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

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

DRAFT FOR PUBLIC COMMENT

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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Introduction

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

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

This manual establishes training, technical assistance, fidelity monitoring and data collection standards for counties[3] and behavioral health practitioners to implement ACT, FACT, CSC and IPS under Medi-Cal and the BHSA.[4] The

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[1] ACT, FACT, and CSC are covered in the Specialty Mental Health Services (SMHS) delivery system only. IPS is covered in the SMHS, Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) delivery systems. See BHIN 25-009 for requirements to cover each EBP under Medi-Cal and claim bundled Medi-Cal payment and the BH-CONNECT EBP Policy Guide for more information on Medi-Cal coverage of ACT, FACT, CSC and IPS.[2] ACT, FACT and IPS must be implemented as part of FSP programs. CSC must be implemented as part of EI programs. See the BHSA Policy Manual for information about BHSA requirements.

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

[3] "County" is inclusive of the SMHS, DMC and DMC-ODS delivery systems, as well as county behavioral health agencies that administer ACT, FACT, CSC and IPS.

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

requirements in this manual apply to services billed to Medi-Cal and services delivered through FSP and EI programs. This manual provides requirements for ACT, FACT, CSC and IPS in addition to standards in BHIN 25-009, the BH-CONNECT EBP Policy Guide, and the BHSA Policy Manual.

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

What is in This Manual?

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

- An **overview of the role of Centers of Excellence (COEs)** established by DHCS in providing training, technical assistance, fidelity monitoring, and data collection for counties and behavioral health practitioners;
- A review of **foundational requirements for counties** to deliver ACT, FACT, CSC and IPS under the BHSA and as optional Medi-Cal benefits; and
- Specific **requirements related to implementing ACT, FACT, CSC and IPS,** including:
    - Training requirements for behavioral health practitioners;
    - Fidelity monitoring requirements, including information about the fidelity tools COEs will use to determine if ACT, FACT, CSC and IPS practitioners are delivering services with fidelity to the evidence-based models, the fidelity assessment process, and specific fidelity thresholds required to achieve and maintain Fidelity Designation;
    - Technical assistance opportunities for counties and ACT, FACT, CSC and IPS practitioners; and
    - Data collection requirements for ACT, FACT, CSC and IPS practitioners to ensure services are improving the health and wellbeing of Californians living with significant behavioral health needs.

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

Centers of Excellence

DHCS has contracted with Centers of Excellence (COEs) to provide training, technical assistance, fidelity monitoring and data collection support for ACT, FACT, CSC and IPS:[5]

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

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

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

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

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

- Completing county consultations with the respective COEs for ACT and FACT, CSC and IPS;
- Ensuring practitioners meet specified training, technical assistance, fidelity monitoring, and data collection standards; and

[5] DHCS also contracted with COEs to support implementation of Multisystemic Therapy (MST), Functional Family Therapy (FFT), Parent-Child Interaction Therapy (PCIT), and Clubhouse Services. Additional information on these EBPs is available in BHIN 25-XXX and BHIN 25-009. DHCS also intends to contract with a COE to support implementation of High-Fidelity Wraparound (HFW). Guidance on HFW is forthcoming.

- Meeting specified implementation milestones for ACT, FACT, CSC and IPS to demonstrate services are delivered with fidelity to the evidence-based models.

County Consultations with COEs

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

Counties are required to participate in consultations with the respective COEs for ACT and FACT, CSC and IPS to establish and/or expand these EBPs consistent with BHSA and, where applicable, Medi-Cal requirements. Consultations for ACT, FACT, CSC and IPS must be complete no later than June 30, 2026.

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

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

Each county must complete a consultation with the ACT and FACT, CSC and IPS COEs:

- Within three months of the EBP effective date indicated on the county's letter of commitment to cover the EBP under Medi-Cal;[6] and/or

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

- No later than June 30, 2026, if the county does not opt to cover the service under Medi-Cal before this date.

Each county must submit a COE Engagement Initiation Form (EIF) on the DHCS COE Resource Hub website to initiate county consultations with the COEs.[7] Counties must submit EIFs for ACT, FACT, CSC and IPS no later than March 31, 2026 to ensure consultations are complete by June 30, 2026.

