Behavioral Health & Developmental Disabilities Administration

Michigan Fidelity Assistance & Support Team Training

August 26 & 27, 2019 make up dates: November 20 & 21, 2019

Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

Introductions, Welcome and Housekeeping

Key BHDDA Contacts

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Mark Lowis, Program Specialist
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Karen Cashen, Grants Manager
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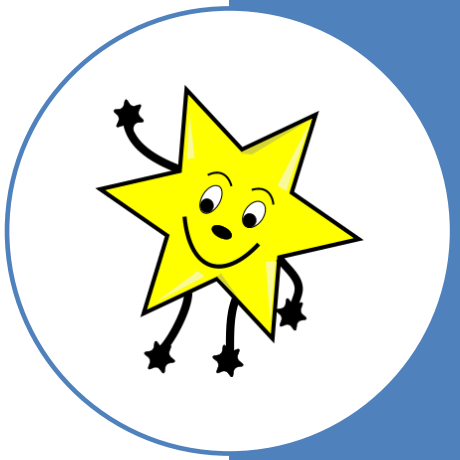


Agenda: Day 1

MIFAST Overview

Recruitment of Reviewers

Etiquette & Do's and Don't's

Process to be Reviewer

Contract Requirements and Reimbursement

Details of What is Involved in Review

Resources to Know

DBT, COD, IDDT and ACT Only:

Brief review of protocols, tools and interview prompts

GOI

Brief Overview of Day 2

MIFAST OVERVIEW

What is MIFAST?

Why do MIFAST?

How is the information used?

Reviewer Recruitment

Process to be a Reviewer
Contract Items and Requirements

- Qualifications and Expectations
  - Lead reviewer
  - Assistant reviewer
  - Shadow
- Annual training
- Quarterly conference call participation

Etiquette

the code of ethical behavior regarding professional practice or action among the members of a profession in their dealings with each other

Do's and Don'ts

Reimbursement

- Invoice Form and Completion *copy of invoice on next page*

- Travel Reimbursement Form and Completion
  - Supporting documentation
  - Maps
  - Detailed receipts (and information needed) include meal amounts and select cities

- Special note about hotel stays
  - April 2018 Overnight Lodging the night before is allowed if traveling 60 miles or more
  - State of Michigan Hotel Listing & Policy Guidelines http://www.michigan.gov/documents/dmb/Active_Hotels_342675_7.pdf?20140906155810s
  - Exception Requests

Community Mental Health Association of Michigan
Training Invoice

FY19 Mental Health and Substance Use Disorder Training and Consulation Services

Training Invoice

To: **Dana Owens**
Community Mental Health Association of Michigan
426 South Walnut Street
Lansing, MI 48933
Email: grantmanager@cmham.org

Date:
Invoice #:

Contractor	Project	Total Contract Amount	Contract Rate
		$ -	

Date	Hours	Service Description	Current Invoice	Billings Year to Date	Remaining Contract Funds
		Billings year-to-date forward		$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			$ -	$ -	$ -
			Total This Period	**Billings Year to Date**	**Remaining Contract Funds**
			$ -	$ -	$ -

Instructions for Invoice Form and Completion

FY19 Mental Health and Substance Use Disorder Training and Consulation Services

Training Invoice

To: **Dana Owens**
Community Mental Health Association of Michigan
426 South Walnut Street
Lansing, MI 48933
Email: grantmanager@mham.org

1 **Date:** 10/25/2018
2 **Invoice #:** JD #2

Vendor	Project Number	Annual Contract Amount	Contract Rate
Jane Doe 3	COD 4	$ 5 10,000.00	$120/hr Lead MIFAST & $45/hr Assistant MIFAST Reviewer + travel expenses 6

Date	Hours	Service Description	Current Invoice	Billings Year to Date	Remaining Contract Funds
		Billings year-to-date forward		$ 7b 500.00	$ 9,500.00
8 10/15/2018	9 8	10 AST Visit Lapeer CMH & expense voucher	$ 11 540.00	$ 12 540.00	$ 8,960.00
13 10/24/2018	8	MIFAST Visit Macomb CMH - Lead	$ 960.00	$ 960.00	$ 8,000.00
			$ -	$ -	$ 8,000.00
			$ -	$ -	$ 8,000.00
			$ -	$ -	$ 8,000.00
			$ -	$ -	$ 8,000.00
			$ -	$ -	$ 8,000.00
			$ -	$ -	$ 8,000.00
			$ -	$ -	$ 8,000.00
			$ -	$ -	$ 8,000.00
			$ -	$ -	$ 8,000.00
			$ -	$ -	$ 8,000.00
			Total This Period	**Billings Year to Date**	**Remaining Contract Funds**
			$ 14 1,500.00	$ 7a 2,000.00	$ 15 8,000.00

Instructions for Invoice Form and Completion

Step	Description
1	Fill in the date of the invoice.
2	Fill in the invoice number, if applicable.
3	Fill in the contractor name.
4	Fill in the project name.
5	Fill in your total contract amount. Once this amount is filled out you will notice the "Remaining Contract Funds" line will populate down the page.
6	Fill in contract rate.
	If you are using this sheet for the 1st time, SKIP STEP #7 and go directly to step #8.
7	a) Look at the previous invoice, find the dollar figure under "Billings Year-to-Date" at the bottom of the invoice.
	b) Enter the amount in 7b.
8	Fill in date of service.
9	Fill in hours, if appplicable.
10	Fill in service description.
11	Fill in the current invoice amount.
12	Fill in the billings year to date column.
13	For additional expenses, repeat steps 8 - 11.
14	Once the invoice has been filled out, the invoice total will populate under "Total This Period".
15	Once the invoice has been filled out, the "Billings Year-to-Date" will populate.
16	Once the invoice has been filled out, the "Remaining Contract Funds" will populate.

Travel Reimbursement Form

TRAVEL POLICIES & EXPENSE VOUCHER – FY19 GRANTS

Community Mental Health Association of Michigan
426 S. Walnut Street, Lansing, MI 48933
Phone: (517) 374-6848
Fax: (517) 374-1053
Email: grantmanager@cmham.org

First & Last Name:	
Make Check Payable To:	
If Receiving an Honorarium, Social Security or Federal ID #:	
Address to Mail Check:	
Project/Training Name:	
Project/Training Date:	
Project/Training Location (City):	

CMHAM Internal Use Ony: Account#: Staff Initials: Date:

			Amount
Honorarium/Contract Fee:			$ -
Travel:	0	# of miles at IRS approved rate ***(.58 new rate as of 1/1/2019)*** (Mapping documentation i.e. Google, Map Quest, etc. is REQUIRED)	$ -
Parking/Tolls:		(Detailed receipts are required)	$ -
Air Fare:		Standard Coach Rate (Detailed receipts are required)	$ -
Car Rental:		(Detailed receipts are required)	$ -
Lodging:	0	Number of nights at $85.00 per night ***(New rate as of 1/1/2019)***	$ -
	0	Hotel Taxes/Resort Fee (Detailed receipts are required)	$ -
Meals:	0	# of Breakfast(s) (Actual cost only; not to exceed $8.50)	$ -
	0	# of Lunch(s) (Actual cost only; not to exceed $8.50)	$ -
	0	# of Dinner(s) (Actual cost only; not to exceed $19.00)	$ -
		Detailed receipts are required; NOT the credit card summary top sheet.	
Miscellaneous			$ -
Miscellaneous			$ -
Miscellaneous			$ -
Total:			$ -

I hereby attest that the travel related expenses reported herein are true and accurate and are submitted in accordance with the MACMHB Travel Policy. It is expected that vouchers will be prepared and submitted within 60 days after any conference/training/meeting attended. Vouchers submitted after 60 days may not be reimbursed.

Date:	Signature:

Instructions for Travel Voucher

***Detailed* receipts must be submitted for all requests.**

TRANSPORTATION BY AUTO:

- Mileage reimbursement request **must be accompanied by mapping documentation** (i.e. Map Quest, Google, etc) printout showing actual mileage. Mileage reimbursement will be at the federal reimbursement rate allowed by the IRS. Rate from 10/01/18 - 12/31/18 is .545 cents a mile. New rate beginning 1/1/19 is .58 cents a mile.
- Rental car (**requires pre authorization):** reserve an economy or standard vehicle. *Luxury cars, SUVs, sports cars, limousines, etc. will not be reimbursed.*

TRANSPORTATION BY AIR:

- All travelers should purchase the least expensive fare available on any one flight (first class airfare or preferred seating is not allowed); detailed receipts must be submitted for common carrier or chartered air travel; whenever meals are served on planes, the traveler shall not be entitled to any meal allowance for those meals.
- Receipts for baggage fees must also be submitted.

HOTEL:

Commuting vs. Staying Overnight

- When the business need is a one-day event, overnight stays within 60 miles of the contractor's home or workstation, whichever is less, **are not reimbursable.**
- When a work assignment to the field will require more than one consecutive day's effort, an overnight stay is reimbursable for destinations 60 or more miles away from either the contractor's home or workstation (whichever is less) only for the consecutive night(s) during the business need.
- The nights prior to the business starting and after the business has been completed are not approved for overnight reimbursement under 60 miles from either the employee's home or workstation (whichever is less).
- When making hotel reservations, you are required to book at the Michigan state rate of $85/night (new rate as of 1/1/2019) + hotel taxes. If the state rate is not available, you must receive prior approval for a higher room rate. **A copy of the detailed hotel bill is required for reimbursement**.
- No incidentals will be reimbursed (housekeeping tips, movies, fitness club, etc.).

State of Michigan Hotel Listing & Policy Guidelines Website Address

https://www.michigan.gov/documents/dmb/Active_Hotels_342675_7.pdf?20140906155810s

Instructions for Travel Voucher Continued

MEALS:

- **Detailed receipts for meals are required: credit card summary top receipts will NOT be accepted.**
- For food and beverage items, you can be reimbursed for a "tip" of no more than 20% as long as the overall cost of the meal and tip together does not exceed maximum state meal reimbursement.
- Charges for alcoholic beverages are not reimbursable.
- No "bulk" purchases of food are allowed. Meals must be from a restaurant, not a grocery store.
- Whenever meals are served as part of the conference/training/meeting, the traveler shall not be entitled to any meal allowance for those meals.
- If receipts are submitted for a higher amount than shown above, you will only be reimbursed for the appropriate amount listed as per the allowance for individual meals schedule above.

Select Cities:

When meetings are held in Ann Arbor, Auburn Hills, Detroit, Grand Rapids, Holland, Mackinac Island, Petoskey, Pontiac, South Haven, Traverse City, Leland, all of Wayne and Oakland County, the following maximum rates apply: breakfast maximum of $10.25; lunch maximum of $10.25; dinner maximum of $24.25.

