized crisis response to relational, strength-based support, allowing systems to address inequities before they widen over time.

1.4 Purpose and Prioritized Outcomes

The Scaling Dyadic Care Grant Program aims to meaningfully advance the availability and quality of integrated dyadic behavioral health services for Medi-Cal children and families across California. The program aims to demonstrate that dyadic care can be implemented equitably and sustainably within pediatric primary care settings, while generating actionable data to inform statewide policy and future scalability.

Prioritized Outcomes

The program is designed to achieve the following goals, organized by theme in Table 1.

Table 1. Prioritized Program Outcomes

THEME	GOALS
SERVICE DELIVERY **Expanding access and integration**	» Increase utilization of dyadic behavioral health services within Medi-Cal pediatric primary care settings » Enhance team-based delivery of care, integrating behavioral health clinicians, pediatric providers, and allied health professionals » Increase early intervention and preventative behavioral healthcare opportunities for children ages 0–5 » Improve access to non-specialty mental health services for underserved Medi-Cal populations
PATIENT AND FAMILY OUTCOMES **Improving health and equity**	» Improve early childhood developmental and behavioral health outcomes, including health outcomes across generations, such as caregiver mental health » Improve social drivers of health (SDOH) outcomes by connecting families with needed support services
SUSTAINABILITY **Building lasting infrastructure**	» Strengthen provider capacity for integrated care, including operational workflows, documentation, and data infrastructure » Advance financial sustainability at the provider level through Medi-Cal dyadic service billing and reimbursement pathways » Improve county and managed care infrastructure to facilitate dyadic service networks and long-term sustainability
SYSTEM LEARNING **Building lasting infrastructure**	» Inform statewide scalability by generating implementation evidence and lessons learned from a concentrated, regionally focused set of participating providers

1.5 Authorizing and Applicable Law

The Scaling Dyadic Care Grant Program is authorized and guided by key state and federal initiatives that collectively advance Medi-Cal transformation, health equity, and integrated pediatric behavioral health. The grant program directly supports implementation of the Medi-Cal Dyadic Services Benefit, as established in All Plan Letter (APL) 22-029 and federally approved through the State Plan Amendment (SPA) 23-0010, which provides sustainable reimbursement pathways for preventive, family-centered behavioral health services delivered in primary care. This grant program aligns with the California Advancing and Innovating Medi-Cal (CalAIM) initiative framework, reinforcing statewide priorities such as early identification, maternal health and birth equity, behavioral health integration, and whole-person care. The grant program also aligns with DHCS's Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) strategy to strengthen coordination, access, and integration across the behavioral health system. The grant program advances the goals of the CYBHI (in accordance with California's Welfare and Institutions (W&I) Code section 5961) by expanding preventive and early intervention access to young children and families within trusted primary care settings, and aligns with DHCS Comprehensive Quality Strategy to strengthen coordination between primary care and behavioral health systems. The grant program further recognizes the California Child and Adolescent Mental Health Access Portal (Cal-MAP) as a complementary statewide resource supporting pediatric primary care providers in identifying and addressing behavioral health needs. Together, these authorities establish a coherent policy foundation for scaling dyadic care statewide in a manner that is equitable, sustainable, and consistent with Medi-Cal's long-term transformation goals.

1.6 Timeline

The overall grant program spans two years to support statewide planning, evaluation, and closeout activities. Provider grantee funding and active implementation activities occur during the 24-month Grant Award Period (April 2027–March 2029).

2026

Planning: Preparation, outreach, grantee selection, and contracting

Key milestones include public release of grant communications (Sept 2026), application release (Sept 2026), a grantee webinar (Sept 2026), application due date (October 2026), award decisions announced (January 2027), and finalization of grantee contracts (Quarter 1 of 2027).

2027–2028

Grant Period: Onboarding and implementation

Technical assistance begins on a quarterly basis in 2027, with the payment schedule and data collection and reporting plan both initiating in the first quarter of grantee funding. Public statewide webinars are proposed semi-annually (December 2027 and May 2028, December 2028 and August 2029).

2028–2029

Grant Period: Scaling and sustainability

Scaling, sustainability, and optimization. Grantees advance through TA modules focused on expanding dyadic services, strengthening billing and revenue generation, and building long term sustainability infrastructure.

2029

Grant Close Out: Evaluation and close out

Final evaluation, grantee offboarding, and synthesis reporting to DHCS.

Figure 1

1.7 Third-Party Administrator

The California Institute for Behavioral Health Solutions (CIBHS) will serve as the Third-Party Administrator (TPA) for the Scaling Dyadic Care Grant Program. The TPA plays a critical role in supporting program infrastructure and ensuring fiscal accountability throughout the grant period.

TPA responsibilities include:

- Grant distribution and disbursement of funds to participating provider service locations
- Contracting and execution of grant agreements with grantees
- Providing fiscal oversight, monitoring, and compliance review
- Payment disbursement aligned with the milestone and performance-based payment methodology
- Administrative coordination to support grantee reporting and compliance requirements

The TPA operates as a decision-making partner at both the executive and operational levels, working closely with TA Vendor and DHCS to ensure that grant deliverables are achieved. The TPA, TA Vendor, and DHCS will collectively establish clear policies, workflows, and decision-making frameworks to guide implementation, monitor progress, and ensure efficient allocation of resources.

1.8 Technical Assistance Model

Technical assistance is the backbone of the Scaling Dyadic Care Grant Program. As the technical assistance provider, the UCSF Center for Advancing Dyadic Care in Pediatrics (CADP) technical assistance approach draws on implementation science and is trauma-informed, relationship-based, and designed to support providers and counties in creating robust, culturally responsive, financially sustainable dyadic care services.

Background on UCSF CADP

The UCSF Center for Advancing Dyadic Care in Pediatrics (CADP) was established with the vision to make family-centered, dyadic behavioral health promotion and prevention a routine and sustainable standard of pediatric health care in early childhood. UCSF CADP's work is grounded in the direct provision of dyadic services at Zuckerberg San Francisco General Hospital (ZSFG) in partnership with the UCSF Department of Psychiatry and Behavioral Sciences, the UCSF Department of Pediatrics, and the San Francisco Department of Public Health.

UCSF CADP brings deep expertise in both clinical practice and technical assistance, developed through years of implementing the HealthySteps model, which is a model for dyadic care, and related integrated behavioral health approaches in diverse publicly insured primary care provider settings. UCSF CADP's team integrates staff dedicated to training and technical assistance for statewide dyadic service implementation with the clinical team at ZSFG, where clinical practices are developed and inform our approach. By learning directly from on-the-ground clinical practice, the UCSF CADP technical assistance model has a uniquely grounded, practical perspective on the challenges providers face in implementing and sustaining dyadic services.

Multi-Level Technical Assistance Structure

Technical assistance will be delivered across three levels to ensure broad reach and depth of support:

- **Provider-Level:** Intensive, hands-on support including individualized site visits, ongoing clinical consultation and coaching, office hours and help desk support, and assistance with data submission and reporting to support continuous quality improvement.
- **County and Regional:** Learning communities and county roundtables convening providers, county agencies, managed care plans, and other partners to promote systems alignment, address shared barriers, and support long-term sustainability of dyadic services. These communities create opportunity for peer learning, shared problem-solving, and mutual support as providers adapt and grow over the course of the grant.
- **Statewide:** Public educational webinars (at least four over the course of the program, and an open-access Dyadic Services Toolkit to promote consistent understanding of dyadic services and how to implement benefit utilization across the Medi-Cal delivery system.

This model provides tailored implementation support while promoting broader system alignment and statewide learning. By adapting technical assistance to provider readiness and needs, the program aims to strengthen implementation capacity, reduce operational burden, and support long-term sustainability.

The county-based implementation approach is designed to extend impact beyond directly funded providers. By concentrating technical assistance within regional ecosystems, the program supports development of local dyadic care expertise, peer learning networks, and shared implementation resources that can inform broader statewide adoption. Through regional learning communities and train-the-trainer approaches, participating providers may serve as future implementation resources for other organizations seeking to adopt dyadic services.

Leveraging Statewide Resources and Connected Medi-Cal Initiatives

Technical assistance will support grantees in understanding and leveraging existing Medi-Cal programs, behavioral health initiatives, and community resources that can strengthen dyadic care implementation and sustainability. This may include education and coordination related to initiatives such as CalAIM, BH-CONNECT, Managed Care Plan (MCP) partnerships, and other statewide efforts designed to improve access to behavioral health services and care coordination. Participating provider service locations will also receive information on available consultation, referral, and resource navigation supports, including programs such as Cal-MAP.

Training and Content Strategy

Training content will focus on key domains necessary for dyadic care implementation and sustainability, including:

- Core components of the Medi-Cal Dyadic Services Benefit, integrated behavioral health, and team-based care
- Early childhood and dyadic behavioral health clinical practice in primary care
- Operational workflows and EHR optimization
- Billing and revenue cycle management
- Community engagement and centering patient and family voice
- Continuous quality improvement and data use
- Sustainability pillars: clinical care, billing and claims, and maximizing the utilization of Medi-Cal for covered services, such as the interweaving of other relevant Medi-Cal benefits

Content will be adapted based on provider readiness and ongoing feedback from grantees and families. The TA Vendor will create a readiness checklist to evaluate grantees' needs when implementing dyadic care, with ongoing monitoring to continually assess and address those needs. A Learning Management System will provide grantees with easy access to dyadic care resources and asynchronous training modules.

