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Michigan Youth Treatment Improvement and Enhancement (MYTIE) Grant Fiscal Year Three Evaluation Report

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Introduction

According to the *National Survey on Drug Use and Health (NSDUH)* between 2017 and 2018, 3.4% of youth aged 12-17 reported needing treatment for a *substance use disorder (SUD)* but not receiving treatment, compared to 13.5% of 18-25-year-olds.

National Survey on Drug Use and Health: (2017-2018)	Age 12-17	Age 18-25
Needing but not receiving treatment for **illicit drug use**	2.52%	6.93%
Needing but not receiving treatment for **alcohol use**	1.56 %	9.07 %

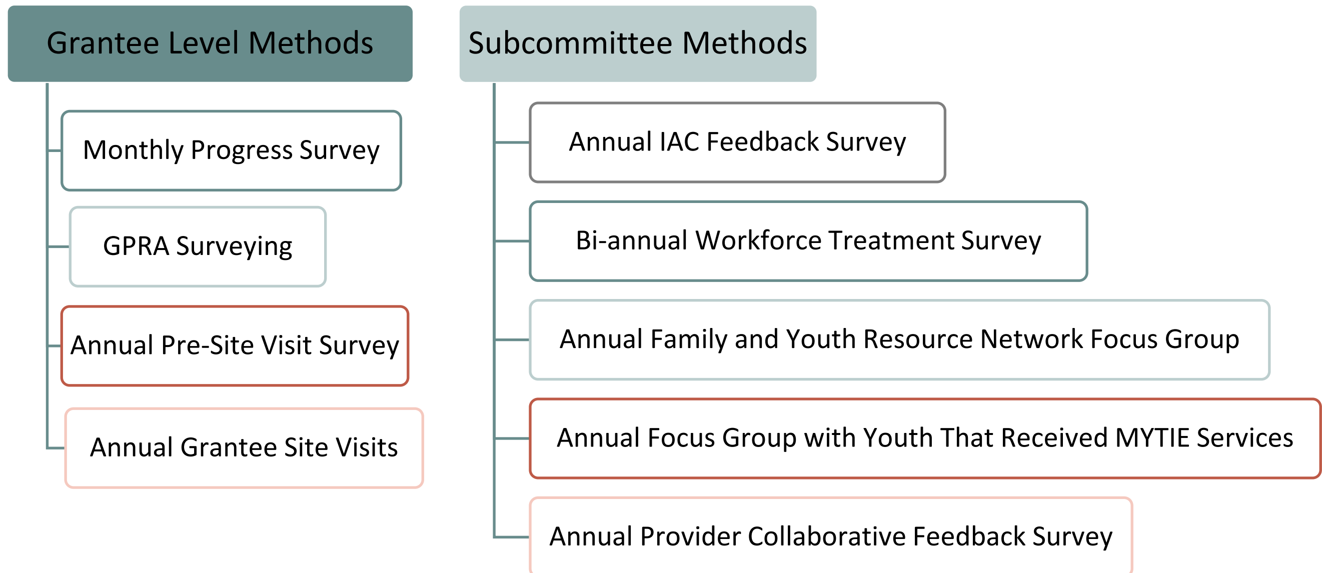
The need to increase access to treatment specifically for transitional aged youth prompted a need for enhanced treatment services specifically targeted to youth 16-21-years-old. A total of twelve awards were granted to grantees across the country through the *Substance Abuse and Mental Health Services Administration (SAMHSA)*. The State of Michigan was awarded $760,000 each year for four years for implementation. Through the *Michigan Youth Treatment Improvement and Enhancement (MYTIE)* grant, The State of Michigan seeks to improve the quality of treatment and recovery support services for adolescents and transitional aged youth 16-21 years old. In collaboration with the *Office of Recovery Oriented Systems of Care (OROSC),* five *Prepaid Inpatient Health Plans (PIHP)* were awarded funding to contract with a total of six individual treatment agencies as grantees. The main goals of the MYTIE grant are: to launch a peer recovery coach curriculum, continue the provider training collaborative, sustain operation of the *Interagency Council (IAC),* continue implementation and training of selected *evidence based practices (EBP)*, and utilize financial mapping to inform practice changes.

Methodology

In developing a comprehensive evaluation report outlining the activities involved with implementation of the MYTIE grant and associated outcomes, several evaluation methods are utilized. Grantee level monitoring ensures each grantee is aligning MYTIE goals and requirements with implementation practices. A main goal of the MYTIE grant is to increase education and access to treatment resources, this is done through several subcommittees including; the Interagency Council (IAC), Provider Collaborative, and Family and Youth Resource Network. Each year focus groups and surveys are completed with all subcommittees of the MYTIE grant, to gain feedback about progress and improvement suggestions. Focus groups are also held with participants who received treatment services through the grant, this allows for clinicians to gain insight into the effectiveness of each EBP being used and target areas for improvement. Due to the Covid-19 pandemic in-person focus groups were not

possible, however feedback was still gathered from clinicians and participants via online platforms. **Figure 1** below highlights both grantee and subcommittee level evaluation methods.

