BEHAVIORAL HEALTH CENTERS OF EXCELLENCE (COE) QUESTIONS AND ANSWERS

Introductory Webinars and Question-and-Answer Sessions

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Document Revision History

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INTRODUCTION

This document contains frequently asked questions (FAQ) related to the Behavioral Health Centers of Excellence (COE) and Evidence-Based Practices (EBP). For more information on the COEs and/or resources related to training, technical assistance, and fidelity monitoring, please visit the Behavioral Health COE Resource Hub.

We value your experience and feedback. If you have additional questions that are not highlighted in this document, we encourage you to reach out to us. Please contact us by:

- Sending an email to bhcoe.info@dhcs.ca.gov.
- Submitting a Behavioral Health COE Questions & Feedback Form.

NOTE: This document does not contain in-depth FAQs related to the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative and the Behavioral Health Services Act (BHSA). For more information, please visit the BH-CONNECT and BHSA page, BH-CONNECT FAQ page, and BHSA and BH-CONNECT EBP Overlap FAQ.

INTERSECTION BETWEEN BH-CONNECT AND THE BEHAVIORAL HEALTH SERVICES ACT (BHSA)

1. **Which EBPs are optional versus required to be implemented under the BHSA and BH-CONNECT?**
   Counties have the option to cover all BH-CONNECT EBPs for adults as bundled Medi-Cal services. However, counties that participate in the option to receive federal financial participation (FFP) for short-term stays in Institutions for Mental Diseases (IMD) must opt to cover Assertive Community Treatment (ACT) and Forensic ACT (FACT), Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP), and Individual Placement and Support (IPS) model of Supported Employment. Counties that cover Community Transition In-Reach Services must opt to cover ACT, FACT, IPS Supported Employment, and Peer Support Services. In addition, counties are required to offer ACT, FACT, CSC, and IPS Supported Employment as part of their county Full Service Partnership (FSP) programs under the BHSA. Counties can meet BHSA requirements without opting in to cover the BH-CONNECT EBPs as bundled Medi-Cal services.

   BH-CONNECT clarifies the obligation for all county behavioral health plans (BHP) to cover EBPs for children and youth, including Multisystemic Therapy (MST), Functional Family Therapy (FFT), Parent-Child Interaction Therapy (PCIT), and High Fidelity Wraparound (HFW).

   For children and youth EBPs, all counties are required to provide MST, FFT, and PCIT to Medi-Cal members under age 21 pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

2. **Can you please clarify which EBPs are included in BHSA or only BH-CONNECT, versus both?**
   ACT, FACT, CSC, IPS, and HFW are included in both BH-CONNECT and the BHSA.

   As part of BH-CONNECT, DHCS also received approval from the Centers for Medicare & Medicaid Services (CMS) to cover Clubhouse Services as a Medi-Cal benefit. DHCS is also clarifying Medi-Cal coverage requirements for MST, FFT, and PCIT under BH-CONNECT.

   There are no EBPs required under the BHSA that are not also part of the BH-CONNECT initiative.

3. **Which EBPs can counties opt-in to provide beginning in 2025? Are counties expected to implement EBPs all at once? Is there a different timeline for BH-CONNECT versus BHSA?**
   Under BH-CONNECT, all counties have the option to cover ACT, FACT, IPS Supported Employment, and CSC under Medi-Cal beginning in 2025. Additional

information about how to opt in to one or more of these EBPs under BH-CONNECT is available in BHIN 25-009.

Under the BHSA, all counties must provide these EBPs beginning July 2026. As described in the BHSA Policy Manual, between July 1, 2026 and June 30, 2029, all counties must:

- Participate in ongoing training and technical assistance.
- Understand gaps to fidelity by December 31, 2027.
- Complete full fidelity reviews and demonstrate counties are implementing EBPs with fidelity by June 30, 2029.

Additional details about the timeline for implementing EBPs with fidelity under the BHSA will be released for public comment in the coming months.

Additional information about the overlap between BHSA and BH-CONNECT can be found in the BHSA and BH-CONNECT EBP Overlap FAQ.

4. **Has the EBP Policy Guide already been released? Does it include service standards and fidelity measures?**
   In May 2025, DHCS released the BH-CONNECT EBP Policy Guide to provide operational guidance and support counties and practitioners in implementing ACT, FACT, CSC, and IPS.