Technical Assistance Delivery Methods

The program will provide TA through multiple modalities to accommodate diverse learning styles and schedules, including:

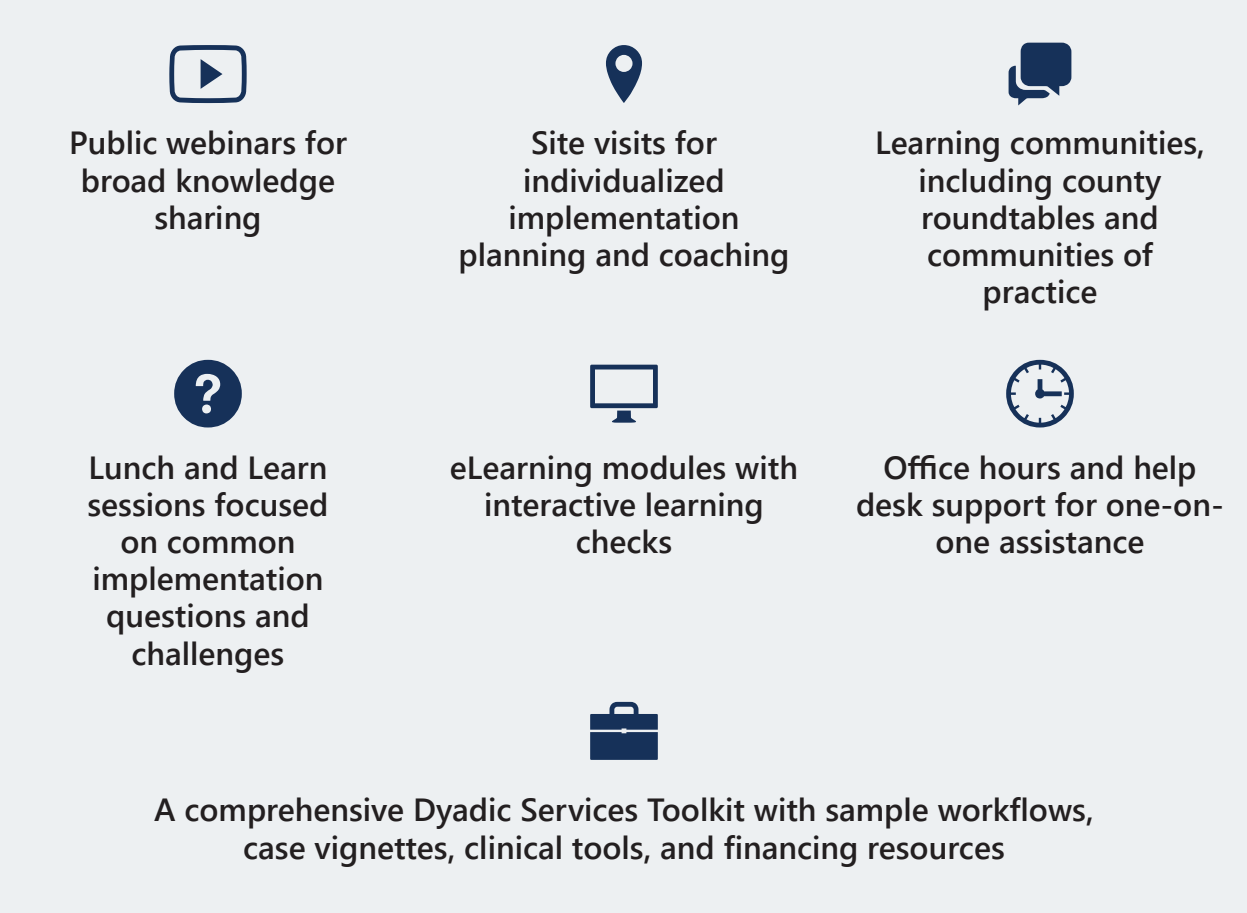

Figure 2

Most technical assistance services will be delivered virtually, with some activities offered in-person where feasible and beneficial.

1.9 Selection and Award Philosophy

The Scaling Dyadic Care Grant Program is structured to support equitable, statewide expansion of pediatric integrated behavioral health and dyadic services.across California's diverse healthcare delivery systems. The application review and award selection methodology is designed to balance objective statewide scoring with equity-driven investment strategies that reflect the diversity of California communities, provider types, and geographic regions.

The program recognizes that communities across California experience varying levels of behavioral health access, workforce capacity, infrastructure readiness, and social and economic barriers impacting children and families. As a result, the selection methodology is designed not only to identify applicants prepared to successfully implement dyadic services, but also to prioritize communities demonstrating significant need for increased behavioral health access and those with a strong commitment to integrated pediatric behavioral health care.

The review process incorporates standardized statewide scoring methodologies, publicly available county-level indicators, and geographic allocation approaches intended to support transparent, reproducible, and equitable funding decisions. The methodology also seeks to ensure representation across California's diverse pediatric Medi-Cal delivery systems.

Through this approach, the program aims to support both high-need communities and providers demonstrating readiness, commitment, and long-term potential to sustainably integrate dyadic services into pediatric care delivery.

Rationale for Approach

This methodology is designed to reduce bias and promote equitable resource allocation by combining:

- Objective, data-informed criteria (application scoring and equity indicators)
- Applicant-driven demand (geographic distribution of applicants)
- Intentional geographic balancing (portfolio-level selection)

By combining an applicant-informed and data-driven geographical analysis, the program ensures that funding is allocated in a manner that is:

- Equitable: Prioritizing communities with the greatest need while ensuring access across regions
- Transparent: Utilizing clearly defined and consistent selection criteria
- Data-informed: Grounded in both application data and community-level indicators

- Operationally feasible: Supporting the formation of effective regional learning communities

This approach supports the DHCS' goals of advancing equitable access, scalable implementation, and long-term sustainability of dyadic services across California.

1.10 Grant Award Overview

The Scaling Dyadic Care Grant Program is designed to accelerate the implementation and long-term sustainability of dyadic services within pediatric primary care settings serving Medi-Cal populations. The grant structure reflects established best practices from state and federal implementation funding models and is intentionally designed to balance access, equity, operational feasibility, and fiscal responsibility.

This approach recognizes that successful implementation of dyadic services requires upfront investment in workforce expansion, infrastructure, training, technical assistance, and care delivery redesign, while also ensuring that funded provider service locations are positioned to sustain services beyond the grant period through Medi-Cal reimbursement pathways.

Tiered Funding Structure

The program utilizes a tiered funding model to align grant awards with provider service location size, pediatric Medi-Cal volume, and capacity to implement dyadic services at scale. Providers will be assigned to Tier 1 or Tier 2 based on the number of Medi-Cal children ages 0–5 served by the applying provider service location or eligible provider service location partnership.

Objective scoring results will be used to determine which applicants are selected for funding; however, scoring will not determine tier placement. Tier placement and corresponding maximum award amounts will be based on the published pediatric Medi-Cal volume thresholds in the RFA.

This approach ensures that funding decisions are:

- Based on clear and objective volume criteria
- Proportionate to expected service delivery capacity
- Consistent across applicants
- Grounded in transparent, data-informed evaluation outcomes

Across both tiers, funding is structured to support a clear pathway to financial sustainability through Medi-Cal reimbursement, with expectations calibrated to the scale, capacity, and starting point of each provider.

Funding will be distributed across two tiers:

Tier 1: Large Provider Service Location(s)

Eligibility Criteria:

- Provider service location (or up to two service locations within the same health organization working in partnership) serving ≥ 1,000 Medi-Cal children (ages 0–5)

Award Amount:

- $700,000

Purpose:

- Supports provider service locations prepared to implement dyadic services, including dedicated staffing and fully integrated workflows, at a minimum volume of their early childhood pediatric population.

Expected Scope:

- Full-time staffing model dedicated to dyadic services, including 1.0 FTE or 100% of a full-time staff member dedicated to the target population in the provision of dyadic care (ages 0-5)
- Integration of dyadic care into routine pediatric workflows
- Early and sustained billing through Medi-Cal dyadic service codes
- Demonstrated pathway to financial sustainability within the grant period

Tier 2: Small to Medium Provider Service Location(s)

Eligibility Criteria:

- Provider service location (or up to two service locations within the same health organization working in partnership) serving ≥ 500 Medi-Cal children (ages 0–5)

Award Amount:

- $500,000

Purpose:

- Supports provider service locations in building the foundational infrastructure necessary to implement dyadic services and progress toward sustainable delivery.

Expected Scope:

- Part-time or phased staffing model, including 0.50 FTE or 50% of a full-time staff member dedicated to the target population in provision of dyadic care (ages 0-5)
- Integration of dyadic care into routine pediatric workflows
- Early and sustained billing through Medi-Cal dyadic service codes
- Demonstrated pathway to financial sustainability within the grant period

Funding tiers are designed to align with the level of service delivery required to support staffing through Medi-Cal reimbursement and sustain dyadic services over time.

The table below provides an illustrative framework linking provide service location volume, implementation scale, and staffing models to long-term financial sustainability. While individual provider service location performance may vary, the structure is intended to position funded service locations for ongoing service delivery beyond the grant period.

Table 2: Initiative Timeline

Tier	Eligibility Criteria	Maximum Award Amount	Illustrative Staffing Capacity
Tier 1	≥ 1,000 Medi-Cal children (0–5)	Up to $700,000	~1.0 FTE +
Tier 2	≥ 500 Medi-Cal children (0–5)	Up to $500,000	~0.5 FTE +

Standardized Award Amounts

Award amounts are fixed within each tier to:

- Reduce administrative complexity for applicants and program administrators
- Ensure equitable and consistent distribution of funds
- Align funding with anticipated implementation scope, staffing models, and service capacity

The tiered model is designed to balance equitable access to funding with the operational realities of provider capacity, using pediatric Medi-Cal volume as a primary proxy for service demand while allowing flexibility for service locations demonstrating strong potential for scale.

1.11 Grant Award Period

The Grant Award Period will span April 2027 through March 2029, aligning with the program's phased approach to implementation, scaling, and sustainability.

The award period is intentionally structured to support provider service locations through three key phases of dyadic service implementation:

Figure 3

Grant funding will be distributed throughout the award period to align with these phases. A portion of funds will be provided upfront to support initial implementation costs, including staffing, information technology enhancements, and administrative capacity. Subsequent payments will be disbursed at regular intervals and tied to implementation milestones and performance indicators.

Payment expectations are calibrated to each implementation phase, recognizing that providers require time to establish workforce, workflows, billing processes, and operational infrastructure prior to full-scale service delivery.

See Table 3 below for an illustrative view of the High-Level Implementation and Payment Timeline.

Table 3: High Level Implementation and Payment Timeline

Phase	Timing	Focus	Primary Activities	Associated Payments
Phase 1: Ramp Up	April–September 2027	Hiring, infrastructure, workflow development	Staffing, leadership alignment, onboarding, implementation planning	Payments 1-2
Phase 2: Standardization and Optimization	October 2027–March 2028	Service launch and operational integration	Initial implementation of dyadic service delivery areas, EHR documentation, billing pathway development, quality improvement planning, early service delivery and utilization growth	Payment 3
Phase 3: Expansion and Optimization	April–September 2028	Expansion of service delivery and workflow refinement	Implementation across all dyadic service delivery areas, PDSA (Plan Do Study Act) cycles, workflow optimization, increased utilization and billing integration	Payment 4
Phase 4: Sustainability and Closeout	October 2028–March 2029	Sustainability, evaluation, and program closeout	Full operation of dyadic services, sustainability planning, final reporting, ongoing billing and utilization, evaluation, and grant closeout activities	Payment 5

1.12 Grant Payment Structure

Grant funds will be distributed through a blended payment methodology that combines upfront funding, milestone-based disbursements, and performance-informed payments. This approach is designed to balance the need for early investment in infrastructure and workforce with accountability for implementation progress and service delivery outcomes.

