FOUNDATION FOR Health Care Quality

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Bree Collaborative 2024 Evaluation Report

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INTRODUCTION

PROBLEM STATEMENT AND PROGRAM DESCRIPTION

Since its creation in 2011, the Bree has created 40+ reports, bundle payment, and warranty recommendations in the areas general care, aging, behavioral health, care transitions, chronic and infectious disease management, pain management, oncology, reproductive health, and surgery. However, little work has been done on assessing the changes in process, outcomes, or impact of these reports.

In 2022 the Bree Collaborative received funding from the Washington State Health Care Authority (HCA) to work on the implementation and evaluation of the Bree Collaborative guidelines. The current funding supports both the evaluation of previously created guidelines (a "look back") and the development and use of evaluation methods, measures, and tools for those currently in development and future guidelines (a "look forward").

This report summarizes the "look back" evaluation work on data collected in 2023 and is part of a broader program to evaluate the implementation and impact of the Bree Collaborative reports.

An evaluation program is currently being developed and, as part of the program, a process of evaluation design will be embedded into each Bree report as they are being developed to leverage the collective knowledge of the workgroup members. Other evaluation tools, such as a theory of change, an evaluation plan, data collection tools, and framework for dashboard reporting, will be created during and soon after the report creation. These methods (score cards, surveys, case studies, etc.) and measurement scales will provide consistency in how we measure implementation. They build on the previous evaluation work in 2016 and will be triangulated with other programmatic activities to provide a fuller picture of the uptake, use, and impact of the Bree guidelines.

REPORT BACKGROUND

Since 2016, the Bree Collaborative has created a diverse group of guidelines that include many different audience types. This report focuses on a subset of audiences (health systems, clinics, and health plans) and covers 30 different Bree reports.

The goals of this "look back" evaluation work is to:

1. better understand concordance of care with guideline recommendations,
2. to understand barriers and facilitators to guideline implementation,
3. understand how to improve the process of guideline development, and
4. measure any impact on variation in care (including equity and cost) and health outcomes.

Prior to 2022, the Bree conducted limited implementation and evaluation support projects as outlined below:

Previous Implementation Support

From 2012 to 2022 the Bree Collaborative primarily supported implementation of their recommendations through webinars, collaborations with the HCA, and pilot implementation projects.

Previous Evaluations

A previous evaluation in 2016 was conducted for 13 of the Bree recommendation topics and the results can be found in Appendix B. Organizations were divided into three categories of Health Plans, hospitals, and medical groups. Each organization was given a mean implementation score by topic based on the

elements of the guidelines that they had implemented. The scale for the scoring was 0 – no action taken, 1- Actively considering adoption, 2- Some/similar adoption, and 3 - Full adoption. Results of this evaluation were used to calculate results for improvement among organizations that participated in both evaluations.

A pilot project that included both implementation support and evaluation was conducted in (year) on Behavioral Health Integration.

2023 EVALUATION DESIGN

PURPOSE

The purpose of this retrospective evaluation was to understand the usefulness of previous Bree reports and the capacity, barriers, and enablers that organizations experience, and to measure the fidelity of current practices with Bree recommendations.

METHODS OF MEASUREMENT

The data for this report was collected through a mixed methods design which included hospital and other stakeholder "score cards", surveys, case studies, document review, and interviews. The same scale from the 2016 evaluation was used for "score cards" which measure concordance of care with Bree Guidelines. Broadly disseminated surveys measured qualitative opinions on the contribution of the guidelines to increased knowledge, increased confidence in decision making, guideline usefulness in identifying goals and objectives of best practices, data capacity to implement guidelines, and opinions on cost relative to outcomes. These surveys were analyzed using standard qualitative methods such as word counts, theme identification, and likert scales. Survey questions can be found in Appendix D.

LIMITATIONS

Currently, the Bree Collaborative has little access to population health data, limiting the extent to which changes to population health can be measured, limiting the extent to which we can assign a percentage of population changes to Bree reports.