   DHCS will supplement the BH-CONNECT EBP Policy Guide with additional policy guidance that establishes training, technical assistance, fidelity monitoring, and data collection requirements for ACT, FACT, CSC, and IPS. This guidance will establish additional requirements that counties and practitioners must meet under BH-CONNECT and the BHSA. DHCS must provide public notice when a Medi-Cal program intends to make changes to statewide standards and methods that affect payment rates (42 CFR 447.205).

ENGAGEMENT INITIATION FORM (EIF) AND COUNTY CONSULTATIONS

1. **When must a county submit an Engagement Initiation Form (EIF)?**
   Counties may submit an EIF at any time on the Behavioral Health COE Resource Hub. All counties must submit a form for each BHSA EBP (ACT, FACT, IPS, and CSC) by March 31, 2026, to ensure consultations for those EBPs are completed by June 30, 2026.

2. **If a community-based agency will be providing an EBP in multiple counties, does each county BHP that it contracts with need to submit the EIF?**
   Community-based agencies and other behavioral health providers should not submit an EIF. Each county is responsible for submitting an EIF and participating in initial consultations with each COE. The county will then work with its community-based agencies and other providers to connect to training, technical assistance, and fidelity monitoring offered by the COE.

3. **Once a county submits an EIF, is the county assigned a COE?**
   Each COE is associated with one EBP. On the EIF, a county can indicate if it would like to initiate a consultation with one or multiple COEs. Additional EIFs can be submitted at any time to engage with additional COEs.

   After the county submits the EIF, it will receive a response from the COE related to the EBP selected on the form within three business days. If a county selects multiple EBPs on the EIF, it will receive responses from the COEs for each of the EBPs selected.

4. **Will an EIF need to be completed if a county is already receiving training and technical assistance from the designated COE through a grant?**
   Yes, the EIF will need to be submitted even if the county is receiving training and technical assistance from the designated COE.

5. **Is the consultation just with the county or is it also with the entity providing the EBP?**
   The consultation(s) will be between the county and COE. County BHPs may choose to include their providers in ongoing consultations, as appropriate.

6. **How many consultations can a county have for a given EBP?**
   All counties must have at least one consultation with the COEs for ACT and FACT, IPS, and CSC. Counties may have follow-up consultations with COEs at any time after the initial consultations to continue discussing county-specific implementation considerations. The number of consultations needed for each county may vary and should be determined in collaboration with the respective COEs.

7. **What guidance can you share on how a county can determine when it is ready to submit an EIF for any given EBP?**
   Counties are encouraged to review the components of the county consultation to determine readiness for a county consultation within three months of submission. Example topics that would be discussed at a county consultation include:

   - County-specific implementation timelines.
   - County-specific resources available to establish and/or expand EBP programs.
   - Anticipated number of individuals in a county that may be eligible for each EBP.
   - Referral sources to support identification of individuals that may be eligible for each EBP.
   - Training, technical assistance, and data collection requirements for each EBP.
   - Adaptations for rural areas.
   - Other county-specific concerns.

   If a county is ready to initiate discussion with a COE and begin the process of implementing an EBP, it should submit an Engagement Initiation Form early in the process to ensure sufficient time to complete consultations, maximize scheduling flexibility, and begin process of implementation. If a county has further questions, please reach out to the Behavioral Health COE Administrative Entity (AE) at bhcoe.info@dhcs.ca.gov.

8. **How can our county behavioral health director designate someone to complete the EIF on their behalf?**
   It is at the county behavioral health director's discretion to identify a designee within the county to oversee the county's engagement with the COE for specific EBPs.

9. **When can we anticipate COEs to provide a training schedule?**
   Training requirements and modalities vary by EBP. Training requirements for each EBP will be established in forthcoming DHCS guidance, and more information about training requirements and accessing required trainings will be shared by each COE during initial county consultations. The COE training schedules are determined by each COE and are developed in collaboration with each county and practitioner team.