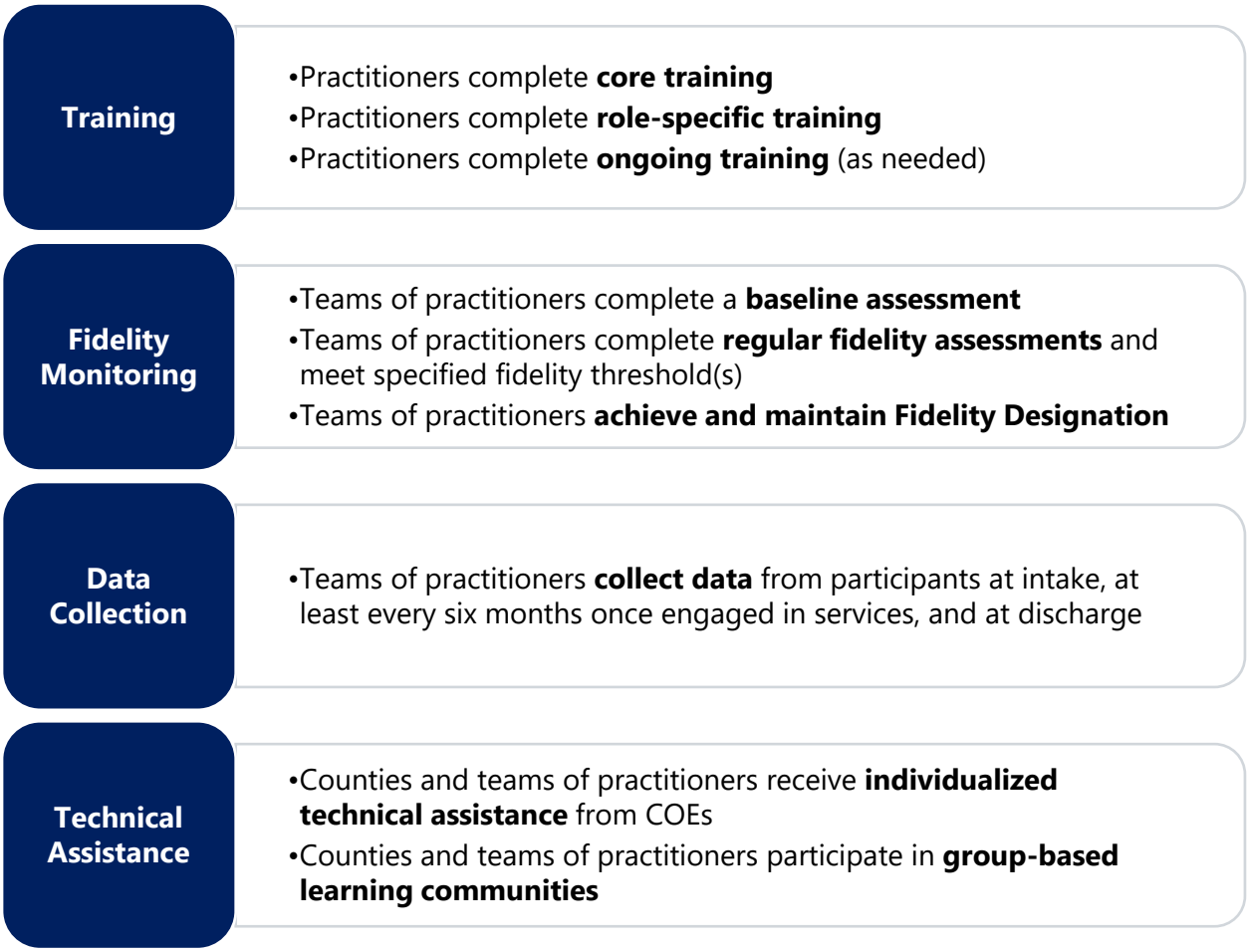
County consultations are required for all counties, including counties that already deliver ACT, FACT, CSC and/or IPS, and counties that do not plan to cover the EBPs as bundled Medi-Cal services. Counties may have follow-up consultations with COEs at any time after the initial consultations to continue discussing county-specific implementation considerations.

Oversight of ACT, FACT, CSC and IPS Practitioners

Counties must ensure all teams of behavioral health practitioners delivering ACT, FACT, CSC and/or IPS practitioners under Medi-Cal and/or as part of FSP or EI programs meet the training, technical assistance, fidelity monitoring, and data collection standards in this manual. Training, technical assistance, fidelity monitoring and data collection requirements are the same for all practitioners delivering each EBP, whether they are delivering services as part of an FSP or EI program or as a bundled Medi-Cal service. Training, technical assistance, fidelity monitoring and data collection standards for each EBP are summarized in Figure 1 and are detailed in the subsequent chapters of this manual.

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

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



County Implementation Timeline

As described above, under the BHSA each county is required to implement ACT, FACT, CSC and IPS. In addition, each county has the option to implement ACT, FACT, CSC and/or IPS as bundled Medi-Cal services.[8] **All counties – regardless of whether they opt in to cover EBPs as bundled Medi-Cal services – must meet specific implementation milestones to demonstrate compliance with BHSA requirements.**

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

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

All counties must:

- Complete county consultations with the ACT and FACT, CSC and IPS COEs, as described in the "County Consultations with COEs" section of this chapter, and begin establishing ACT, FACT, CSC and IPS teams no later than **June 30, 2026**;[9]
- Ensure a projected number of teams[10] delivering each EBP complete a baseline fidelity assessment and receive Baseline Fidelity Designation no later than **December 31, 2027**;[11]
- Ensure a projected number of teams delivering each EBP complete a first fidelity assessment and achieve Minimum Fidelity Designation no later than **June 30, 2028**; and
- Ensure a projected number of teams delivering each EBP complete a second fidelity assessment and achieve Full Fidelity Designation no later than **June 30, 2029**.