Limitations to this report are being addressed by using other methods of evaluation as companion work. These methods include case studies, evaluations using COAP data, requests for organizational level evaluations, and embedding evaluation into future report designs with cohort methods of follow-up.

Our evaluation is based on convenience sampling, so we are unable to assess the effects of bias on the responses. At this time the Bree is unable to randomize, create test/re-test groups or use other methods that could provide stronger evidence for causality. Finding participants who had the time and capacity to participate was a challenge.

The entities that fall under the HCA contracting choose which projects and benchmarks they would like to include in their contracts, which introduces selection bias into the metrics data reported by the HCA.

Finally, the findings for this report are not generalizable.

RESULTS

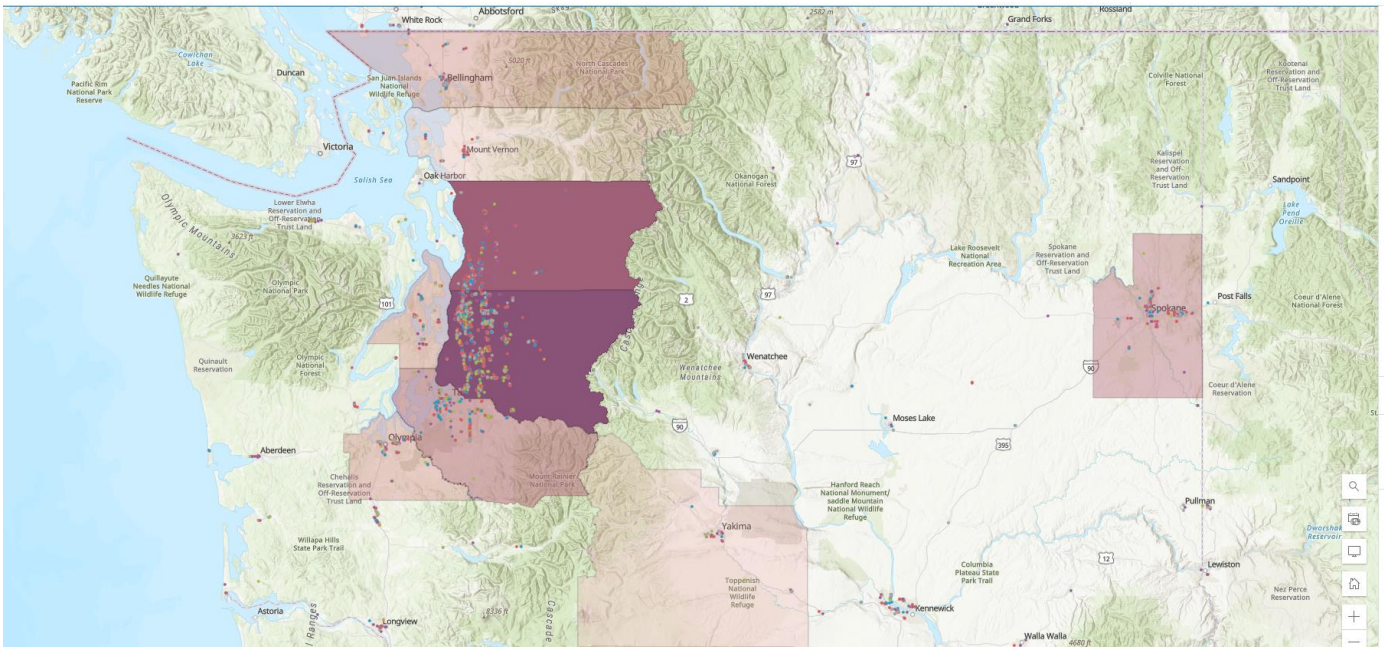
PARTICIPATION – HEALTH SYSTEMS, CLINICS, HEALTH PLANS

Organizations that responded to our request for participation in the evaluation are described in the tables below. They represent three of the ten largest health systems in Washington State.

Other independent and small health care organizations also participated, including critical access hospitals, individual clinics within larger systems, and surgical groups.

