*S*tate *H*ealth *A*uthority *Y*ardstick

The SHAY Rating Scale

Version of 3-12-07

This scale is described in:

Finnerty, M. T., Rapp, C. A., Bond, G. R., Lynde, D. W., Ganju, V. J., & Goldman, H. H. (2009). The State Health Authority Yardstick (SHAY). *Community Mental Health Journal, 45*, 228-236.

a. **Rater: _____**
b. **EBP (separate SHAY must be completed for each EBP): _____**
c. **State: _____**
d. **Number of outpatient programs implementing this EBP model statewide: _____**
e. **Total number of outpatient MH programs statewide: _____**
f. **Penetration: calculate EBP sites/total outpatient MH programs = _____**
g. **Today's Date: _____**
h. **Date the state committed to implementation of this EBP (e.g. state "kick off", initiation of state campaign): _____**
i. **Date the first site initiated implementation of the EBP (e.g. began training in the EBP): _____**

Instructions:
Ideally the SHAY should be completed by two raters, who make independent ratings, then discuss their scores, and come to a final consensus score for each item. Raters may need to interview one or more state staff in order to rate items (e.g. the commissioner, EBP point person, operations staff, budget staff) as well as site staff (e.g. EBP program leader). When there are differences across EBP sites, rate the typical program.

1. EBP Plan

The SMHA has an EBP plan to address the following:
(Use boxes to identify which components are included in the plan)
Note: The plan does not have to be a written document, or if written, does not have to be distinct document, but could be part of the state's overall strategic plan. However if not written the plan must be common knowledge among state employees, e.g. if several different staff are asked, they are able to communicate the plan clearly and consistently.

☐	1)	A defined scope for initial and future implementation efforts,
☐	2)	Strategy for outreach, education, and consensus building among providers and other stakeholders,
☐	3)	Identification of partners and community champions,
☐	4)	Sources of funding,
☐	5)	Training resources,
☐	6)	Identification of policy and regulatory levers to support EBP,
☐	7)	Role of other state agencies in supporting and/or implementing the EBP,
☐	8)	Defines how EBP interfaces with other SMHA priorities and supports SMHA mission
☐	9)	Evaluation for implementation and outcomes of the EBP
☐	10)	The plan is a written document, endorsed by the SMHA

Score

☐	1. No planning activities
☐	2. 1 – 3 components of planning
☐	3. 4 – 6 components of planning
☐	4. 7 – 9 components
☐	5. 10 components

Evidence Used to Justify Rating

2. Financing: Adequacy

Is the funding model for the EBP adequate to cover costs, including direct service, supervision, and reasonable overhead? Are all EBP sites funded at the same level? Do sites have adequate funding so that practice pays for itself?
Note: Consider all sources of funding for the EBP that apply (Medicaid fee-for-service, Medicaid waiver, insurance, special grant funds, vocational rehabilitation funds, department of education funds, etc.) Adequate funding (score of 4 or 5) would mean that the practice pays for itself; all components of the practice financed adequately, or funding of covered components is sufficient to compensate for non-covered components (e.g. Medicaid reimbursement for covered supported employment services compensates for non-covered on inadequately covered services, e.g. job development in absence of consumer). Sources: state operations and budget, site program managers. If financing is variable among sites, estimate average.

Score:

	1. No components of services are reimbursable
	2. Some costs are covered
	3. Most costs are covered
	4. Services pays for itself (e.g. all costs covered adequately, or finding of covered components compensates for non-covered components)
	5. Service pays for itself and reimbursement rates attractive relative to competing non-EBP services.

Evidence Used to Justify Rating

3. Financing: Start-up & Conversion Costs

Are costs of start up and or conversion covered, including: 1) Lost productivity for staff training, 2) hiring staff before clients enrolled (e.g. ACT), 3) any costs associated with agency planning and meetings, 4) changing medical records if necessary, 5) computer hardware and/or software if necessary, etc. *Note: If overall fiscal model is adequate to cover start-up costs then can rate 5. If financing is variable among sites, estimate average. Important to verify with community EBP program leaders/ site program managers.*

Score:

	1. No costs of start-up are covered
	2. Few costs are covered
	3. Some costs are covered
	4. Majority of costs are covered
	5. Programs are fully compensated for costs of conversion

Evidence Used to Justify Rating

4. Training: Ongoing consultation and technical support

Is there ongoing training, supervision and consultation for the program leader and clinical staff to support implementation of the EBP and clinical skills:
(Use boxes to indicate criteria met.)
Note: If there is variability among sites, then calculate/estimate the average visits per site..