Box 1. What is Fidelity Designation?
Fidelity Designation is granted to each team of practitioners delivering an EBP in each county. Fidelity Designation indicates that the team has achieved the required fidelity score for that fidelity assessment. There are three levels of Fidelity Designation:

[9] An "established" team reflects a group of practitioners that has been staffed according to the standards of the EBP and is beginning to deliver and be paid for services delivered to individuals living with behavioral health needs. A "team" is a multidisciplinary group of practitioners that are delivering services to a specified caseload of members and participating in fidelity assessments; the structure and size of a team may shift over time.

[10] Staffing projections will be reviewed and approved by DHCS as part of the BHSA Integrated Plan (IP) process. More information is available in the BHSA Policy Manual.

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

Box 1. What is Fidelity Designation?

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

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

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

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

Counties that do not opt to provide EBPs as bundled Medi-Cal services must also ensure teams delivering ACT, FACT, CSC and/or IPS achieve and maintain Fidelity Designation.[12] As described in the BHSA Policy Manual, each county must submit staffing projections for each EBP in their 2026 Integrated Plan (IP) submission, and may adjust those projections as part of the 2027 Annual Update (AU) process. Counties are encouraged to consult with COEs to determine staffing projections for each EBP that account for county resources and capacity. Staffing projections will be reviewed by DHCS as part of the IP/AU process.

[12] Fidelity Designation reflects that the service is being implemented "with fidelity," consistent with BHSA Policy Manual requirements.

The projected number of teams identified in the IP/AU for fiscal year 2026-2027 must achieve Baseline, Minimum and Full Fidelity Designation on the timeline specified above.[13] Counties that are unable to demonstrate that their projected number of teams meet the fidelity requirements for the respective EBPs as described in this manual must consult with the respective COEs and establish county-specific EBP fidelity plans to meet DHCS' fidelity standards.

For example, if a county projects that it will establish four ACT teams in fiscal year 2026-2027 but only one ACT team completes a baseline assessment before December 31, 2027, the county must work with the ACT COE to establish a plan for expanding their ACT program and completing the requisite fidelity assessments for the remaining three teams.[14] If a county projects that it will establish four ACT teams in fiscal year 2026-2027 and four ACT teams complete the baseline assessment in 2027, but only one ACT team achieves Minimum Fidelity Designation by June 2028, the county must also work with the ACT COE on a county-specific EBP fidelity plan to improve fidelity implementation for the remaining three teams. Counties must be prepared to share their county-specific EBP fidelity plans upon request from DHCS.

Box 2. Summary of ACT and FACT, CSC and IPS Fidelity Designations			
	ACT and FACT	**CSC**	**IPS**
Fidelity Tool	Tool for Measurement of ACT (TMACT)[15]	First Episode Psychosis Services – Fidelity Scale (FEPS-FS) Version 1.1	IPS Fidelity Scale
Baseline Fidelity Designation	Assess foundational ACT competencies	Assess foundational CSC competencies	Assess foundational IPS competencies
Minimum Fidelity Designation	TMACT score of ≥3.3	Meet specified CSC competencies	IPS Fidelity Scale score of ≥80

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

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

[15] FACT teams will also be assessed on items from the Rochester FACT (R-FACT) tool.

Box 2. Summary of ACT and FACT, CSC and IPS Fidelity Designations			
	ACT and FACT	**CSC**	**IPS**
Full Fidelity Designation	TMACT score of ≥3.7	FEPS score of ≥4 and meet all CSC competencies	IPS Fidelity Scale score of ≥100 and 3 or more on community-based services

Assertive Community Treatment (ACT)

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

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

ACT Training Requirements

Every behavioral health practitioner delivering ACT under Medi-Cal or through a FSP program must complete training covering the evidence-based approaches and core practices comprising the ACT service model. Each practitioner must also complete role-based training.[16,17]

Behavioral health practitioners may begin delivering services on an ACT team prior to completing training, as long as all practitioners complete 40 initial training hours within two years of starting to deliver ACT. An overview of the ACT training curricula is in Box 3.[18] After the initial 40 training hours, each practitioner must complete 20 training hours per year on an ongoing basis.

The annual 20 training hours requirement is met through completing any combination of topics in Box 3 and additional topics that will be available in the California ACT/FACT

[16] See the BH-CONNECT EBP Policy Guide for additional information about roles on ACT teams.
[17] ACT teams with a caseload of >25% of individuals who meet eligibility criteria for FACT must also complete specialized FACT training. See additional details in the "Forensic ACT" chapter of this manual.
[18] The ACT training curricula may change over time. All current training requirements will be specified on the California ACT/FACT Learning Center.

Learning Center. Continuing education credits will be available for many of the available trainings.

Training sequencing and pacing can be flexible.

Box 3. ACT Training Curricula	
Foundational Curriculum	**Role-Based Curriculum**
• Recovery-Oriented Care • Trauma-Informed Care • Harm Reduction • Boundaries and Provider Wellbeing • Suicide Assessment and Prevention • Motivational Interviewing • Cultural Humility and Engagement • Safety and De-Escalation	• Team Lead • Peer Specialist • Prescriber • Nurse • Employment Specialist • Case Manager • Mental Health Clinician • Substance Use Disorder Specialist

Tracking Training Status

ACT team leads[19] must maintain an accurate roster of ACT team members and their respective roles on the ACT team as well as their training status. ACT team leads can access the current training status of all ACT team members through the California ACT/FACT Learning Center. ACT team leads will also receive reports from the ACT COE that list all ACT team members, their respective roles on the ACT team, and their training status. If an ACT team member fails to complete training requirements within the required timelines, the ACT team lead must act promptly to ensure the training requirements are met or replace the team member with a different practitioner.