Figure 1: Evaluation Methods



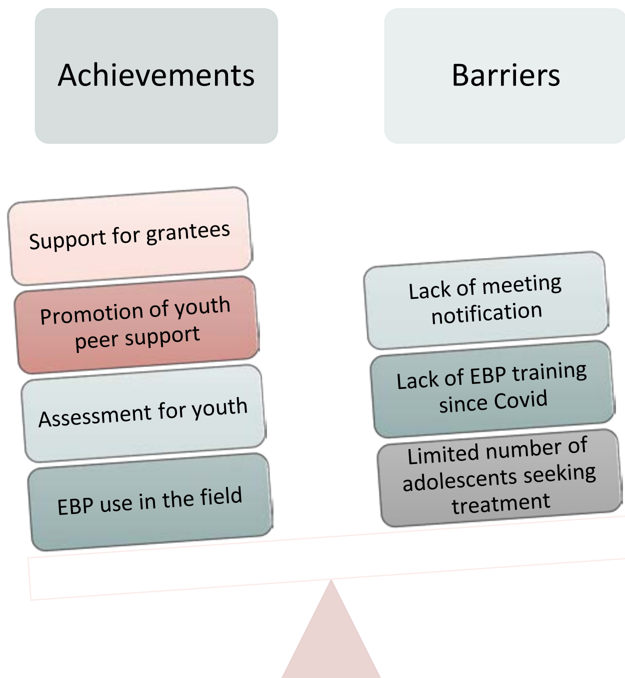
Interagency Council

The Interagency Council meetings have been held monthly since 2015 during the planning grant period. Though membership has changed over the years, new members are continuously added. During fiscal year three, an Oakland County based recovery high school contact was added to the group. IAC meetings offer SUD providers across the state an opportunity to network and share resources. Several trainings were shared this year including the impact of SUD on the developing brain of adolescents and SUD interventions for transitional aged youth. The goal for the IAC is to become a permanent group that seeks to maintain the systems and infrastructure for effective adolescent and transitional youth SUD treatment and recovery supports.

Annually an IAC satisfaction survey is sent to all members of the group via the online surveying tool Qualtrics. The goal of the survey is to gather valuable feedback about council performance and suggested improvements. A total of nine members completed the feedback survey this year. **Table 1** highlights respondents understanding of the goals of the IAC, including communication effectiveness and progress satisfaction. Although given the option, no respondent selected the strongly disagree scale point therefore it was removed from **Table 1.**

Table 1: IAC Satisfaction	Disagree	Neutral	Agree	Strongly Agree
The goals of the IAC were clear for the year.	11%	11%	44%	33%
Goals of the MYTIE grant are clear.	0%	33%	22%	44%
Goals of the MYTIE grant directly align with the goals of my agency.	0%	22%	33%	44%
Grant plans and activities are reachable.	11%	33%	44%	11%
Communication from OROSC staff is clear.	0%	11%	56%	33%
Communication from OROSC staff is timely.	0%	11%	56%	33%
IAC Meetings are organized and productive.	0%	33%	33%	33%
I am satisfied with our grant progress to date.	11%	22%	56%	11%
I feel prepared to participate in IAC meetings.	22%	11%	33%	33%

Figure 2: IAC Achievements & Barriers



Since March 2020, IAC meetings have transitioned to virtual video calls due to the Covid-19 pandemic restricting in person meetings. Respondents to the survey reported that adding a video option for those that would typically only have access to a conference call line has greatly improved their level of participation in meetings. Additionally, respondents reported satisfaction with the continuation of meetings throughout the current pandemic.

When asked to provide suggestions for improvements for the IAC in the next year respondents requested: assistance with outreach/ advertising treatment services to adolescents, more information about providers involved with or discontinuing grant implementation, clarification of IAC members roles, and better communication from IAC administrators. In terms of products IAC

members would like to see in the next year respondents reported: feedback on implementation progress for grantees, media/information to communicate available services to the public, and Trauma Focused Cognitive Behavioral Therapy (TF-CBT) training.

