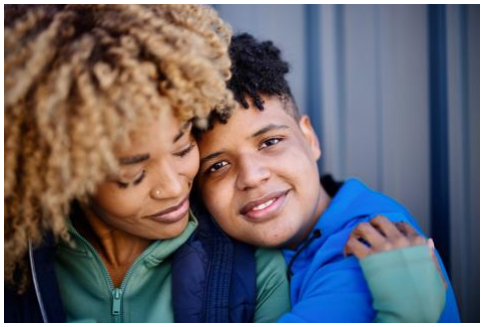
Multisystemic Therapy (MST)

Key Continuous Quality Improvement (CQI) Considerations

CQI BRIEF FOR CALIFORNIA COUNTIES AND EBP PROVIDERS

INTRODUCTION

As California continues to strive for excellence in child welfare, the implementation of evidence-based practices (EBPs) is a fundamental component of the Family First Prevention Services (FFPS) prevention plan. **This policy brief is designed to provide counties and providers with a comprehensive framework for implementing Multi-Systemic Therapy (MST)**, a well-supported evidence-based practice approved by the Family First Prevention Services Clearinghouse to meet the diverse needs of at-risk youth and their families.



This policy brief guides counties and providers in applying continuous quality improvement (CQI) activities to support the effective implementation of MST under **California's Five-Year State Prevention Plan**. It outlines requirements for data collection, reporting, and review to meet both **federal CQI requirements under the Family First Prevention Services Act (FFPSA)** and **state expectations for CQI activities outlined in California's CQI Plan**. Together, these activities support real-time program monitoring, data-driven decision-making, and compliance with IV-E reimbursement standards.

Counties and agencies delivering MST should use this brief as a guide for measuring the success of MST in their local context, applying required CQI activities, and ensuring implementation meets federal IV-E reimbursement requirements. This brief supports local discussions, outlines the data tracking and sharing requirements established in the CQI Plan, and establishes feedback loops that inform program delivery and continuous improvement. The CQI prompts are designed to support reflection on program effectiveness, address implementation challenges, and guide data-driven decision-making to better meet the needs of children and families.

The information presented in this resource, including service descriptions, target populations, program or service delivery, and implementation details, is informed by several key sources. These include meetings with the MST developer/purveyor and California's Family First Prevention Services CQI Subcommittee, Family First Prevention Services Advisory Committee, Community Pathway Advisory Committee, and IV-E Advisory Committee.

Key Terms

Developer/Purveyor: The entity responsible for creating and supporting the implementation of the EBP. They provide training, resources, and guidance to ensure fidelity and effective implementation.

Provider: The individual or organization delivering the EBP services directly to children and families.

MULTISYSTEMIC THERAPY PROGRAM OVERVIEW

Multisystemic Therapy (MST) is an intensive treatment for youth delivered in multiple settings. MST aims to promote prosocial behavior and reduce criminal activity, mental health symptomology, out-of-home placements, and illicit substance use in 12- to 17-year-old youth. The MST program addresses the core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the youth, his or her family, and school and community. The intervention strategies are personalized to address the identified drivers.

Who is Eligible?

Youth ages 12 to 17 with serious emotional or behavioral needs, along with their families, are eligible for the MST program. However, the program excludes youth living independently, those referred primarily for psychiatric behaviors or severe psychiatric issues such as being actively suicidal, homicidal, or psychotic, those referred solely for sex offenses without other antisocial or delinquent behaviors, and youth with moderate to severe autism.

Program Goals

Increase competence in promoting healthy development and managing common child behavior problems and developmental issues

Reduce use of coercive and punitive methods of disciplining children

Increase use of positive parenting strategies in managing their children's behavior

Increase confidence in raising their children

Decrease behavior problems in their children for families experiencing difficult child behaviors and reduce stress associated with raising children

Families Need to Know

Treatment using MST typically involves multiple weekly visits between the therapist and family, over an average timespan of 3 to 5 months

The intensity of services can vary based on clinical needs; the therapist and family work together to determine how often and when services should be provided throughout the course of treatment

Therapists can deliver MST in multiple settings, including the home, school, and community

Cultural Relevance

MST has been shown to have positive outcomes for Black and Latinx children and families

MST has materials available in languages other than English, including Spanish and several European languages

MST's approach emphasizes the importance of cultural humility and cultural competence

DATA REQUIREMENTS FOR CQI

CQI is a critical part of implementing EBPs as part of California's Family First Prevention Services (FFPS) Prevention Plan. The California CQI Plan outlines expectations for counties and EBP providers to collect, analyze, and use data to monitor program delivery and support continuous improvement.