The ACT COE will also maintain a record of the training status of all ACT teams.

Training Exemptions

ACT team members may request exemptions from one or more required trainings if they can demonstrate they have completed equivalent training in the past 12 months. All training exemption requests are subject to review and approval by the ACT COE on an individual basis. To demonstrate equivalent training, the ACT team member must

[19] All ACT teams must have a designated ACT team lead. The ACT team lead has full clinical, administrative, and supervisory responsibility for the ACT team. Find additional guidance in the BH-CONNECT EBP Policy Guide.

provide syllabi or other documents that show the content of the training (e.g., slides, readings, etc.) and proof of their completion of the training.

Fidelity Monitoring

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

In counties that opt to cover ACT as a bundled Medi-Cal service, ACT teams must achieve and maintain Fidelity Designation for the county to claim bundled Medi-Cal payment for ACT on an ongoing basis.[20] ACT teams established through FSP programs must also achieve and maintain Fidelity Designation to comply with BHSA requirements.

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

- **Baseline Fidelity Designation.** ACT teams must complete a baseline fidelity assessment to receive Baseline Fidelity Designation. Baseline fidelity assessments must be completed within nine months of establishing a new ACT team.[21] The baseline fidelity assessment assesses if an ACT team meets foundational fidelity standards and identifies key gaps an ACT team must address before their first fidelity assessment. The ACT COE will conduct baseline fidelity assessments using the Core Components Checklist. The Core Components Checklist includes seven domains of team functioning consistent with the evidence-based ACT model. All ACT teams that complete the baseline fidelity assessment receive Baseline Fidelity Designation.
- **Minimum Fidelity Designation.** To move from Baseline Fidelity Designation to Minimum Fidelity Designation, ACT teams must pass[22] an in-person fidelity assessment conducted by the ACT COE using the Tool for Measurement of ACT

[20] Counties may claim the bundled Medi-Cal rate for ACT for up to nine months before teams of practitioners complete their baseline fidelity assessments. See BHIN 25-009.
[21] An "established" team reflects an ACT team that has been staffed and is beginning to deliver and be paid for ACT services delivered to individuals living with behavioral health needs.
[22] ACT teams that do not achieve the specified TMACT score to pass a fidelity assessment will enter a probationary period and will not automatically lose their Fidelity Designation, as described below.

(TMACT).[23] The first fidelity assessment must be completed within 15 months of establishing a new ACT team. ACT teams must achieve a TMACT score of 3.3 or higher to pass the first fidelity assessment and receive Minimum Fidelity Designation.

- **Full Fidelity Designation.** To move from Minimum Fidelity Designation to Full Fidelity Designation, ACT teams must pass a second fidelity assessment conducted by the ACT COE using the TMACT. The second fidelity assessment must be completed within 12 months of the first fidelity assessment. ACT teams must achieve a TMACT score of 3.7 or higher to pass the second fidelity assessment and receive Full Fidelity Designation.
- **Maintaining Full Fidelity Designation.** To maintain Full Fidelity Designation, ACT teams must pass biennial fidelity assessments to demonstrate they continue to deliver high-quality ACT services. ACT teams must achieve a TMACT score of 3.7 or higher on biennial fidelity assessments to maintain Full Fidelity Designation.

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

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

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

As described in the "County Implementation Timeline" section of the "Foundational Medi-Cal and BHSA Requirements for Counties Implementing ACT, FACT, CSC and IPS" chapter of this manual, the projected number of ACT teams approved by DHCS in each

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

county's IP/AU must achieve Baseline Fidelity Designation by December 31, 2027; Minimum Fidelity Designation by June 30, 2028; and Full Fidelity Designation by June 30, 2029. Counties that are unable to demonstrate that their projected number of teams meet the fidelity requirements for ACT as described in this manual must consult with the ACT COE and establish a county-specific EBP fidelity plan to meet DHCS' fidelity standards. Counties must be prepared to share the county-specific EBP fidelity plan upon request from DHCS.

Probationary Fidelity Period

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

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

ACT teams that do not pass the required fidelity assessment after their probationary period will lose their Fidelity Designation.[24] Teams that lose their Fidelity Designation must work with the ACT COE to determine key fidelity gaps and identify specific steps to re-gain Fidelity Designation. As described in BHIN 25-009, bundled Medi-Cal payment cannot be claimed if a team loses Fidelity Designation.

ACT in Rural Areas

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

The ACT COE may adjust fidelity expectations for ACT teams delivering services in small counties and rural areas based on lower demand for ACT. Fidelity adjustments will be program-specific. Rural adjustments may include, but are not limited to:

- Adjustments to ACT team structure (e.g., "small teams" with fewer practitioners than a typical ACT team)[25]
- Modified Core Components Checklist criteria
- TMACT adaptations and/or scoring adjustments for fidelity assessments

Tracking Fidelity Monitoring Status

ACT team leads must track the ACT team's fidelity status and ensure the ACT team undergoes the required fidelity assessments on the cadence described above. ACT team leads can access results from previous fidelity assessments through the California ACT/FACT Learning Center. ACT team leads will also receive reminders from the ACT COE when it is time to schedule their next fidelity assessment.

