MRSS Team Fidelity Tool 5.21.2025

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MRSS TEAM FIDELITY TOOL					
Rating	**0**	**1**	**2**	**3**	**4**
1. Benchmark Score		**Emerging Implementation** Less than 69% of total points 25 or fewer points)	**Developing Implementation** 79-70% of total points (26-29)	**Effective Implementation** 89-80% of total points (33-30)	**Best Practice Implementation** 100-90% of total points (38-34)
2. Initial Mobile Response	a) Paraprofessionals respond to mobiles individually b) Elements of crisis assessment are missing c) No collaborative safety planning d) Staff providing interventions outside of scope of practice e) Clinicians are not involved in the mobile response	Initial mobile response includes 3 out of 5 elements (e required)	Initial mobile response includes 4 out of 5 elements (e required)	**a)** staff composition at initial response **b)** MRSS Comprehensive Crisis Assessment c) Collaborative safety planning d) Stabilization strategies consistent with a crisis response, within staff scope of practice. e) If a clinician is not present for the initial mobile response, paraprofessionals contact the MRSS clinician before leaving the response so that the clinician can participate in the initial mobile response by telehealth, phone, or in person.	**a)** Staff composition at initial response **b)** MRSS Comprehensive Crisis Assessment **c)** Collaborative safety planning **d)** Stabilization strategies consistent with a crisis response, within staff scope of practice **e)** A clinician physically responds to all initial mobile responses

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3. Safety planning	Comprehensive safety planning done in less than 100% of charts and includes two or less of seven criteria (a-e)	Comprehensive safety planning in less than 100% of charts and includes three out of seven criteria (a–e).	Comprehensive safety planning in less than 100% of charts and includes four out of seven criteria (a-e).	Comprehensive safety planning is present in 100% of stabilization charts reviewed and includes six out of seven criteria (a-e).	Comprehensive safety plans are present in 100% of charts reviewed. **a)** Assessment of safety concerns, risk behaviors, escalation patterns, and crisis triggers. **b)** Safety plans have actionable crisis stabilization steps created in collaboration with youth and family with strategies that are easily understood. **c)** Risk mitigation and safety promotion steps were identified, implemented, monitored, and updated as needed. **d)** Safety plans incorporate natural supports & do not rely exclusively on professional resources. **e)** Individualized safety plans, signed by youth, caregiver, and **MRSS staff**. Documentation of plan being provided to the family. f) Safety plans developed by non-licensed staff are reviewed and approved by licensed clinical staff
4). MRSS Plan	MRSS plans include 1 or less out of 5 criteria listed	MRSS plans include 2 out of 5 criteria listed	MRSS plans include 3 out of 5 criteria listed	MRSS plans are present in 100% of charts reviewed and include 4 out of 5 criteria listed	MRSS Plans are present in 100% of charts reviewed **a**) Includes youth/family voiced goal **b**) Appropriate provider and youth/family objectives and interventions **c**) individualized to the unique strengths, needs, and risk/safety factors of youth/family d) Youth/family collaboration to create MRSS plan **e**) If created by paraprofessional, a licensed clinician is consulted and approves the MRSS plan

5. Stabilization Services	MRSS program routinely provide 0 of 6 services listed	MRSS program routinely provide 1-2 of 6 services listed	MRSS program routinely provide 3-4 of 6 services listed	MRSS program routinely provides 5 of 6 services listed	**Trauma-informed stabilization services and supports are provided as evidenced by:** **a**) Ongoing crisis stabilization activities appropriate for staff's scope of practice. **b)** System navigation, advocacy, continuity of care (inclusive of connection with existing BH providers) and linkage/referrals **c) E**vidence of youth and caregiver skill building. **d)** Individual and family support network development. **e**) MRSS episode of care exceeds 42 days in less than 10% of the cases served. **f)** Evidence of transition meeting and/or cross system team planning.
6. System of Care Perspective	MRSS is implemented utilizing system of care principles as evidenced by meeting 2 or less of the 6 criteria (a-f).	MRSS is implemented utilizing system of care principles as evidenced by meeting 3 out of the 6 criteria (a-f).	MRSS is implemented utilizing system of care principles as evidenced by meeting 4 out of the 6 criteria (a-f).	MRSS is implemented utilizing system of care principles as evidenced by meeting 5 out of the 6 criteria (a-f).	**MRSS is implemented utilizing System of Care principles including:** **a)** Culturally and linguistically appropriate **b)** Trauma-informed **c)** Resiliency–focused and developmentally appropriate **d)** Strength-based **e)** Youth guided, family-driven **f)** Individualized to the unique needs and strengths of the youth and family