To guide this work, the CQI Plan identifies four core categories of data collection, each essential to understanding implementation and driving progress.

Key Metrics for Continuous Quality Improvement (CQI)

To support continuous improvement and federal IV-E compliance, agencies delivering evidence-based programs (EBPs) must regularly collect and review data across four core categories:

1. ***Capacity –*** *Measures the staffing, infrastructure, and resources required to deliver services effectively. Capacity data tracks the number of trained staff, supervisors, and service sites, helping counties and providers assess whether programs are adequately resourced to meet the needs of families.*

2. ***Reach –*** *Tracks the extent to which eligible children, youth, and families are identified, referred, and engaged in services. Reach data helps ensure services are accessible and equitably distributed, identifying gaps in engagement or disparities in service delivery.*

3. ***Outcomes*** *– Captures the impact of services on children, youth, and families, including measures of engagement, behavior change, and safety outcomes. Outcome data helps counties and providers understand whether services are achieving their intended goals and where additional support or adjustments may be needed.*

4. ***Fidelity –*** *Monitors whether services are delivered as intended, using approved fidelity monitoring tools or guidelines. Fidelity data helps ensure staff are meeting competency standards and following model expectations, which is critical for achieving desired outcomes and maintaining IV-E compliance.*

These metrics provide a comprehensive view of program effectiveness and should be used to guide local CQI activities and inform state-level monitoring.

More information on this framework can be found here: Measurement Framework for Implementing and Evaluation Preventive Services.

Together, these categories form the foundation for EBP-related CQI activities. Regularly reviewing data across these areas helps counties and EBP providers assess performance, surface barriers, and make informed adjustments to better support children and families.

Detailed definitions, indicators, and reporting expectations for each category specific to MST are provided in Appendix A.

MST-SPECIFIC DATA REQUIREMENTS

The MST Measurement Framework outlines how counties and EBP providers delivering MST should collect and use data across the four CQI domains – capacity, reach, fidelity, and outcomes. **Counties and EBP providers are expected to track data regularly across all domains to ensure timely, complete, and accurate information is available to support both local and state-level CQI activities.**

The California CQI Plan emphasizes the importance of both local and state-level CQI processes to promote continuous learning and accountability. **At the county level, data is used to assess implementation progress, identify barriers, and inform continuous improvement.** Counties are encouraged to partner with providers—ideally through CQI teams—to review and apply data to local decision-making. County CQI Team leads will pull relevant reports from CARES on a regular basis: monthly for site-level capacity and individual-level reach data, quarterly for individual-level fidelity and outcomes data, and biannually for aggregate-level dashboards.

At the state level, the CDSS uses data submitted through the CARES Provider Portal and MST's database, MSTI, to monitor program performance, generate Tableau dashboards, and fulfill Title IV-E reporting requirements under FFPSA. Federal reimbursement is contingent on meeting the requirements outlined in California's Five-Year Prevention Plan (see pages 27, 39, and 52). The CDSS is also working with the MST developer/purveyor to ensure biannual completion of the aggregate fidelity and outcomes templates (Appendix D) for upload into CARES.

Appendices A and B outline the required measures, data elements, and templates used for MST data collection across all four domains.

Data Collection and Use

Child Welfare agencies and Community-Based Organizations (CBOs) delivering MST should track utilization daily.

Site-Level Capacity Data

- ***Collection***: Entered into the CARES Provider Portal by MST providers and CBOs for families receiving MST services. Elements collected are listed in **Table 1** of Appendix A.
- ***Use***: CARES capacity reports will be pulled monthly by County CQI Team leads in preparation for their county CQI Teams and by the CDSS for statewide monitoring.

Individual-Level Reach Data

- ***Collection***: Entered into CARES for child welfare-involved families and into the CARES Provider Portal for Family First community pathway candidate families who are not involved with child welfare or probation. Elements collected are listed in **Table 2** of Appendix A.
- ***Use***: CARES reach reports will be pulled monthly by County CQI Team leads and by the CDSS for statewide monitoring.