As such, the payment structure is intentionally designed to:

- Provide early financial support to initiate hiring, training, and system changes
- Align funding with measurable progress over time, rather than requiring full implementation at the outset
- Support incremental growth and continuous improvement, with expectations calibrated to each phase of the program

Performance expectations are assessed relative to each grantee's starting point and approved Implementation Action Plan, ensuring that providers are evaluated based on their own progress and goals rather than across service locations. Payment awards will be structured to correspond with established milestones and the grantee reporting schedule.

The payment methodology is aligned with the program's broader approach to technical assistance and monitoring, which emphasizes capacity-building, flexibility, and sustained implementation, while maintaining accountability for progress and use of funds.

Payment Methodology and Disbursement Structure

The payment structure is intentionally designed to reflect the realities of clinical transformation, including an initial ramp-up period during which providers are building workforce, infrastructure, and workflows prior to achieving consistent service delivery and billing. Payments are aligned with the program's phased implementation approach and associated milestone and performance expectations.

Performance indicators are evaluated in the context of each grantee's implementation phase, approved Action Plan, provider service location size, and operational context, rather than through uniform statewide utilization thresholds alone.

Payment Timing and Disbursement Schedule

Payments will be distributed in alignment with the program's quarterly reporting cycles and phased approach to establishing dyadic care, including progression toward fidelity to the dyadic service model. With the exception of the initial upfront

payment, all payments will be issued in arrears, following review of submitted reports, implementation progress, and compliance with program requirements.

Payments will generally be issued within 45-60 days following the end of each reporting period, allowing sufficient time for review and approval. Payment may be delayed for an incomplete or unsupported submission, additional review, corrective action, or required DHCS approval. Payment dates are estimates, and all payments remain subject to the Grant Agreement, available funds, reconciliation, disallowance, offset, and recoupment.

Table 4. Payment Disbursement Schedule

Payment	Evaluating Reporting Period	Reports Due	Payment Issued	Payment Type	% of Total Award
Payment 1	N/A	N/A	April–July 2027	Upon Contract Execution	30%
Payment 2	April–Sept 2027	July 2027, Oct 2027	Nov–Dec 2027	Milestone-Based	20%
Payment 3	Oct 2027–March 2028	Jan 2028, April 2028	May–June 2028	Milestone + Performance	20%
Payment 4	April–Sept 2028	July 2028, Oct 2028	Nov–Dec 2028	Milestone + Performance	20%
Payment 5	Oct 2028–March 2029	Jan 2029, Final Report Upon Grant Completion	Feb–March 2029	Milestone + Performance	10%

Payment Conditions and Earned Funds

Payments may include payments issued following completion of specified milestones or reporting periods, or a combination of both, as outlined in the Payment Disbursement Schedule above.

Regardless of payment timing, all payments remain contingent upon grantee compliance with program requirements, including completion of required activities and milestones, submission of required reports and documentation, achievement of applicable performance expectations, and use of funds for allowable and approved grant purposes.Payments may include payments upon deliverable submissions or contract execution, payments issued following completion of specified milestones or

reporting periods, or a combination of both, as outlined in the Payment Disbursement Schedule above.

Regardless of payment timing, all payments remain contingent upon grantee compliance with program requirements, including completion of required activities and milestones, submission of required reports and documentation, achievement of applicable performance expectations, and use of funds for allowable and approved grant purposes.

Contract execution payments are not considered fully earned upon receipt and may be subject to reconciliation against implementation progress, allowable expenditures, completed deliverables, technical assistance participation, and required documentation. Payments issued following reporting periods remain subject to review and approval of submitted reports, documentation, invoices, and other required materials.

TPA, in partnership with UCSF and DHCS, may withhold, reduce, offset, or require repayment/recoupment of funds determined to be unallowable, unsupported, unearned, or not used in accordance with grant requirements.

Understanding Program Accountability Structure

The program utilizes three complementary accountability structures designed to support implementation progress, responsible stewardship of funds, and continuous quality improvement:

I. **Payment Requirements**
   a. Payment requirements are the primary and controlling requirements used to determine payment eligibility. These requirements are outlined in Table 5 in the "Payment Structure and Requirement Overview" section below and include required reports, implementation milestones, performance indicators, and associated deliverables tied to each payment period.

II. **Ongoing Monitoring and Technical Assistance Activities**
   a. Ongoing monitoring and technical assistance activities serve as tools to support implementation oversight, continuous quality improvement, and early identification of barriers. These activities may include participation in technical assistance, implementation tracking, site visits, fidelity review, and data reporting.

III. **Corrective Action and Remediation Procedures**
   a. Corrective action procedures are utilized when implementation, compliance, fiscal, or reporting concerns are identified and are intended to support remediation and successful continuation of program participation whenever feasible.

Payment Structure and Requirements Overview

The Payment Requirements below outline the primary and controlling requirements associated with each payment period, including required reports, implementation milestones, and performance indicators.

In addition to payment requirements, grantees are expected to participate in ongoing technical assistance, monitoring, and reporting activities throughout the grant period.

Table 5. Payment Requirements

Payment and Type	Reports Due	Milestone Requirements	Performance Indicators
#1 Contract Execution Payment	N/A	» Full execution of grant agreement » Participation in onboarding activities » Initial implementation planning initiated » Timely submission of required reporting	N/A
#2 Milestone-Based	Quarterly Dyadic Services Provider Data Quarterly Sustainability Report Semiannual Expenditure Report	» Completion of Action Plan Part 1* » Established implementation team and leadership structure » Workflow planning initiated » Marketing and patient engagement plan developed » Initial staffing and onboarding activities initiated	N/A

Payment and Type	Reports Due	Milestone Requirements	Performance Indicators
#3 Milestone + Performance-Informed	Quarterly Dyadic Services Provider Data Quarterly Sustainability Report Semiannual Expenditure Report	» Completion of Action Plan Part 2* » Initial implementation across ≥4 dyadic service delivery areas » EHR documentation templates established » Billing pathways and workflows established » Quality improvement tracking approach defined » Timely submission of required reporting	Growth from baseline in: » Dyadic services volume and utilization from baseline » Increased claims submission from baseline » Screening completion » Referral activity
#4 Milestone + Performance-Informed	Quarterly Dyadic Services Provider Data Quarterly Sustainability Report Semiannual Expenditure Report	» Completion of Action Plan Part 3 » Full implementation across ≥4 dyadic service delivery areas » Timely submission of required reporting	Continued increase relative to prior reporting period: » Utilization, service volume » Screening completion rates (child + caregiver) » Follow up after positive screens » Referral completion rates » Claims submission for Dyadic Services across reporting periods

Payment and Type	Reports Due	Milestone Requirements	Performance Indicators
#5 Milestone + Performance-Informed	Quarterly Dyadic Services Provider Data Quarterly Sustainability Report Semiannual Expenditure Report Final closeout documentation	» Completion of Action Plan Parts 4 » Implementation across all 6 dyadic service delivery areas » Sustainability plan completed and approved » Workflow refinement and implementation activities completed » Final patient and provider experience findings submitted » Timely submission of required reporting	Continued increase relative to prior reporting period: » Utilization, service volume » Screening completion rates (child + caregiver) » Follow up after positive screens » Referral completion rates » Claims submission for Dyadic Services across reporting periods

Note: Payments are aligned with the phased implementation structure of the program and are intentionally calibrated to reflect varying stages of operational readiness, service delivery, and sustainability development. **Please see Appendix 1 for more details of the Implementation Action Plan and related definitions.*

Alignment with Monitoring and Technical Assistance Framework

Monitoring activities may include review of:

- Technical assistance participation and engagement
- Implementation Action Plan progress
- Quarterly provider data reporting
- Site visit documentation and fidelity assessments
- Fiscal and compliance reporting

Grantees are expected to participate in required technical assistance activities and submit required reports and data in accordance with program timelines. The program will utilize a supportive, improvement-oriented monitoring approach focused on early identification of implementation barriers and collaborative problem-solving whenever feasible.

Payment Review and Determination

The TA Vendor will review submitted materials, data, and progress indicators to determine payment eligibility. Based on this review, TPA, in partnership with UCSF CADP and DHCS, may issue a full, partial or delayed payment, depending on the circumstances.

If payment requirements are not fully met within a reporting period, the Grant Monitoring Team (TA Vendor, TPA, and DHCS) will assess the extent of progress, engagement, and implementation barriers. Grantees may be required to submit additional documentation or participate in corrective action planning, as appropriate. The program utilizes a supportive, improvement-oriented approach, focusing on remediation whenever feasible prior to formal payment escalation or corrective action procedures.

PART 2: GRANT REQUIREMENTS

The following section outlines the operational, participation, reporting, and compliance requirements associated with participation in the Scaling Dyadic Care Grant Program.

For purposes of this RFA, a provider service location is a distinct physical clinical site where pediatric or family-serving primary care services are delivered and Medi-Cal Dyadic Services may be implemented. A provider service location typically:

- Is a distinct physical location where patient care is provided;
- Operates as an individual care delivery site;
- Has its own Medi-Cal enrollment and/or National Provider Identifier (NPI), as applicable; and
- Is operated by an eligible applicant organization.

2.1 Eligible Applicant

Eligible applicants are organizations that operate Medi-Cal enrolled service settings that provide pediatric primary care services to children and families and are responsible for overseeing grant implementation, fiscal management, and program participation.

Applicants must meet the following criteria:

I. **Organizational Eligibility:**

   a. Applicants must be a legal entity capable of entering into a grant agreement and managing awarded funds. Eligible entities include Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Indian Health Care Providers (IHCPs), hospital-affiliated health systems, or other community-based organizations that operate Medi-Cal enrolled primary care clinics. Eligibility includes all clinics as outlined in SPA 23-0010.

II. **Reporting & Compliance:**

   a. Applicants must demonstrate the organizational capacity to comply with all program reporting, monitoring, fiscal, and data submission requirements throughout the grant period.

III. **Operational Authority and Oversight:**

   a. The applicant must have the authority and direct operational oversight to implement clinical, operational, and administrative changes within the proposed provider service location(s), including staffing, workflows, billing practices, and data reporting.