Individual meal reimbursement will be based on the following schedule:

Breakfast -- When travel commences prior to 6:00 a.m. and extends beyond 8:30am
Lunch -- When travel commences prior to 11:30 a.m. and extends beyond 2:00pm
Dinner -- When travel commences prior to 6:30 p.m. and extends beyond 8:00pm

Travel Reimbursement Form and Completion Check List

- Supporting documentation
- Maps for mileage
- Receipts (and information needed) include meal amounts and select cities

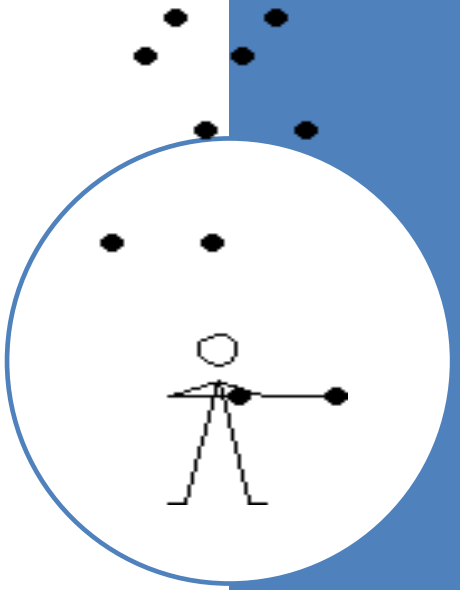
So–

What is Involved in a visit?

(and who..what..where..why..when..?)

- Initial contacts for launching the process
- MDHHS-MIFAST@Michigan.gov
- Pre-Visit Consultation Call with Agency
- MIFAST Site Visit
  - Lead Reviewer (paid at contract rate)
  - Assistant reviewer if needed (paid at contract rate)
  - Shadowing for training (unpaid except travel)
- Report
  - Consensus meeting/discussion for scoring
  - Final Submission
  - Contracts will specify what you can invoice for
- Post-Visit Consultation
- Technical Assistance (must submit event documentation with invoice)
- Follow-Up

(all activities are discussed with and pre-approved by the CPI Lead Staff)



Summary
(So far….)

- Timeframes
- Structure
- Expectations

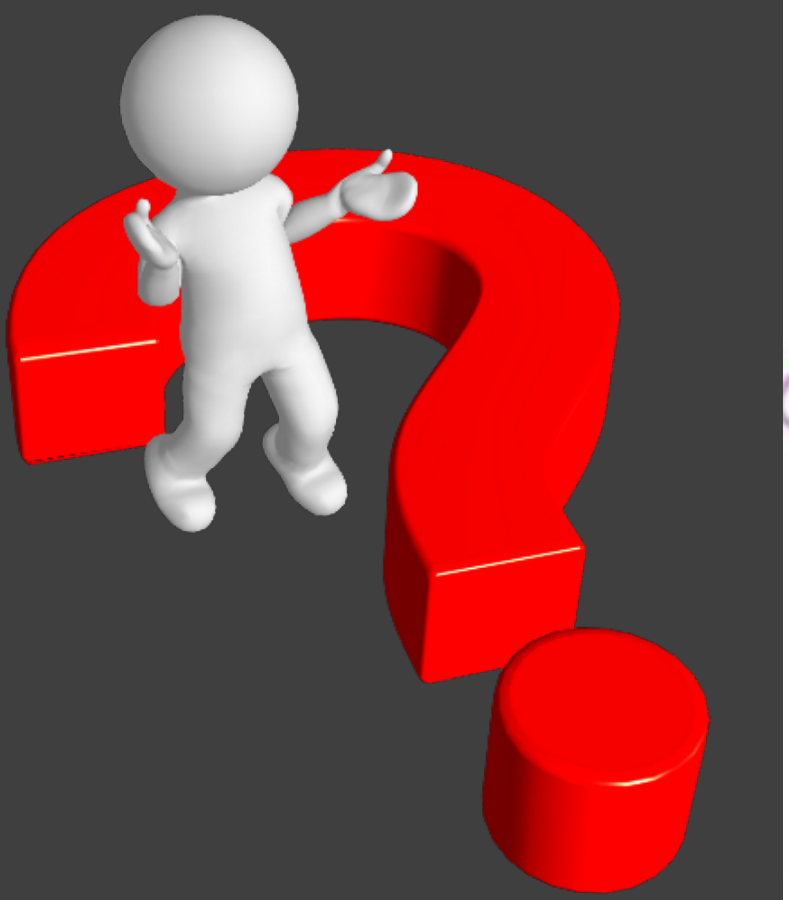
Resources to Know

Michigan Medicaid Provider Manual (current version)

SAMHSA Toolkits

Find Most Current MIFAST Visit Prep Materials on imp

Pathways to a MiFAST Visit-



Questions

DBT, COD, IDDT, and ACT Reviewers

You get to stay!

DBT, COD, IDDT, and ACT Reviewers

- Brief review of protocols
- Brief review of tools
- Interview prompts

Global Organization Index (GOI)

- G1 Program Philosophy
- G2 Eligibility or Consumer Identification
- G3 Penetration
- G4 Assessment
- G5 Individualized Treatment Plan
- G6 Individualized Treatment
- G7 Training
- G8 Supervision
- G9 Process Monitoring
- G10 Outcome Monitoring
- G11 Quality Assurance (QA)
- G12 Personal Choice Regarding Service Provision

MIFAST Scoring Inter-Rater Reliability Process

- Objectives: For each element:
  - Define the element
  - Give clear rationale as to why the element is necessary to establish fidelity
  - Describe the sources of information or evidence needed to complete scoring
  - Give an example of each level of scoring
  - Discuss with the wider group

G1 Program Philosophy

- No more than 1 of 5 sources shows clear understanding of program philosophy or All sources have numerous major areas of Discrepancy
- 2 of 5 sources show a clear understanding of program Philosophy or all sources have several major areas of discrepancy
- 3 of 5 sources have a clear understanding of program philosophy or Sources mostly aligned to program philosophy but have 1 major area of discrepancy
- 4 of 5 resources show clear understanding of program philosophy or sources mostly aligned to program philosophy, but have 1 or 2 major areas of discrepancy
- All 5 sources show clear understanding and commitment to program philosophy

G2. Eligibility/Client Identification

- 20% of people receive standardized screening and/or agency DOES NOT systematically track eligibility
- 21-40% of people receive standardized screening and agency systematically tracts eligibility
- 41-60% of people receive standardized screening and agency systematically tracks eligibility
- 61-80% of people receive standardized screening and agency systematically tracks eligibility
- >80% of people receive standardized screening and agency tracks eligibility

G3 Penetration

- Ratio: 20%
- Ratio: 21-40%
- Ratio: 41-60%
- Ratio: 61-80%
- Ratio: >80%

G4 Assessment

- Assessments are completely absent or completely non-standardized
- Pervasive deficiencies in 2 of the following: Standardization, Quality of assessments, Timeliness, Comprehensiveness
- Pervasive deficiencies in 1 of the following: Standardization, Quality of assessments, Timeliness, Comprehensiveness
- 61-80% of participants receive standardized, high-quality assessments at least annually or information is deficient for 1 or 2 assessment domains
- 80% of participants receive standardized, high-quality assessments; the information is comprehensive across all domains and updated a least annually

G5 Individualized Treatment Plan

- 20% of participants in EBP services have explicit individualized treatment plans, related to EBP, updated every 3 months
- 21% - 40% of participants in EBP services have explicit individualized treatment plans, related to EBP, updated every 3 months
- 41% - 60% of participants in EBP services have explicit individualized treatment plans, related to EBP, updated every 3 months or Individualized treatment plan updated every 6 months for all consumers
- 61% 80% of participants in EBP services have explicit individualized treatment plans, related to EBP, updated every 3 months
- >80% of participants in EBP services have explicit individualized treatment plans related to EBP, updated every 3 months

G6 Individualized Treatment

- 20% of participants in EBP services receive individualized services meeting goals of the EBP
- 21% - 40% of participants in EBP services receive individualized services meeting goals of EBP
- 41% - 60% of participants in EBP services receive individualized services meeting goals of EBP
- 61% - 80% of participants in EBP services receive individualized services meeting goals of EBP
- >8040% of participants in EBP services receive individualized services meeting goals of EBP

G7 Training

- <20% of program staff receive standardized training annually
- 21% - 40% of program staff receive standardized training annually
- 41% - 60% of program staff receive standardized training annually
- 61% - 80% of program staff receive standardized training annually
- >80% of program staff receive standardized training annually

G8 Supervision

- <20% of EBP practitioners receive supervision
- 21% - 40% of EBP practitioners receive weekly structured, consumer-centered supervision or all EBP practitioners receive informal supervision
- 41% - 60% of EBP practitioners receive weekly structured, consumer-centered supervision or all EBP practitioners receive informal supervision
- 61% - 80% of EBP practitioners receive weekly structured, consumer-centered supervision or all EBP practitioners receive informal supervision
- >80% of EBP practitioners receive weekly structured, consumer-centered supervision or all EBP practitioners receive informal supervision

G9 Process Monitoring

- No attempt at monitoring process is made
- Informal process monitoring is used at least annually
- Process monitoring is deficient on 2 of these 3 criteria: Comprehensive and standardized, Completed every 6 months, Used to guide program improvements or Standardized monitoring is done annually only
- Process monitoring is deficient in 1 of these criteria: Comprehensive and standardized, Completed every 6 moths, Used to guide program improvements
- Standardized comprehensive process monitoring occurs at least every 6 months and is used to guide program improvements

G10 Outcome Monitoring

- No outcome monitoring occurs
- Outcome monitoring occurs at least 1 time per year but results are not shared with EBP practitioners
- Outcome monitoring occurs at least 2 times per year but results are not shared with EBP practitioners
- Standardized outcome monitoring occurs at least 2 times per year and results are shared with practitioners
- Standardized outcome monitoring occurs quarterly and results are shared with practitioners

G11 Quality Assurance

- No review or no committee
- QA committee has been formed but reviewing EBP less than annually
- Explicit QA review occurs less than annually or QA review is superficial
- Explicit QA review occurs annually
- Explicit QA review occurs every 6 months by QA group or steering committee for EBP

G12 Personal Choice Regarding Service Provision

- Person-centered services are absent
- Few sources agree that type and frequency of EBP services reflect consumer choice
- Half of the sources agree that type and frequency of EBP services reflect consumer choice
- Most sources agree that type and frequency of EBP services reflect consumer choice or Agency fully embraces consumer choice with one exception
- All sources agree that type and frequency of EBP services reflect consumer choice

Questions and Summary of Day 1

SEE YOU TOMORROW

Brief Overview of Day 2

Focus on COD, ACT, IDDT, and ACT/IDDT

- In-depth review of tool
- In-depth protocols
- Activities to practice reviewer skills
- Videos for group work to rank

Practice and Discussion

The MiFAST Tool

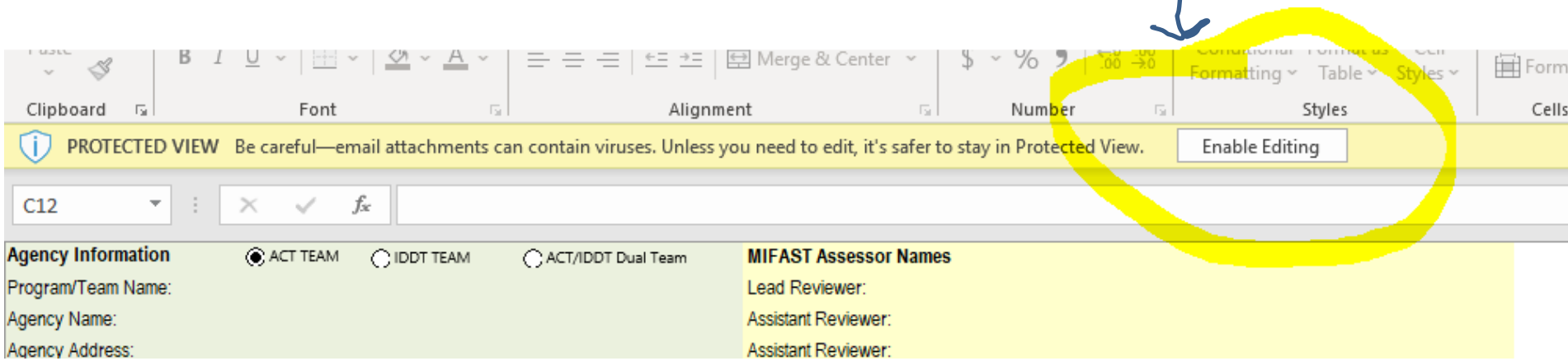
Measures How Closely the Practice Reflects the Model