Individual-Level Fidelity and Outcomes Data

- ***Collection***: Collected by MST providers and CBOs using a standardized template (Appendix B) or pulled from the MSTI.

- ***Use***: MST providers and CBOs will prepare and share this data quarterly with the County CQI Team leads, using either the standardized template or exports from the MSTI.

Aggregate-Level Fidelity and Outcomes Data

- ***Collection:*** Fidelity data reporting is split between MST providers and the developer/purveyor. MST providers will use the template in Appendix C to report some fidelity data biannually via the FFPSA portal in CARES. The CDSS is in the process of contracting with the MST developer/purveyor to complete the biannual purveyor templates (Appendix D) and submit them to the CDSS for upload into CARES.
- ***Use****:* County CQI Team leads will access aggregate-level fidelity and outcomes Tableau dashboards in CARES every six months for use in county CQI Teams.

For a full list of required MST measures and indicators, see Appendix A.

CQI TRAINING

To support the implementation of California's FFPS CQI Plan and the MST program, required training will be provided to county FFPS leads and MST providers. This training will be delivered over the course of up to three days and is designed to build the knowledge and skills needed to effectively engage in CQI activities. Additional information about the required CQI training is available in the California Family First Prevention Services Continuous Quality Improvement Implementation Plan.

RESOURCES

To ensure the successful implementation of MST, it is crucial to establish a strong relationship between the MST provider, the MST developer/purveyor, and the county. Here are the steps to initiate this process:

Providers Contact MST Services: Reach out to MST Services, the official developer/purveyor of Multisystemic Therapy. Contact information can be found on their website: www.mstservices.com. Initiate a conversation to discuss your interest in implementing MST and to seek guidance on the next steps.

Providers and County Leaders Contact Your Local CPP Lead: Providers or counties looking to implement MST for IV-E reimbursement should contact their local Comprehensive Prevention Planning Lead to ensure their implementation plans align with state and federal requirements, including IV-E reimbursement guidelines. Follow this link to determine your point of contact: https://cdss.ca.gov/Portals/9/CCR/FFPSA/ffps-title-iv-eagency-county-contact-list.pdf

You can also submit additional questions to the FFPS Inbox at FFPSAPreventionServices@dss.ca.gov

STAY CONNECTED!

The California Family First Prevention Services Continuous Quality Improvement (CQI) Plan was developed with input from the CDSS leadership, counties, and advisory subcommittees across the state. It outlines core CQI structures, guidance, and tools to support counties and providers.

California will continue to build on this work through the CQI Implementation Plan and other prevention resources. Check for updates at Prevention Resources – Child and Family Policy Institute of California, and reach out to FFPSAPreventionServices@dss.ca.gov to share questions, experiences, or lessons learned.

REFERENCES

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APPENDIX A: MST MEASUREMENT FRAMEWORK

This appendix outlines the data elements, indicators, reporting expectations, and CQI prompts for each of the four core measurement domains: capacity, reach, fidelity, and outcomes. **It is recommended that all stakeholders review and familiarize themselves with this information to clearly understand the expectations for tracking and assessing critical components of program implementation.** CQI prompts are included to guide discussions, identify successes, address barriers, and support effective program implementation and oversight.

Capacity

Capacity refers to the resources dedicated by the agency or program to effectively deliver services to children and families, including staffing, infrastructure, and service availability. Adequate capacity is essential for successful implementation of MST and influences the program's ability to meet community needs.

Table 1 outlines key capacity measures required to monitor program implementation. **MST providers will submit capacity data for each provider site monthly through the CARES Provider Portal.** Counties should review capacity data and conduct CQI activities monthly.