Provider Collaborative

A Provider Collaborative has been established to increase knowledge of treatment resources and recovery supports statewide. The collaborative offers a venue for providers to share information and resources as well as discuss challenges they face. One main goal of the group is to ensure that information regarding services and availability is shared throughout the field; with the hope of leading to more effective treatment service. No cost continuing education credits are typically offered to collaborative participants to encourage clinicians from across the state to participate in meetings while also gaining new skills. The networks established within the collaborative will also provide information for professionals outside of the SUD systems to help these professionals locate resources for their clients.

In a typical year, a one day full in person meeting and one four-hour virtual meeting would occur. However, due to barriers related to the Covid-19 pandemic, in person meetings were not able to be held for the collaborative in fiscal year three. However, the MYTIE Program Director is currently working to develop content and a possible virtual training for members of the group to take place in fiscal year four.

Financial Map

Throughout the grant planning period a financial map was originally created based on the results of exploration of funding streams and activities related to treatment services for adolescents and transitional aged youth throughout the state. Each year the original financial map is updated to reflect current progress: including changes which recently involved condensing of service categories available for expenditure reporting. The goal of the financial map is to allow partners to: identify, braid, allocate, and leverage needed resources to the culturally and linguistically diverse service population to reduce health disparities. Each year one subcategory of the financial map is selected by IAC members to investigate possible opportunities for improvement. The financial map for fiscal year three is currently in progress, data will be available soon for analysis and dissemination.

Evidence Based Practice Implementation

Each grantee is offered evidence-based practice training in the following practices: *Motivational Interviewing (MI), Trauma Focused Cognitive Behavioral Therapy (TF-CBT),* or *Adolescent Community Reinforcement Approach (ACRA).* Following training, clinicians must complete the certification process which includes fidelity measures to be considered proficient in the practice. Grantees are expected to implement at least one EBP but up to four practices can be chosen. Additionally, the number of clinicians trained for implementation is left to the discretion of grantees. Throughout fiscal year two, each grantee focused heavily on EBP training and the completion of fidelity measures. This led to no additional trainings being held for in fiscal year three. Grantees were still able to complete Seeking Safety training virtually as needed.

To capture the impact of EBP use with clients, three feedback questions were added to the *Government Performance and Results Act (GPRA)* surveying tool at discharge only. The questions were asked on a volunteer basis in leu of a focus group that is typically held with adolescents each year. Due to the Covid-19 pandemic, an in-person focus group was not possible this year. One limitation of this surveying style is; the questions are asked in the presence of a clinician which in some cases was the same clinician who rendered services to the youth. Despite possible limitations, this data collection method was chosen at the request and in collaboration with clinicians implementing the grant with the safety of youth in mind. The questions were made live in August of 2020, and since then seven clients have provided feedback. This data collection method will be continued through the end of the grant to gather as much feedback from youth as possible.

When asked to provide feedback on specific components of treatment that were found to be most helpful youth reported: feeling supported, having someone to talk to, learning to refocus stress without turning to drugs, group and anger management, access to Alcoholics Anonymous/ Narcotics Anonymous meetings, and SUD groups in which negative effects of use were discussed. In discussing skills learned during treatment youth reported learning: coping skills, identifying problems within themselves, identifying when to ask for help, and to think from different points of view. Overall, the feedback gathered for participants was overwhelming positive, specially regarding the use of EBP skills and techniques.

In the third fiscal year of implementation, many clinicians had completed the certification process involved with training and were ready for implementation. **Table 2** highlights the number of times each EBP was used in a treatment instance with each grantee. **Table 2** data was gathered from each grantee

through the monthly progress survey that is submitted to the evaluation team. Grantees implementing in group settings, showed a considerable higher rate of EBP delivery than grantees implementing on an individual basis.

Table 2: Number of Times an EBP Was Used in Treatment				
Grantee	Seeking Safety	MI	A-CRA	TF-CBT
Assured Family Services	0	3	0	4
Catholic Human Services	NA	78	NA	NA
Great Lakes Recovery	347	896	NA	0
Holy Cross	405	NA	NA	NA
Macomb Family Services	0	96	NA	NA
Wedgwood	21	15	41	30
TOTAL	**773**	**1088**	**41**	**34**

In addition to EBP practice use, the monthly progress survey completed by grantees offers an opportunity for clinicians to provide EBP use feedback. Gathering feedback from participants and clinicians allows an analysis of the overall impact each EBP has produced. **Table 3** highlights feedback received from clinicians based on their experience with EBP implementation. Gaining participant buy-in and offering the opportunity to gain new coping skills have been the most positive outcomes shared by clinicians and participants alike.