ACT Teams

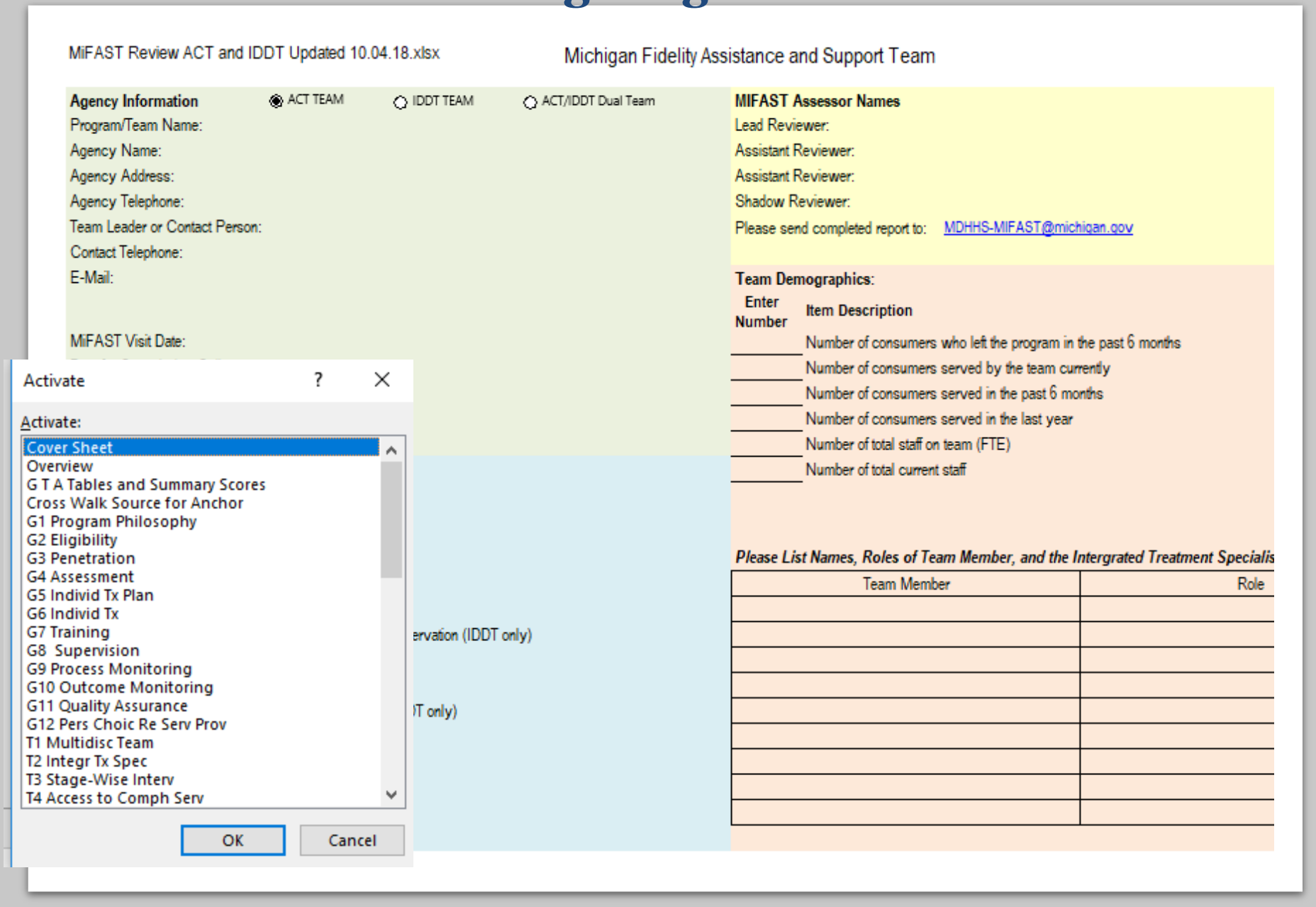
ACT/IDDT Teams

IDDT Teams

When you open the current excel tool- Do this first:



Navigating


MiFAST Review ACT and IDDT Updated 10.04.18.xlsx
Michigan Fidelity Assistance and Support Team
Agency Information
ACT TEAM
IDDT TEAM
ACT/IDDT Dual Team
Program/Team Name:
Agency Name:
Agency Address:
Agency Telephone:
Team Leader or Contact Person:
Contact Telephone:
E-Mail:
MiFAST Visit Date:
MIFAST Assessor Names
Lead Reviewer:
Assistant Reviewer:
Assistant Reviewer:
Shadow Reviewer:
Please send completed report to: MDHHS-MIFAST@michigan.gov
Team Demographics:
Enter Number
Item Description
Number of consumers who left the program in the past 6 months
Number of consumers served by the team currently
Number of consumers served in the past 6 months
Number of consumers served in the last year
Number of total staff on team (FTE)
Number of total current staff
Please List Names, Roles of Team Member, and the Intergrated Treatment Specialis
Team Member
Role
Activate
Activate:
Cover Sheet
Overview
G T A Tables and Summary Scores
Cross Walk Source for Anchor
G1 Program Philosophy
G2 Eligibility
G3 Penetration
G4 Assessment
G5 Individ Tx Plan
G6 Individ Tx
G7 Training
G8 Supervision
G9 Process Monitoring
G10 Outcome Monitoring
G11 Quality Assurance
G12 Pers Choic Re Serv Prov
T1 Multidisc Team
T2 Integr Tx Spec
T3 Stage-Wise Interv
T4 Access to Comph Serv
OK
Cancel

Navigating

MiFAST Review ACT and IDDT Updated 10.04.18.xlsx

Michigan Fidelity Assistance and Support Team

Agency Information ◉ ACT TEAM ○ IDDT TEAM ○ ACT/IDDT Dual Team

Program/Team Name:
Agency Name:
Agency Address:
Agency Telephone:
Team Leader or Contact Person:
Contact Telephone:
E-Mail:

MiFAST Visit Date:
Date for Consultative Call:
Date Program/Team Started:

MIFAST Assessor Names

Lead Reviewer:
Assistant Reviewer:
Assistant Reviewer:
Shadow Reviewer:
Please send completed report to: MDHHS-MIFAST@michigan.gov

Team Demographics:

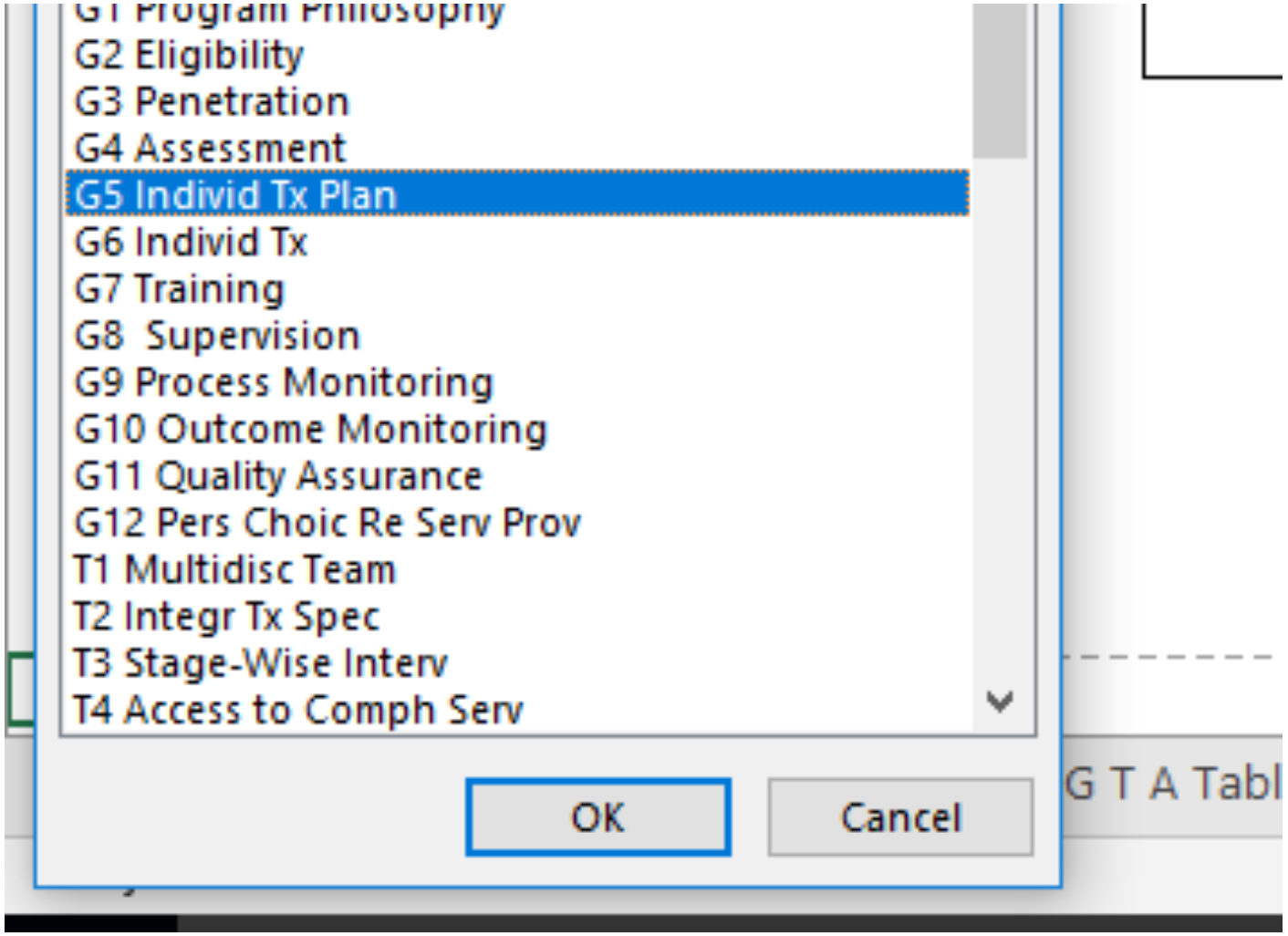
Enter Number	Item Description
	Number of consumers who left the program in the past 6 months
	Number of consumers served by the team currently
	Number of consumers served in the past 6 months
	Number of consumers served in the last year
	Number of total staff on team (FTE)
	Number of total current staff

Information Sources used for fidelity visit:

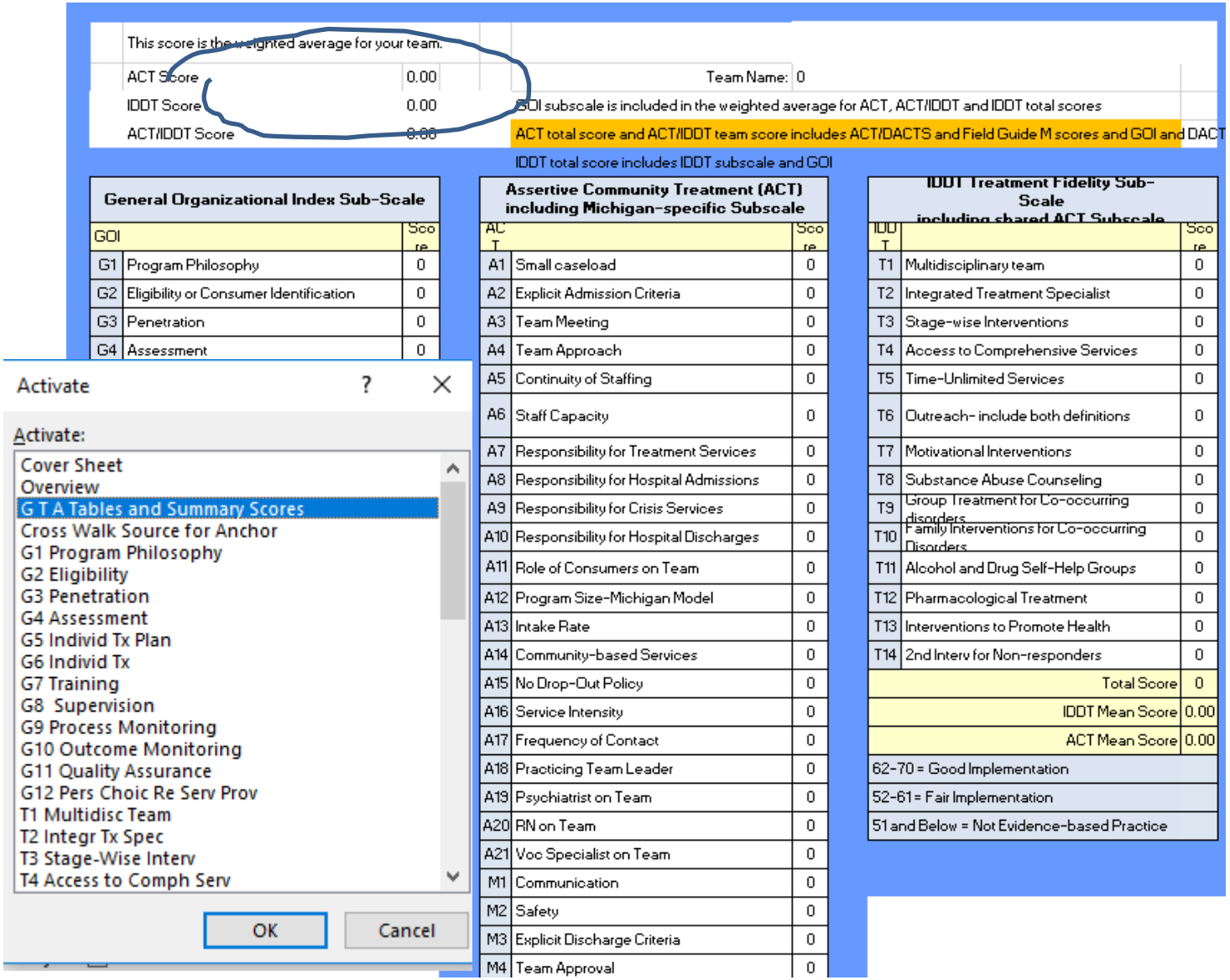
Enter Number	Item Description
	Chart Review
	Treatment Team Meeting Observation
	Supervisory Meeting Obseravation
	Group or Individual Counseling Session Observation (IDDT only)
	Program Leader Interview
	ACT Team Interviews
	Integrated Treatment Specialist Interview (IDDT only)
	Consumer Interviews
	Family Member Interviews
	Other Staff Interviews
	Brochure Review
	Other (List): Description

Please List Names, Roles of Team Member, and the Intergrated Treatment Specialis

Team Member	Role

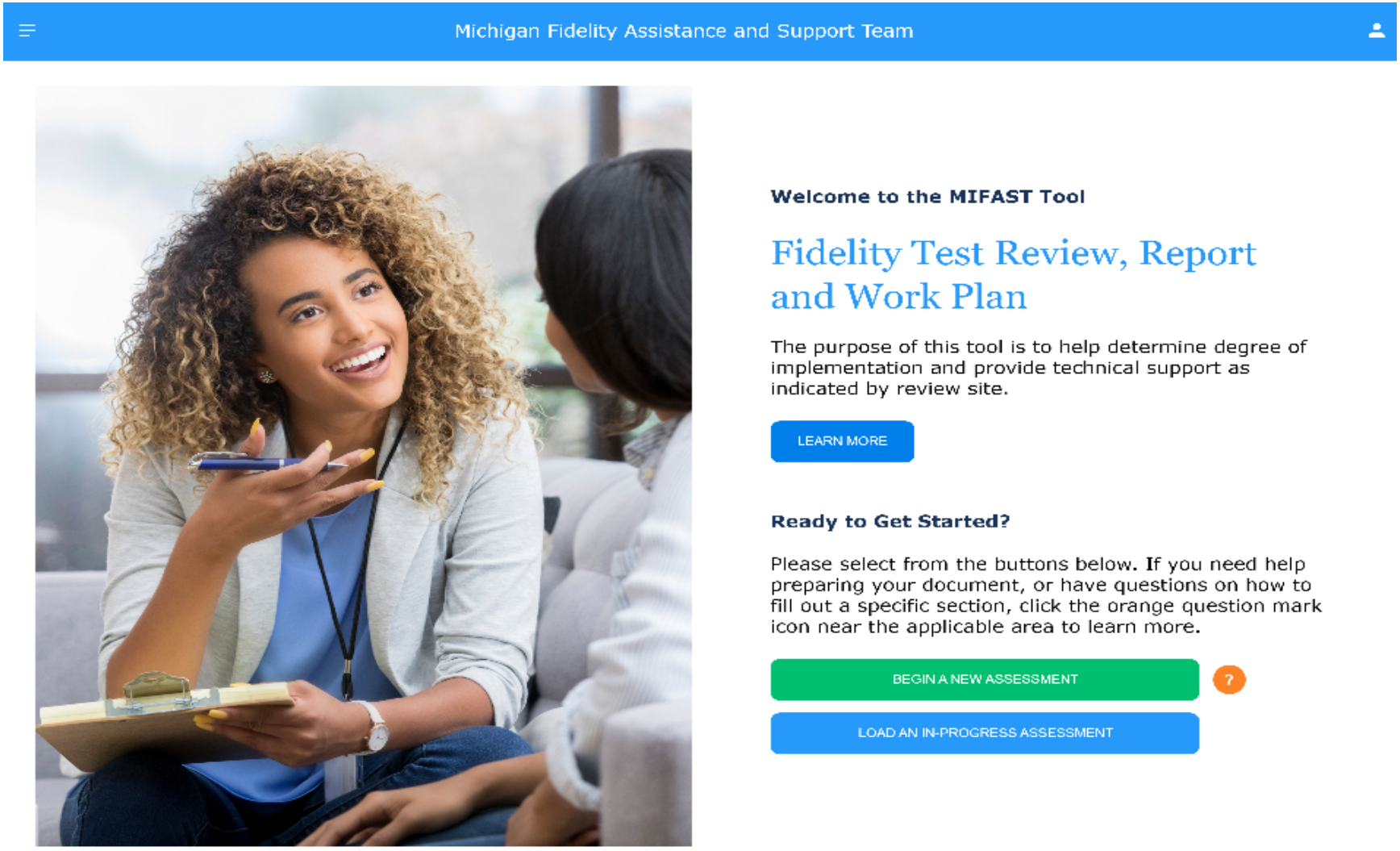

G1 Program Philosophy
G2 Eligibility
G3 Penetration
G4 Assessment
G5 Individ Tx Plan
G6 Individ Tx
G7 Training
G8 Supervision
G9 Process Monitoring
G10 Outcome Monitoring
G11 Quality Assurance
G12 Pers Choic Re Serv Prov
T1 Multidisc Team
T2 Integr Tx Spec
T3 Stage-Wise Interv
T4 Access to Comph Serv
OK
Cancel
G T A Tabl

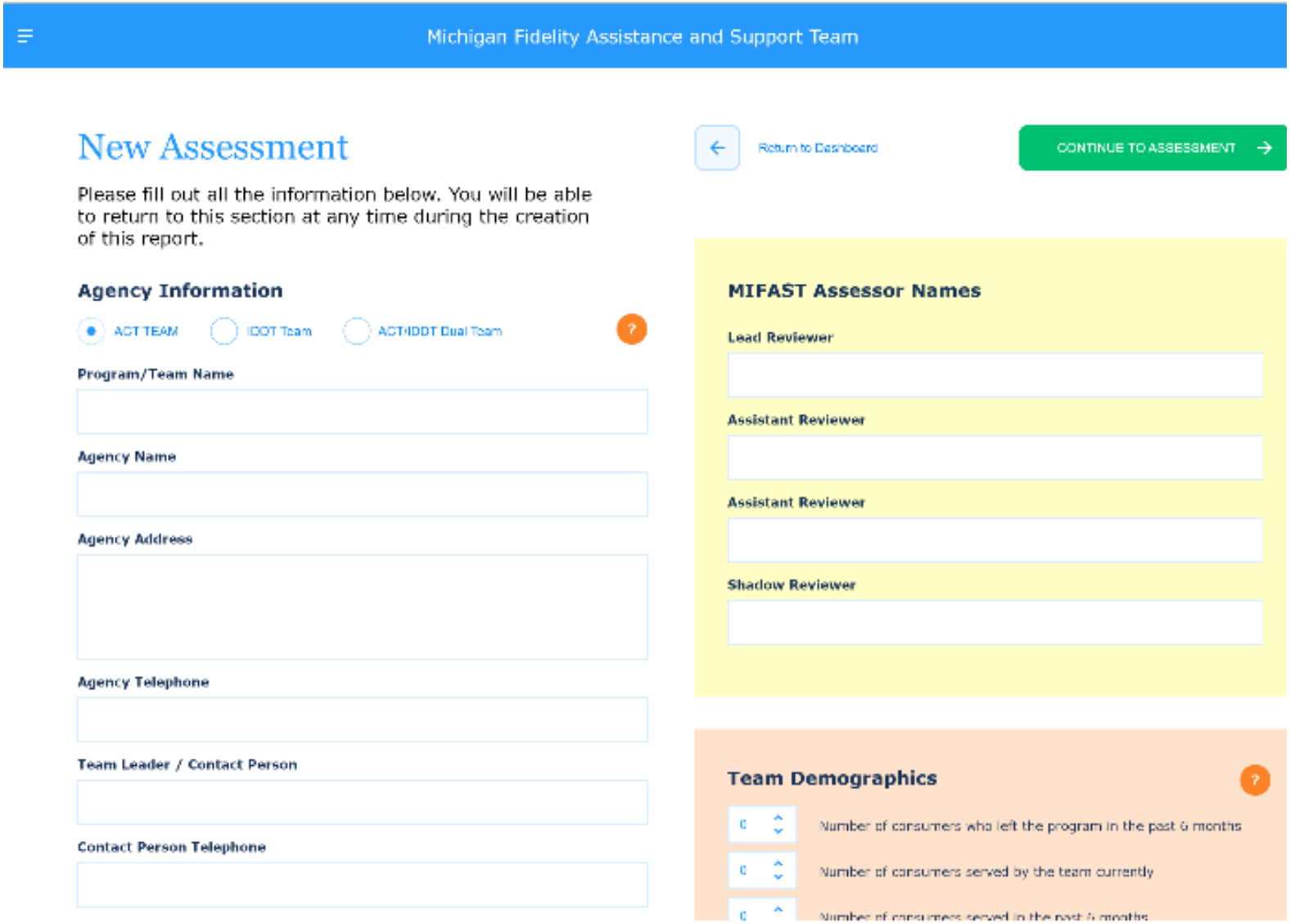
Item	Definition		Rationale	
G5. Individualized Treatment Plan	For all EBP people, an explicit, individualized treatment plan exists (even if it is not called this) related to the EBP that is consistent with assessment and updated every 3 months. "Individualized" means that goals, steps to reaching the goals, services and interventions, and intensity of involvement are unique to this person. Plans that are the same or similar across participants are not individualized. One test is to place a treatment plan without identifying information in front of the supervisor and see if they can identify the person.		Core values of EBP include individualizing services and supporting pursuit of a person's goals and progress in their recovery at their own pace. Therefore, the treatment plan needs ongoing evaluation and modification.	
Questions to ask when completing scoring:	1) (Consumer interview) What are the goals in your life? How did the team help you develop those? How are they helping you meet your goals? 2) (Team member interviews) What is your process of treatment provision with consumers? Who all is involved? How do you provide services to people who are early stage readiness or resistant to services? 3) (Senior staff interview) What innovations has your organization come up with to provide ACT/IDDT consumers with the best care possible? What partners have you developed in the community to accomplish this? 4) (Clinical records review) Look for evidence that treatment is stage-matched and individualized. Look for evidence that there are attempts to provide innovative and creative services to meet the needs of consumers.			
Ratings/Anchors			Place 1-5 Rated Score here:	
1.	2.	3.	4.	
20% of participants in EBP services have explicit individualized treatment plans, related to EBP, updated every 3 months	21% - 40% of participants in EBP services have explicit individualized treatment plans, related to EBP, updated every 3 months	41% - 60% of participants in EBP services have explicit individualized treatment plans, related to EBP, updated every 3 months Or Individualized treatment plan updated every 6 months for all consumers	61% - 80% of participants in EBP services have explicit individualized treatment plans, related to EBP, updated every 3 months	>80% of participants in EBP services have explicit individualized treatment plans related to EBP, updated every 3 months
Note Strengths:				
Recommendations (None if the score is a 5):				
Work Plan Activity Log - Based upon Score and Recommendations:				