Table 1. Description of MST Capacity Data Elements

Measure	Indicator	Data Collection & Submission Responsibility	Data Collection Frequency	Data Submission Level (Counties & CDSS)	Data Submission Format (Counties & CDSS)	Reporting Cadence	
						Counties	CDSS
Staffing	Total # of provider agency sites	CBO/EBP Provider	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly
	Total # of full-time model-trained or certified practitioners	CBO/EBP Provider	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly
	Total # of supervisors	CBO/EBP Provider	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly
Supervisor / Practitioner Ratio	1:4	CBO/EBP Provider	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly
Full-time Caseload *(Part-time practitioners are not permitted)*	4-6 families for full-time practitioners	CBO/EBP Provider	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly
Service Duration	16 weeks	CBO/EBP Provider	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly

Capacity CQI Prompts:

- **Analyze Waitlist and Capacity Data: Combine waitlist information, reach data, and staffing levels to identify if more clinicians or service slots are needed in specific communities.**
- **Address Staffing Challenges: If Supervisor/Clinician ratios, caseloads, or service duration are not meeting standards, collaborate with providers to identify barriers and develop solutions.**
- **Evaluate Capacity Trends: Regularly review capacity data to detect patterns of increased demand and adjust staffing or resources accordingly.**

Reach

Reach refers to the extent to which the program engages its target population by ensuring eligible children and families are identified, referred, and actively enrolled in services. It measures how well MST is serving those it is intended to reach and whether the service is accessible to those in need.

Table 2 lists the reach data elements to be tracked for effective outreach and engagement. **MST providers will submit reach data monthly through the CARES Provider Portal.** Counties should review reach data and conduct CQI activities monthly.

Table 2. Description of Standardized Reach Data Elements

Measure	Indicator	Data Collection & Submission Responsibility	Data Collection Frequency	Data Submission Level (Counties & CDSS)	Data Submission Format (Counties & CDSS)	Reporting Cadence	
						Counties	CDSS
Eligible Child Welfare & Probation Candidates	Total # of FM/VFM/602 youth who come to the attention of the agency[1]	County Title IV-E Agency	Monthly	Individual-level	CARES	Monthly	Monthly
	Total # identified as a Family First candidate • FM – Family Maintenance • VFM – Voluntary Family Maintenance • 602 WIC Petition[2]	County Title IV-E Agency	Monthly	Individual-level	CARES	Monthly	Monthly
	Total # identified as a Family First pregnant or parenting youth in care (PPY)	County Title IV-E Agency	Monthly	Individual-level	CARES	Monthly	Monthly
	Total # not identified as a candidate	County Title IV-E Agency	Monthly	Individual-level	CARES	Monthly	Monthly
Eligible Community Pathway Candidates	Total # of community pathway children granted IV-E agency candidacy approval	County Title IV-E Agency	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly

	Total # of community pathway children denied IV-E agency candidacy approval
	• Reason for denial
	  ○ MH, SA, or PS imminent risk/need not identified
	  ○ Child outside of age range of the recommended EBP
		County Title IV-E Agency	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly

EBP Referrals to Providers	Total # candidates referred to an EBP provider	EBP Provider/CBO	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly
EBP Service Uptake	Total # candidates who started the EBP	EBP Provider/CBO	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly
	Total # candidates who did not start the EBP	EBP Provider/CBO	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly

[1] *Total number of referrals to Probation (inclusive of citations and arrests)*

[2] *Youth referred to Probation by a Law Enforcement Agency for alleged involvement in delinquent behavior that could result in a WIC 602 petition*

	• Reason did not start the EBP ○ No action taken; referral still in process ○ Placed on waitlist; median days on waitlist ○ Provider rejected referral ○ Provider unable to contact or engage with the family ○ Family did not consent, etc. ○ Other						
EBP Service Completion	Total # candidates who completed the full EBP	EBP Provider/CBO	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly
	Total # candidates who did not complete the full EBP • Reason did not complete the full EBP ○ Provider unable to contact or engage with family ○ Family withdrew ○ Family no longer eligible ○ Provider capacity issues ○ Other	EBP Provider/CBO	Monthly	Individual-level	CARES Provider Portal	Monthly	Monthly

Reach CQI Prompts:

Look at eligible child welfare and probation candidates and compare with the number referred to MST, started MST, and completed MST. Discuss strategies to address:

- **Service Flow: Compare eligible candidates to those referred, enrolled, and completed.**
- **Waitlists: Identify causes and reduce delays.**
- **Referral Rejections: Address common reasons for declined referrals.**
- **Family Contact: Improve provider outcome and engagement.**
- **Consent Issues: Increase family consent rates.**
- **Withdrawals: Identify strategies to reduce early terminations.**
- **Eligibility Changes: Minimize service disruptions.**
- **Provider Capacity: Align staffing and resources to demand.**

Outcomes

Outcomes refer to the measurable impacts of the program on children and families, demonstrating whether MST is achieving its intended goals. These metrics help assess program effectiveness and inform continuous quality improvement efforts.