Washington State has approximately 13 large health plan providers that offer commercial, Medicaid, and Cascade Care plans. Two health plan providers (15%) participated directly in our evaluation. Information about sites, number of hospital beds, locations, and services can be found in Appendix C.

Map 1. Density of health care delivery sites in Washington State compared to areas where evaluation was done.



PARTICIPATION – OTHER SURVEYS

In addition to the score card evaluations, thirty organizations responded to our *Health System Survey* on the usefulness of the Bree Guidelines. Ten organizations responded to our *Data Capacity Survey* to better understand the IT infrastructure that may support implementation of best practices.

PARTICIPATION – DECLINES

Of the ten large health systems and thirteen health plans, two health systems and two health plans declined to participate after being invited. The primary reason cited was capacity constraints. All health plans invited indicated that they use the Bree reports in their program development and two health plans provide a brief summary of their work. Other systems and health plan providers were not able to reached for invitations to participate.

EVALUATION OUTCOMES

SCORE CARD RESULTS

Overall scores were calculated for each report and include health systems, FQHCs, individual hospitals or clinics, critical access hospitals and school districts, where the service line was applicable.

Table 1. Average scores, ranges, and item averages among all respondents.

Report Name	Score	Range	Metrics (tracking)	Selected Item score
Addiction and Dependence Treatment	2.1	1.9-3.0	1.3	Health plan declines to contract with organizations not offering SBRIT – 0 Health services stigma and bias training – 2.2 Health Services screening and follow-up – 1.8
Alzheimer's and other dementias	1.3	0-2.8	1.3	Coordinated care – 1.4 Tracking patient satisfaction – 1.3
Behavioral Health Integration	1.8	0-3.0	1.2	PCMH alignment – 1.5 Collaborative care – 2.2 Screening for depression in primary care – 1.6
Cervical Cancer Screening	1.8	0-3.0	1.4	Equity – 1.8 Vaccination – 1.6 Financing/Benefits – 1.5
Colorectal Cancer Screening	2.2	0-3.0	2.0	Equity – 2.6 Shared decision making – 1.7 Financing/Benefits – 3.0 Population health – 2.6
End-of-life Care	1.7	0-3.0	1.0	Patient engagement – 2.0 Care Planning – 1.8
Equity	2.5	2.0-2.9	2.1	Demographic Data Collection – 2.9 SDOH Data Collection – 2.4 SOGI Data Collection – 3.0 Uses data for population health – 2.4 Tribal Liaison – 1.2
Hepatitis C	1.0	0-1.8	1.0	Value-based payment –1.4 Patient access – 0.8 Patient treatment – 0.9
LGBTQ Care	2.1	0-2.8	1.5	Policies for equitable, unbiased care – 2.4 Financing/Benefits – 3.0 Referrals and family inclusion – 2.2
Low Back Pain	1.5	0-3.0	N/A	Screening – 2.0 QI – 1.3 Benefits – 2.5 Patient education/engagement – 2.0
Obstetrics	1.7	0-3.0	1.5	Financing/reimbursement – 2.3 Policies and procedures – 1.7 Patient education – 1.2
Oncology	2.1	0-3.0	N/A	Appropriate imaging – 1.9 Patient education/engagement – 2.3 Reimbursement alignment– 2.5 Palliative Care – 2.0
Opioid Prescribing	1.4	0-3.0	2.3	Older Adults – 0.5 Long-term – 0.3
Opioid Use Disorder Treatment	2.0	1.0-2.9	N/A (asked in prescribing)	MAT – 1.8 Patient costs and reimbursement – 2.5 Staff training – 1.8 Naloxone prescription – 1.6
Outpatient Infection Control	2.1	0-3.0	1.5	Precautions and policies – 2.2 Vaccination and vaccine education – 1.8 Reimbursement – 2.6
Palliative Care	1.8	0-3.0	1.5	Definitions and requirements for care – 1.4 Reimbursement – 2.3 PCMH alignment – 3.0
Pediatric Psychotropics	2.1	0-3.0	2.0	Evaluation process – 1.5 Referrals – 2.2 Care Coordination – 1.7 Reimbursement – 3.0