	1) Initial didactic training in the EBP provided to clinicians (e.g. 1-5 days intensive training)
	2) Initial agency consultation re. implementation strategies, policies and procedures, etc. (e.g. 1 - 3 meetings with leadership prior to implementation or during initial training)
	3) Ongoing training for practitioners to reinforce application of EBP and address emergent practice difficulties until they are competent in the practice (minimum of 3 months, e.g. monthly x 12 months)
	4) On site supervision for practitioners, including observation of trainees clinical work and routines in their work setting, and feedback on practice. Videoconferencing that includes clients can substitute for onsite work (minimum of 3 supervision meetings or sessions for each trainee, e.g. monthly x 12 months).
	5) Ongoing administrative consultation for program administrators until the practice is incorporated into routine work flow, policies and procedures at the agency (minimum of 3 months, e.g. monthly X 12 months)

Score

	1. 0-1 components
	2. 2 components
	3. 3 components
	4. 4 components
	5. 5 components

Evidence Used to Justify Rating

5. Training: Quality

Is a high quality training delivered to each site? High quality training should include the following:
(Use boxes to indicate which components are in place.
Note: If there is variation among sites calculate/estimate the average number of components of training across sites.)

- ☐ 1) credible and expert trainer,
- ☐ 2) active learning strategies (e.g. role play, group work, feedback,
- ☐ 3) good quality manual, e.g. SAMHSA Toolkit,
- ☐ 4) comprehensively addresses all elements of the EBP,
- ☐ 5) modeling of practice for trainees, or opportunities to shadow/observe high fidelity clinical work delivered,
- ☐ 6) high quality teaching aides/materials including workbooks/work sheets, slides, videos, handouts, etc, e.g. SAMHSA Toolkit/ West Institute.

Score:

- ☐ 1. 0 components
- ☐ 2. 1 - 2 components
- ☐ 3. 3 - 4 components
- ☐ 4. 5 components
- ☐ 5. all 6 components of a high quality training

Evidence Used to Justify Rating:

6. Training: Infrastructure / Sustainability

Has the state established a mechanism to allow for continuation and expansion of training activities related to this EBP, for example relationship with a university training and research center, establishing a center for excellence, establishing a learning network or learning collaborative. This mechanism should include the following components:
(Use boxes to indicate which components are in place)

- ☐ 1) offers skills training in the EBP,
- ☐ 2) offers ongoing supervision and consultation to clinicians to support implementation in new sites,
- ☐ 3) offer ongoing consultation and training for program EBP leaders to support their role as clinical supervisors and leaders of the EBP,
- ☐ 4) build site capacity to train and supervise their own staff in the EBP,
- ☐ 5) offers technical assistance and booster trainings in existing EBP sites as needed,
- ☐ 6) expansion plan beyond currently identified EBP sites,
- ☐ 7) one or more identified model programs with documented high fidelity that offer shadowing opportunities for new programs,
- ☐ 8) SMHA commitment to sustain mechanism (e.g. center of excellence, university contracts) for foreseeable future, and a method for funding has been identified.

Score:

- ☐ 1. No mechanism
- ☐ 2. 1 - 2 components
- ☐ 3. 3 - 4 components
- ☐ 4. 5 - 6 components
- ☐ 5. 7 - 8 components

Evidence Used to Justify Rating:

7. Training: Penetration

What percent of sites have been provided high quality training (score of 3 or better on question #5, see note below), and ongoing training (score of 3 or better on question #4, see note below).