COUNTY BEHAVIORAL HEALTH PLAN (BHP) CONTRACTING, EXEMPTIONS, AND RESPONSIBILITIES

1. **How will HMA support small counties with limited staff in managing and meeting the requirements associated with each COE?**
   HMA and the COEs will support small counties in meeting specified requirements and demand. HMA will work with DHCS to develop and coordinate the approach with small counties. Adaptive approaches and modifications to the COE consultation and subsequent follow-up approach or EBP implementation must be coordinated with the COEs and approved by DHCS.
2. **Do the exemptions for small counties include just the fidelity requirements post-2029? Or do they also include exemptions for any offerings?**
   All counties are expected to engage with the COEs for ACT and FACT, CSC, IPS, and HFW through 2029 to support fidelity implementation of these EBPs. After June 30, 2029, some counties may apply for an exemption from meeting the specified fidelity requirements, consistent with the BHSA Policy Manual. More information on BHSA exemptions will be in forthcoming guidance.
3. **Do you envision different types of training for BHP administrative functions (e.g., contracts monitoring, clinical audits) versus clinical care delivery (e.g., practitioners and teams)?**
   The COEs were established to support counties and behavioral health practitioners in establishing and/or expanding EBP programs consistent with BH-CONNECT and BHSA requirements. County-level support includes individual county consultations that will cover topics such as:
   - County-specific implementation timelines for ACT, FACT, IPS, and CSC.
   - County-specific resources available to establish and/or expand ACT, FACT, IPS, and CSC programs.
   - Anticipated number of individuals in a county that may be eligible for each EBP.
   - Referral sources to support identification of individuals that may be eligible for each EBP.
   - Training, technical assistance, and data collection requirements for each EBP.
   - Adaptations for rural areas.
   - Other county-specific concerns.

   Practitioner-level support is primarily focused on clinical care delivery.

4. **Will COEs provide training materials to counties to support county training teams to continue these trainings for all county behavioral health staff and contractors?**
   COEs will provide training and technical assistance, including access to training materials for county-operated and county-contracted behavioral health practitioners who engage with them. Some EBP trainings (asynchronous/static materials) may be available immediately, but it will be important to engage the COEs to ensure trainings are tailored to the county/practitioner needs. County training teams are encouraged to work with the COEs to determine how to support the training and technical assistance efforts within each county. Please refer to the Behavioral Health COE Resource Hub and links to specific COEs for available materials.

5. **Will each COE have a dedicated contact working with the county? Or might counties be communicating with different contacts every time we engage with COEs?**
   Yes, each individual COE will have dedicated staff working with the county.

6. **Would it be possible for COEs to engage directly with the contracted agencies? Or is the training and technical assistance only for county administrators?**
   Yes, COEs will support county-operated and county-contracted behavioral health practitioners that serve the Medi-Cal and/or uninsured populations. COEs will work with counties to identify practitioners to participate in training, technical assistance, and fidelity monitoring for each EBP.

7. **What is the fiscal responsibility for counties to receive consultations, trainings, and ongoing support from the COEs?**
   DHCS has contracted with the COEs to provide training, technical assistance, fidelity monitoring, and data collection support. Training and support are free of charge for counties and behavioral health providers that serve the Medi-Cal and/or uninsured population. COE support is available to counties and providers beginning in August 2025.

8. **Will EBP certification by respective COE be at the county level, at the FSP program level, or somewhere in between?**
   Fidelity monitoring and certification/designation occurs at the provider level, not at the county level. Team-based EBPs (e.g., ACT) are monitored at the team level, while services delivered by individual practitioners (e.g., PCIT) are monitored at the practitioner level.

9. **What kind of support will be provided to quality improvement (QI) staff to appropriately review documentation of the EBPs?**
   County staff are encouraged to engage with the COE to identify technical assistance needs to support establishing the EBP to fidelity.

10. **If counties are sending the COEs data, is a Business Associate Agreement (BAA) needed with each COE?**
    COEs may receive de-identified data to support training, technical assistance, and fidelity monitoring for EBPs. COEs will establish business associate agreements (BAA), data use agreements (DUA), or service use agreements (SUA) with counties to allow the sharing of information related to training and technical assistance and fidelity monitoring for EBPs.