Table 3: Clinician EBP Use Feedback				
Grantee	Seeking Safety	MI	A-CRA	TF-CBT
Assured Family Services	NA	Promotes client engagement and facilitates client buy-in to treatment.	NA	Has ensured ongoing caregiver participation in treatment.
Catholic Human Services	NA	Helps clients recognize their change talk, values, decisions and motivation for treatment.	NA	NA

Great Lakes Recovery	Allows clients to expand on weekly goals outside of group therapy. Assists clients with implementing coping skills and the ability to process through trauma.	MI can work in any situation within residential treatment. Best results have been achieved with a new group of clients who are all struggling with their stage of change. MI has been most helpful with a large group of new clients who are resistant to treatment because of the non-confrontational manner of the practice.	NA	Works best in individual treatment however is not always appropriate for residential treatment due to the time involved in full implementation.
Holy Cross	Used daily in intensive group therapy for all clients in residential programs. If the client missed group, the materials are used for individual session to make up those hours allowing for flexibility.	NA	NA	NA
Macomb Family Services	Beneficial when using telehealth and can benefit treatment modality through video and corresponding worksheets.	Effective with adolescents to explore their choices and elicit change. Proven successful with adolescents because it allows the clinician to give the client the power to move towards stopping use rather than being told they must.	NA	NA
Wedgwood	Clients are taught to enhance future safety and create increased resilience through the implementation of this treatment model.	Utilized with clients who are in the early stages of change. Helps clients to identify discrepancies in their language and recognize reasons for change.	Reviewing skills learned through A-CRA provides good reminders to clients as they practice these skills daily.	Helpful in assisting clients to manage their emotions and navigate their trauma. Clients are very receptive to the model and are appreciative for the services. Facilitates treatment in a way that helps clients who have experienced trauma to

				engage better and to build resilience and hope.

GAIN I Core

All grantees are required to utilize the *Global Appraisal of Individual Needs (GAIN)* to complete clinical assessments of need and individualized treatment planning with all clients served through the grant. The GAIN was selected for implementation due to the appropriateness for the target population, specifically for adolescents over the age of twelve. The GAIN also incorporates *American Society of Addiction Medicine (ASAM)* level of care determination; which sets a standard for recovery-oriented recovery services. Training and certification for the GAIN can be a lengthy process; participants are required to submit voice recordings to trainers to demonstrate proper use of the tool to obtain certification. All six grantees have completed training and certification for at least one clinician in the GAIN assessment. Four grantees are currently implementing the assessment as expected; the remaining two grantees will begin implementing by the start of the next fiscal year.

When asked to provide feedback regarding implementation of the GAIN assessment tool, clinicians reported that the length involved in administration of the tool to be troublesome. However, with continued use clinicians reported the length of time needed to complete the assessment has decreased as they become familiar with the tool. While the GAIN is a very comprehensive assessment tool, clinicians reported the final report document automatically created by the tool to be very useful for treatment purposes. Adopting an entirely new assessment tool is bound to be accompanied by barriers and stress, after the initial startup concerns were alleviated clinicians have been extremely successful with use of the GAIN assessment.

Family and Youth Coordinator

The main objectives for the Family and Youth Coordinator are to: attend IAC meetings, assist with the development and training of the youth peer recovery coach curriculum, and develop a community resource network by facilitating the Family and Youth Resource Network.

The Family and Youth Coordinator maintains a Resource Network of sixteen members. The group was established to promote family and youth involvement in SUD treatment and recovery services for

adolescents. One goal of the resource network is to provide access to information for youth and their families. To fulfill this duty the Family and Youth Coordinator developed a resource website after much input and discussion from community partners.

The Family and Youth Coordinator is responsible for establishing adolescent community center partners throughout the state, this process was started in fiscal year three however due to staff turnover progress has been delayed. The MYTIE Program Director is currently in the process of interviewing candidates to fill the Family and Youth Coordinator position. One main goal for the new coordinator in fiscal year four will be to begin training the community on the newly developed Peer Recovery Coach Curriculum and build strong community resource relationships.