Note: *If both criteria are not met, does not count for penetration. Refers to designated EBP sites only.*

High quality training should include 3 or more of the following components:

1) *credible and expert trainer,*
2) *active learning strategies (e.g. role play, group work, feedback,*
3) *good quality manual (e.g. SAMHSA toolkit),*
4) *comprehensively addresses all elements of the EBP,*
5) *modeling of practice for trainees, or opportunities to shadow/observe high fidelity clinical work delivered,*
6) *high quality teaching aids/ materials including workbooks/ work sheets, slides, videos, handouts, etc. e.g. SAMHSA toolkit/ West Institute.*

Ongoing training should include 3 or more of the following components:

1) *Initial didactic training in the EBP provided to clinicians (e.g. 1-5 days intensive training)*
2) *Initial agency consultation re. implementation strategies, policies and procedures, etc. (e.g. 1 - 3 meetings with leadership prior to implementation or during initial training)*
3) *Ongoing training for practitioners to reinforce application of EBP and address emergent practice difficulties until they are competent in the practice (minimum of 3 months, e.g. monthly x 12 months)*
4) *On site supervision for practitioners, including observation of trainees clinical work and routines in their work setting, and feedback on practice. Videoconferencing that includes clients can substitute for onsite work (minimum of 3 supervision meetings or sessions for each trainee, e.g. monthly x 12 months).*
5) *Ongoing administrative consultation for program administrators until the practice is incorporated into routine work flow, policies and procedures at the agency (minimum of 3 months, e.g. monthly X 12 months)*

Score:

- [ ] 1. 0-20%
- [ ] 2. 20-40%
- [ ] 3. 40-60%
- [ ] 4. 60-80%
- [ ] 5. 80-100%

Evidence Used to Justify Rating:

8. SMHA Leadership: Commissioner Level

Commissioner is perceived as a effective leader (influence, authority, persistence, knows how to get things done) concerning EBP implementation who has established EBPs among the top priorities of the SMHA as manifested by:
(Use boxes to indicate components in place.)
Note: Rate existing Commissioner, even if new to post.

- ☐ 1) EBP initiative is incorporated in the state plan, and or other state documents that establish SMHA priorities,
- ☐ 2) Allocating one or more staff to EBP, including identifying and delegating necessary authority to an EBP leader for the SMHA,
- ☐ 3) Allocation of non-personnel resources to EBP (e.g. money, IT resources, etc.),
- ☐ 4) Uses internal and external meetings, including meetings with stakeholders, to express support for, focus attention on, and move EBP agenda,
- ☐ 5) Can cite successful examples of removing policy barriers or establishing new policy supports for EBP.

How long has the current Commissioner held the post? _____
How long has the current Commissioner worked in the agency? _____

Score:

- ☐ 1. 0 - 1 component
- ☐ 2. 2 components
- ☐ 3. 3 components
- ☐ 4. 4 components
- ☐ 5. all 5 components

Evidence Used to Justify Rating:

9. SMHA Leadership: Central Office EBP Leader

There is an identified EBP leader (or coordinating team) that is characterized by the following:
(Use boxes to indicate which components in place.)
Note: Rate current EBP leader, even if new to post.

☐	1) EBP leader has adequate dedicated time for EBP implementation (min 10%), and time is protected from distractions, conflicting priorities, and crises,
☐	2) There is evidence that the EBP leader has necessary authority to run the implementation,
☐	3) There is evidence that EBP leader has good relationships with community programs,
☐	4) Is viewed as an effective leader (influence, authority, persistence, knows how to get things done) for the EBP, and can site examples of overcoming implementation barriers or establishing new EBP supports.

How long has the current EBP leader held the post? _____
How long has the current EBP leader worked in the agency? _____

Score:

- ☐ 1. No EBP leader
- ☐ 2. 1 component
- ☐ 3. 2 components
- ☐ 4. 3 components
- ☐ 5. All 4 components

Evidence Used to Justify Rating

10. Policy and Regulations: Non SMHA State Agencies

The SMHA has developed effective interagency relations (other state agencies, counties, governors office, state legislature) to support and promote the EBP as necessary/appropriate, identifying and removing or mitigating any barriers to EBP implementation, and has introduced new key facilitating regulations as necessary to support the EBP.

Ask SMHA staff and site leadership: What regulations or policies support the EBP implementation? What regulations or policies get in the way? Note: give most weight to policies that impact funding.