Pediatric Asthma	1.6	0-3.0	1.8	Policy alignment – 1.3 Patient assessment and care planning – 1.8 Reimbursement/payment – 3.0
Primary Care	2.1	0-3.0	1.0	Screening – 2.0 Hep C and vaccination – 1.8 Financing – 3.0 Patient communication and education – 3.0 QI for health disparities – 3.0
Prostate Cancer Screening	1.6	0-3.0	1.8	Shared decision making – 1.7 Financing – 0.5
Potentially Avoidable Hospital Readmissions	2.6	2.0-3.0	N/A	Financing/reimbursement – 2.5 Communication with PC – 2.7 Medication reconciliation – 2.3
Reproductive and Sexual Health	1.5	0-2.8	0.7	Screening – 1.2 Shared Decision Making – 1.4 Fertility/pregnancy – 2.5 Demographic data – 1.9 PCMH alignment – 1.4
Risk of Violence Towards Others (health plans only)	3.0	N/A	N/A	Reimbursement – 3.0 Data identification – 3.0 Partnerships -3.0
Shared Decision Making	1.5	0-3.0	N/A	For surgery – 1.4 For behavioral health – 1.4 For advanced care planning – 1.6 For screening/other – 1.6 For Labor – 1.6
Suicide Care	2.1	0-3.0	2.0	Reimbursement – 2.3 Tracking and data sharing – 2.7 Linkage to care/follow up – 2.1 Screening/prevention – 2.4
Telehealth	1.7	0-3.0	1.1	QI for telehealth – 1.9 Vendor requirements – 3.0 Reimbursement – 3.0 Patient relationships – 3.0

HEALTH SYSTEM SURVEY RESULTS

The Health System Survey received 30 responses from 21 different organizations with a response rates to each question ranging from 37% to 100% (see Appendix D). This survey was intended to measure the usefulness of past reports and cost/benefit perceptions that may contribute to an organization's decision to implement the guidelines. The survey used a Likert Scale of 1= Strongly Disagree, 2= Disagree, 3= Neutral, 4= Agree, 5= Strongly Agree. Eleven respondents (37%) answered the following questions:

Table 2: Health System Survey Results, Usefulness, Overall N=11

Question	**Health Care systems**	**Health Plans**	**FQHCs/Critical Access/Community Orgs**
The use of the guidelines increased my/our understanding of the topic	4.2	5.0	4.0
The use of the guidelines increased my/our confidence in decision making.	4.0	5.0	3.5
The patient recommendations provided our patients with increased knowledge about the topic	3.5	4.0	3.3
I/we could easily identify appropriate goals from the Bree guidelines	3.8	5.0	3.8
I/we would easily identify the objectives needed to reach goals in the Bree guidelines.	3.8	4.5	3.3
The overall costs of the implementation project(s) were worth the benefits.	3.8	4.5	3.3

Any increases in workforce costs or workloads to implement guideline(s) was in proportion to the benefits.	2.8	4.5	3.0
The cost of implementing the guideline(s) was reasonable for our facility or organization.	3.0	4.0	3.3

The Bree Collaborative has created a roadmap with three "pillars of transformation" (Appendix E). When asked about the reports contributions to increases in knowledge in these three areas (on a scale of 1-5 with 1=knowledge was not increased at all and 5=knowledge was greatly increased), respondents indicated weak increases in knowledge.