TRAINING COSTS, REQUIREMENTS, MODALITIES, AND APPROACH

1. **Are providers required to be trained and certified to provide EBPs? If so, when and who is providing the trainings? Are trainings free?**

   Yes, all EBP practitioners must meet training and fidelity monitoring standards. DHCS is developing guidance that outlines training and fidelity monitoring requirements for counties and EBP practitioners which will be released for public comment in the coming months.

   DHCS has contracted with the COEs to provide training, technical assistance, fidelity monitoring, and data collection support. Training and support are free of charge for counties and behavioral health providers that serve the Medi-Cal and/or uninsured population. COE support is available to counties and providers beginning in August 2025.

2. **Will COEs be providing direct training for clinical teams on the specified models?**
   Yes, COEs will provide both county-level and practitioner-level support. This includes county consultations, practitioner training, technical assistance, fidelity monitoring, and data collection support.

3. **Is there a funding source for cost of staff time to receive training and participate in fidelity monitoring activities, as well as supervisory requirements from in-house supervisors?**

   Each COE will work with counties to support delivery of EBPs with fidelity to the evidence-based models. In addition, DHCS encourages counties and behavioral health providers to utilize funding available through the BH-CONNECT Workforce Initiative to support the recruitment and retention of a robust behavioral health workforce. The Workforce Initiative includes funding for backfill costs while practitioners participate in training for EBPs.

4. **Will there be any in-person trainings available for staff who thrive in person versus virtual learning?**

   Yes, training requirements and modalities vary by EBP and will include some in-person training options. Training requirements for each EBP will be established in forthcoming DHCS guidance, and more information about training requirements and accessing required trainings will be shared by each COE during initial county consultations.

5. **Can you provide clarity on the EBP trainings and training/certification for the subspecialities of staff required to implement the overall EBP (e.g., Certified Peer Support Specialists)?**
   Training requirements for each EBP will be established in forthcoming DHCS guidance, and more information about training requirements and accessing required trainings will be shared by each COE during initial county consultations. There may be role-specific trainings for provider team members, team leads, or supervisors. This will vary by EBP.

MULTISYSTEMIC THERAPY (MST)

1. **What is the process of obtaining an exception for 10-, 11-, and 18-year-olds? Does this need to come from the MST consultants? If so, what is needed to support obtaining this exception?**

   The MST inclusionary and exclusionary criteria are based on the youth involved in the initial randomized studies of MST, which were 12-17 years old; therefore, this is the population that the model is demonstrated to successfully treat. However, there are occasions when a youth outside of our age range can be successful in MST. This exception process, facilitated by the MST expert in collaboration with the team supervisor and referrer, assesses if the problematic behavior and other systems variables meet the inclusionary criteria of the model other than the age range. This assessment progress is completed quickly upon referral, so the youth can either begin MST treatment quickly or be referred to a better suited program. MST's aim is to ensure providers can serve all youth and their ecology who would benefit from MST while also ensuring the model is the best fit for the client.

2. **Is "arrest" (or other terms) defined by the COE or differently by each county/community? If defined differently, how would the results across counties be measured (i.e., it may not be apples to apples comparison of data)?**

   In MST, Ultimate Outcomes are measured using "hard data" (objective measures) that indicate if the youth is living at home and in school or working at discharge. In addition, we evaluate if the youth has had a new arrest during treatment. Generally, MST programs define a new arrest during treatment as an incident in which there was police involvement resulting in an arrest. The results of the arrest (e.g., placement, probation requirements) are documented elsewhere in our Case Discharge Form as well as in treatment planning documents. In addition, when reporting on youth placement, MST differentiates in the Case Discharge Form whether a youth placement during treatment was the result of a preexisting incident (e.g., youth on probation when referred to MST then ultimately placed during treatment for probation violations) or if placed during treatment due to an incident that occurred during MST treatment. This differentiation allows the provider and key stakeholders to better understand and address reasons for youth placement and collaborate on how to best keep the youth in the home and community (when appropriate) instead of relying on placement as the sole/primary consequence to antisocial behavior. These data definitions and rationale are included in each provider's

Goals & Guidelines document at the conclusion of the Program Development process.

3. **Do the ongoing MST trainings continue through the life of the model?**

   Yes. Based on the body of research including an independent study that evaluated the effectiveness of MST when delivered without the agency and team receiving ongoing continuous quality improvement (CQI) and quality assurance (QA) processes, there is clear evidence that the ongoing CQI and QA processes are vital to model implementation and in obtaining sustained treatment gains.