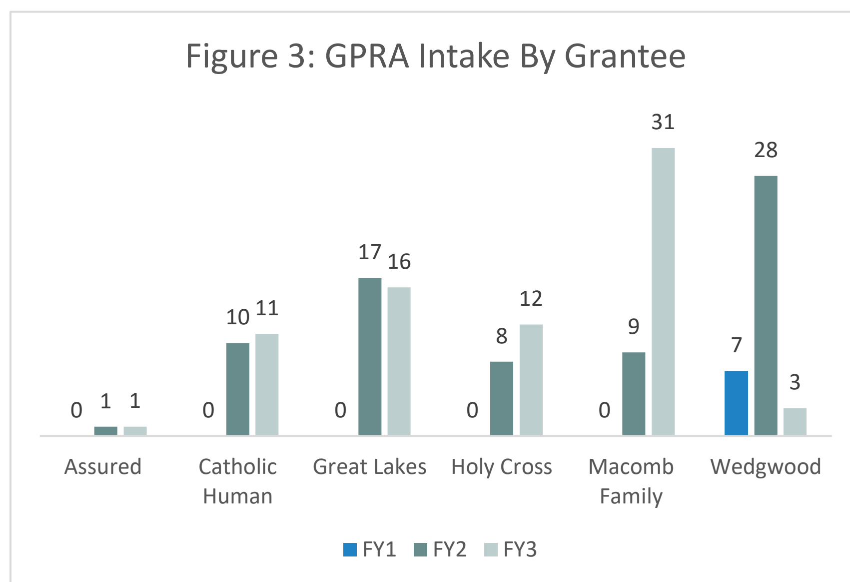
Youth Recovery Coach Curriculum

Led by the Family and Youth Coordinator, the Youth Recovery Coach Curriculum Workgroup developed a comprehensive training manual for Youth Recovery Coaches. Members of the workgroup brought various levels of expertise to the group which allowed for the creation of an inclusive and culturally competent manual. Based on the Washington State model of Peer Recovery Coach Curriculum, the curriculum was adapted for Michigan based recovery coaches and the needs of the target population. The curriculum was completed in fiscal year two of grant implementation however final editing has been delayed. The finalized curriculum is expected to be available for dissemination and training within the next few months.

GPRA Update

As a requirement of providing treatment services with Federal funding, each grantee is expected to complete Government Performance and Results Act surveying for each client served through the grant. GPRA surveying occurs at; intake, discharge, and six month follow up. The goal of GPRA surveying is to highlight positive outcomes in the adolescent's life following treatment. GPRA surveying consists of questions based on the following topics: demographics, substance use, family/living conditions, education/employment, criminal justice status, mental and physical health, and social connectedness. Grantees are expected to serve twenty-five clients per year through the MYTIE grant, this requirement is tracked through GPRA surveying for each grantee. **Figure 3** provides intakes counts separated by grantee for each fiscal year of implementation. While grantees have worked to increase intake rates each year of implementation, the Covid-19 pandemic brought about a stark decrease in referral rates for

all grantees. While intake rates have slowly returned, grantees expect to see rates return to a normal rate as agencies return to normal operations.



One key component of GPRA surveying is the completion of the six month follow up. Follow up surveying is expected to be completed at least eighty percent of the time, as defined by the Federal Government. Clinicians are allotted between five to eight months following intake to complete follow up surveying with each participant. To adapt to Covid-19 restrictions, grantees were granted access to complete all GPRA surveying via telephone conference until further notice. Several grantees reported an increase in access to participants to gather GPRA surveying due to the new adaptation. Due to the length of time allotted to complete follow up surveying, fiscal year three data is not currently complete.

Due to the incomplete status of fiscal year three data, analysis was completed on fiscal year two data which became complete in the spring of 2020. In reviewing statewide follow up change reports for fiscal year two, several categories showed improvements. A total of forty-two cases were received out of seventy-six cases that were due, showing a fifty-five percent follow up completion rate. **Table 4** highlights favorable changes in: abstinence, and health/behavioral/social consequences for adolescents after receiving MYTIE services.

Table 4: FY2 Follow Up Change Report	Number of Valid Cases	Percent at Intake	Percent at 6-Month Follow-up
Abstinence: did not use alcohol or illegal drugs	41	14.6%	41.5%
Employment/Education were currently employed or attending school	42	83.3%	83.3%
Health/Behavioral/Social Consequences: experienced no alcohol or illegal drug related consequences	41	70.7%	92.7%
Social Connectedness: were socially connected	42	83.3%	88.1%

Stability in Housing: had a permanent place to live in the community	42	85.7%	81%

Following the completion of fiscal year three data, grantees will receive a comprehensive GPRA report from the evaluation team. Additionally, grantees will continue to receive monthly GPRA reports to highlight progress throughout the year. Providing grantee level data is a time-consuming process however the benefits for grantees to have access to agency specific data that highlights outcomes of their work is invaluable.

Updates from Grantees

Assured Family Services:

Assured Family Services (AFS), has been very active in MYTIE activities since they began implementing the grant three years ago. Agency staff have worked diligently to educate local agencies about the benefits of MYTIE interventions. In fiscal year three presentations were made to: Care Management Organizations, Wayne County's Department of Health/Human/Veterans Services, and Child Welfare Staff Meetings. AFS has secured and trained a team of seven clinicians to implement the MYTIE grant. Additionally, processes have been put into place to track clients throughout the treatment process to ensure all components of the grant are within compliance. Clinicians share an excel tracking document which tracks GPRA surveying and gift card distribution to participants.