The ACT COE will also maintain a record of the fidelity status of all ACT teams, which will be shared with DHCS on a regular basis.

Data Collection

ACT teams must collect data on member outcomes to ensure ACT is effectively supporting the recovery of participating individuals. The ACT COE has developed a tool that ACT teams must use to collect member outcomes data. The ACT data collection tool is available through the California ACT/FACT Learning Center.

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

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

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

[25] See the BH-CONNECT EBP Policy Guide for additional information on ACT team structure.

identified data may be used by the ACT COE to identify areas where technical assistance is needed, and by DHCS to assess the effectiveness of ACT across the state.[26]

Technical Assistance

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

ACT teams and counties may request technical assistance through the California ACT/FACT Learning Center.

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

- Overview of the ACT model (ACT 101 and Setting the Foundation for Fidelity)
- Organizational Readiness for ACT: Predictors of Implementation Success
- The Multi-Disciplinary Team: Foundational Infrastructure for ACT
- Maximizing ACT Service Array for Program Effectiveness
- Collaborative Team-Based Care in ACT
- Outreach and Engagement in ACT: A Persistent and Committed Approach
- Daily Clinical Management in ACT
- Person-Centered Care in ACT: Addressing Client Preferences & Supporting Self-Determination
- ACT Transitions in Care
- Sustaining Continuous Quality Improvement in ACT
- Delivery of ACT for Co-Occurring Conditions

Individual and group-based technical assistance opportunities (e.g., virtual learning communities, consultations) and tailored technical assistance topics will also be

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

available. ACT programs are encouraged to consult the ACT COE when they are establishing a new team. The ACT COE may also recommend specific technical assistance opportunities following completion of a fidelity assessment for continuous quality improvement.

As described in the "County Consultations with COEs" section of the "Foundational Medi-Cal and BHSA Requirements for Counties Implementing ACT, FACT, CSC and IPS" chapter of this manual, each county is required to participate in at least one county consultation with the ACT COE to establish and/or expand their ACT program. Additional technical assistance is optional for counties.

Forensic ACT (FACT)

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

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

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

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

FACT Training Requirements

All behavioral health practitioners on a FACT team[27] are required to complete all of the FACT-specific training topics in Box 4, in addition to their ACT training hours.

Box 4. FACT Training Curricula
• Reducing Recidivism: Understanding and Addressing the Factors that Contribute to Re-Arrest • Justice System Navigation • Mass Incarceration, Criminal Justice and Mental Health: A Racial Equity Perspective • Cross-Systems Collaboration: Supporting Mandated Clients • First Person Perspectives: From Incarceration to Recovery • SPECTRM: Sensitizing Providers to the Effects of Incarceration on Treatment

[27] Defined as an ACT team for which at least 25% of their caseload meets service criteria for FACT. Service criteria for FACT are in the BH-CONNECT EBP Policy Guide.

Fidelity Monitoring for FACT

FACT teams must meet the same fidelity monitoring requirements as ACT teams. In addition to the TMACT assessment, FACT teams will also be assessed on two fidelity items from the Rochester Forensic Assertive Community Treatment (R-FACT)[28] model:

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

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

Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)

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

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

CSC Training Requirements

Every behavioral health practitioner delivering CSC under Medi-Cal or through an EI program must complete training in the evidence-based CSC model. Trainings include foundational and role-based trainings offered in didactic and small group experiential modalities.[29]

Behavioral health practitioners may begin delivering services on a CSC team prior to completing training, as long as they complete required training within one year of hire.[30] An overview of the CSC training curricula is in Box 5.[31] The CSC training curricula comprises approximately 40 training hours.

After the initial 40 training hours, the CSC COE may require some practitioners (e.g., the CSC team lead) to participate in 1-2 ongoing training hours per week to achieve proficiency in utilizing new tools, skills, or best practices. If the curriculum for a specific role is updated, CSC practitioners must also complete any new trainings within six

[29] See the BH-CONNECT EBP Policy Guide for additional information about roles on CSC teams.
[30] If a CSC team is delayed in establishing the Beehive system for data collection, practitioners may receive additional time from the COE to complete the Beehive curriculum.
[31] The CSC training curricula may change over time. All current training requirements will be specified on the California CSC Learning Center.

months of the update. The CSC COE may also require ongoing training hours and/or technical assistance for a CSC team following completion of a fidelity assessment. This may include small group experiential training in key areas of the CSC model (e.g. assessment, individual therapy).