FUNCTIONAL FAMILY THERAPY (FFT)

1. **If there is turnover of one or more staff on a certified team, does the team lose certification until new staff are up to speed?**

   Staff turnover is common. FFT LLC would not stop certifying a team if it loses staff as long as it continues to meet the team size standards (three to eight therapists) by hiring new staff. FFT LLC will offer weekly virtual "Replacement Training" for any new staff hired that will be joining an already trained and certified FFT LLC team.

2. **How long is the total training time for FFT's phase 1?**

   More information about training requirements and accessing required trainings will be shared by each COE during initial county consultations. If FFT teams are meeting FFT LLC standards, each phase of training is approximately one year.

3. **Does the Client Services System (CSS) allow import from other electronic health record (EHR) systems, or will this require duplicate entry for county staff?**

   FFT LLC does offer an application programming interface (API) that downloads to EHRs (there is no upload function available to upload from EHRs into the CSS). There are specific technical specifications that an agency would need to meet to get the API set up on their end, which can be sent if a team is interested in this option.

4. **Could you share more about the targeted population for FFT vs. MST? Why are both required since both EBPs serve the same population?**

   All counties are required to provide MST, FFT, PCIT, and HFW to Medi-Cal members under age 21 pursuant to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements.

   The target population for MST includes youth who are at risk of severe consequences within their family, school, or community due to serious externalizing, anti-social, and/or challenging behaviors.

   The following are indicators that MST may be medically necessary and appropriate:

   - The youth is aged 12 to 17 or of an appropriate developmental age to receive the service.

- The youth exhibits serious externalizing, anti-social, aggressive, and/or criminogenic behaviors that may place the child or youth at risk of out-of-home placement.
- The youth resides in a family, community, or home-like setting that is conducive to a family-focused treatment model.

The target population for FFT includes youth who are at risk or have moderate to severe behavioral or emotional challenges, such as conduct disorder, violent acting-out, substance use, and criminal behavior.

The following are indicators that FFT may be medically necessary and appropriate:

- The youth is aged 11 to 18 or of an appropriate developmental age to receive the service.
- The youth is at risk of or has moderate to severe behavioral or emotional challenges, such as conduct disorder, violent acting-out, substance use disorder (SUD), or delinquency.

Table 1. Key Similarities: MST and FFT EBPs

Key Similarities	
Provider	Single therapist assigned to each case working within a team and supported by an on-site supervisor.
Staff Credentials	Master's level is preferred. Exceptions can be made for highly skilled bachelor's level clinical staff.
Treatment Outcomes	Improved family communication, youth remains in the home/community, and reduction of youth and parent/caregiver risk factors.
Referral Criteria	Youth who exhibit with emotional or behavioral risk factors in the community or at home. These risk factors may have been elevated to "systems of care" involvement (i.e., juvenile justice, child welfare, school).
Cultural Responsiveness	A philosophy/belief system about people which includes a core attitude of respectfulness of individual difference, culture, ethnicity, sexual orientation, gender identity, and family form.
Crisis Prevention	Safety planning to prevent escalation and prepare families to address conflict is embedded within the treatment process.

Table 2. Key Similarities: MST and FFT EBPs

EBP Component	MST	FFT
Service Area	Therapist caseloads are within a 90-minute drive time radius.	Serves families in the agency's catchment area.
Caseload Requirements	Average of 5 families per therapist.	Average of 10 families per therapist.
Definition of "Client"	The entire ecology around the young person with systemic interventions implemented to address priority needs.	FFT is a family therapy model. FFT prioritizes the family as the client; changes are then generalized to other systems involved with the family.
Referral Age Range	12–17-year-olds	11–18-year-olds
Service Delivery	Multiple sessions with the family occur per week as needed to meet the treatment needs.	Sessions occur weekly with families; however, sessions and contact hours per family per week across the course of treatment.
Staff Availability	Expectation that staff will work flexible schedule based upon needs of the family. 24/7 team on-call availability.	Expectation that staff will work flexible schedule based upon needs of the family. No requirement for 24/7 on-call availability.
Staff Employment Status	Full-time therapists with no other duties outside of MST. Supervisor commitment of 50% time per team as a minimum.	Preference is for full-time staff but part-time staff working with a minimum caseload of 5 families is acceptable.
Team Service Capacity	45-60 families per year.	120-160 families per year.