Unfortunately, as an agency AFS has experienced a lack of referrals from the Wayne County treatment access center, Wellplace. The Covid-19 pandemic further complicated the access AFS has to referral sources which led to a lack of clients served in fiscal year three. Due to continued barriers making reach to the target population very difficult, AFS has chosen to discontinue participation in the MYTIE grant following the conclusion of fiscal year three.

Catholic Human Services:

To date *Catholic Human Services (CHS)* has served eleven clients through the MYTIE grant by utilizing enhanced Motivational Interviewing skills to provide greater treatment services for clients. To keep grant activities manageable one clinician was chosen for implementation of the MYTIE grant. The clinician chosen has extensive MI experience and direct access to the target population through local schools and juvenile justice outlets. One main focus for CHS staff this year was to improve surveying

follow up rates of GPRA. However, due to the Covid-19 pandemic schools remained closed for much of the year making it difficult to reach clients, a barrier that CHS has not previously experienced.

This year has demonstrated the resiliency of many service providers including CHS. Amid a global pandemic, CHS transferred all treatment services to a telehealth model. Since transitioning to telehealth, CHS observed a dramatic decrease in missed appointments by clients. Telehealth has also offered faster GPRA surveying for both clinicians and clients and has eliminated transportation barriers. While transitioning to telehealth has come with benefits, CHS experienced a drastic decrease in referrals for service when both schools and circuit courts closed. When schools reopen, CHS staff expect to return to typical referral and treatment patterns which have been very successful prior to the pandemic.

Great Lakes Recovery:

Great Lakes Recovery Center (GLRC) has served a total of sixteen clients through the MYTIE grant for residential treatment services in fiscal year three. A total of four clinicians are trained in the EBPs; Motivational Interviewing and Seeking Safety. Due to the rural nature of the Upper Peninsula, GLRC serves clients from various regions including areas outside of the region in which their main PIHP, Northcare Network, operates.

In fiscal year three of implementation, GLRC invested in developing processes to ensure proper implementation of MYTIE services. The development of a clear implementation and tracking process has significantly improved operations for GLRC clinicians when implementing the MYTIE grant. Another area in which GLRC targeted for improvement was the capturing of GPRA follow up surveying of existing clients. Increasing reporting numbers from fiscal year two remained a priority throughout the year, GLRC was able to improve follow up rates by thirty-one percent to date in fiscal year three.

Holy Cross:

As a third-year grantee, Holy Cross serves MYTIE clients through residential and outpatient services. The agency has chosen to implement the EBP, Seeking Safety with adolescent clients. A total of four clinicians are currently implementing the MYTIE grant at Holy Cross. One clinician was appointed to be the MYTIE Coordinator for the agency however that position has recently become vacant. At the time of the departure of the MYTIE Coordinator, Holy Cross had experienced a large influx of staff turnover directly related to the Covid-19 pandemic. Following careful consideration for the current barriers facing Holy Cross in regards to a staffing shortage, administrative staff within the agency chose to withdraw participation in the MYTIE grant following the conclusion of fiscal year three.

Macomb Family Services:

Macomb Family Services (MFS) began their second year of implementation with processes in place that led to a success in fiscal year three. Currently one clinician is implementing the MYTIE grant in an alternative high school where the EBP: Motivational Interviewing and Seeking Safety are utilized with clients seeking treatment. Ensuring grant activities are kept to a manageable implementation size has proven very successful for MFS in implementation progress.

Each client receives a total of six treatment encounters with the MYTIE clinician, which created an opportunity to clearly define the cost per modifier utilized for billing purposes. Without a clearly defined treatment schedule it can be difficult to estimate the cost per treatment encounter for modifier purposes. MFS has reached the target number of clients served per year for fiscal year three and is on track to spend all allocated funds by the close of the year. MFS had an extremely success year of implementation despite barriers related to the global pandemic eliminating access to their main referral source, alternative high schools.

Wedgwood:

In the third year of implementation, Wedgwood experienced two major shifts in staffing which had an impact on the agency and grant implementation. Despite turnover, Wedgwood staff continue to be optimistic as several new staff have been onboarded and are eager to provide excellent treatment services throughout the community. Wedgewood is currently implementing Seeking Safety and TF-CBT: however, with the onboarding of new staff further training in evidence-based practices is anticipated. Despite the global pandemic, the majority of Wedgwood clinicians have been able to keep a full caseload using a telehealth model. A new development this year that was not previously experienced was a lack of referrals for adolescents in the target age range for the grant, 16-21 years old. Wedgwood staff are working diligently to identify eligible clients and seek out new referral sources including considerations for additional group implementation and community outreach.