This score is the weighted average for your team.
ACT Score 0.00
IDDT Score 0.00
ACT/IDDT Score 0.00
Team Name: 0
GOI subscale is included in the weighted average for ACT, ACT/IDDT and IDDT total scores
ACT total score and ACT/IDDT team score includes ACT/DACTS and Field Guide M scores and GOI and DACT
IDDT total score includes IDDT subscale and GOI
General Organizational Index Sub-Scale
GOI Score
G1 Program Philosophy 0
G2 Eligibility or Consumer Identification 0
G3 Penetration 0
G4 Assessment 0
Assertive Community Treatment (ACT) including Michigan-specific Subscale
ACT Score
A1 Small caseload 0
A2 Explicit Admission Criteria 0
A3 Team Meeting 0
A4 Team Approach 0
A5 Continuity of Staffing 0
A6 Staff Capacity 0
A7 Responsibility for Treatment Services 0
A8 Responsibility for Hospital Admissions 0
A9 Responsibility for Crisis Services 0
A10 Responsibility for Hospital Discharges 0
A11 Role of Consumers on Team 0
A12 Program Size-Michigan Model 0
A13 Intake Rate 0
A14 Community-based Services 0
A15 No Drop-Out Policy 0
A16 Service Intensity 0
A17 Frequency of Contact 0
A18 Practicing Team Leader 0
A19 Psychiatrist on Team 0
A20 RN on Team 0
A21 Voc Specialist on Team 0
M1 Communication 0
M2 Safety 0
M3 Explicit Discharge Criteria 0
M4 Team Approval 0
IDDT Treatment Fidelity Sub-Scale including shared ACT Subscale
IDDT Score
T1 Multidisciplinary team 0
T2 Integrated Treatment Specialist 0
T3 Stage-wise Interventions 0
T4 Access to Comprehensive Services 0
T5 Time-Unlimited Services 0
T6 Outreach- include both definitions 0
T7 Motivational Interventions 0
T8 Substance Abuse Counseling 0
T9 Group Treatment for Co-occurring disorders 0
T10 Family Interventions for Co-occurring Disorders 0
T11 Alcohol and Drug Self-Help Groups 0
T12 Pharmacological Treatment 0
T13 Interventions to Promote Health 0
T14 2nd Interv for Non-responders 0
Total Score 0
IDDT Mean Score 0.00
ACT Mean Score 0.00
62-70 = Good Implementation
52-61 = Fair Implementation
51 and Below = Not Evidence-based Practice
Activate
Activate:
Cover Sheet
Overview
G T A Tables and Summary Scores
Cross Walk Source for Anchor
G1 Program Philosophy
G2 Eligibility
G3 Penetration
G4 Assessment
G5 Individ Tx Plan
G6 Individ Tx
G7 Training
G8 Supervision
G9 Process Monitoring
G10 Outcome Monitoring
G11 Quality Assurance
G12 Pers Choic Re Serv Prov
T1 Multidisc Team
T2 Integr Tx Spec
T3 Stage-Wise Interv
T4 Access to Comph Serv
OK
Cancel

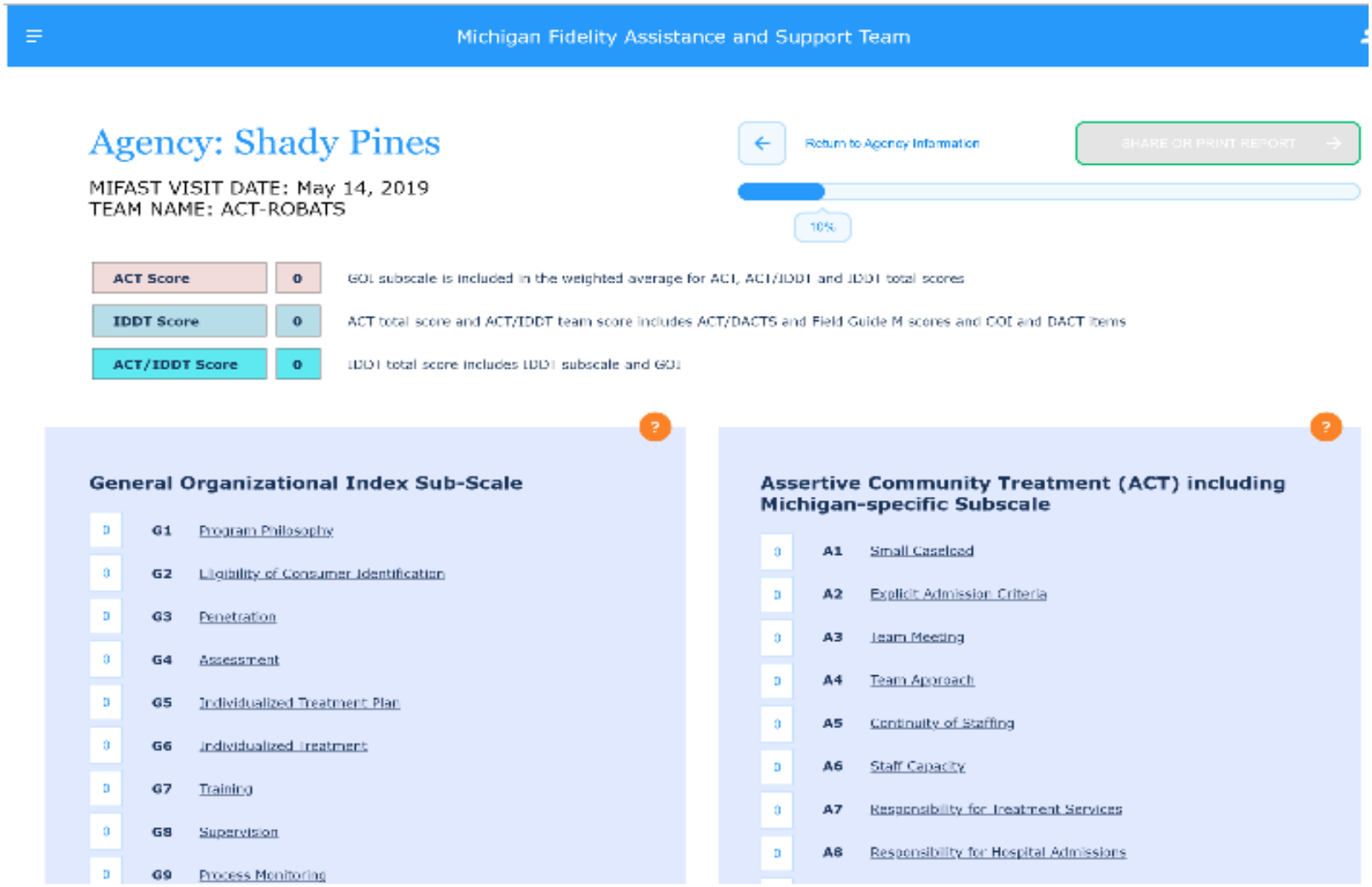
Cross Walk Source for Anchor/Item	MIFAST Tool	ACT SAMHSA EBP Toolkit	IDDT SAMHSA EBP Toolkit	Michigan Field Guide to ACT			MA Manu
Program Philosophy	G1	G1	G1				4.3
Eligibility or Consumer Identification	G2	G2	G2	PPP2			4.4
Penetration	G3	G3	G3				
Assessment	G4	G4	G4				
Individualized Treatment Plan	G5	G5	G5	PPP7	ATP1		4.4
Individualized Treatment	G6	G6	G6				4.4
Training	G7	G7	G7	TF8			4.3
Supervision	G8	G8	G8				
Process Monitoring	G9	G9	G9				
Outcome Monitoring	G10	G10	G10				
Quality Assurance (QA)	G11	G11	G11				
Personal Choice Regarding Service Prov	G12	G12	G12				
Small Caseload/ Provider Ratio	A1	H1		TF6			4.3
Explicit Adm Criteria	A2	O1		PPP2			4.4
Team Meeting	A3	H3		TF3	TF4	TF5	4.3
Team Approach	A4	H2		TF1	TF2	PI2	4.3
Staffing Continuity	A5	H5,		TF9			