IV. Fiscal and Administrative Capacity:

a. Applicants must demonstrate the capacity to manage grant funds in accordance with state requirements, including budgeting, expenditure tracking, and financial reporting. The applicant will be responsible for ensuring that all funds are used for allowable program purposes.

V. Commitment to Program Participation:

a. Applicants must commit to full participation in the TA program, including required trainings, site visits, learning communities, and data reporting activities.

VI. Single-Service Location or Multi-Service Location Application:

Organizations may submit:

- A single-service location application on behalf of one eligible provider service location; or
- A multi-service location application on behalf of two eligible provider service locations operating under the same legal entity or through a formal partnership.

Each participating provider service location must independently meet the eligibility requirements described in Section 2.2.

For multi-service location applications:

- Each participating organization must execute the grant agreement, when applicable.
- One organization must serve as the Grantee of Record and be responsible for:
  - Receiving and administering grant funds;
  - Coordinating implementation across participating provider service locations; and
  - Ensuring compliance with all grant requirements.

2.2 Eligible Service Locations

Eligible service settings are the locations where dyadic services will be implemented under this program and defined as a distinct physical clinical service location delivering services, a location that typically has its own Medi-Cal enrollment/National Provider Identifier, a service location that operates as a unique care delivery setting, and part of the same level entity. Detailed information on how each eligibility domain will be evaluated is described in Section 3.3.

Eligibility requirements establish the minimum criteria for participation. Eligible applicants will subsequently be evaluated through the competitive scoring and award selection process described in Section 3.

To be eligible, provider service location(s) must meet the following criteria:

I. **Primary Care Services:**

   a. The service setting must provide pediatric or family-serving primary care services and routinely deliver well-child visits to Medi-Cal enrolled children. Service settings must be authorized to deliver Medi-Cal Dyadic Services consistent with SPA 23-0010 and applicable DHCS guidance.

II. **Medi-Cal Dyadic Services Eligibility:**

   a. The service location must maintain at least one rostered provider eligible to deliver and bill Medi-Cal dyadic services. For applicants that are not Indian Health Care Providers (IHCPs), the service location must be contracted to provide NSMHS. IHCPs are exempt from the requirement to contract to provide NSMHS.

III. **Pediatric Population Served:**

   a. The service location must serve Medi-Cal-enrolled children and youth and demonstrate a focus on young children ages 0–5. Consistent with the program's emphasis on prevention and early intervention, applicants must demonstrate the opportunity to integrate dyadic services into routine well-child care and other pediatric primary care services. While Medi-Cal Dyadic Services may be delivered to eligible children and youth across the pediatric age spectrum, this program prioritizes early childhood due to the critical importance of the first five years of life, the frequency of well-child visits during this period, and the opportunity to establish sustainable dyadic care models that can be expanded to broader pediatric populations over time.

IV. **Minimum Volume Thresholds:**

   a. The service setting, or paired service settings applying jointly, must meet the pediatric Medi-Cal volume requirements established under the Tiered Funding Structure. Joint applicants may aggregate eligible patient volume when operating under a shared implementation approach and coordinated service delivery model.

V. **Implementation Readiness:**

   a. The service setting must demonstrate readiness to implement dyadic services within primary care, including willingness to adapt workflows, support team-based care, and integrate behavioral health services.

VI. Workforce Capacity and Hiring Readiness:

a. The provider service location must demonstrate the ability to recruit, hire, and onboard qualified staff in a timely manner to support implementation of dyadic services. This includes the ability to fill roles relevant to dyadic care delivery (e.g. Provider types eligible for providing dyadic services in accordance with the Dyadic Care Provider Manual) and to operationalize staffing models within the initial phase of the grant period.

2.3 Eligible and Ineligible Expenditures

Eligible Expenditures

Allowable uses of funds include the following categories:

I. Workforce Development and Staffing

Costs associated with hiring, supporting, and retaining staff necessary to implement dyadic services.

Examples:

- Salaries and benefits for licensed or license-eligible behavioral health clinicians
- Salaries and benefits for ancillary dyadic care team members if BH clinician is already on staff (e.g., community health workers, patient advocates, QI support)
- Partial salary support for existing staff transitioning into dyadic roles
- Hiring and onboarding costs (e.g., recruitment, training time)
- Clinical supervision, professional development, and consultation related to dyadic care delivery

II. Training and Technical Assistance Participation

Costs associated with building staff knowledge and capacity to deliver dyadic services.

Examples:

- Staff time participating in required technical assistance activities (e.g., learning communities, site visits, trainings)
- Meetings among provider staff that occur between required implementation site visits in order to design operational changes that are needed as part of the Dyadic Care Implementation Action Plan.
- Training in dyadic care models or evidence-based practices (e.g., HealthySteps, Dulce, CPP-informed approaches)
- Continuing education and certification related to perinatal and early childhood behavioral health

III. Workflow Redesign and Care Model Integration

Costs associated with redesigning care delivery to integrate dyadic services into primary care.

Examples:

- Staff time for workflow development, care team integration, and implementation planning
- Development of screening, referral, and care coordination protocols as needed
- Quality improvement (QI) activities to support implementation
- Protected time for leadership and program management

IV. EHR Enhancements and Data Infrastructure

Costs to support documentation, billing, reporting, and data-driven care.

Examples:

- EHR configuration or modification to support dyadic documentation and billing
- Development of templates, registries, or tracking tools
- Data reporting systems or dashboards
- IT support related to implementation and reporting requirements

V. Administrative and Operational Capacity

Costs necessary to support program implementation, reporting, and participation.

Examples:

- Staff time for data reporting, monitoring, and compliance
- Administrative coordination of program activities
- Financial tracking and reporting related to grant requirements
- Participation in program governance or advisory activities

Allowable Administrative and Participation Costs: Grant award amounts are intended to account for a portion of the administrative and operational effort required to participate in the program, including reporting, monitoring, coordination, and participation activities. Grantees may additionally use awarded funds toward the eligible administrative and operational capacity costs listed above when additional resources are needed to support successful implementation and participation in program requirements.

Ineligible Expenditures

Grant funds may not be used for costs that are not directly related to the implementation, delivery, or sustainability of dyadic services. Ineligible uses include, but are not limited to:

I. **Non-Programmatic or Unrelated Costs**
   a. Expenses not directly tied to dyadic service implementation or program participation
   b. General organizational expenses unrelated to the project, ***not covered by indirect costs and not attributable to program activities.***
   c. Supplanting existing funding
   d. Replacing or offsetting existing funding streams for services already in place
   e. Covering costs that are already reimbursed through Medi-Cal or other funding sources without expanding capacity

II. **Capital or Major Infrastructure Projects**
   a. Construction, renovation, or facility expansion
   b. Major capital equipment purchases not directly tied to service delivery or data reporting

III. **Non-Allowable Administrative Costs**
   a. General overhead not attributable to program activities
   b. Executive compensation unrelated to program oversight

IV. **Incentives and Non-Service Costs**
   a. Patient incentives (e.g., gift cards, stipends) unless explicitly approved
   b. Entertainment or non-essential expenses

V. **Unallowable or Non-Compliant Costs**
   a. Any costs that do not comply with state or federal funding requirements
   b. Costs incurred outside the approved grant period
   c. Fundraising
   d. Taxes
   e. Debts, late payments fees, contingency funds

2.4 Technical Assistance Engagement and Participation Requirements

Active participation in Technical Assistance (TA) is an essential requirement of the program and a condition of receiving grant funding. The TA model is designed to support practice transformation, strengthen implementation capacity, and advance long-term sustainability of dyadic services.

TA activities will include participation from members of the Grantee Implementation Teams, though not all members will be required to attend every activity. Grantee Implementation Teams will consist of 2–3 representatives from clinical, operational, and leadership roles. Teams (comprised of a minimum of 3 individuals per provider service location for certain activities and up to 6 individuals for other activities) are expected to participate in approximately 65 hours of TA activities over the 24-month grant period, delivered through a combination of virtual and in-person formats. Grantees will receive a detailed calendar of events as part of their TA onboarding process, outlining objectives, required audience, and scheduled dates and times. Table 6 contains a high-level overview of these TA modules.

Table 6: High-level Overview of Technical Assistance Modules

Module # and Time Frame	Module Title	Audience	Hours per quarter
Module 1: April–June 2027	Building Strong Foundations: Leadership Approaches for Implementing Dyadic Care	Grantee Implementation Teams	8 hrs
Module 2: July–Sept 2027	Strengthening Operational Infrastructure for Dyadic Care	Grantee Implementation Teams	7 hrs, 15 min
Module 3: Oct–Dec 2027	Dyadic Care in Action: Policy and Practice	Grantee Implementation Teams	7 hrs, 30 min
Module 4: Jan–March 2028	Launching Dyadic Care Services & Billing	Grantee Implementation Teams	7 hrs, 15 min
Module 5: April–June 2028	Accelerating Impact: Scaling Implementation of Dyadic Care Services	Grantee Implementation Teams	7 hrs, 45 min

Module # and Time Frame	Module Title	Audience	Hours per quarter
Module 6: July–Sept 2028	Expanding Dyadic Care Services	Grantee Implementation Teams	7 hrs, 45 min
Module 7: Oct–Dec 2028	Sustainability of Dyadic Care Part 1: Troubleshooting	Grantee Implementation Teams	6 hrs, 15 min
Module 8: Jan–March 2029	Sustainability of Dyadic Care Part 2: Building a Community of Ongoing Support	Grantee Implementation Teams	7 hrs, 45 min

TA activities are structured to align with key phases of implementation, including planning, service launch, scaling, and sustainability. ***Current required hours of commitment are approximate and subject to change; TA Vendor will communicate any impactful changes to Grantees.***

Participation Expectations

I. **Designate a Project Lead**
Identify a primary point of contact (e.g., Provider Champion, Behavioral Health Manager, Medical Director, Program Manager, Coordinator, or Project Manager) to lead participation in the California Dyadic Service Grant and Technical Assistance Program. The Project Lead will be responsible for overall program implementation, outcomes, and required reporting.