Box 5. CSC Training Curricula		
Foundational Curriculum	**Role-Based Curriculum**	**Beehive Curriculum**
• Overview of EPI-CAL • Overview of CSC • Introduction to Psychosis • Impact of Structural Inequities in CSC • Roles on the CSC Team • Peer Support • CSC Service Flow • Supports in CSC • Crisis Considerations in FEP Care	• Clinic Coordinator/ Administrator • Team Lead • Education/Employment Specialist or Occupational Therapist • Peer Support Specialist • Family Specialist • Clinician/Therapist • Case Manager • Physician/Physician Assistant/Nurse Practitioner/Nurse • Clinic Leadership	• Introduction to Data Collection Using Beehive • How to Use Individual-Level Data in Care • Explore Data Collected in Your Clinic • Outcomes Assessment Training • How to Use the Beehive Application on a Tablet • Program Administrator Trainings

Tracking Training Status

CSC team leads[32] must maintain an accurate roster of CSC team members and their respective roles on the CSC team as well as their training status. CSC team leads can access the current training status of all CSC team members through the California CSC Learning Center. CSC team leads will also receive reports from the CSC COE that list all CSC team members, their respective roles on the CSC team, and their training status. If a CSC team member fails to complete training requirements within the required timelines, the CSC team lead must act promptly to ensure the training requirements are met or replace the team member with a different practitioner.

[32] All CSC teams must have a designated team lead. The CSC team lead has full clinical, administrative, and supervisory responsibility for the CSC team. Find additional guidance in the BH-CONNECT EBP Policy Guide.

The CSC COE will also maintain a record of the training status of all CSC teams.

Training completion will also be assessed at each fidelity assessment, beginning with the first fidelity assessment. Training completion will not be assessed during baseline assessments. For all practitioners that have been in their roles for less than one year at the point of a fidelity assessment, completion of training requirements will be prorated (for example, a practitioner that was hired six months prior to a fidelity assessment needs to have 50% of required training completed by the time of the fidelity assessment).

Training Exemptions

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

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

Fidelity Monitoring

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

In counties that opt to cover CSC as a bundled Medi-Cal service, CSC teams must achieve and maintain Fidelity Designation for the county to claim bundled Medi-Cal payment for CSC on an ongoing basis.[33] CSC teams established through EI programs must also achieve and maintain Fidelity Designation to comply with BHSA requirements.

[33] Counties may claim the bundled Medi-Cal rate for CSC for up to nine months before teams of practitioners complete their baseline assessments. See BHIN 25-009.

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

- **Baseline Fidelity Designation.** CSC teams must complete a baseline fidelity assessment to receive Baseline Fidelity Designation. The baseline fidelity assessment must be completed within nine months of establishing a new CSC team.[34] The baseline fidelity assessment assesses if a CSC team meets foundational fidelity standards and identifies key gaps a CSC team must address before their first fidelity assessment. The CSC COE will conduct baseline fidelity assessments through a structured interview with the CSC team lead. The structured interview will review eight fidelity areas aligned with the First Episode Psychosis Services – Fidelity Scale (FEPS-FS).[35] All CSC teams that complete the baseline fidelity assessment receive Baseline Fidelity Designation.
- **Minimum Fidelity Designation.** To move from Baseline Fidelity Designation to Minimum Fidelity Designation, CSC teams must pass their first fidelity assessment conducted by the CSC COE.[36] The first fidelity assessment must be completed within 15 months of establishing a new CSC team. CSC teams must demonstrate all the competencies assessed in the baseline assessment, must have completed required training, and must have implemented processes to collect and evaluate outcomes data and assess member feedback to pass the first fidelity assessment and receive Minimum Fidelity Designation.
- **Full Fidelity Designation.** To move from Minimum Fidelity Designation to Full Fidelity Designation, CSC teams must pass a second fidelity assessment conducted by the CSC COE. The second fidelity assessment must be completed within 12 months of the first fidelity assessment. CSC teams must achieve a mean FEPS-FS score of 4 or higher and continue to demonstrate all CSC competencies assessed in previous assessments to pass the second fidelity assessment and receive Full Fidelity Designation.

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[34] An "established" team reflects a CSC team that has been staffed and is beginning to deliver and be paid for CSC services delivered to individuals living with behavioral health needs.
[35] The FEPS-FS is a widely used scale to assess the degree to which mental health teams deliver evidence-based care to individuals receiving a first episode of psychosis.
[36] CSC teams that do not meet the specified requirements to pass a fidelity assessment will enter a probationary period and will not automatically lose their Fidelity Designation, as described below.

- **Maintaining Full Fidelity Designation.** To maintain Full Fidelity Designation, CSC teams must pass biennial fidelity assessments to demonstrate they continue to deliver high-quality CSC services. CSC teams must achieve a mean FEPS-FS score of 4 or higher and continue to demonstrate all CSC competencies on biennial fidelity assessments to maintain Full Fidelity Designation.

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

CSC teams that previously completed a fidelity assessment with EPI-CAL may be exempt from one or more Fidelity Designation levels. CSC teams that received a mean FEPS-FS score of 4 or higher through EPI-CAL will receive Full Fidelity Designation and must complete their next fidelity assessment within two years of their previous assessment. In the next assessment, the CSC team must achieve a mean FEPS-FS score of 4 or higher and demonstrate all CSC competencies to maintain Full Fidelity Designation.

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

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

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

Probationary Fidelity Period

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

For example, if a CSC team does not pass their first fidelity assessment, they must still achieve a mean FEPS-FS score of 4 or higher and demonstrate all CSC competencies during their second fidelity assessment. If a CSC team passes their first assessment but does not achieve a mean FEPS-FS score of 4 or higher or demonstrate all CSC competencies on their second fidelity assessment, they must complete a third assessment within twelve months of the second assessment and pass that fidelity assessment to receive Full Fidelity Designation.