Grantee Best Practices

Each grantee has developed an implementation plan and style that is best suited for their agency needs and available resources. There are however several common practices that produce positive outcomes and outputs for grantees. To begin, aligning MYTIE services with current services provided by the grantee is crucial, as the MYTIE grant is meant to enhance existing services for adolescents. Grantees who selected an EBP that clinicians were already implementing or an EBP that directly aligned with

existing services performed significantly better than grantees who elected to implement all four offered EBPS. In addition to complementing existing services, grantees who piloted or scaled MYTIE implementation to a manageable number of clinicians experienced favorable results. The goal of the MYTIE grant is to service twenty-five clients per year, grantees who made this target their focus and kept services to a small number of clinicians with the most access to the target population performed very well.

There are many moving parts to the MYTIE grant including several different reporting requirements. Management of GPRA surveying for each grantee can also be challenging despite tracking and informational documents provided by the evaluation team. To best track and ensure compliance, grantees who have appointed a MYTIE coordinator to oversee each clinician performing implementation services, has been very successful in reporting. Simply assigning one staff member a few hours per week to monitor MYTIE services, billing and reporting can make a substantial difference in compliance rates. Moreover, appointing one staff member to complete all required reporting produces consistent results and decreases missed deadlines.

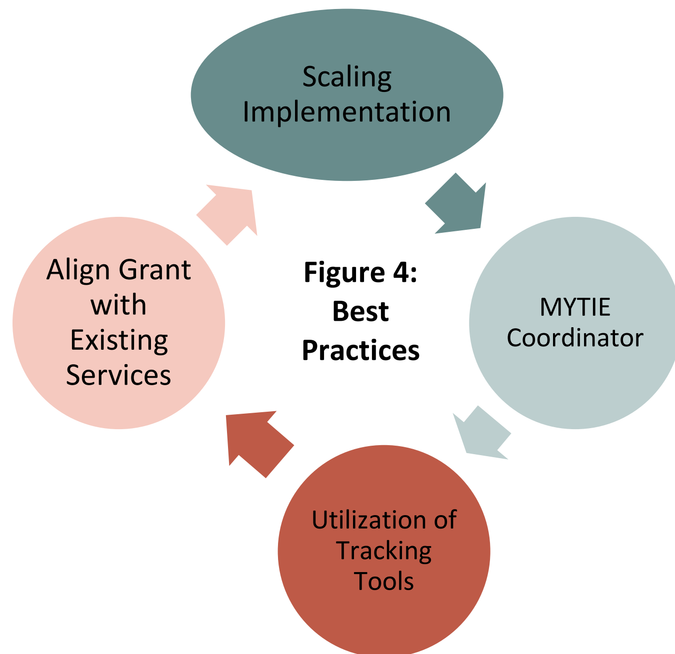


Figure 4: Best Practices

In addition to GPRA tracking documents, the evaluation team has created a resource website for MYTIE clinicians. Use of tools provided by the evaluation team has assisted grantees with management of all reporting aspects and timely GPRA surveying. The resource website has many helpful infographics to highlight reporting requirements, GPRA training materials, and direct links to surveying tools. It is suggested that each grantee maintain a shared GPRA tracking tool across all clinicians implementing the grant as an internal check and balance which can be compared to the tracking provided by the evaluation team.

Grantee Barriers

Communication:

A total of five PIHP regions across the state have received funds to contract with a total of six grantees for MYTIE implementation. Each grantee is required to collaborate with their PIHP to establish: a work plan, billing processes, and reporting requirements. Communication between grantee departments and PIHP regions are not often as connected as needed. Additionally, communication between grantee administrators and clinicians implementing the grant is often segmented. Creating a team involved with developing implementation strategies and executing those plans is critical to grantees success with the MYTIE grant. Several grantees have reported that clinicians often forget to follow through with MYTIE activities or fail to identify eligible clients; as MYTIE eligibility is restrictive and often applies to a small number of clients on clinician's caseloads. Ensuring MYTIE activities and updates are communicated during staff meetings and communications with PIHP level staff across departments will lead grantees to successful implementation of the grant.

Billing:

Each PIHP is required to work with grantees to ensure proper billing is utilized when tracking MYTIE services. Each grantee is required to track specified MYTIE modifiers in the *Treatment Episode Data Set (TEDS)* system for all MYTIE clients. This process becomes more challenging when grantees serve clients outside of the region in which the PIHP that holds their contract operates. For this reason, staffing grants were introduced for grantee utilization however, MYTIE modifiers must still be tracked for all PIHP regions served for all MYTIE clients.