Table 3: Health System Survey results, Knowledge, N=7

Question	Average response
How to provide, support, or advocate for more EQUITABLE ACCESS AND CARE for the topic specific condition	3 - knowledge was somewhat increased
How to provide, support, or advocate for BETTER COORDINATED CARE for the topic specific condition	3 - knowledge was somewhat increased
How to incorporate, support, advocate for and/or USE DATA FROM OTHER SOURCES to inform care	2 - knowledge was slightly increased

DATA CAPACITY SURVEY RESULTS

This survey asked questions about knowledge, goals identification, and capacity to carry out data exchange and analytics recommendations. Respondents agreed that Bree reports increased their understanding of the topic but were neutral on the reports usefulness in identifying goals for referrals and on increasing their ability to implement data sharing solutions and increase data analytics capabilities. Data Exchange capabilities were assessed using the HIMSS Continuity of Care model (CCMM) and the Analytics Model or Analytics Maturity (AMAM). More information on this model can be found here.

Table 4: Data Capacity Survey results, N=10

HIMSS HL7 Continuity of Care Model Stages (CCMM)	Average Response	HIMSS Analytics Model or Analytics Maturity (AMAM)	Average Response
Stage 0 – Limited or no E-communication	0	Stage 0 – Fragmented Point Solutions	0
Stage 1 – Basic Peer-to-peer Data Exchange	0	Stage 1 - Foundation building: data aggregation and initial data governance	1
Stage 2 – Patient-Centered Clinical Data Using Basic System-to-System Exchange	0	Stage 2 - Core data warehouse workout: centralized database with an analytics competency center	2
Stage 3 – Normalized Patient Record Using Structural Interoperability	0	Stage 3 - Efficient, consistent internal and external report production and agility	1
Stage 4 - Care coordination based on actionable data using a semantic interoperable patient record	2	Stage 4 – Measuring and Managing Evidence Based Care, Care Visibility and Waste Reduction	0
Stage 5 - Community-wide patient records using applied information with patient engagement focus	3	Stage 5 - Enhancing quality of care, population health, and understanding the economics of care	2
Stage 6 - Closed loop care coordination across care team members	1	Stage 6 - Clinical risk intervention & predictive analytics	2

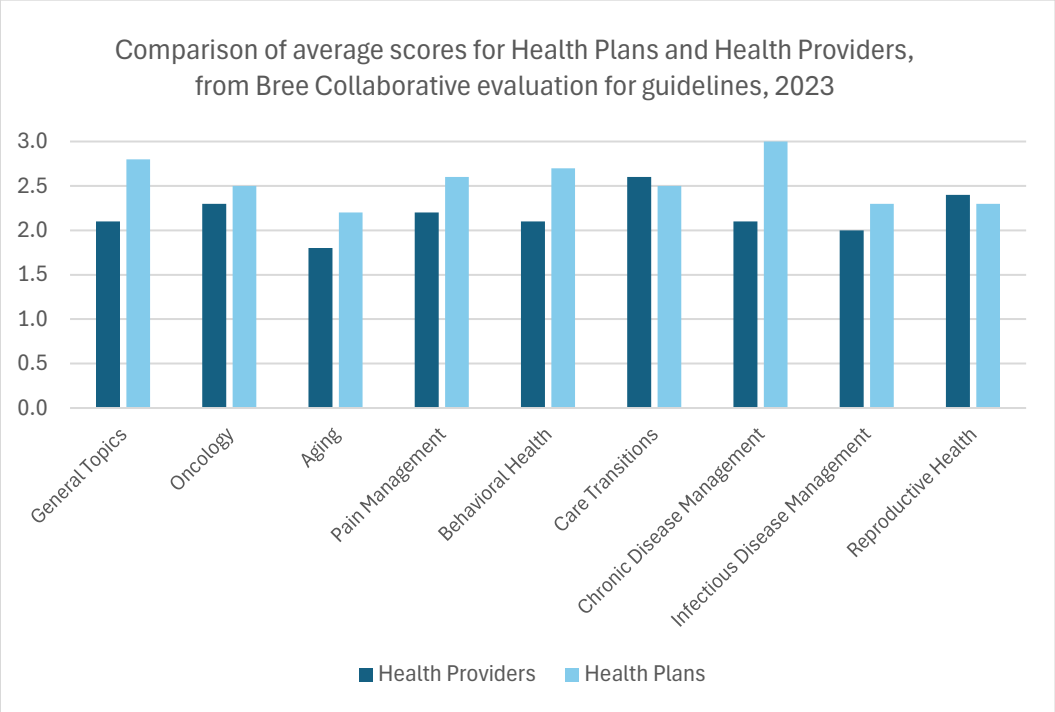
Stage 7 - Knowledge driven engagement for dynamic, multi-vendor, multi-organizational interconnected healthcare delivery model	4	Stage 7 - Personalized medicine & prescriptive analytics	1