7. Clinical Supervisory Management, Support, and Availability	Supervisory support as evidenced by one or fewer criteria met.	Supervisory support as evidenced by 2 out of 5 criteria.	Supervisory support as evidenced by 3 out of 5 criteria (criteria a required).	Supervisory support as evidenced by 4 out of 5 criteria (criteria a required).	**Best practice criteria:** **a)** Staff receive individual supervision, that is appropriate for the staff person's role, scope, and expertise. **b)** Weekly group supervision conducted by a clinical supervisor or alternate clinical supervisor. **c)** Supervisory support is available 24/7 to MRSS staff for emergency consultation and supervision. **d)** Clinical Supervisor or alternate clinical supervisor is available for on-call back up for MRSS families. **e**) Work in alignment/cooperation with RMP for triaging and monitoring of level of acuity for every youth and family served is conducted by the clinical supervisor or clinical alternate supervisor who also assists staff in tailoring the service intensity to the stabilization needs of each youth and family.
8. Professional training and development	Professional training and development as evidenced by one of the five criteria (a-c).	Professional training and development as evidenced by 2 out of 5 criteria (a-c).	Professional training and development as evidenced by 3 out of 5 criteria (a-c).	Professional training and development as evidenced by 4 out of 5 criteria (a-d).	**Best practice criteria:** **a**) Every MRSS staff member, including the supervisor and peer supervisor, complete the MRSS required trainings within the designated time frame for their role. **b**) Each MRSS staff including supervisor, peer supervisor, and after-hours coverage staff have an individualized training plan based on an assessment of his or her specific training needs. **c)** Each MRSS supervisor receives training specific to the clinical & administrative supervision of MRSS. **d)** Each agency has a written description of the skills and competencies required to provide MRSS service. **e)** The agency's training plan includes provisions for quarterly trainings specific to the identified training needs of the staff.

9. Quality Management and Practice improvement	Quality and practice improvement strategies utilized as evidenced by 1 or less of 5- no Family Satisfaction data submitted	Quality and practice improvement strategies utilized as evidenced by 2 out of 5.	Quality management and practice improvement as evidenced by 3 of the 5 criteria	Quality management and practice improvement as evidenced by 4 of the 5 criteria (criteria a required).	**Best practice criteria:** **a**) Family Satisfaction with services data is collected and utilized for quality improvement. (comprehensive FSI report from BG or paper copies) **b)** External clinical consultant utilized. **c**) Benchmarks are regularly tracked and reviewed (i.e., response time for initial call etc.) and utilized in program quality improvement. **d**) Data is regularly shared and reviewed with MRSS team **e)** Has an integrated quality management and practice improvement structure between the MRSS team and the RMP
10. Worker Safety	Worker safety protocols are evidenced by 2 out of 6 criteria.	Worker safety protocols are evidenced by 3 out of 6 criteria.	Worker safety protocols are evidenced by 4 out of 6 criteria	Worker safety protocols are evidenced by 5 out of 6 criteria.	**Worker Safety includes the following criteria:** **a)** Program has written protocols and policies for worker safety. **b)** Supervisor and/or team leader as well as administrative supervisor have access to staff schedules. **c)** Program has a protocol for staff check-ins when appointments are finished. **d)** Supervisor/licensed consultant are available 24/7 **e)** Safety screening protocol for first visit is utilized **f)** Staff are issued agency cell phones and hot spot technology (or are reimbursed for these).

11. MRSS Staffing	**Team Composition and Program Capacity**: **a)** Independently licensed clinical Supervisor (less than 24% dedicated to the program). **b)** No access to psychiatrist or certified nurse practitioner or clinical nurse specialist. **c)** MRSS staff member(s) operate in isolation **d**) No licensed clinician on the team.	**Team Composition and Program Capacity**: **a)** Independently licensed clinical supervisor (25 -49% dedicated to the program) and **b)** Licensed clinician; and **c)** QBHS; OR a certified family or young adult peer support. **d)** Limited or no access to psychiatrist or certified nurse practitioner or clinical nurse specialist.	**Team Composition and Program Capacity**: **a)** Independently licensed clinical Supervisor (50-74% dedicated to the needs of the program); and **b)** Licensed clinician; and **c)** QBHS; OR a certified family or young adult peer support. **d)** Timely access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes.	**Team Composition and Program Capacity**: **a)** Independently licensed clinical Supervisor(s) (75%-99% dedicated to the needs of the program); and **b)** Licensed clinician; and **c)** QBHS; OR a certified family or young adult peer support. **d)** Timely access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes.	**Team Composition and Program Capacity**: **a)** Independently licensed clinical Supervisor(s) (100% dedicated to the needs of the program); and **b)** Licensed clinician; and **c)** QBHS; OR a certified family or youth peer supporter. **d)** Timely access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes.

12. MRSS Capacity	a) MRSS Services are available for an immediate mobile response only during weekday business hours.	a) MRSS service. available during 8.00 am - 8.00 pm Monday thru Friday, excluding holidays evidenced by the weekly staffing schedule. b) Insufficient staff are available to respond next business day to calls received after hours c) Insufficient staff are available during periods of high-call volume and staff do need to reschedule stabilization.	a) MRSS service. available during 8.00 am - 8.00 pm Monday thru Friday, including holidays evidenced by the weekly staffing schedule. b) Sufficient staff are available to respond next business day to calls received after hours c) Sufficient staff are available during periods of high-call volume and staff do not need to reschedule stabilization.	a) MRSS service. available during 8.00 am - 8.00 pm, including holidays and weekends, evidenced by the weekly staffing schedule. b) Sufficient staff are available to respond next business day to calls received after hours c) Sufficient staff are available during periods of high-call volume and staff do not need to reschedule stabilization.	a) Mobile services are available for an immediate full 24/7 response, as evidenced by weekly staffing schedule. b) Sufficient staff are available during periods of high-call volume - staff do not need to reschedule stabilization.