CSC teams that do not pass the required fidelity assessment after their probationary period will lose their Fidelity Designation.[37] Teams that lose their Fidelity Designation must work with the CSC COE to determine key fidelity gaps and identify specific steps to re-gain Fidelity Designation. As described in BHIN 25-009, bundled Medi-Cal payment cannot be claimed if a team loses Fidelity Designation.

CSC in Rural Areas

The CSC COE may adjust fidelity expectations for CSC teams delivering services in small counties and rural areas based on lower demand for CSC. Fidelity adjustments will be program-specific. Rural adjustments may include, but are not limited to:

- Adjustments to CSC team structure[38]
- Modified baseline fidelity assessment criteria
- FEPS-FS adaptations and/or scoring adjustments for fidelity assessments

Tracking Fidelity Monitoring Status

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

[38] See the BH-CONNECT EBP Policy Guide for additional information on CSC team structure.

CSC team leads must track the CSC team's fidelity status and ensure the CSC team undergoes the required fidelity assessments on the cadence described above. CSC team leads can access results from previous fidelity assessments through the California CSC Learning Center. CSC team leads will also receive reminders from the CSC COE when it is time to schedule their next fidelity assessment.

The CSC COE will maintain a record of the fidelity status of all CSC teams, which will be shared with DHCS on a regular basis.

Data Collection

CSC teams must collect data on member outcomes to ensure CSC is effectively supporting the recovery of participating individuals. Member outcomes must be assessed using the following data collection tools, which are available through the California CSC Learning Center:[39]

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

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

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

Any member of the CSC team can collect member outcomes data. All data must be securely submitted through an online portal established by the CSC COE. CSC teams should review member outcomes data on a regular basis to ensure CSC is being delivered effectively and meeting the needs of enrolled individuals. In addition, de-identified data may be used by the CSC COE to identify areas where technical assistance is needed, and by DHCS to assess the effectiveness of CSC across the state.[40]

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

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

Technical Assistance

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

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

CSC teams and counties may request technical assistance through the California CSC Learning Center.

Individual Placement and Support (IPS) Supported Employment

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

Counties and IPS practitioners must work with the IPS Employment Center (from this point forward, "IPS COE") to meet these requirements. IPS COE resources are available free of charge for counties and IPS practitioners that serve the Medi-Cal and uninsured populations. The IPS COE maintains the California IPS Learning Center, which can be accessed through the DHCS COE Resource Hub website.

IPS Training Requirements

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

Behavioral health practitioners may begin delivering services on an IPS team prior to completing training, as long as the team completes one and a half days of site-based, in-person training with an IPS trainer within six months of starting to deliver IPS.[41] During the site-based training, the IPS trainer will:

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

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

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

Following the site-based trainings, the IPS trainer will join IPS team meetings twice monthly for three months to help the team brainstorm how to address different situations using the IPS approach. For the next six months, the IPS trainer will meet with the IPS team's employment supervisor[42] at least once per month to review program outcomes and discuss strategies for improvement.

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

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

A summary of IPS training requirements is in Box 6.[43]

Box 6. IPS Training Requirements			
1.5 Day Site-Based Training	**Virtual Synchronous Trainings**	**Virtual Asynchronous Training**	**Follow-Up Meetings with IPS Trainer**
• Informational Session • Career Profile Development • Building Relationships with Employers	• IPS for Individuals with Criminal Justice System Involvement • Individualized Job Supports	• IPS for Co-Occurring Conditions	• Twice monthly meetings to brainstorm IPS scenarios (3 months) • One-day site visit (3 months

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

[43] The IPS training curricula may change over time. All current training requirements will be specified on the California IPS Learning Center.

Box 6. IPS Training Requirements			
1.5 Day Site-Based Training	**Virtual Synchronous Trainings**	**Virtual Asynchronous Training**	**Follow-Up Meetings with IPS Trainer**
• Making Employer Contacts • Individualized Job Searches			after site-based training) • Monthly meetings on IPS outcomes and improvement strategies (6 months) • One-day site visit (6 months after site-based training)

Tracking Training Status

IPS employment supervisors must maintain an accurate roster of IPS employment specialists in their program and ensure they are trained to deliver IPS. Employment supervisors can access the current training status of all IPS team members through the California IPS Learning Center. Employment supervisors will also receive reports from the IPS COE that list training status for all IPS team members in their program. If an employment specialist fails to complete training requirements within the required timelines, the IPS employment supervisor must act promptly to ensure the training requirements are met or replace the team member with a different practitioner.

The IPS COE will also maintain a record of the training status of all IPS teams.

Training Exemptions

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

Fidelity Monitoring

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

In counties that opt to cover IPS as a bundled Medi-Cal service, IPS teams must achieve and maintain Fidelity Designation for the county to claim bundled Medi-Cal payment for IPS on an ongoing basis.[44] IPS teams established through FSP programs must also achieve and maintain Fidelity Designation to comply with BHSA requirements.