The MiFAST Tool- under development

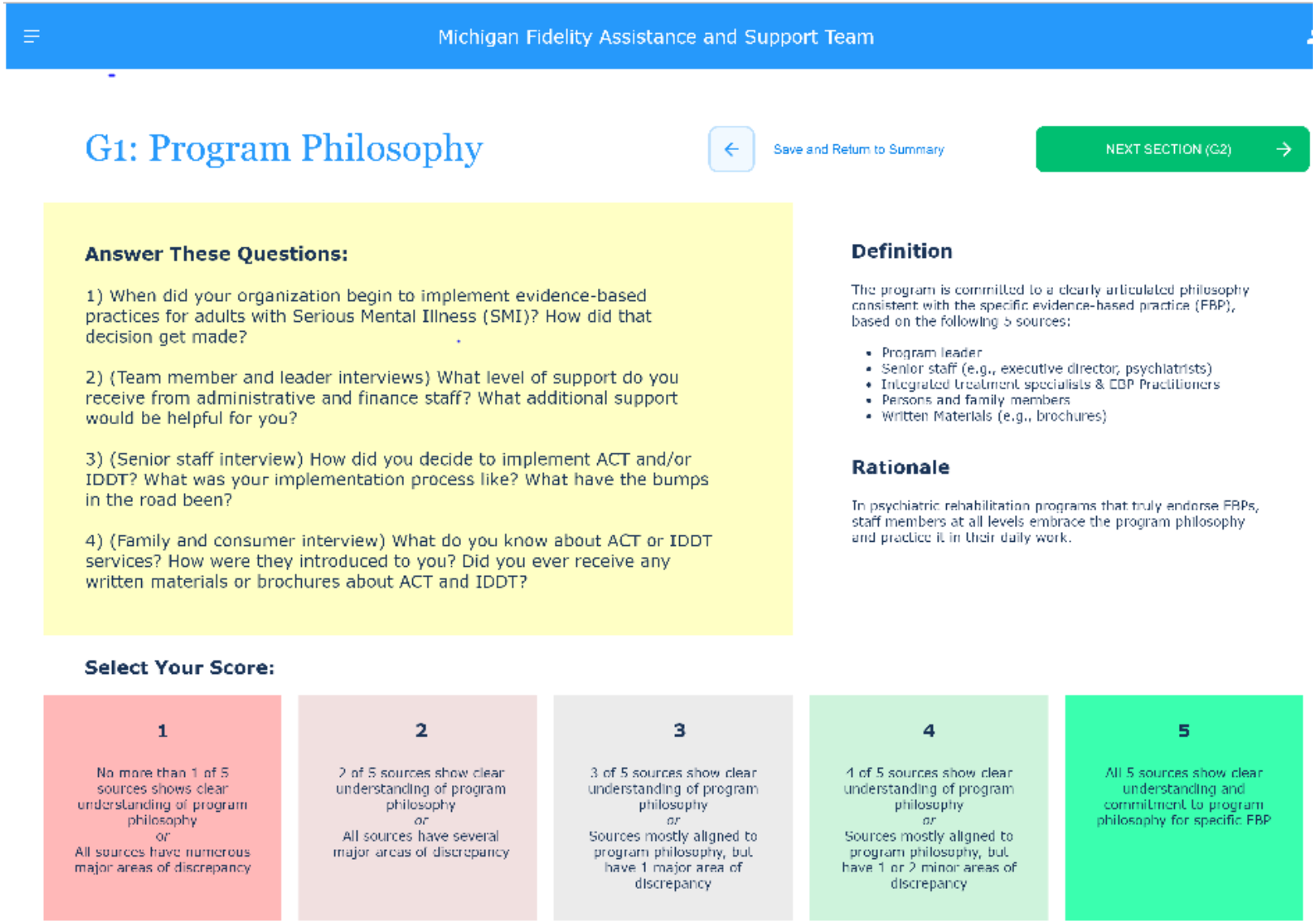



Michigan Fidelity Assistance and Support Team
New Assessment
Please fill out all the information below. You will be able to return to this section at any time during the creation of this report.
Return to Dashboard
CONTINUE TO ASSESSMENT
Agency Information
ACT TEAM
IDDT Team
ACT/IDDT Dual Team
Program/Team Name
Agency Name
Agency Address
Agency Telephone
Team Leader / Contact Person
Contact Person Telephone
MIFAST Assessor Names
Lead Reviewer
Assistant Reviewer
Assistant Reviewer
Shadow Reviewer
Team Demographics
Number of consumers who left the program in the past 6 months
Number of consumers served by the team currently

Navigating the MiFAST Tool (example G1; 1 of 5 slides)



Navigating the MiFAST Tool continued- using G1 2 of 5 slides



Navigating the MiFAST Tool continued- using G1 3 of 5 slides

Select Your Score:

1	2	3	4	5
No more than 1 of 5 sources shows clear understanding of program philosophy *or* All sources have numerous major areas of discrepancy	2 of 5 sources show clear understanding of program philosophy *or* All sources have several major areas of discrepancy	3 of 5 sources show clear understanding of program philosophy *or* Sources mostly aligned to program philosophy, but have 1 major area of discrepancy	4 of 5 sources show clear understanding of program philosophy *or* Sources mostly aligned to program philosophy, but have 1 or 2 minor areas of discrepancy	All 5 sources show clear understanding and commitment to program philosophy for specific FBP

Note Strengths:

Recommendations (not necessary if score is a 5)

Work Plan Activity Log - Based upon Score and Recommmendations

Navigating the MiFAST Tool continued- using G1 4 of 5 slides

G1: Program Philosophy

Save and Return to Summary

NEXT SECTION (G2)

Answer These Questions:

1) When did your organization begin to implement evidence-based practices for adults with Serious Mental Illness (SMI)? How did that decision get made?

2) (Team member and leader interviews) What level of support do you receive from administrative and finance staff? What additional support would be helpful for you?

3) (Senior staff interview) How did you decide to implement ACT and/or IDDT? What was your implementation process like? What have the bumps in the road been?

4) (Family and consumer interview) What do you know about ACT or IDDT services? How were they introduced to you? Did you ever receive any written materials or brochures about ACT and IDDT?

Definition

The program is committed to a clearly articulated philosophy consistent with the specific evidence-based practice (EBP), based on the following 5 sources:

- Program leader
- Senior staff (e.g., executive director, psychiatrists)
- Integrated treatment specialists & EBP Practitioners
- Persons and family members
- Written Materials (e.g., brochures)

Rationale

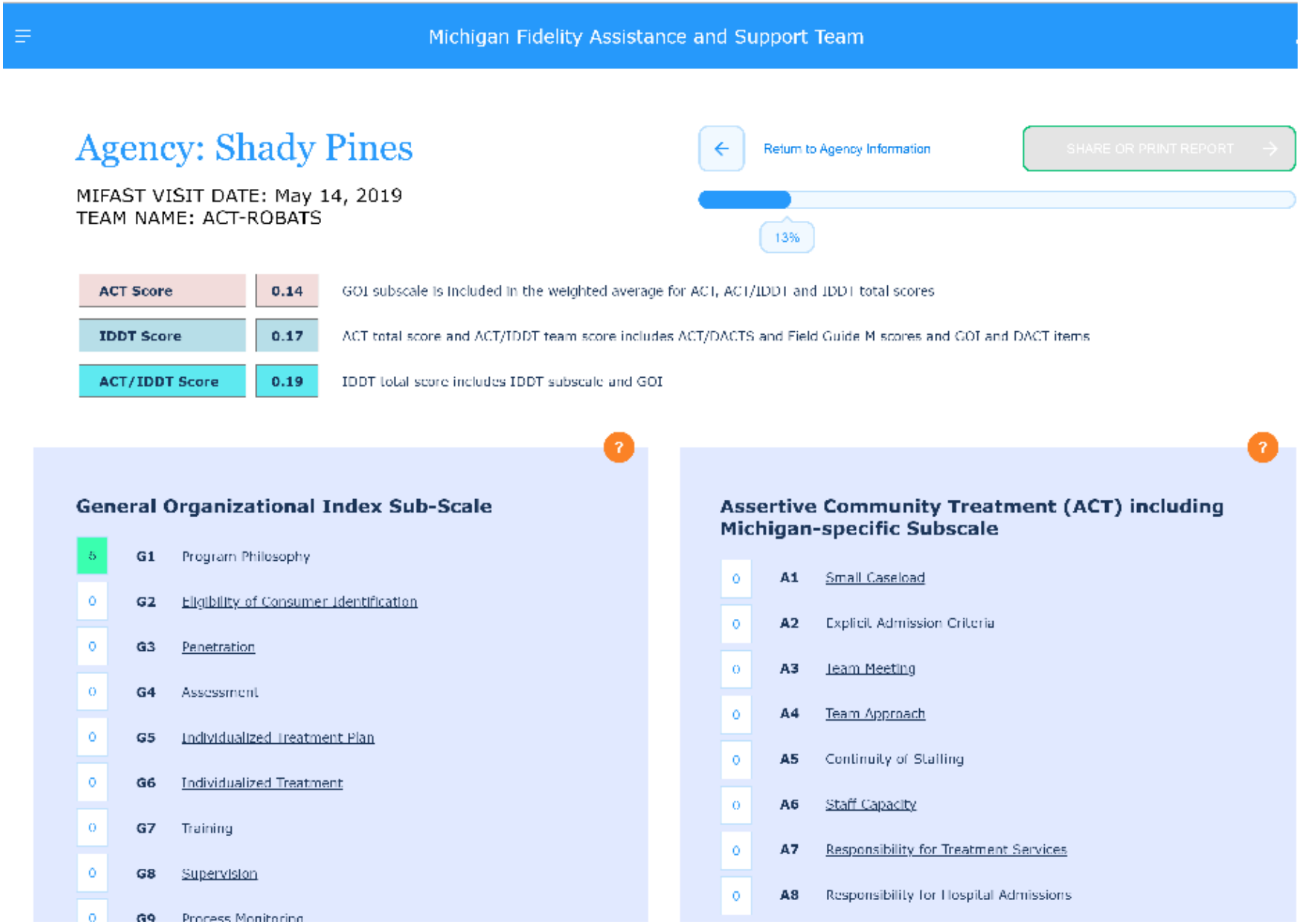
In psychiatric rehabilitation programs that truly endorse EBPs, staff members at all levels embrace the program philosophy and practice it in their daily work.

Select Your Score:

1	2	3	4	5
No more than 1 of 5 sources shows clear understanding of program philosophy *or* All sources have numerous major areas of discrepancy	2 of 5 sources show clear understanding of program philosophy *or* All sources have several major areas of discrepancy	3 of 5 sources show clear understanding of program philosophy *or* Sources mostly aligned to program philosophy, but have 1 major area of discrepancy	4 of 5 sources show clear understanding of program philosophy *or* Sources mostly aligned to program philosophy, but have 1 or 2 minor areas of discrepancy	All 5 sources show clear understanding and commitment to program philosophy for specific EBP

Note Strengths:

Navigating the MiFAST Tool continued- using G1 5 of 5 slides



Key Elements

Yes, I am singing to the choir!

+ Critical Ingredients

Expected Outcomes

Key Elements of ACT

(Endorsed by >80% of Experts)

- Clearly identified population
- Low client:staff ratio
- Home and community visits
- Team approach with daily meetings
- Team has Nurses and Social Workers
- Team Involved in hospital admissions and discharges

(Gary Bond, presentation ACTA Conference 2003)

+ Critical Ingredients Most Predictive of Good Outcomes

- Nurse(s) on team
- Shared caseloads
- Daily team meetings
- Team Leader sees consumers in community
- Contacts average 120 min/wk

(McGrew, Bond, 1994)

= Good Outcomes

- live independently in a place called home
- gain an education
- have a job
- avoid the spirit breaking experiences of
  - Hospitalization
  - Incarceration

A1 Small Caseload

ACT is a ‘they get me’ service for consumers –enough time and staff to help

(MiFAST is a ‘they get me’ service for ACT teams)

Staff to Consumer Ratio = 1:10

True Story from the Field -What will YOU say?