Table 3 outlines the key outcome measures needed to monitor and evaluate program success. **The MST developer/purveyor will use a standardized template to submit outcome data to the CDSS biannually. The CDSS will upload developer/purveyor outcome data into the CARES backend for county CQI activities.** Counties should review outcome data and conduct CQI activities quarterly.

Table 3. Description of MST Outcome Data Elements

Measure	Indicator	Target Level	Data Collection Instrument	Data Collection Frequency	Data Submission Level		Data Submission Format		Data Reporting Cadence	
					Counties	CDSS	Counties	CDSS	Counties	CDSS
Maintain Family Stability	At discharge, % of youth still at home.	90%	Case Discharge Form	Collected at discharge	Individual-level	Aggregate	County-specific	Developer/Purveyor Template	Quarterly	Biannually
Maintain Educational & Vocational Involvement	At discharge, % of youth in school or working.	90%			Individual-level	Aggregate	County-specific	Developer/Purveyor Template	Quarterly	Biannually
Reduce Arrests	At discharge, % of youth not arrested during treatment.	90%			Individual-level	Aggregate	County-specific	Developer/Purveyor Template	Quarterly	Biannually

Outcomes CQI Prompts:

- **Review Discharge Data: Analyze youth discharge reports biannually to identify outcome trends and challenges. Share successful strategies among providers.**
- **Assess Population Impact: Compare reach data to identify which candidacy groups (e.g. probation vs. child welfare, FM vs. VFM) are benefitting most, considering factors like race, ethnicity, gender, and age.**

Fidelity

Fidelity refers to how closely the program follows the prescribed MST model to ensure services are delivered as intended. Maintaining high fidelity is crucial for achieving positive outcomes and ensuring program integrity.

Table 4 outlines the fidelity measures required to assess program adherence. Reporting on fidelity data will be divided between the provider and the developer/purveyor. **The MST developer/purveyor will submit their fidelity data to the CDSS using a standardized template biannually, while MST providers will use a separate template to report additional fidelity data biannually. The CDSS will upload developer/purveyor data into the CARES backend. Providers are responsible for uploading some training and staffing qualification data biannually via the FFPSA portal in CARES.** Counties should review fidelity data and conduct CQI activities quarterly.

Table 4. Description of MST Fidelity Data Elements

Measure	Indicator	Target Level	Data Collection Instrument	Data Collection Frequency	Data Submission Level		Data Submission Format		Data Reporting Cadence	
					Counties	CDSS	Counties	CDSS	Counties	CDSS
Provider Received & Maintained Required Training	% of therapists who have been working more than 2 months who complete the 5-day orientation training and obtain certification in MST.	100%	Collected by provider agencies	Collected once initial therapist training is completed	Individual-level	Aggregate	County-specific	Developer/Purveyor Template	Quarterly	Biannually
	% of supervisors who complete supervisor orientation training.	100%		Collected once initial supervisor training is completed	Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually
	% of therapists who participate in quarterly booster training.	100%		Collected quarterly	Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually
Provider Meets Staffing Qualification Requirements	% of therapists that have a master's degree in social work or counseling.	66%	Collected by provider agencies	Collected at program start-up and every six months during the Program Implementation Review	Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually
	% of clinicians who are part of a licensed MST program.	100%			Individual-level	Aggregate	County-specific	Provider Template	Quarterly	Biannually
Completion of the Therapist Adherence Measure Revised (TAM-R)	% of TAM-R due that are completed.	70%	Therapist Adherence Measure Revised (TAM-R)	Completed by caregivers during the second week of therapy and approximately every 4 weeks thereafter	Individual-level	Aggregate	County-specific	Developer/Purveyor Template	Quarterly	Biannually
	% of youth with at least one TAM-R interview.	100%			Individual-level	Aggregate	County-specific	Developer/Purveyor Template	Quarterly	Biannually
	Overall average TAM-R adherence score.	0.61			Individual-level	Aggregate	County-specific	Developer/Purveyor Template	Quarterly	Biannually
	% of youth reporting adherence above the threshold of 0.61.	80%			Individual-level	Aggregate	County-specific	Developer/Purveyor Template	Quarterly	Biannually