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

- **Baseline Fidelity Designation.** IPS teams must complete a baseline fidelity assessment to receive Baseline Fidelity Designation. The baseline fidelity assessment must be completed within nine months of establishing a new IPS team.[45] The baseline fidelity assessment assesses if an IPS team meets foundational fidelity standards and identifies key gaps an IPS team must address before their first fidelity assessment. The IPS COE will conduct baseline fidelity assessments for IPS through a structured interview process. All IPS teams that complete the baseline fidelity assessment will receive Baseline Fidelity Designation.
- **Minimum Fidelity Designation.** To move from Baseline Fidelity Designation to Minimum Fidelity Designation, IPS teams must pass a fidelity assessment conducted by the IPS COE using the IPS Fidelity Scale.[46,47] The first fidelity assessment must be completed within 15 months of establishing a new CSC team. CSC teams must score at least 80 points on the IPS Fidelity Scale to pass the first fidelity assessment and receive Minimum Fidelity Designation.

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[44] Counties may claim the bundled Medi-Cal rate for IPS for up to nine months before teams of practitioners complete their baseline fidelity assessments. See BHIN 25-009.
[45] An "established" IPS team reflects an IPS team that has been staffed and is beginning to deliver and be paid for IPS services delivered to individuals living with behavioral health needs.
[46] The IPS Fidelity Scale translates the 8 principles of IPS into a 25-item fidelity scale that is used to assess the quality of IPS services.
[47] IPS teams that do not achieve the specified score to pass a fidelity assessment will enter a probationary period and will not automatically lose their Fidelity Designation, as described below.

- **Full Fidelity Designation.** To move from Minimum Fidelity Designation to Full Fidelity Designation, IPS teams must pass a second fidelity assessment conducted by the IPS COE using the IPS Fidelity Scale. The second fidelity assessment must be completed within 12 months of the first fidelity assessment. IPS teams must score at least 100 points with a score of 3 or higher on community-based services on the IPS Fidelity Scale to pass the second fidelity assessment and receive Full Fidelity Designation..
- **Maintaining Full Fidelity Designation.** To maintain Full Fidelity Designation, IPS teams must pass triennial fidelity assessment to demonstrate they continue to deliver high-quality IPS services. IPS teams must score at least 100 points with a score of 3 or higher on community-based services to maintain Full Fidelity Designation.[48] The IPS team must undergo continuous quality improvement (CQI) reviews conducted by the IPS COE in years in which they do not have formal fidelity assessments to support IPS teams to stay on track to maintain Full Fidelity Designation.[49]

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

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

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[48] Ongoing fidelity assessments may be required on a more frequent cadence (e.g., biennial) if there is a drop in employment outcomes or a change in the team's employment supervisor.
[49] The CQI review is not scored but is intended to support teams in continuing to deliver high-quality services.

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

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

Probationary Fidelity Period

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

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

IPS teams that do not pass the required fidelity assessment after their probationary period will lose their Fidelity Designation.[50] Teams that lose their Fidelity Designation must work with the IPS COE to determine key fidelity gaps and identify specific steps to re-gain Fidelity Designation. As described in BHIN 25-009, bundled Medi-Cal payment cannot be claimed if a team loses Fidelity Designation.

Fidelity Action Planning

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

Tracking Fidelity Monitoring Status

IPS employment supervisors must track the IPS team's fidelity status and ensure the IPS team undergoes the required fidelity assessments on the cadence described above. Employment supervisors can access results from previous fidelity assessments through the California IPS Learning Center. Employment supervisors will also receive reminders from the IPS COE when it is time to schedule their next fidelity assessment.

The IPS COE will also maintain a record of the fidelity status of all IPS teams, which will be shared with DHCS on a regular basis.

Data Collection

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

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

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

- At intake (i.e., when a new individual is enrolled in IPS)
- During weekly IPS team meetings when individuals start jobs, end jobs, begin school or training, earn a degree or training certificate, obtain a DOR counselor, are closed from DOR services and are closed from IPS services
- Every six months to capture outcomes related to housing status and quality of life
- At discharge

Any member of the IPS team can collect member outcomes data. All data must be securely submitted through an online portal established by the IPS COE. IPS teams should review outcomes data on an regular basis, set goals for improvement, and identify where additional training or technical assistance may be needed. In addition, de-identified data may be used by DHCS to assess the effectiveness of IPS across the state.[51]

Technical Assistance

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

IPS teams and counties may request technical assistance through the California IPS Learning Center.

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

- Regional trainings facilitated by the IPS COE
- Learning community for IPS teams to share best practices
- Monthly virtual IPS Practice Principles webinars (for new practitioners)
- Monthly employer relationship webinars (for all practitioners)

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

IPS teams are encouraged to consult the IPS COE when they are establishing a new team. The IPS COE may also recommend specific technical assistance opportunities following completion of a fidelity assessment to support continuous quality improvement.

As described in the "County Consultations with COEs" section of the "Foundational Medi-Cal and BHSA Requirements for Counties Implementing ACT, FACT, CSC and IPS" chapter of this manual, each county is required to participate in at least one county consultation with the IPS COE to establish and/or expand their IPS program. Additional technical assistance is optional for counties.