A2 Explicit Admission Criteria

Difficulties might include:

- Maintaining or having interpersonal relationships with family and friends more
- Accessing needed MH and PH care
- Issues relating to aging, especially where SMI symptoms may be exacerbated or confused by complex medical conditions or complex med regimens
- Performing ADLs or other life skills
- Managing meds without ongoing support
- Maintaining housing

A2 Explicit Admission Criteria p2

- Avoiding arrest and incarceration, navigating the legal system, transitioning back to the community
- Coping with relapses or return of symptoms given an increase in psychosocial stressors or changes in the environment (frequent use of hospital services, ED, CS, CR programs or homeless shelters)
- Maintaining recovery to meet the challenges of a co-occurring SUD
- Encountering difficulty in past or present progress toward recovery despite participation in long-term and/or intensive services

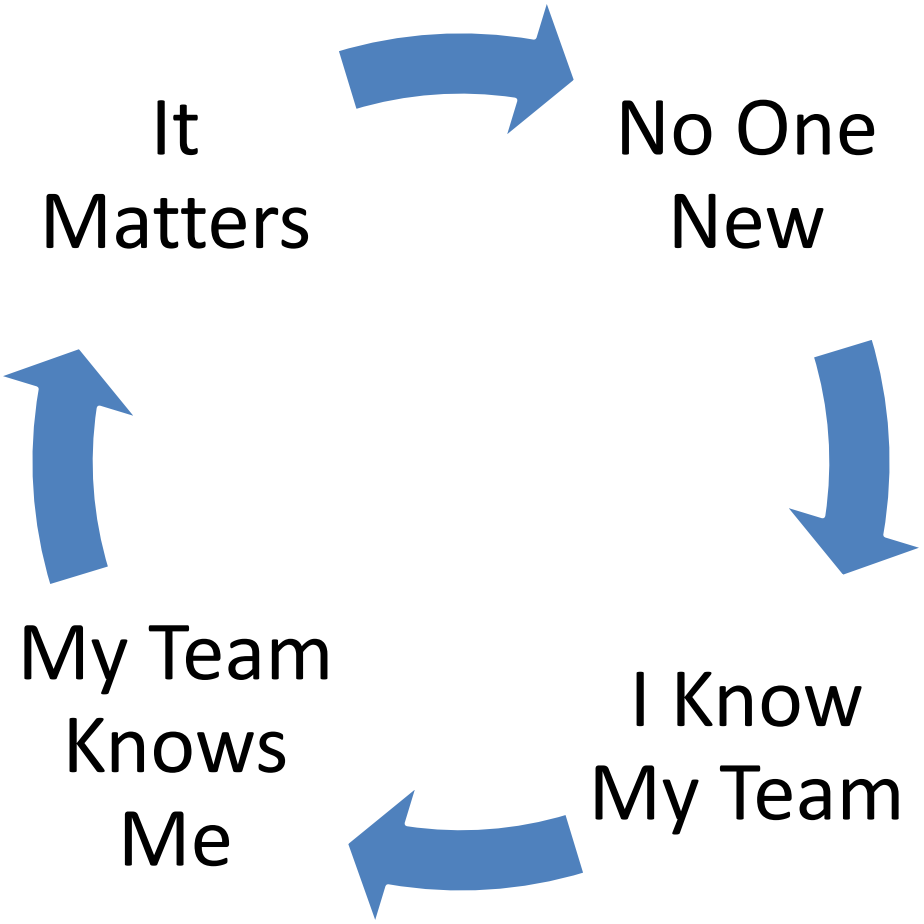
A3 Team Meeting

A4 Team Approach/Shared Caseload

The Sum of the Whole > than the Sum of the Parts

- functioning as a single unit of expertise
- assists with activities supporting consumers lives in the community
- an invisible, dynamic whole
- team members' actions are highly interrelated and in ACT
- relationships are **Everything!**

A5 Continuity of Staffing



A6 Staff Capacity

Teams require a sufficient number of qualified staff to assure the provision of an intensive array of services on a 24-hour basis.

Name 5 ways to determine capacity

A7 Fixed Point of Responsibility

What does this really mean?

A8 Responsibility for Hospital Admissions- ACT in unique position for:

Prodromal identification

Rapid Response to Emergent Conditions

Possible Diversion

Pre-Admission Screen

What does this really mean?

A9 Responsibility for Crisis Services

24/7/365

On Call Structure?

A10 Responsible for Hospital Discharge

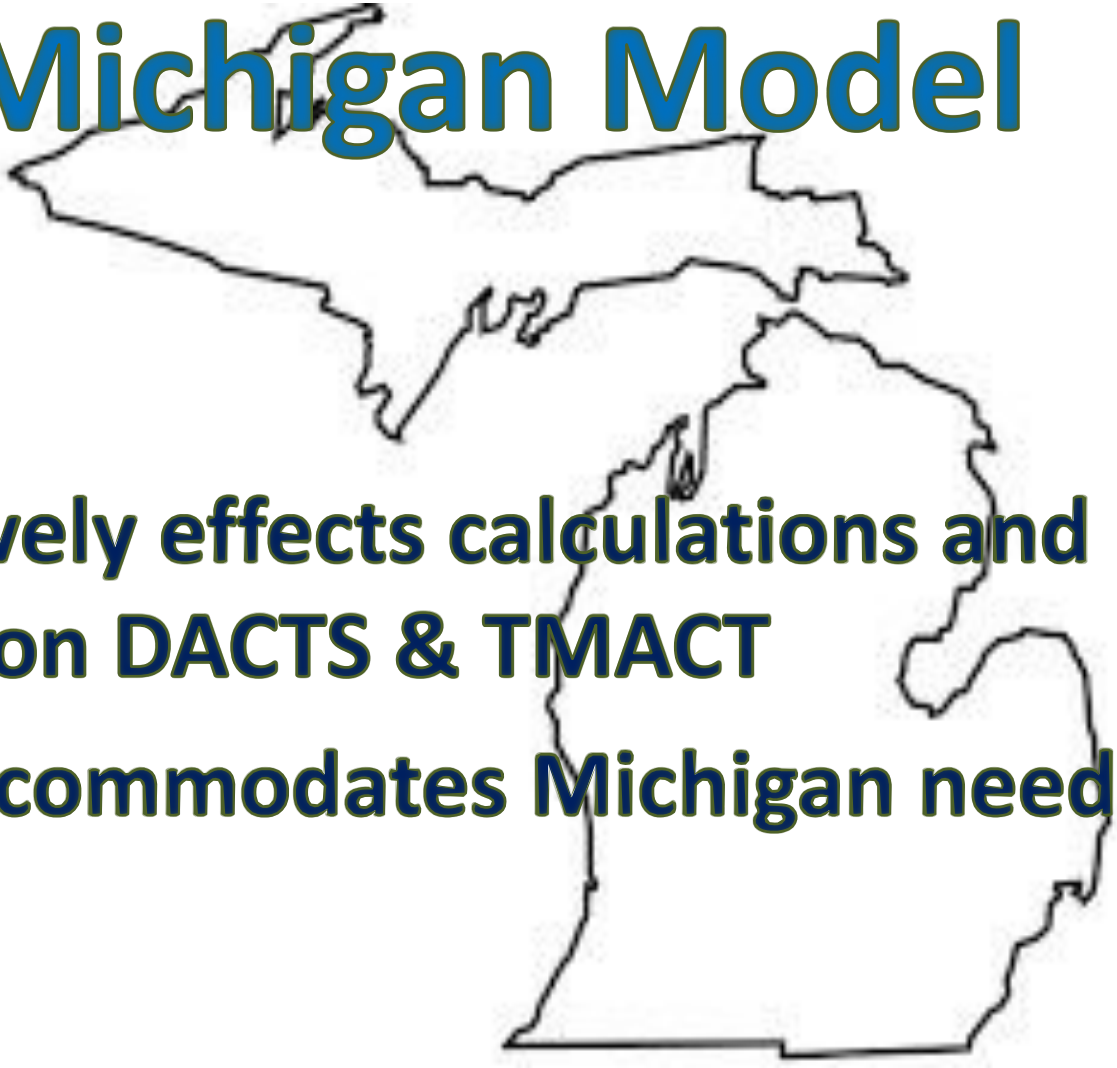
What works?

A11 Role of Consumers on Team

The Power of Peers and Paraprofessional Staff

A12 Program Size

Michigan Model



- Negatively effects calculations and scores on DACTS & TMACT
- Tool accommodates Michigan needs

A13 Intake Rate

Information you need:

- # new ACT Consumers in last 6 months
- total # allocated caseload (the FTE of ACT staff positions x 10)

Calculate the answer:

$$\frac{\text{\# new consumers in last 6 months}}{\text{total \# allocated team for caseload}}$$

Multiply x 100

A14 Community-based Services

A15 No Drop Out Policy

Checking in
(sometimes relentlessly)
to see what's up,
provide treatment,
and ID other ways
ACT can help

A16 Intensity of Service

2 or more hours
each week is a critical
ingredient for success

A17 Frequency of Contact

As per IPOS
Adjusted as needed

A18 Practicing Team Leader

Research indicates Critical Ingredient! (FT required!)

A19 Psychiatrist on Team

15 minutes
per consumer
Per week gets the work done

Available to team 24/7

A20 Nurse(s) RN on Team

Research indicates Critical Ingredient (FT required, more nursing help if needed)

T2 Integrated Treatment Specialist on Team

SAMHSA requires IT on ACT team

Medicaid requires COD is provided in ACT

IDDT requires IT

A21 Vocational/Employment Specialist on team

SAMHSA requires on ACT team

Medicaid requires team to provide OR broker

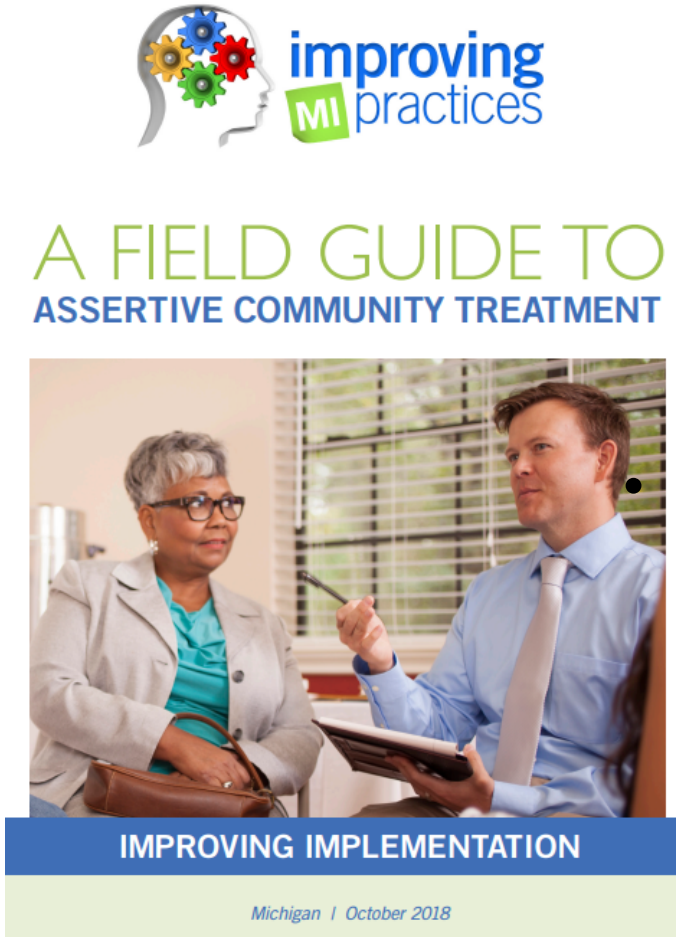
M1 Communication-Field Guide

- Provided with laptops or communication devices to use in the field
- Provided with cell phones or reimbursed for the business use of their personal cell phone
- Teams are provided with a team ‘on-call’ phone
- Or provided with pagers or other means of communicating in areas of poor cell service