II. **Create an Implementation Team**
Each grantee must assign appropriate staff to create an Implementation Team and participate in TA activities, including clinical, operational, and leadership representatives. Specifically, this includes a

- ❒ Designate a Lead
- ❒ Create an Implementation Team
- ❒ Engage in Required Training and TA Activities
- ❒ Participate in Grantee Advisory Board
- ❒ Promote the Opportunity of Joining the Family Accountability Board
- ❒ Establish and Maintain Partnerships
- ❒ Participate in Monitoring Activities
- ❒ Submit Required Reports and Documentation
- ❒ Comply with Contractual and Funding Requirements
- ❒ Ensure Compliance with Funding Requirements
- ❒ Ensure Equitable Service Delivery and Civil Rights Compliance

behavioral health leader, a medical provider champion, and a representative from practice management or nursing leadership. If the assigned representative(s) is unavailable, grantees should identify other individual(s) from their provider service location with a similar background to attend in their place.

III. **Engage in Required Training and TA Activities**
Attend and actively participate in all required training and TA opportunities, including attending scheduled sessions, completing training modules, and participating in discussions and feedback opportunities

IV. **Participate in Grantee Advisory Board**
Participate in Grantee Advisory Board: Each grantee will designate one representative from its Implementation Team to participate in the Grantee Advisory Board (GAB), which will provide feedback to inform ongoing technical assistance design, implementation supports, and program improvement efforts. Participation will require up to approximately three hours every quarter and is in addition to the estimated 65 hours of required technical assistance activities and events.

V. **Promote the Opportunity of Joining the Family Accountability Board**
Each grantee will support the recruitment of families for the Family Accountability Board through activities such as marketing and recommending potential candidates. Recruitment and facilitation of the Family Accountability Board will be operated by another entity, and grantees will not be responsible for overseeing this component of the grant.

VI. **Establish and Maintain Partnerships**
Develop and sustain relationships with subcontractors, partner organizations, and a broader network of service providers to support program implementation and coordination.

VII. **Participate in Monitoring Activities**
Engage in all required coaching calls, desk reviews, and site visits conducted by the TA Vendor, DHCS, and/or TPA

VIII. **Submit Required Reports and Documentation**
Submit all required reports, respond to ad hoc requests, and provide any additional documentation or information in a timely and complete manner to support ongoing monitoring, compliance, and program evaluation.

IX. **Comply with Contractual and Funding Requirements**
Adhere to all contract requirements, including but not limited to provisions related to insurance and indemnification, HIPAA compliance, and fiscal management.

Ensure Compliance with Funding Requirements

Adhere to all federal and state funding restrictions, reporting expectations, and compliance requirements as determined by DHCS for the use of grant funds (see Section 2.3 for allowable costs).

Ensure Equitable Service Delivery and Civil Rights Compliance

Serve all individuals equitably and administer programs in full compliance with applicable federal civil rights laws, including those that prohibit discrimination based on race, color, national origin, disability, age, religion, and sex (including gender identity, sexual orientation, and pregnancy).

Participation requirements associated with payment eligibility are incorporated into the milestone and performance expectations outlined in the Payment Tables in Section 1.2.

A Note on Enrollment with and Use of Evidence-Based Practices for Dyadic Care: Participating in training for evidence-based practices, while highly encouraged, can require a significant time investment. This is not a requirement of this grant, which does not require any specific certification in an evidence-based dyadic care model. Therefore, participation in training for an evidence-based model, such as HealthySteps, would require time in addition to what is required for technical assistance and training participation in this grant. Certification in an evidence-based model, while a welcome component of this grant project plan, may take up to a year and therefore must not delay the start of offering dyadic services as part of performance aspects of this grant.

2.5 Data Reporting and Grant Monitoring Requirements

Grantees are required to participate in ongoing data reporting and monitoring activities to support program oversight, continuous quality improvement, and evaluation of implementation outcomes. The program utilizes a multi-domain monitoring framework that integrates data across technical assistance engagement, service utilization, implementation progress, and fiscal performance.

Core Reporting Requirements Include:

Figure 4

I. **Quarterly Provider Data Reporting**
   a. Grantees will submit standardized data on a quarterly basis, including:
      i. Dyadic service utilization and billing activity
      ii. Patient demographics and equity indicators
      iii. Screening, referral, and service delivery metrics
      iv. Workforce and implementation indicators
      v. Sustainability goals and progress

II. **Technical Assistance and Implementation Monitoring**
   a. Implementation progress will be documented through structured inputs into the TA Monitoring Dashboard, including:
      i. Participation in technical assistance and training activities
      ii. Implementation milestones and progress updates
      iii. Operational barriers and action plans

III. **Fiscal Reporting**
   a. Grantees will submit expenditure reports every six months, including:
      i. Actual versus budgeted expenditures

ii. Allowable cost documentation (Section 2.3)
iii. Progress aligned with implementation milestones

IV. Additional Reporting (as applicable)

a. Grantees may be asked to participate in:

i. Ad hoc data requests to support program evaluation
ii. Qualitative feedback activities (e.g., interviews, surveys)
iii. Participation in learning and evaluation activities
iv. Engagement in Grantee Advisory Board

Data Submission and System Requirements

All data will be submitted through a TA Vendor-managed data platform, ensuring secure data collection, standardized reporting, and real-time monitoring. For more information on Reporting Requirements, please see Appendix 3. Submission of patient health information (PHI) is not required as part of this grant.

The system will enable:

- Consistent data submission across provider service locations
- Integration of multiple reporting domains into a centralized dashboard
- Ongoing access to data for program monitoring and continuous improvement

Integrated Monitoring and Technical Assistance Framework

Monitoring Framework

Program monitoring will be conducted through an integrated, multi-layered approach that combines real-time data tracking with high-touch technical assistance to support implementation, equity, accountability, and continuous improvement.

The program applies the RE-AIM framework to guide performance monitoring across five domains:

- **Reach:** Engagement of diverse providers and equitable access to dyadic services among Medi-Cal children and families, including populations of focus.
- **Effectiveness:** Utilization trends, dyadic service code uptake, and improvements in service delivery capacity.
- **Adoption:** Provider participation in the TA program, workforce readiness, and integration of dyadic services into practice settings.

- **Implementation Progress:** Advancement of clinical workflows, billing practices, and operational systems necessary to support dyadic care.
- **Maintenance:** Sustainability planning, managed care alignment, and continuation of dyadic services beyond the grant period.

At the core of this approach is a centralized TA Monitoring Dashboard, which aggregates data across key domains, including:

- TA engagement and participation
- Provider implementation progress
- Training and LMS analytics
- Provider-reported utilization and performance data

This centralized system enables timely visibility into provider performance and supports proactive identification of implementation challenges.

Technical Assistance and Monitoring

In addition to data-driven monitoring, the program utilizes a high-touch, relationship-based TA model, in which clinical and programmatic TA consultants work closely with grantees throughout the implementation period. Technical assistance activities may include site visits, implementation meetings, learning communities, regional roundtables, and ongoing coaching and consultation.

These activities enable insight into implementation progress, strengthen operational and clinical capacity, and identify barriers related to workflow integration, service delivery, billing, and care coordination.

Accountability Alignment

Monitoring activities support assessment of implementation progress, technical assistance needs, and compliance with milestone and performance expectations outlined in the Payment Tables in Section 1.2.

Accountability and Continuous Improvement

The program utilizes a collaborative oversight structure involving grantees, TA Vendor, TPA, and DHCS. Each entity plays a distinct role in supporting implementation, technical assistance, fiscal administration, monitoring, and program oversight throughout the grant period. The accountability framework is designed to support continuous improvement while maintaining responsible stewardship of public funds and alignment with program goals.

Remediation Plan and Corrective Action Procedures

The program utilizes a structured, tiered remediation and corrective action framework designed to support early identification of implementation challenges while maintaining accountability for program requirements and responsible stewardship of public funds. The program prioritizes collaborative problem-solving, technical assistance, and supportive remediation whenever feasible prior to escalation to formal corrective action procedures.

Monitoring Activities

Monitoring activities will be used to identify implementation barriers, missed milestones, reporting concerns, or compliance issues as early as possible through ongoing review of implementation progress, participation, reporting, fiscal monitoring, and technical assistance engagement.

Triggers for Remediation

The following indicators would signal a need for remediation:

- Missed attendance at TA activities (e.g., site visits [that have not otherwise been rescheduled], Learning Communities) or missed completion of asynchronous modules.
- Lack of completion of implementation milestones, deliverables, or reporting requirements outlined in the Implementation Action Plan or Payment Tables.
- Fiscal or budget concerns, including unallowable expenditures.
- Quality or implementation concerns impacting program requirements.
- Staffing or operational barriers affecting implementation progress.
- External disruptions impacting the ability to meet program expectations.

Corrective Action Process

If implementation or compliance concerns persist, the program may implement progressive corrective action procedures, including:

1. Informal consultation and problem-solving discussions
2. Written notification and remediation timeline
3. Desk review and/or remedial site visit
4. Formal Corrective Action Plan (CAP)
5. Payment withholding, termination, or fund recoupment, if necessary

This progressive approach is intended to provide successful implementation while ensuring accountability to DHCS requirements and program expectations.

See our Corrective Action Procedures in Figure 5.

Corrective Action Procedures

Steps to Initiate Remediation:

If non-compliance continues, formal corrective action procedures ensue in a progressive manner as follows:

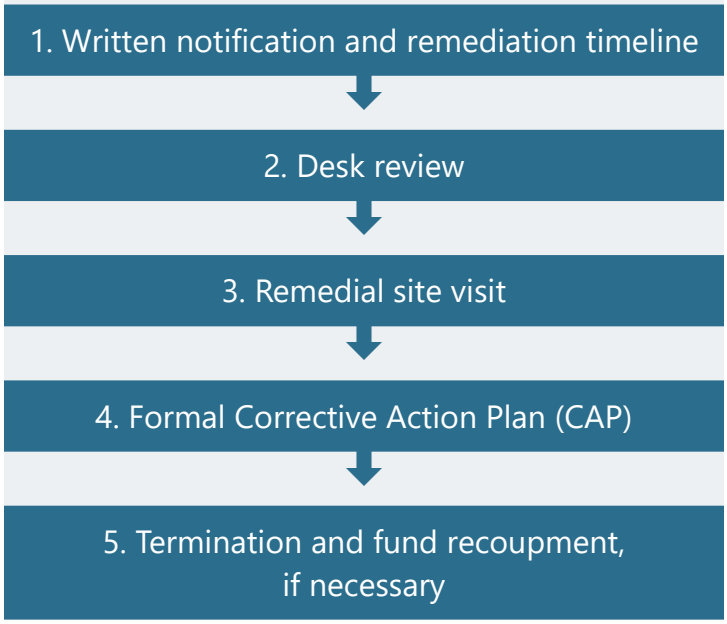

Figure 5

PART 3: APPLICATION COMPONENTS AND EVALUATION CRITERIA

3.1 Application and Submission Format

All grant applicants are expected to complete the Scaling Dyadic Grant Program Grant Application. To be complete, applications must include a Letter or Statement of Support from Executive level leadership (e.g., provider director, CEO, or other entity of authority to institute changes and allocate resources) and a proposed budget (using the Grantee Budget Template, see Appendix 4) for use of grant funds aligned with eligible expenditures. Responses are structured to assess organizational eligibility, population need, implementation feasibility, and the provider's ability to deliver, sustain, and improve integrated dyadic care services within pediatric primary care settings.