ANALYSIS

IMPROVEMENTS– 2016-2023

Some organizations that participated in 2016 were unable or unwilling to participate in 2023. Additionally, the landscape of health systems has changed, with mergers and acquisitions of some participating organizations. Since we are unable to control for these factors, measurement/remeasurement scores were calculated for those organizations that participated in both evaluations. These measures represent changes in concordance of care with 10 Bree reports (Opioid prescribing represents and average over three reports) in 16 large hospitals and 30+ clinics located in King, Pierce, Thurston, Spokane, Kitsap, Clark, Cowlitz, and Yakima Counties.

Table 5.



Despite only having two of the 13 largest health plans respond, we were able to collect supplemental data on Cascade Care (public option plans), Medicaid, and PEBB/SEBB plans which indicated similar averages for concordance of care among those business lines. This supplemental data was not specific enough to include in this report, however it will be used in future reports, analyses, and to inform future Bree Collaborative work.

VARIABILITY

Because the sample for this study was small, it was not feasible to measure variability with traditional statistical methods. We opted to look at ranges to gain a better understanding of variability among respondents.

There is no clear topic pattern for reports that showed more variability, however smaller care delivery organizations scored lower, on average than larger ones. This is likely due to both the sample size and to an organization's resources, based on an evaluation of the comments associated with low scores.

We looked at variability three different ways. First, what is the average among those who have implemented best practices. Second, what is the average and variability among all respondents in health delivery? Third, what is the average and variability among all respondents that were health plans?

Table 6: Averages for organizations that responded to specific topics, averages and ranges for health delivery overall and for health plans overall.