M2 Safety -Field Guide

- Trained in techniques and skills to keep safe in the field
- When safety is of concern, contacts by groups of two or more
- Concerns about specific consumers discussed in team
- When safety relates to housing (i.e., dangerous neighborhood, inaccessible location, dilapidated dwelling, infestations of rodents and/or insects), potential environmental changes are discussed with the consumer

M3 Team Approval



- EACT team has met the minimum ACT Medicaid standards and has been approved to use H0039 to indicate ACT services

M4 Explicit Discharge Criteria

- Sufficient recovery to maintain functioning without support of act as identified through the person centered planning process and consumer no longer meets severity-of-illness criteria and has demonstrated the ability to meet all major role functions for a period of time sufficient to show clinical stability.

T1 Multidisciplinary Team

- ≤20% of participants receive care from multidisciplinary team or cannot rate due to no fit
- 21-40% of participants receive care from a multidisciplinary team
- 41-60% of participants receive care from a multidisciplinary team
- 61-80% of participants receive care from a multidisciplinary team
- >80% of participants receive care from a multidisciplinary team with a strong emphasis on accessing a broad range of excellent communication among all disciplines

T2 Integrated Treatment Specialist

- No integrated treatment specialist connected with the agency or cannot rate due to no fit
- Consumers with COD are referred to a separate Integrated Treatment program within the agency (e.g.: referred to integrated treatment specialist not on the team)
- Integrated treatment specialists serve as consultants to the team but do not attend meetings and not involved in treatment planning
- Integrated treatment specialists are assigned to treatment teams but are no fully integrated, attend some meetings, may be involved in treatment planning but not systematically
- Integrated treatment specialists are fully integrated members of the treatment team, attend all team meetings, are involved in treatment planning, model and train other staff on integrated treatment for COD

T3 Stage-wise Interventions

- ≤20% of interventions are consistent with each participant's stage of treatment or cannot rate due to no fit
- 21 – 40% of interventions are consistent with each participant's stage of treatment
- 41 – 60% of interventions are consistent with each participant's stage of treatment
- 61 – 79% of interventions are consistent with each participant's stage of treatment
- 80% of interventions are consistent with each participant's stage of treatment

T4 Access to Comprehensive Services

- Fewer than 2 services are provided by the agency or participants do not have genuine access to these services or cannot rate due to no fit
- 2 services are provided by the agency and participants have genuine access to these services
- 3 services are provided by the agency and participants have genuine access to these services
- 4 services are provided by the agency and participants have genuine access to these services
- All 5 2 services are provided by the agency and participants have genuine access to these services

T5 Time-Unlimited Services

- Services are provided on a time-unlimited basis ≤20% of the time (e.g.: participants are closed out of most services after a defined period of time)
- Services are provided on a time-unlimited basis 21-40% of the time
- Services are provided on a time-unlimited basis 41-60% of the time
- Services are provided on a time-unlimited basis 61-79% of the time
- Services are provided on a time-unlimited basis with intensity modified according to each participant's needs ≥21-40% of the time

T6 Outreach

- Integrated Treatment Specialists
  - Are passive in recruitment and re-engagement; almost never use outreach mechanisms or cannot rate due to no fit
  - Make initial attempts to engage but generally focus efforts on most motivated participants
  - Try outreach mechanisms only as convenient
  - Usually have plan for engagement and use most available outreach mechanisms
  - Have plan for engagement and use most available mechanisms

T7 Motivational Interventions

- Integrated Treatment Specialists:
  - do not understand motivational interventions ≤20% of interactions with participants are based upon motivational approaches
  - understand motivational interventions and 21-40% of interactions with participants are based upon motivational approaches
  - do not understand motivational interventions and 41-60% of interactions with participants are based upon motivational approaches
  - do not understand motivational interventions and 61-79% of interactions with participants are based upon motivational approaches
  - do not understand motivational interventions and ≥80% of interactions with participants are based upon motivational approaches

T8 Substance Abuse Counseling

- Integrated treatment specialists
  - Do not understand basic SUD counseling principles and ≤20% of people in active treatment stage or relapse prevention stage receive SUD counseling or cannot rate due to no fit
  - Some understand basic SUD counseling principles and 21-40% of people in active treatment or relapse prevention stages receive SUD counseling
  - Most understand basic SUD counseling principles and 41-60% of people in active treatment or relapse prevention stages receive SUD counseling
  - All understand basic SUD counseling principles and 61-79% of people in active treatment or relapse prevention stages receive SUD counseling
  - All understand basic SUD counseling principles and ≥80% of people in active treatment or relapse prevention stages receive SUD counseling

T9 Group Treatment for Co-occurring Disorders

- ≤20% of participants regularly attend group treatment
- 20-34% of participants regularly attend group treatment
- 35-49% of participants regularly attend group treatment
- 50-65% of participants regularly attend group treatment
- >65% of participants regularly attend group treatment

T10 Family Interventions for Co-occurring Disorders

- Participants:
  - are not asked for permission to involve family (or others) or ≤20% of families (or others) receive family interventions for COD
  - are asked for permission to involve family (or others) and 20-34% of families (or others) receive family interventions for COD
  - are asked for permission to involve family (or others) and 35-49% of families (or others) receive family interventions for COD
  - are not asked for permission to involve family (or others) and 50-65% of families (or others) receive family interventions for COD
  - are not asked for permission to involve family (or others) and ≥65% of families (or others) receive family interventions for COD

T11 Alcohol and Drug Self-Help Groups

- <20% of people in the active treatment or relapse prevention stages attend self-help programs in the community or cannot rate due to no fit
- 20-34% of people in the active treatment or relapse prevention stages attend self-help programs in the community or cannot rate due to no fit
- 34-49% of people in the active treatment or relapse prevention stages attend self-help programs in the community or cannot rate due to no fit
- 50-65% of people in the active treatment or relapse prevention stages attend self-help programs in the community or cannot rate due to no fit
- >65% of people in the active treatment or relapse prevention stages attend self-help programs in the community or cannot rate due to no fit

T12 Pharmacological Treatment

- Prescribers use less than 2 of the strategies listed or cannot rate due to no fit
- Approximately 2 of 5 strategies Used
- Approximately 3 of 5 strategies Used
- Approximately 4 of 5 strategies Used
- All 5 strategies are used: medications are prescribed despite active substance use, prescribers receive pertinent input from the treatment team about medication decisions, use strategies to maximize adherence to psychiatric medications, avoid prescribing medications that are addictive and offer medications known to be effective for reducing addictive behavior

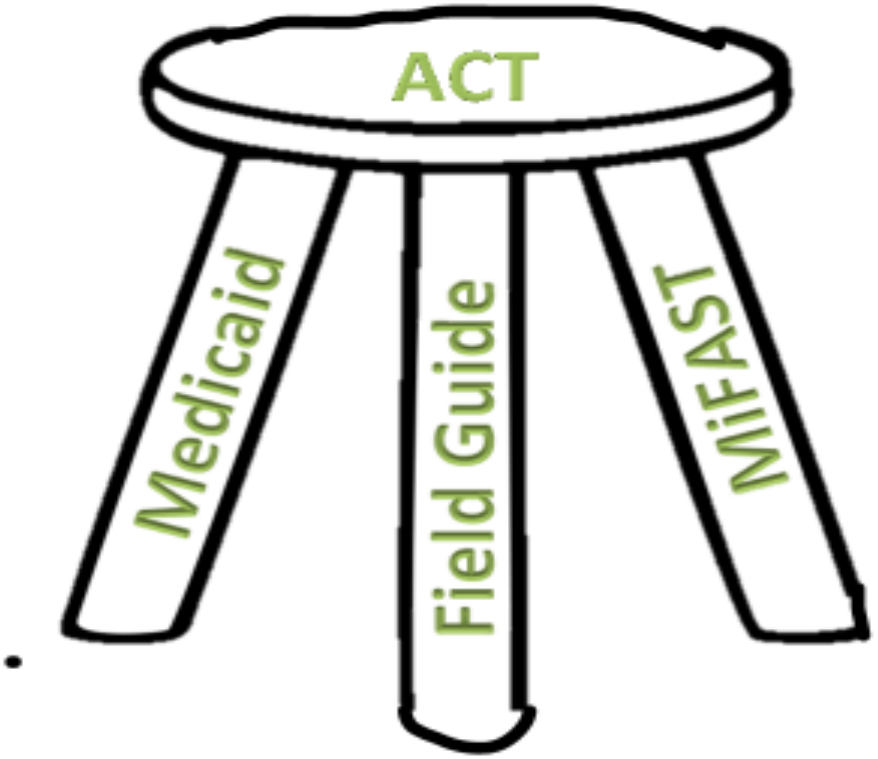
T13 Interventions to Promote Health

- Integrated treatment specialists offer no interventions to promote health
- Integrated treatment specialists may have some knowledge of reducing negative consequences of substance abuse but rarely use concepts
- Less than half of all participants receive services to promote health, integrated treatment specialists use concepts unsystematically
- 50-79% of participants receive services to promote health; all integrated treatment specialists are well versed in techniques to reduce negative consequences of substance use
- >80% of participants receive services to promote health; all integrated treatment specialists are well versed in techniques to reduce negative consequences of substance abuse

T14 Secondary Interventions for Non-responders

- ≤20% of non-responders are evaluated and referred for secondary interventions OR there is no recognition of a need for secondary interventions for non-responders OR cannot rate due to no fit
- 21-40% of non-responders are evaluated and referred for secondary interventions OR secondary interventions are not systematically offered or available to non-responders
- Program has protocol and 41%-60% of non-responders are evaluated and referred for secondary interventions OR no formal method to identify non-responders
- Program has protocol and 61%-79% of non-responders are evaluated and referred for secondary interventions
- Program has protocol to identify non-responders and ≥80% are evaluated and referred for secondary interventions

Main ACT Resources



Bibliography & References:

- **DACTS: ACT Fidelity Scale Protocol (1/16/03)**
- Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in assertive community treatment: Development and use of a measure. American Journal of Orthopsychiatry, 68, 216-232.
- Integrated Treatment for Co-occurring Disorders KIT, Center for Mental Health Services, SAMHSA, US Dept. of health and Human Services, 2009
- improvingMIpractices.org
- Case Western Reserve Center for EBP www.center forebp.case.edu
- ACT Center of Indiana; ACT daily team meeting & staff roles part 1


Thank You!