Examples of supporting policies:

- Medicaid agency provides reimbursement for the EBP (If Medicaid not under the SMHA)
- The state's vocational rehabilitation agency pays for supported employment programs
- The state's substance abuse agency pays for integrated treatment for dual disorders
- Department of Professional Licensing requires EBP training for MH professionals

Examples of policies that create barriers:

- Medicaid agency excludes EBP, or critical component, e.g. disallows any services delivered in the community (If Medicaid agency not under the SMHA)
- State substance abuse agency prohibits integrated treatment, or will not reimburse for integrated treatment
- State substance abuse agency and state mental health authority are divided, and create obstacles for programs attempting to develop integrated service programs
- State vocational rehabilitation agency does not allow all clients looking for work access to services, or prohibits delivery of other aspects of the supported employment model
- Department of Corrections policies that create barriers to implementation of EBPs

Score:

	1. Virtually all policies and regulations impacting the EBP act as barriers
	2. On balance, policies that create barriers outweigh policies that support/promote the EBP
	3. Policies that are support/promote the EBP are approximately equally balanced by policies that create barriers
	4. On balance, policies that support/promote the EBP outweigh policies that create barriers
	5. Virtually all policies and regulations impacting the EBP support/promote the EBP

Evidence Used to Justify Rating:

11. Policies and Regulations: SMHA

The SMHA has reviewed its own regulations, policies and procedures to identify and remove or mitigate any barriers to EBP implementation, and has introduced new key regulations as necessary to support and promote the EBP.

Ask SMHA staff and site leadership: What regulations or policies support the EBP implementation? What regulations or policies get in the way?

Examples of supporting policies:

- *SMHA ties EBP delivery to contracts*
- *SMHA ties EBP to licensing/ certification/ regulation*
- *SMHA develops EBP standards consistent with the EBP model*
- *SMHA develops clinical guidelines or fiscal model designed to support model EBP implementation*

Examples of policies that create barriers:

- *SMHA develops a fiscal model or clinical guidelines that directly conflict with EBP model, e.g. ACT staffing model with 1:20 ratio*
- *SMHA licensing/ certification/ regulations directly interfere with programs ability to implement EBP*

Score:

	1. Virtually all policies and regulations impacting the EBP act as barriers
	2. On balance, policies that create barriers outweigh policies that support/promote the EBP
	3. Policies that are support/promote the EBP are approximately equally balanced by policies that create barriers
	4. On balance, policies that support/promote the EBP outweigh policies that create barriers
	5. Virtually all policies and regulations impacting the EBP support/promote the EBP

Evidence Used to Justify Rating:

12. Policies and Regulations: SMHA EBP Program Standards

The SMHA has developed and implemented EBP standards consistent with the EBP model with the following components:
(Use boxes to identify which criteria have been met)

	1) Explicit EBP program standards and expectations, consonant with all EBP principles and fidelity components, for delivery of EBP services. *(Note: fidelity scale may be considered EBP program standards, e.g. contract requires fidelity assessment with performance expectation)*
	2) SMHA has incorporated EBP standards into contracts, criteria for grant awards, licensing, certification, accreditation processes and/or other mechanisms
	3) Monitors whether EBP standards have been met,
	4) Defines explicit consequences if EBP standards not met (e.g. contracts require delivery of model supported employment services, and contract penalties or non-renewal if standards not met; or licensing/accreditation standards if not met result in consequences for program license.)

Score:

	1. No components (e.g. no standards and not using available mechanisms at this time)
	2. 1 component
	3. 2 components
	4. 3 components
	5. 4 components

Evidence Used to Justify Rating:

13. Quality Improvement: Fidelity Assessment

There is a system in place for conducting ongoing fidelity reviews by trained reviewers characterized by the following components:
(Use boxes to indicate criteria met.)
Note: If fidelity is measured in some but not all sites, answer for the typical site.