Applicants who have a demonstrated track record of serving populations of focus but do not have the organizational capacity to complete a written grant application may request that portions of this grant application be completed in an alternative format (e.g., video submission).

To request an alternative application, please contact the CIBHS by October 13, 2026, by 5:00 p.m. PT by emailing scalingdyadic@cibhs.org. As part of your request, please include a justification for the request and an explanation of how granting the request will further DHCS' goals of promoting diversity, equity and inclusion. DHCS, TA Vendor, and TPA will make reasonable efforts to grant these requests. Please note that most alternative applications will still be required to submit an application by 11:59 pm PT on October 26, 2026, though it may be possible to address certain questions with an alternative format submission (e.g., video submission, virtual interview).

Milestone	Deadline
RFA Release	September 2026
Informational Webinar	September 23, 2026 12:00–1:00 pm Register here.
Application Deadline	October 26, 2026 by 11:59 pm PT
Awards Announced	January 2027

3.2 Application Components

The application is designed to collect standardized and comprehensive information to assess applicant eligibility, organizational readiness, population need, and capacity to implement and sustain dyadic care services within pediatric primary care settings.

Applicants are required to complete all components of the application. Applicants applying as multi-provider sites will be prompted within the application tool to complete a separate application. Instructions are included in this tool on which questions require collaborative responses and which questions require only lead entity response or separate responses from both providers.

The application consists of the following sections: 1. Eligibility Confirmation and Program Commitment; 2. Provider Profile and Organizational Characteristics; 3. Leadership Letter of Support; 4. Proposed Budget for Use of Grant Funds; 5. Proposed Approach for Dyadic Services; 6. Provider Survey; and 7. Application Attestation.

1. Eligibility Confirmation and Program Commitment

Applicants must attest to meeting all eligibility requirements and program expectations, including agreement to requirements outline in:

- Eligible Service Setting criteria as defined in section 2.1 Eligible Applicant criteria
- TA Engagement and Participation Requirements as defined in Section 2.4 TA Engagement and Participation Requirements
- Data Reporting and Grant Monitoring Requirements as defined in Section 2.5 Data Reporting and Grant Monitoring Requirements

2. Provider Profile and Organizational Characteristics

Applicants designate the Tier for which they are applying and whether they are applying in partnership with another provider. Applicants complete service location profiles for participating providers including:

- Provider name, location, and primary county of service
- Point of contact information for grant application
- Organizational designation (e.g., FQHC, RHC, community provider, medical group)
- Pediatric care model (e.g., pediatrics-only, family medicine)
- Managed care participation and contracting

3. Leadership Letter of Support

Applicants upload a Letter of Support from executive leadership (e.g., provider service location director, CEO, or other lead that has authority to institute change and allocate resources) describing their role within the organization and their commitment to this grant program, including specific actions taken and how they plan to support dyadic care implementation moving forward (e.g., percentage of protected staff time that will be allocated for administrative activities, resource allocation, prioritization).

4. Proposed Budget for Use of Grant Funds

Applicants upload a proposed budget of intended use of grant funds aligned with eligible proposed expenditures as outlined in Section 2.3 Eligible and Ineligible Expenditures. Please see Appendix 4 for a sample Grantee Budget Template to be used in this submission.

5. Applicant Survey

I. Patient volume and Population of Focus

Applicants must provide quantitative data describing the population served, including:

- Primary county of patient population
- Total unduplicated patient count stratified by age group (0-5 years, 6-20 years, 21+ years)
- Medi-Cal enrollment by age group (0-5 years, 6-20 years, 21+ years)
- Total annual well-child, adolescent well-care, or annual physical visit by age group (0-5 years, 6-20 years, 21+ years)
- Patient demographic characteristics for Medi-Cal members by race and ethnicity
- Percent of the population best served in a language other than English

II. Cultural Responsiveness and Community Engagement

Applicants complete information on:

- How language needs are addressed
- How the provider engages with the community in quality improvement efforts

III. Workforce and Service Capacity

Applicants provide information on clinical staffing levels stratified by age groups served (0-5 years, 6-20 years, 21+ years) for the following staff:

- Medical provider staffing
- Behavioral health provider staffing for dyadic service billing-eligible providers
- Behavioral health trainees staffing
- Behavioral health hiring needs for dyadic services

IV. Dyadic Care Implementation Support

Applicants provide information on current and planned staffing to support dyadic care implementation, including identification of key responsibilities, some of which may be occupied by the same person as long as there are three distinct participants representing medical, behavioral health, and operations perspectives:

- Designated project lead
- Behavioral health representative
- Medical provider representative
- Data and reporting support
- Billing and operations support

V. Data reporting and quality improvement infrastructure

Applications provide information on medical record documentation, reporting, and quality improvement processes:

- Medical record system used
- Adaptability of medical record documentation systems (e.g., modifying documentation templates, creating structured data elements, adding billing codes), including level of reliance on internal staff versus external/vendor support
- Staffing for data analysis and reporting
- Reporting ability and data use for decision making
- Use of data for addressing health disparities

VI. Dyadic Service Maturity and Implementation Readiness

Applicants complete structured assessments of current clinical integration and service delivery, including:

- Use of the Integrated Practice Assessment Tool (IPAT) to assess level of behavioral health integration
- Implementation status and capacity for implementation of core dyadic service components (e.g., screening, care coordination, dyadic visits, referrals)
- Experience with Medi-Cal dyadic billing codes

6. Proposed Approach for Dyadic Services

Clinics provide narrative statements of the clinic's rationale and proposed approach for dyadic services addressing the following areas:

- The target population for dyadic services (age groups, demographics) and the specific gaps and needs that dyadic services are intended to address within this population, including disparities in access and outcomes and how these relate to the identified target population, including why dyadic services are a good fit for this population and anticipated impacts of dyadic services on patient care and/or provider service location operations. (Max 500 words)
- The dyadic service components or approaches the provider aims to prioritize during the grant period and why. (Max 250 words)
- Who will provide dyadic services (e.g., using existing staff, hiring new staff, and the percentage of staff time that will be dedicated to each age group). (Max 200 words)
- How the grant opportunity would increase or support the provider's dyadic service goals (Max 250 words)

7. Application Attestation

Applicants certify that all information provided is accurate and complete, and that the organization agrees to comply with all program requirements.

3.3 Required Documents & Registrations

The application requires you to upload the following additional documents:

- Curriculum vitae or resumes of program lead and other key staff
- Organizational Chart
- Audited Financial Statement
- Federally Approved Indirect Rate Cost Letter, if applicable.
- W-9 Form

If awarded, grantees will be required to submit all necessary administrative documentation to facilitate contracting and payment, including:

- Funding Award Plan
- Certificate of Insurance
  - Commercial General Liability Insurance: Minimum coverage of $1,000,000 per occurrence and $2,000,000 aggregate.
  - Workers' Compensation Insurance: Coverage meeting statutory requirements, including waiver of subrogation endorsement.
  - Automobile Liability Insurance: Minimum coverage of $1,000,000 combined single limit for owned, hired, and non-owned vehicles, if applicable to grant-funded activities.
  - Additional Insured Requirement: The COI and applicable endorsements must name the Department of Health Care Services/California Institute for Behavioral Health Solutions (CIBHS)/Heluna Health/The Regents of the University of California, San Francisco and their respective officers, directors, employees, agents, and affiliates as additional insureds, as applicable.
- Completed CIBHS Vendor Information Form
  - Federal System for Award Management (SAM.gov) Unique Entity Identifier (UEI).
  - Proof of registration with the California Secretary of State business registry.
- California Attorney General's Registry of Charitable Trusts, if applicable.

3.4 Application Scoring Criteria

The Scaling Dyadic Care Grant Program will utilize a transparent, equitable, and data-informed application review and award selection process designed to support statewide expansion of dyadic services within pediatric Medi-Cal delivery systems.

Applications will undergo a standardized multi-step review process to assess organizational readiness, implementation capacity, alignment with program goals, and community need, while also promoting geographic diversity and statewide representation across California's diverse communities.

The review process additionally incorporates publicly available county-level indicators related to pediatric Medi-Cal enrollment, social drivers of health, and pediatric behavioral health infrastructure and readiness. Funding decisions will be informed through this application review and scoring process as outlined in the "Application Review and Scoring Process Overview" section below.

Final funding recommendations will prioritize the highest-scoring competitive applications within each geographic allocation category while balancing statewide representation, geographic diversity, implementation readiness, and funding availability. Applications scoring below established minimum competitive thresholds may not advance to final award consideration.

The program's review methodology is intended to support objective, reproducible, and equitable funding decisions aligned with statewide pediatric behavioral health and dyadic care priorities.

Application Review and Award Selection Overview

STEP 1: Eligibility Review

Applications will undergo an initial eligibility and completeness review. Incomplete, non-responsive, or ineligible applications will not advance to scoring review.

STEP 2: Geographic Classification

Eligible applications will be categorized according to:

- Geographic region
- Geography type (urban, suburban, rural/frontier)
- Applications will be assigned to predefined geographic allocation pools.

Step 3: Standardized Application Scoring

Applications will be evaluated using the standardized statewide scoring rubric, including:

- Provider Equity
- Implementation Readiness
- Program Impact
- Strategic Alignment
- County Composite Index
- Workforce Development Incentive Adjustment

The Workforce Development Incentive Adjustment will function as a standardized scoring adjustment applied during rubric scoring for applicants meeting predefined workforce development criteria.

STEP 4: Minimum Competitive Threshold Review

Applications scoring below established overall or domain-specific minimum thresholds may be removed from final award consideration

STEP 5: Final Award Selection

Final awards will prioritize the highest-scoring competitive applications within each geographic allocation pool while maintaining:

- Regional representation targets
- Geographic diversity goals
- Funding availability considerations
- Minimum quality thresholds

Additional Considerations

The administering entity may request additional information or clarification from applicants as needed. Submission of an application does not guarantee funding; all applications will be evaluated based on defined criteria and overall competitiveness. Please see Application Review and Award Selection Overview above regarding the different phases of application review.