Fidelity CQI Prompts:

- **Verify Training and Qualifications: Review MSTI reports biannually to ensure adherence to training requirements, staff qualifications, and TAM-R completion rates.**
- **Address Implementation Challenges: If issues are identified, collaborate with providers and the model developer to develop solutions.**

APPENDIX B: STANDARDIZED PROVIDER TEMPLATE

This template is optional. MST providers will either pull all of the fidelity and outcome data fields depicted in the tables below from the MSTI on a quarterly basis for review during county CQI Team meetings, or complete the MST Fidelity and Outcomes Report Template, which can be downloaded from the Child and Family Policy Institute of California (CFPIC) website at this link. The standardized template can be used to examine differences in the indicators by gender, race, and ethnicity as defined in Technical Bulletin #1 which is necessary for identifying potential disparities in program outcomes and addressing them through the county CQI Team.

Below are sample screenshots of a portion of the outcome and fidelity data captured at the individual level in the standardized template. This is not the template that the MST purveyor will complete in aggregate on a biannual basis. Those templates can be found in Appendix D.

Fidelity			
Agency Name:		Site Name:	
Staff Identifier	Provider Received & Maintained Required Training		
Staff Name	**Has the therapist completed the 5-day orientation training and obtained certification in MST?**	**Has the supervisor completed orientation training?**	**Has the therapist participated in quarterly booster training?**

Outcomes											
Agency Name:			Site Name:								
Child Identifier											
DCFS/Probation Unique Identifier	**Model Child ID**	**Child Date of Birth**	**Child Sex**	**Child Hispanic or Latino Ethnicity**	**Child Race: White**	**Child Race: Black or African American**	**Child Race: Asian**	**Child Race: Native Hawaiian or Other Pacific Islander**	**Child Race: American Indian or Alaska Native**	**Child Race: Declined**	**Child Race: Unknown**

Outcomes		
Maintain Family Stability	Maintain Educational & Vocational Involvement	Reduce Arrests
At discharge, was the youth still at home?	**At discharge, was the youth in school or working?**	**At discharge, was the youth not arrested during treatment?**

APPENDIX C: PROVIDER FIDELITY TEMPLATE

Providers will complete the aggregate fidelity template provided below. Providers are responsible for uploading their own fidelity documentation biannually via the FFPSA portal in CARES. Counties will be able to access this data in aggregate through Tableau dashboards.

MST Fidelity Measures

Multisystemic Therapy (MST)				
Providers submit percentage for <u>each location</u> via data file.				
Measure	**Provider received and maintained required training**		**Meets staffing qualification requirements**	
Indicator	*% of supervisors who complete supervisor orientation training.*	*% of therapists who participate in quarterly booster training.*	*% of therapists who have a master's degree in social work or counseling.*	*% of clinicians who are part of a licensed MST program.*
Target Level	100%	100%	100%	100%
Site 1				
Site 2				

APPENDIX D: DEVELOPER/PURVEYOR OUTCOME & FIDELITY TEMPLATES

The developer/purveyor will complete the aggregate fidelity and outcome templates provided below and will submit these to the CDSS biannually. The CDSS will upload them into the backend of CARES. Counties will be able to access this data in aggregate through Tableau dashboards.

MST Outcome Measures

Multisystemic Therapy (MST)			
Purveyor will submit percentage for <u>each location</u> via data file.			
Measure	**Maintain family stability**	**Maintain educational and vocational involvement**	**Reduce arrests**
Indicator	*At discharge, % of youth still at home.*	*At discharge, % of youth in school or working.*	*At discharge, % of youth not arrested during treatment.*
Target Level	90%	90%	90%
Site 1			
Site 2			

MST Fidelity Measures

Multisystemic Therapy (MST)					
Purveyor will submit percentage for <u>each location</u> via data file.					
Measure	**Provider received and maintained required training**	**Completion of the Therapist Adherence Measure Revised (TAM-R)**			
Indicator	*% of therapists who have been working for more than 2 months who completed the 5-day orientation training and obtained certification in MST.*	*% of TAM-R due that are completed.*	*% of youth with at least one TAM-R interview.*	*Overall average TAM-R adherence score.*	*% of youth reporting adherence above the threshold (>0.61).*
Target Level	100%	70%	100%	0.61	80%
Site 1					
Site 2					