PARENT-CHILD INTERACTION THERAPY (PCIT)

1. **Will PCIT International provide guidance on equipment needed for PCIT, as well as build-out specifications? Does PCIT International have recommended or required equipment?**

   Yes, PCIT International will support providers in understanding infrastructure and equipment needs for PCIT. The Implementation Specialist assigned to the Provider Agency will assist in tailoring the technology recommendations to the particular agency. There are a variety of options and price points for "PCIT Suites," from observation windows to video observation to telehealth platforms, as well as for bug-in-the-ear devices and toys. PCIT International will work with each provider agency to find the best fit for their practice.

ASSERTIVE COMMUNITY TREATMENT (ACT) AND FORENSIC ACT (FACT)

1. **Will there be an ACT and FACT training schedule?**

   Training in core skills and practices underlying ACT and FACT are available on an on-going basis, and providers do not need to complete a specific training prior to starting the delivery of ACT services. Providers may go to PMHP at UCLA's learning center and create a free account. PMHP at UCLA currently has a large array of training resources available, and many more are on the way.

   Providers will need to complete 20 hours of training per year covering the evidence-based approaches and practices comprising the ACT service model. Curricula for specialized roles on the team and for practitioners on FACT teams will also be required. The 40 training hours within the first two years must cover the foundational topics as well as the role-specific and FACT-specific topics.

2. **How does FSP Intensive Case Management (ICM) fit into EBP implementation and COE support?**

   DHCS established FSP ICM as a standardized step-down level from ACT or provided to avert the higher ACT level of care. FSP ICM is for individuals who may not meet ACT eligibility criteria but who still have significant behavioral health needs and can benefit from FSP supports.

   There is no COE for FSP ICM. However, the ACT COE will support counties and practitioners in identifying which individuals are appropriate for ACT and which individuals may be more appropriate for a lower level of care like FSP ICM.

3. **If there are two teams providing ACT in one county, will each team have to individually be certified?**

   Yes, all ACT teams must meet training and fidelity monitoring standards. DHCS is developing guidance that outlines training and fidelity monitoring requirements for counties and EBP practitioners.

4. **How familiar is PMHP at UCLA with small and medium counties? Will PMHP at UCLA be making the effort to understand the counties? What will those efforts be?**

   PMHP at UCLA will use a data-driven approach to examine factors such as population density and geographic features of small and medium counties that will impact implementation considerations such as demand for ACT and FACT, as well as resources and capacity to deliver services. PMHP at UCLA practices a community-partnered approach to support EBP implementation while

responding to the unique needs, learning from our county partners, and understanding preferences and constraints of systems.

5. **Is there an established number of ACT and FACT teams per county (i.e., a minimum standard)?**

   Under the BHSA, all counties must provide ACT, FACT, IPS Supported Employment, and CSC beginning July 2026. As described in the BHSA Policy Manual, between July 1, 2026, and June 30, 2029, all counties must:

   - Participate in ongoing training and technical assistance.
   - Understand gaps to fidelity by December 31, 2027.
   - Complete full fidelity reviews and demonstrate counties are implementing EBPs with fidelity by June 30, 2029.

   DHCS will release additional details about the minimum capacity standards and the timeline for implementing EBPs with fidelity under the BHSA.

6. **Will the COEs be working with counties to create or reformulate the FSP to the Tool for Measurement of ACT (TMACT) model? If so, when will that start?**

   Under the BHSA, all counties are required to provide ACT, FACT, and IPS Supported Employment in their FSP programs and to provide CSC in their Early Intervention programs. DHCS is also establishing training, technical assistance, and fidelity standards for each of these EBPs. COEs will support counties and behavioral health practitioners in meeting these training, technical assistance, and fidelity standards.

   To clarify, TMACT is not an EBP model but rather a validated fidelity tool to support monitoring fidelity of ACT.

   Counties can reach out to COEs to set up a consultation to learn more about these EBPs using the Engagement Initiation Form (EIF).