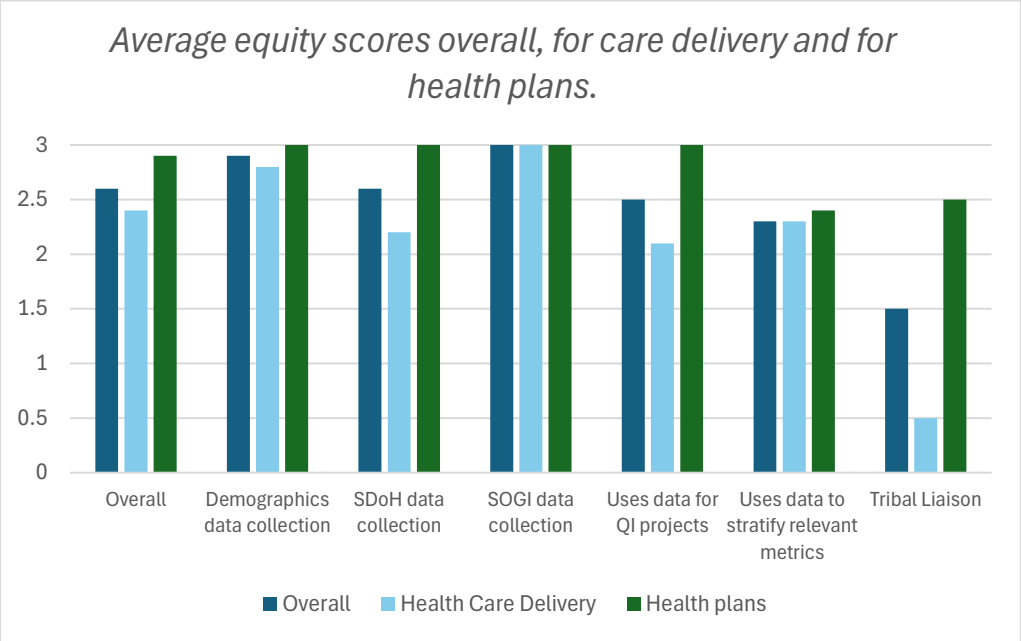
Topic Area	Report	Health Care Delivery, topic response only	Health Care Delivery, all (N=5)*unless otherwise noted	Health Plans (N=2) (*N=1)
Behavioral Health	Addiction and Dependence Treatment	2.0	2.0 (0-2.4)	2.6 (2.2-3.0)
Behavioral Health	Behavioral Health Integration	2.4	1.4 (0-3.0)	2.8 (2.5-3.0)
Behavioral Health	Opioid Use Disorder Treatment	1.7	1.7 (1.0-2.0)	2.6 (2.4-2.9)
Behavioral Health	Pediatric Psychotropics	2.3	1.3 (0-2.9)	2.9 (2.8-3.0)
Behavioral Health	Risk of Violence Towards others	N/A	No answers	3.0 (3.0-3.0)
Behavioral Health	*Suicide Care (N=6)	2.0	1.5 (0-3.0)	2.5 (2.5-2.5)
Behavioral Health		**2.1**	**1.7 (0-3.0)**	**2.7 (2.6-2.8)**
Aging	Alzheimer's and other dementias	1.1	0.8 (0-2.2)	2.0 (1.2-2.2)
Aging	End-of-life Care	1.8	1.5 (0-2.0)	2.4 (1.8-3.0)
Aging		**1.5**	**1.2 (0-2.1)**	**2.2 (1.5-2.9)**
Oncology	Cervical Cancer Screening	2.0	1.6 (0-2.3)	2.5 (2.0-3.0)
Oncology	Colorectal Cancer Screening	2.4	1.9 (0-2.9)	3.0 (3.0-3.0)
Oncology	Oncology (inpatient, early treatment)	2.8	2.2 (0-3.0)	2.2 (1.3-3.0)
Oncology	Prostate Cancer Screening	2.0	1.6 (0-3.0)	1.5 (1.0-2.0)
Oncology		**2.3**	**1.8 (0-2.8)**	**2.5 (2.2-2.7)**
Pain Management	Low Back Pain	1.5	1.2 (0-2.3)	2.5 (2.0-3.0)
Pain Management	Opioid Prescribing (Metrics, Older adults, Long-term)	2.4	1.3 (0-3.0)	2.8 (2.5-3.0)
Pain Management	Palliative Care	2.1	1.3 (0-2.7)	2.5 (1.5-3.0)
Pain Management		**2.0**	**1.2 (0-2.4)**	**2.4 (2.1-2.8)**
Reproductive Health	Obstetrics	2.7	1.6 (0-3.0)	2.3 (0-2.3)*
Reproductive Health	Reproductive and Sexual Health	1.7	1.3 (0-2.8)	2.3 (2.3-2.3)
Reproductive Health		**2.2**	**1.4 (0-2.7)**	**2.3 (0-2.3)**
Infectious Disease Management	Outpatient Infection Control	2.3	1.7 (0-2.7)	2.8 (2.5-3.0)
Infectious Disease Management	Hepatitis C	1.6	0.8 (0-1.6)	1.5 (1.3-1.8)

Infectious Disease Management		**1.9**	**1.3 (0-2.7)**	**2.3 (2.2-2.3)**
Chronic Disease Management	Pediatric Asthma	1.9	1.1 (0-2.3)	3.0 (3.0-3.0)
Care Transitions	Potentially Avoidable Hospital Readmissions	2.6	2.1 (0-3.0)	2.5 (2.0-3.0)
General	Primary Care	2.4	1.9 (0-3.0)	3.0 (3.0-3.0)
General	Shared Decision Making	1.6	1.0 (0-2.2)	2.8 (2.5-3.0)
General	Telehealth	2.2	1.3 (0-3.0)	3.0 (3.0-3.0)
General	LGBTQ Care	2.1	1.6 (0-2.8)	2.5 (2.5-2.5)
General		**2.1**	**1.4 (0.15-2.3)**	**2.8 (2.7-2.8)**

EQUITY

Measurements of equity focused primarily on pragmatic actions that organizations can take to address health equity issues and these scores represent the capacity of organizations to address them. At this time, we are unable to collect data on the outcomes of these actions.