Scoring Domains and Evaluation Components

Below are the five domains by which applicants will be evaluated for using a standardized rubric, along with their corresponding weights. Applicants applying as multi-provider sites will complete one application for multi-site applicants. These applicants will receive one score per application and the weights described below will apply for this application.

Scoring Domains and Evaluation Components	Weight
Provider Equity Scoring centers providers serving high-need and underserved populations and who evidence actions to reduce health disparities, evaluated by: » Population demographics of pediatric patients served » Extent of provider activities to address health disparities aligned with Brooks et al.'s PETAL framework for how the provider prioritizes health equity, engages communities in quality improvement, targets and address health disparities, and learns and improves » Potential to mitigate projected behavioral health staffing shortages through supporting workforce training, particularly among providers within recognized shortage areas	**20%**
Implementation Readiness Scoring focuses on initial infrastructure and staffing readiness, evaluated by: » Leadership commitment » Implementation team readiness » Behavioral health staffing ability for dyadic services » Medical record and quality improvement infrastructure	**20%**

Scoring Domains and Evaluation Components	Weight
Program Impact Scoring prioritizes providers where grant funds and TA support will make the greatest difference, evaluated by: » The extent that the grant can enhance existing services and support sustainability through billing » Workforce capacity for dyadic services » Quality improvement goals and needs	**20%**
Strategic Alignment Scoring ranks how well dyadic services align with provider needs and goals are, evaluated by the provider's narrative statement demonstrative appropriateness of grant fit with: » Intended population of focus » Prioritized needs and goals » Rationale for dyadic services and use of grant funds » Proposed dyadic service staffing	**20%**
County Composite Index Scoring integrates county and regional level publicly available indicators to prioritize high-need and low-resourced communities, evaluated by: » Medi-Cal Enrollment Among Children and Teens » California Healthy Places Index (HPI) » Pediatric Behavioral Health Infrastructure & Innovation Capacity	**20%**
TOTAL	**100%**

Workforce Development Incentive

Additional points may be awarded to service locations that demonstrate active participation in behavioral health workforce development, such as trainee placements, clinical supervision, partnerships with academic or workforce training programs, or serve behavioral health workforce shortage regions.

Tie Breakers

In the event that two or more applications receive identical final scores, a structured, stepwise tie-breaking process will be applied to support consistent and equitable funding decisions. If necessary, applicants may be contacted for additional information needed to adequately assess tie-breaking criteria.

Step 1: Implementation Readiness

In the event of a tie score, priority will then be given to the applicant demonstrating stronger readiness for implementation, as reflected in Capacity and Infrastructure Readiness, including leadership commitment and staff readiness.

Step 2: Equity Prioritization

If a tie remains, priority will be given to the applicant with the higher score in Provider Equity, reflecting the program's emphasis on serving high-need and underserved populations and advancing health equity.

Step 3: Grant Impact

If a tie remains, priority will be given to the applicant with the higher score in Grant Impact on Stated Goals, favoring providers where grant funding and technical assistance are expected to produce the greatest measurable impact.

Step 4: Community and Regional Need

If still tied, the applicant with the higher score in the County Composite Index will be prioritized, based on indicators of community-level need and resource constraints.

PART 4: ADMINISTRATIVE DETAILS

4.1 Administrative Details

Inquiries

All RFA related inquires must be directed via email to scalingdyadic@cibhs.org. Grant Administrators will respond directly to each applicant submitting an inquiry, with an initial response provided within 24 hours and any additional triage requests occurring within 48 hours.

Reasonable Accommodations

For applicants with disabilities, TA Vendor will provide assistive services such as reading or writing assistance, conversion of the RFA, questions/answers, RFA addenda, or other Administrative Notices to Braille, large print, audiocassette, or computer disk. To request copies of written materials in an alternate format, please direct all requests to: scalingdyadic@cibhs.org.

Compliance with California Public Records

The application is a public record that is available for public review pursuant to the California Public Records Act CPRA, Government Code, Title 1, Division 10—"Access to Public Records" [commencing with Section 7920.000]). After final awards have been issued, DHCS may disclose any materials provided by the applicant to any person making a request under the CPRA. Applicants are cautioned to use discretion in providing information not specifically requested, such as personal phone numbers and home addresses.

Disposition of Applications

All materials submitted in response to this solicitation will become the property of the State of California and will be returned only at TA Vendor's option and at the applicant's expense. At a minimum, the master copy of the application shall be retained for official files and will become a public record after the Notice of Intent to Award is posted. However, materials TA Vendor considers confidential information will be returned upon request of the applicant.

Appeals

California law does not provide a protest or appeal process of award decisions made through an informal selection method. Applicants submitting a response to this RFA may not protest or appeal the award decision. TA Vendor's and DHCS's award decision shall be final.

Modification of contract terms and conditions will be considered only under exceptional circumstances.

Applicant Scoring

Each application will be reviewed for technical compliance, completeness, and budget reasonableness. The contents will be scored, and applications will be ranked. Successful applicants presenting the most complete and responsive applications, demonstrating the most favorable mix of credentials, capacity, and potential to best meet TA Vendor's needs and goals, will be selected. In addition to the application score, additional factors (such as the specific population served and geographic diversity) may also be considered to select the most favorable mix of grantees across the state. Decisions are at the sole discretion of TA Vendor and subject to DHCS approval. TA Vendor may conduct interviews to clarify the content of the application.

Award Process

Once selections have been made, selected applicants will receive a conditional award notification to initiate contract development and negotiation. These negotiations may include adjustments to the proposed budget, scope of work, timelines, or other application elements. Not all applicants will receive the full amount requested, and the TA Vendor and TPA reserve the right to determine final award amounts, including partial or full funding of proposed activities.

Selected applicants may be required to participate in negotiations and submit revised budgets, technical information, or other application materials. The contents of the successful applicant's submission may be incorporated into the final agreement as contractual obligations. Failure to agree to these terms or execute the agreement may result in withdrawal or cancellation of the award.

A Subaward Agreement from the TPA and a Collaboration Agreement from the TA Vendor will be emailed to the selected applicants, and it must be signed, returned, and fully executed prior to the release of any funds.

Reservation of Rights

Funding decisions are contingent upon the availability of funds to TPA, and nothing in this solicitation obligates TA Vendor and TPA to make an award. The submission of a response to this RFA does not obligate TA Vendor and TPA to make a contract award. TA Vendor and TPA may request clarifications or require adjustments to applications or budgets as a condition of funding. TA Vendor and TPA reserve the right to deem incomplete responses as non-responsive to the RFA requirements. TA Vendor and TPA reserves the right to modify or cancel the RFA process at any time.

The following occurrences may cause Grant Administrators to reject a response from further consideration:

- Failure to meet the state applicant requirements by the submission deadline.
- Failure to comply with a request to submit additional documents in a timely manner, if needed.
- Failure to comply with all performance requirements, including milestone and reporting requirements outlined in Section 1.2, terms, conditions, and/or exhibits that will appear in the resulting contract.
- Failure to submit an RFA response by 11:59 pm PT, October 26, 2026.

APPENDICES

Appendix 1. Dyadic Services Action Plan

The Action Plan is designed to guide and support grantees in the implementation of dyadic care services. It is structured into four distinct parts, each containing specific requirements that must be fulfilled to secure payment. This framework helps ensure steady progress, accountability, and alignment with program goals, while providing grantees with a clear pathway to achieve successful outcomes in delivering high-quality dyadic care services. The information included in the action plans must be reviewed and approved by the TA Vendor.

Dyadic Services Action Plan Part 1 (Module 1 & 2; April–Sept 2027)

Category	Requirement
Established Implementation Team	» Identified names, roles, responsibilities » Identified dedicated behavioral staff
Established Governance Structure	» Identified communication pathways for decision making with leadership
Completion of Priorities Worksheet	» Identified outcomes that align with system priorities » Completion of implementation timeline for dyadic service delivery areas
Established Dyadic Care Grant Program Marketing Plan	» Identified orientation materials and workflows for introduction of dyadic services to families

Dyadic Services Action Plan Part 2 (Module 3 & 4; Oct 2027–March 2028)

Category	Requirement
Established Initial Implementation in a minimum of 4 Dyadic Care Service Delivery Areas	» Completion of Dyadic Care Service Delivery Areas Checklist *see Appendix 2
Completion of Dyadic Service Documentation Templates	» Templates built within EHR

Category	Requirement
Established Dyadic Service Billing Utilization pathway	» Dyadic service codes within EHR » Billing team and MCP communications in progress
Identified Program Training Needs with Plan	» Meeting with leadership
Completion of Continuous Quality Improvement Worksheet	» Identified methods for tracking implementation progress

Dyadic Services Action Plan Part 3 (Module 5 & 6; April–Sept 2028)

Category	Requirement
Established Initial Implementation in all 6 Dyadic Care Service Delivery Areas	» Completion of Dyadic Care Service Delivery Checklist *see below
Completion of PDSA Worksheet	» Review of implementation progress in 6 dyadic service delivery areas » Identified a minimum of 2 dyadic service delivery areas to transition into full operation » Gather feedback from patients and providers on initial implementation to help identify and inform needed adjustments

Dyadic Services Action Plan Part 4 (Module 7 & 8; Oct 2028–March 2029)

Category	Requirement
Established Full Operation in a minimum of 4 Dyadic Care Service Delivery Areas	» Completion of Dyadic Care Service Delivery Checklist *see below
Team Worksheet	» Review of implementation progress in 6 dyadic service delivery areas » Identified necessary steps to transition final 2 dyadic service delivery areas into full operation » Created a plan for continued dyadic service delivery
Gathered PDSA Feedback from Providers on Initiative	» Plan distribution » Feedback gathered and consolidated for presentation
Gathered PDSA Feedback from Patients on Initiative	» Plan distribution » Feedback gathered and consolidated for presentation

Definitions

This section provides detailed definitions of terms and key dyadic care service delivery areas that will be referenced throughout this program in technical assistance and in monitoring activities. These definitions will serve as a foundation to guide implementation efforts and track progress towards program goals.