	1) EBP fidelity (*or functional equivalent designed to assess adherence to all critical components of the EBP model) is measured at defined intervals*
	2) GOI fidelity (*or functional equivalent designed to assess adherence to all critical components required to implement and sustain delivery of EBP) is measured at defined intervals.*
	3) Fidelity assessment is measured independent – i.e. not assessed by program itself, *but by SMHA or contracted agency*
	4) Fidelity is measured a minimum of annually
	5) Fidelity performance data is given to programs and used for purposes of quality improvement
	6) Fidelity performance data is reviewed by the SMHA +/- local MHA
	7) The SMHA routinely uses fidelity performance data for purposes of quality improvement, to identify and response to high and low performers (e.g. recognition of high performers, or for low performers develop corrective action plan, training & consultation, or financial consequences, etc.).
	8) The fidelity performance data is made public (e.g. website, published in newspaper, etc.)

Score:

	1. 0 – 1 components
	2. 2 –3 components
	3. 4 – 5 components
	4. 6 – 7 components
	5. All 8 components

Evidence Used to Justify Rating

14. Quality Improvement: Client Outcomes

A mechanism is in place for collecting and using client outcome data characterized by the following:
(Use boxes to indicate criteria met.)
Note: Client outcomes must be appropriate for the EBP, e.g. Supported employment outcome is persons in competitive employment, and excludes prevoc work, transitional employment, and shelter workshops. If outcome measurement is variable among sites, consider typical site.

	1) Outcome measures, or indicators are standardized statewide, AND the outcome measures have documented reliability/validity, or indicators are nationally developed/recognized
	2) Client outcomes are measured every 6 months at a minimum
	3) Client outcome data is used routinely to develop reports on agency performance
	4) Client specific outcome data are given to programs and practitioners to support clinical decision making and treatment planning
	5) Agency performance data are given to programs and used for purposes of quality improvement
	6) Agency performance data are reviewed by the SMHA +/- local MHA
	7) The SMHA routinely uses agency performance data for purposes of quality improvement; performance data trigger state action. Client outcome data is used as a mechanism for identification and response to high and low performers (e.g. recognition of high performers, or for low performers develop corrective action plan, training & consultation, or financial consequences, etc.).
	8) The agency performance data is made public (e.g. website, published in newspaper, etc.)

Scores:

	1. 0 components
	2. 1 – 2 components
	3. 3 – 5 components
	4. 6 – 7 components
	5. All 8 components

Evidence Used to Justify Rating

15. Stakeholders

The degree to which consumers, families, and providers are opposed or supportive of EBP implementation.
Note: Ask - Did stakeholders initially have concerns about or oppose EBPs? Why? What steps were taken to reassure/engage/partner with stakeholders. Were these efforts successful? To what extent are stakeholders currently supportive this EBP? Opposed? In what ways are stakeholders currently supporting/ advocating against this EBP? Rate only current opposition/support.

Scores:

1. Active, ongoing opposition to the EBP
2. Opposition outweighs support, or opinion is evenly split, but no active campaigning against EBP
3. Stakeholder is generally indifferent
4. Generally supportive, but no partnerships, or active proponents.
5. Stakeholder advocacy organization leadership/opinion leaders currently offer active, ongoing support for the EBP. Evidence of partnering on initiative.

	15. Summary Stakeholder Score: (Average of 3 scores below)
	15.a Consumers Stakeholders Score
	15.b Family Stakeholders Score
	15.c Providers Stakeholders Score

Evidence to Justify Ratings:

Summary of Scores

1. EBP Plan _____
2. Financing: Adequacy _____
3. Financing: Start-up and Conversion Costs _____
4. Training: Ongoing Consultation & Technical Support _____
5. Training: Quality _____
6. Training: Infrastructure / Sustainability _____
7. Training: Penetration _____
8. SMHA Leadership: Commissioner Level _____
9. SMHA Leadership: EBP Leader _____
10. Policy and Regulations: Non-SMHA _____
11. Policy and Regulations: SMHA _____
12. Policy and Regulations: SMHA EBP Program Standards _____
13. Quality Improvement: Fidelity Assessment _____
14. Quality Improvement: Client Outcome _____
15. Stakeholders: Aver. Score (Consumer, Family, Provider) _____

Stakeholders: individual scores

15.a Consumers : 15.b Families: 15.c Providers:

OVERALL SHAY SCORE = SUM TOTAL _____ ÷15 = _____