CLUBHOUSE SERVICES

1. **Is there a deadline to opt into Clubhouse Services as it is optional?**

   There is no deadline to opt in to provide Clubhouse Services under Medi-Cal. Additional information about how to opt in to cover Clubhouse Services is available in BHIN 25-009.

2. **Where in the United States does Clubhouse International have a training center?**

   Clubhouse International is exploring the potential of establishing a California specific training center. Currently, Clubhouse International has five training centers in:

   - Alliance House: Salt Lake City, Utah
   - Fountain House: New York City, New York
   - Gateway: Greenville, South Carolina
   - Genesis Club: Worcester, Massachusetts
   - Independence Center: St. Louis, Missouri

3. **Clubhouses were not part of the listed mandated FSP. Do counties have to offer Clubhouses?**

   No, Clubhouse Services is an optional Medi-Cal benefit that is not required under the BHSA. See BHIN 25-009 for more information about counties can opt to cover Clubhouse Services and other optional Medi-Cal benefits under BH-CONNECT.

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

1. **During a recent Behavioral Health COE webinar, it was shared that CSC serves ages 12 through 40 years old. However, the FEP Fidelity scale states the age range served must be 14 to 65 years old. Will this discrepancy be taken into consideration?**

   CSC is appropriate for any individual for whom the service is medically necessary. Past research indicates that in most cases, CSC is appropriate for adolescents and young adults up to age 40; however, DHCS recognizes that in some cases CSC is appropriate for older adults.

INDIVIDUAL PLACEMENT AND SUPPORT (IPS) MODEL OF SUPPORTED EMPLOYMENT

1. **With IPS required for several other EBPs, how can COEs support counties to determine the most effective approach? For example, in our county we have a stand-alone IPS program that we intend to integrate employment specialists with a variety of other treatment teams across our network of care (ACT providers, CSC, FSP, and outpatient teams), all of which might be operated by different organizational providers. Does this model align with fidelity and with COE ability to coordinate training and technical assistance?**

   The IPS Employment Center recommends that IPS programs closely observe and implement the main principles of IPS and regularly refer to the fidelity tool during implementation for optimal performance. Outstanding programs often foster strong relationships with the COE and technical assistance providers. The IPS Employment Center anticipates a variety of staffing configurations and will work with programs to meet fidelity benchmarks, with training and technical support provided along the way.

   Regarding staffing the IPS program, a good strategy is to determine all the sources that will refer to the IPS program and hire enough employment specialists. Ideally, each employment specialist works with one mental health treatment team, although two is acceptable according to fidelity. It is challenging for one IPS specialist to collaborate with multiple mental health treatment teams, due to the time it takes to attend meetings and the complexity of coordinating with multiple teams and practitioners.

   For effective integration of services, IPS Employment Center recommends that the IPS specialists each have office space with their assigned mental health treatment team(s). IPS specialists will still be supervised by the same IPS supervisor and meet with other IPS specialists on their team weekly, for the vocational unit meeting. Employment specialists typically work closely with about 20 clients at a time.

   This is a complicated question, but the IPS Employment Center will work with each county to discuss different staffing configurations that align with the IPS fidelity approach.

RESOURCES FOR COUNTIES

1. **Where can I access trainings, technical assistance, and fidelity monitoring resources?**

   You can visit the Behavioral Health COE Resource Hub or join the newsletter to stay up to date on COE and EBP resources. Additionally, if you have any questions or feedback, please consider emailing bhcoe.info@dhcs.ca.gov or submitting a Behavioral Health COE Questions & Feedback form.

2. **Can office hours be more frequent if needed?**

   The cadence of office hours will be determined and adjusted based on need and considered within the context of COE-specific training and technical assistance efforts. DHCS and HMA will work with the COEs to determine the appropriate focus and cadence of office hours.

3. **How will counties and practitioners be informed of/invited to Office Hours?**

   Everyone that registered for these webinars will receive information about the Office Hours. County staff and behavioral health practitioners are also encouraged to sign up for the newsletter listserv at this link. Please visit the Events page on the Behavioral Health COE Resource Hub for the latest information on upcoming events.

4. **Can we please make sure that HMA office hours do not overlap with other State office hours?**

   Yes, DHCS and HMA will coordinate to avoid conflicts with existing Office Hours and other meetings.