Grantees are given the choice between a staffing grant or straight modifier style billing format. Grantees must work with their PIHP to decide which billing style is best suited for their agency. Grantees have expressed difficulty working with PIHP staff to turn on MYTIE modifiers in the billing system, which often requires assistance from the PIHPs *information technology (IT)* department. Working across agencies and departments can often be a difficult process however, proper billing is critical for implementation success of grantees.

In fiscal year three modifier use data from the TEDS system was pulled and showed that only three of the current six grantees are currently tracking MYTIE modifiers. Due to the barriers related to billing that grantees have expressed, the MYTIE Program Director will be putting together a technical assistance session in collaboration with the evaluation team. The goal of the session is to gather PIHP staff with

grantee staffing including billing representatives to ensure each grantee has a billing plan established and ready for implementation.

Staff Turnover:

Prior to the implementation of MYTIE activities, clinicians must be trained in proper reporting procedures including GPRA surveying. Clinicians must also be certified in at least one EBP chosen by the state for implementation which can be a lengthy process. Investing time in training and onboarding staff is a key goal of the MYTIE grant however, staff turnover following the completion of training creates a barrier for grantees to implementation of grant activities. Grantees often try to scale implementation to a manageable group of clinicians, while this is a best practice it also creates a barrier when clinicians need to be replaced following turnover. Assigning a MYTIE coordinator has also been established a best practice, however replacing an individual so invested in grant processes has proven to be very difficult for grantees. Development of an onboarding and transition plan to prepare for staff turnover will be key to alleviating this barrier.

Recommendations

Communication became a theme throughout fiscal year three, from IAC meetings to site visits with grantees. Overall respondents of the IAC feedback survey requested increased communication from OROSC staff: specifically, regarding the purpose of meetings and changes to MYTIE grantees. Formatting IAC meetings with a system or policy-based lens may appeal to more community members to expand the group from a grantee only focus. In addition to improved communication to IAC members, more frequent and action-oriented communication is needed between PIHP staff and grantees. Throughout site visits several grantees expressed difficulties developing billing processes with their PIHP. Consideration of quarterly check-ins between all involved staff at the PIHP and grantee level may help to alleviate barriers related to communication. More frequent communication between grantee administrators and clinical staff is also needed to communicate grant updates and upcoming requirements. Grantees that hold monthly staff meetings with MYTIE implementation staff, consistently perform better with on time reporting and continued recruitment of new participants. Considerations must also be made regarding the caseload of clinicians in relation to the small number of clients that may be eligible for the MYTIE grant, it is very easy for clinicians to place MYTIE activities on the back burner and eventually stop implementation altogether. Monthly staff meetings and reminders of the eligibility requirements and benefits to adolescents will assist with the continued implementation success of the grant.

The second theme or area for improvement is: workforce training and sustainability management. Many grantees experienced staff turnover this year which ultimately lead to one grantee needing to discontinue MYTIE implementation. Having a plan for staff turnover and onboarding of new staff is critical to implementation success. Assigning a MTIE coordinator to manage implementation and reporting tasks can be extremely beneficial however, staff turnover of a coordinator can be devastating if a plan is not developed to manage any lapse in staffing. While it is suggested to keep grant implementation to a manageable size, training clinicians in one of the selected EBPs can be a lengthy process. For this reason, it may be helpful to have a team of clinicians trained in at least one EBP as a mechanism for dealing with potential staff turnover.

In the final year of implementation, grantees will need to work diligently to reach the target number of twenty-five clients served for the year. This includes developing a plan for participant recruitment and outreach to promote MYTIE services. Grantees have reported success with targeting clinicians whom operate in an alternative high school or school-based environments which offer access to the target population. Ensuring proper identification of eligible clients by intake staff may also be helpful in ensuring the target served per year is reached.

Finally, the biggest barrier facing all grantees in fiscal year three was billing for MYTIE services. Grantees will need to collaborate with their PIHP and agency billing department to ensure billing for MYTIE services is done properly. Currently half of grantees are reporting MYTIE modifiers in the TEDS system, tracking MYTIE modifiers is mandatory and will need to be a top priority for all grantees. It is highly suggested that grantees hold a meeting with all involved staff and PIHP representatives to secure a billing protocol for all clinicians to follow. An in-person meeting is highly encouraged, in addition to quarterly progress updates to ensure the process developed is operating as intended. To assist with questions regarding barriers to proper billing, the MYTIE Program Director and evaluation team will be holding a technical assistance session with all grantees. Additionally, grantees that have successfully developed a system in which modifiers are properly tracked, will be asked to share their practices with all grantees at an upcoming IAC meeting.