Dyadic Care Service Delivery Areas:

1. **Health Prevention & Promotion**
   Dyadic Behavioral Health Visits involving >1 care team role (Behavioral Health, Medical)
2. **Universal Screenings for Child Development, Behavior and Autism**
   Recommended behavioral health and developmental screenings (e.g., ASQ-3, autism screening) offered universally to all patients in accordance with Bright Futures guidelines
3. **Universal Screenings for Social Drivers of Health**
   Recommended screening for areas of need related to social drivers of health screenings (e.g., housing, food, financial, legal, etc.)
4. **Universal Screenings for Caregiver Mental Health**
   Recommended caregiver depression screener (e.g., Edinburgh Postnatal Despression Screener for perinatal mood and anxiety symptoms) offered universally to all caregivers of patients in accordance with Bright Futures guidelines
5. **Case Based Consultation**
   Team-based or stand-alone behavioral health visits related to development, behavior, social needs or caregiver wellness referrals from medical providers
6. **Care Coordination**
   Coordination and tracking for all referrals made related to development, behavior, social needs and family/caregiver mental health

Stages of Implementation: Stages of Implementation will serve as a framework to guide and support grantee progress in delivery of dyadic care services. While exploration stage is considered a pre-grant activity, grantees will be supported to move through installation stage, initial implementation, and full operation stage, through which progress will be evaluated.

Overview of Implementation Stages

Implementation science shows that implementing a new program or practice is a process that occurs in overlapping stages.[6] Similarly, dyadic care implementation often occurs in increments as systems build capacity and evolve in their understanding of dyadic care and system needs. As such, components of dyadic care implementation may be at different stages at one time, or a system may need to revisit previous stages in response to learning or to adapt to internal or external developments.

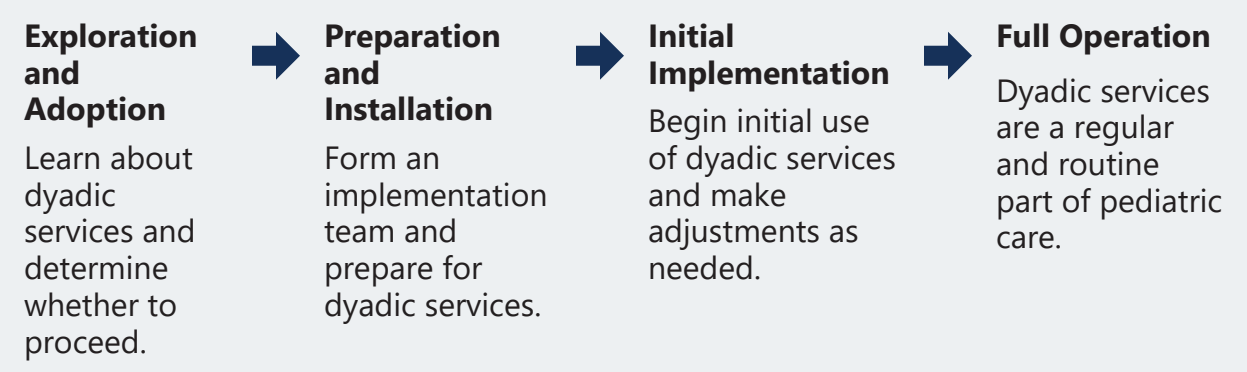

Figure 6

Initial Implementation

Initial Implementation refers to the early operational phase in which dyadic services are actively launched and delivered at a limited or targeted scale to test, refine, and standardize workflows prior to broader expansion. During this phase, providers are expected to engage in continuous learning and adaptation, including structured quality improvement activities such as Plan-Do-Study-Act cycles.

Initial Implementation goals may be evaluated using the following parameters:

- Demonstrated initiation of dyadic service delivery to a defined subset of the intended population
- Relative increase from baseline service delivery targets established by the provider implementation team and approved through the TA process
- Establishment of foundational operational workflows, staffing models, referral pathways, documentation practices, and care coordination processes

[6] The overview of implementation stages on this and subsequent pages is summarized from Fixsen, D. L., Nacom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). Implementation Research: A Synthesis of the Literature. Tampa, FL: University of South Florida, Louis de Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231). Additional details and specifics related to dyadic care are informed from training and technical assistance work of UCSF Center for Advancing Dyadic Care in Pediatrics.

- Demonstrated workforce onboarding, training, and early workforce capacity development
- Active participation in quality improvement and workflow testing activities to identify operational barriers and needed adaptations
- Early implementation of data collection, reporting, and billing workflows to support future sustainability

During Initial Implementation, the primary focus is operational launch, workforce development, workflow standardization, and establishment of clinical service delivery processes. Measurement of long-term quality outcomes, full population reach, and financial sustainability through billing pathways are considered emerging areas of development during this phase.

Full Operation

Full Operation refers to the phase in which dyadic services have become a routine, integrated, and sustainable component of pediatric care delivery. At this stage, workflows have been standardized, service delivery has expanded to the intended population of focus, and providers are engaged in ongoing quality improvement and sustainability activities .

Full Operation goals may be evaluated using the following parameters:

- Relative increase in dyadic service delivery from Initial Implementation targets established by the provider implementation team and approved through the TA process
- Demonstrated expansion of services to the full intended population of focus, such that dyadic services are broadly accessible within routine care workflows
- Standardized and sustainable operational workflows supporting consistent service delivery across clinical teams and settings
- Ongoing quality improvement activities, including continued PDSA cycles focused on workflow optimization, efficiency, fidelity, and quality outcomes
- Demonstrated utilization of billing pathways and financial processes supporting long-term sustainability of dyadic services
- Routine collection and use of quality, utilization, and operational data to guide continuous improvement and program refinement

During Full Operation, the primary focus shifts from operational launch to sustained delivery, population-level access, quality performance, workflow optimization, and long-term financial sustainability .

Appendix 2. Dyadic Care Service Delivery Areas Checklist Template

Fidelity Component	Description	Completion Status
Health Prevention and Promotion	Count of prevention focused dyadic behavioral health encounters provided to child–caregiver dyads involving >1 care team role (BH, Medical)	❑ Not yet started ❑ Planning for implementation ❑ Initial implementation in progress ❑ Full operation complete
Universal Screenings for Child Development, Autism, and Behavior	Rate of completion of recommended behavioral health and developmental screenings (e.g. ASQ, autism screening)	❑ Not yet started ❑ Planning for implementation ❑ Initial implementation in progress ❑ Full operation complete
Universal Screenings for Social Drivers of Health (SDOH)	Rate of completion of recommended social drivers of health screenings (e.g. housing, food, financial, legal, etc.)	❑ Not yet started ❑ Planning for implementation ❑ Initial implementation in progress ❑ Full operation complete
Universal Screenings for Caregiver Mental Health	Rate of completion of recommended caregiver depression screener (e.g., Edinburgh Postnatal Depression Screenings or PHQ-9)	❑ Not yet started ❑ Planning for implementation ❑ Initial implementation in progress ❑ Full operation complete

Fidelity Component	Description	Completion Status
Case Based Consultation	Count of team-based or stand-alone dyadic behavioral health visits related to development, behavior, social needs or caregiver wellness questions or concerns	❑ Not yet started ❑ Planning for implementation ❑ Initial implementation in progress ❑ Full operation complete
Care Coordination	Rate of service connection outcomes tracked for referrals made through dyadic care program	❑ Not yet started ❑ Planning for implementation ❑ Initial implementation in progress ❑ Full operation complete

Appendix 3. Grantee Reporting Requirements

Report	Frequency	Contributing Entity	Key Data Elements/ Components
Dyadic Service Utilization	Quarterly	Providers	Population demographics including age ranges of members receiving Dyadic services; Provider utilization data; Dyadic service encounters; Unique Providers billing for dyadic services; Percentage change of dyadic services billed by quarter
Dyadic Service Sustainability Report	Quarterly	Providers	CPT codes billed and submitted for Dyadic services, CPT codes reimbursed
Expenditure Report	Bi-Annually	Providers	Budget-to-actual
TA Participation	Ongoing	TA Vendor with provider input	Attendance at learning communities, site visits, county roundtables, office hours; Type and duration of TA
Implementation Action Plan	Ongoing (Updated During Site Visits)	TA Vendor with provider input	Implementation stage; Implementation checklist; Staffing changes; Team demographics; Operational barriers/progress
Training and Modules	Ongoing	TA Vendor's LMS Platform	Module completion rates; Time spent in modules; Completion by provider; Training compliance benchmarks
Participant Survey	Ongoing	TA Vendor	Knowledge, skills, and attitudes, qualitative feedback

Appendix 4: Grantee Budget Template

Scaling Dyadic Care Grant Program
Grantee Budget Template

To complete this budget template, review the Eligible and Ineligible Expenditures (Part 2.3 of the Request for Application) for guidance, and provide responses in the tables below with as much accurate detail as possible.

Applicant Information

Provider or Entity Name	
Email	
Phone	
County or Tribal Nation	
Required Funding Tier	

Section B – Personnel Costs - Support Staff

Position Title	Role in Program	FTE	Annual Rate	FY 26-27	FY 27-28	FY 28-29	Amount
							$
							$
							$
							$
							$
							$
							$
							$
Subtotal				$	$	$	$
Benefits & Taxes	Percentage			$	$	$	$
Total				$	$	$	$

Section C – Personnel Costs - Direct Service Staff

Position Title	Role in Program	FTE	Annual Rate	FY 26-27	FY 27-28	FY 28-29	Amount
							$
							$
							$
							$
							$
							$
							$
							$
Subtotal				$	$	$	$
Benefits & Taxes	Percentage			$	$	$	$
Total				$	$	$	$

Section D - Services & Supplies

Expense Category	Please Provide a Detailed Description and Associated Cost Breakdown for Each Category	FY 26-27	FY 27-28	FY 28-29	Amount
Equipment & Supplies					$
Outreach & Communications					$
Planning Costs					$
Program Operations					$
Participant Materials					$
Technology & Data Infrastructure					$
Training & Technical Assistance					$

Expense Category	Please Provide a Detailed Description and Associated Cost Breakdown for Each Category	FY 26-27	FY 27-28	FY 28-29	Amount
Travel (if applicable)					
					$
					$
					$
Subtotal					$
Subcontractors					
					$
					$
					$
					$
Subtotal		$	$	$	$
Total		$	$	$	$

Section E - Indirect Costs

Expense Category	Please identify the organization's indirect cost methodology (e.g., federally negotiated indirect cost rate agreement [NICRA], de minimis rate, or other methodology subject to approval)	Indirect Cost Rate %	FY 26-27	FY 27-28	FY 28-29	Amount
Indirect Costs						
Total						
Total Costs						

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