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| TITLE / ROLE | Barriers to implementation of the Bree Collaborative Guidelines |
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| INTRODUCTION |
| In 2023 the Bree Collaborative launched two different methods for collecting data on barriers and facilitators to the implementation of the Bree Collaborative Guidelines.  |
| METHODS |
| Score cards were sent out to selected organizations via email as part of the Bree’s 2023 “look back” evaluation.The survey was posted on the Bree collaborative website and social media and sent out to select organizations via email. Organizations were selected to receive both the survey and the score cards if they are part of the Bree Collaborative or if any of their staff had attended a Bree Collaborative event. We used two different methods to capture information about barriers due to technology constraints. The “score card” method asked respondents to rank a list of barriers from 1-5 with one being the highest and five being the lowest. To generate the Y axis scores for the “score card method” ranks were then averaged across all respondents to create an average score. Scores were then weighted taking the inverse of the average score (5-average score) and multiplying it by number of respondents. Score Cards were sent out to organizational leads. The barriers list was similar to the 2016 Bree Collaborative evaluation in order to better understand if barriers had changed between 2016 and 2023 (see Evaluation report for results). The “Health System Survey” method provided a list and asked respondents to choose their top three. To generate the Y axis scores for “surveys” scores were calculated on the number of picks for each item (simple count). The Health System Survey was posted on the Bree Collaborative website and open to all organizations and all staff at any level of the organization. Both methods relied on convenience reporting and both methods provided an “other” option for organizations to fill in responses not listed.  |
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| DATA |
| Respondents for this survey included large health systems, health plans, educational organizations, behavioral health organizations, physician’s groups, and community-based organizations. The score card method received responses from 5 organizations over 8 lines of business. The survey method received 27 responses between June 9th, 2023, and July 8th, 2024.Scores used for Chart 1 were calculated as noted in the Methods section above.Scores used for Chart 2 were calculated as noted in the Methods section above.Scores for Chart 3 were calculated as described in the methods section above. The Y axis represents the score for the score card method and a proportion for the survey method. The difference in methods is unlikely to have much impact on the findings when comparing the two. Because the score card method used counts only, comparison of barriers by audience type was done using percentages for Chart 4. Health plans and purchasers had an N of 4 and health systems had an N of 11. The survey method was calculated as a proportion using an N of 6.The score card method allowed for direct comparison of scores by audience type as shown in Chart 5, which identifies the top four barriers. |

DESCRIPTION OF FINDING |
| These methods provided the Bree Collaborative with some initial data to identify barriers broadly and to measure changes in barriers from the previous evaluation in 2016.The difference in methods provides some understanding of perceptions and actual barriers at different levels of organizations, however two primary themes rose to the top for both surveys – business case and data. In the Health System Survey, more concerns about personnel were highlighted, while in the Score Card survey, concerns about contracting were highlighted. Lack of data and data infrastructure rose to the top in both methods, indicating a system-wide issue with data collection and sharing. **Business Case**Although it was not always the highest ranked or most often chosen “lack of a business case or economic rewards” was a common barrier in the top five across both surveys. **Data**Burden of collecting data, including lack of infrastructure and lack of credibility or availability of data constituted a second common theme across both surveys. Lack of data infrastructure (e.g., EHR system, broadband issues, lack of integration with behavioral health systems, etc.) is a particular challenge for behavioral health and community organizations as well as more important for health systems compare to health plans.**Capacity and Cost**Time, cost, and personnel rounded out the top barriers for all audience types, but particularly for community and health care provider organizations.**Contracting**Challenges around contracting partnerships were close to equal in importance for health plans and health systems.**Other Barriers** Internal awareness/support of Bree Recommendations received a score of 6 on the score card method. On the Health System Survey 6 out of 27 respondents answered, “I have no knowledge of the Bree Guidelines and 7 out of 27 answered “I don’t know” to the question “Has your organization taken any actions to implement the Bree Guidelines?” The majority of the roles responding with these answers were clinicians and managers. Those answering that they had implemented or evaluated an implementation of Bree guidelines were primary in director roles. Information that was provided about “other” barriers was:

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| ***Health Plans*** | ***Community Partners*** |
| Limited bed capacity for SUD REHAB unrelated to network | Lack of institutional resources and staffing |
| Improved outcomes | Organizational purpose alignment - health care is secondary |
| Multitude of critical business needs that may or may not align with work of the Bree |  |
| Regulatory constraints, i.e. HIPPA, etc. impacts SUD measures  |  |

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| CHALLENGES AND LIMITATION |
| Multiple challenges exist with this data collection method. Ranking was used in one survey; however technological constraints didn’t allow for it to be used in another. A balance needed to be struck between aligning with the 2016 evaluation to do a “remeasure” of barriers and updating response options for clarity, consistency, or address changes to the health care environment. Data limitations include small responses, lack of response options overlap between the two methods, and bias generated by having a pre-defined list of barriers. The Bree lacks the capacity and influence to be able to conduct a randomized survey currently.The ability to spread these surveys throughout the health care system is limited to the Bree’s scope of influence and willingness of partners to assist (e.g. sharing the survey among their staff, advertising in newsletters, etc.)Although the survey method was crafted to collect data on specific guidelines that were implemented, we had very little data on barriers specific to Bree topics due to a lack of response and a small survey response.  |

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| LESSONS LEARNED AND NEXT STEPS |
| The Bree Collaborative has largely solved our technological issues by acquiring other survey technology. Although these surveys also asked questions about facilitators for implementation, they were less clear to individuals filling out these surveys. Respondents often interpreted barriers and facilitators as a supply/deficit question rather than two separate questions. Only 13 out of 27 respondents answered the question about barriers. The Bree staff will need to craft or edit questions about facilitators to gain more knowledge about what was most predictive of the success of an implementation. The Bree staff also developed a survey for IT specialists, however questions about barriers were not included in this iteration. Further exploration of barriers to data capture and IT infrastructure is warranted, given that it is a common barrier identified by clinical and administrative staff. A reporting initiative is being designed to gather more information about who is adopting the Bree Guidelines, so target questions about barriers can be provided to them. Strategies for learning about why organizations that know about the Bree guidelines but haven’t adopted strategies to better understand topic specific barriers and facilitators need to be explored. |

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| **CALLS TO ACTION 1** |
| **Bree Collaborative members can assist in this work by helping define a list of barriers or categories for barriers for our next round of surveys. Bree staff will be providing an opportunity for this towards the end of 2024.**  |

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| **CALL TO ACTION 2** |
| **Bree Collaborative members can assist with data collection by participating in reporting their PERINATAL BEHAVIORAL HEALTH BASELINE DATA or for awards for other topics throughout 2024.** [**https://www.qualityhealth.org/bree/evaluation/bree-collaborative-awards/**](https://www.qualityhealth.org/bree/evaluation/bree-collaborative-awards/) |

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| **CALL TO ACTION 3** |
| **Currently organizations can report GUIDELINE USE, submit EXAMPLES OF SURVEYS or SURVEY QUESTIONS used in their evaluations, or submit RESULTS OF AN EVALUATION through our Submission Portal:** [**https://www.qualityhealth.org/bree/evaluation/submission-portal/**](https://www.qualityhealth.org/bree/evaluation/submission-portal/) |

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| **CALL TO ACTION 4** |
| **Organizations can submit or participate in CASE STUDIES by contacting Karie Nicholas at** **knicholas@qualityhealth.org** |