Table 7.



The Foundation for Health Care Quality has implemented other strategies besides this evaluation to gather more data on activities and outcomes that organizations are implementing to improve equity across the care continuum. An equity report will be released in the second half of 2024.

PERFORMANCE SUMMARY

Health plans scored better on fidelity with recommendations across all reports compared to health care delivery sites. Although bias may play a role in the scores, qualitative information from health plans suggests that the requirements for inclusion of Bree guidelines in public contracts is also used in commercial contracts.

Variation among the types of services provided within health care delivery organizations made it difficult to measure concordance with some reports. Two health care delivery organizations were unable to collect data across their organizations. The differences between performance for those who responded for each report and the overall score reflects a lack of data, not necessarily a lack of action. All organizations that responded to the equity items reported the best performance on data collection, particularly for SOGI data, and the worst performance on including Tribal Liaisons.

All organizations were least concordant with guidelines on Aging and Aging and General guidelines had the largest disparities between health care delivery organizations and health plans. Among those who provided scores for specific guidelines, organizational practices were most concordant with Oncology guidelines.

The topics most consistent with Bree guidelines, across all measures, were Addiction and Dependence Treatment, Oncology topics, Opioid Prescribing, Outpatient Infection Control, Potentially Avoidable Hospital Readmissions and Primary Care. The topics least consistent were Alzheimer's, Pediatric Asthma, and Hepatitis C.

Qualitative information on the usefulness of the reports show that guidelines were most useful for payers and for identifying broad goals and objectives. Guidelines were perceived as being least useful in determining cost/benefit outcomes and for data use (as opposed to collection).

EFFECTS OF LIMITATIONS

Data collections and measurement limitations affected these findings in different ways. Lack of knowledge about practices, limited sample and sampling methods, and time since report release all likely resulted in a shift towards lower scores. Some of these limitations are demonstrated in Table 6. Much of the feedback from those were contacted to participate and those who did participate was focused on the amount of time and effort evaluations are. Health systems and clinics responded more often and health plans, state agencies and other community organizations responded less often.

WHAT WE LEARNED: KEY LESSONS

WHAT IS MISSING

Our evaluation work so far has collected minimal, qualitative data on cost/benefit comparisons and no information from patients or about patient outcomes. This evaluation was designed to support future Bree work and report revisions.

READINESS AND DATA CAPACITY

Our data capacity survey results suggest that guideline developers should align their data exchange recommendations with HIMSS Models and focus on guidelines that will be implementable for organizations between HIMSS CCMM levels 4-6. For Recommendations on analytics guideline developers should consider that organizations vary widely on their abilities to perform data analytics. The findings from the data capacity model are supported by the findings from the score cards for specific analytics recommendations. Organizations may need more resource support in order to implement the overall data sharing and analytics goals included in reports.

HOW TO IMPROVE THE BREE COLLABORATIVE PROCESS

Information on barriers and challenges to implementing the Bree Guidelines was collected through both the score cards and the health system survey. Results were consistent across health plans and care delivery sites. The following information should be provided to future work groups in order to help them address topic-specific barriers and challenges.

Barrier and challenges

- Multiple critical business needs that may not align with work of the Bree (1)
- Lack of a business case (1)
- Regulatory constraints (2)
- Internal Awareness/support of Bree Recommendations (2)
- Availability and credibility of data (3)
- Burden or ease of collecting data (3)

Key success factors

A clear business case and internal awareness of the Bree guidelines were also seen as the key factors in the successful implementation of recommendations, especially for health care providers. Other enabling factors varied by the type of organization. For health plans partnerships for value-based purchasing was also a key factor in their ability to implement guidelines.

Improvement opportunities

1. Internal awareness of the Bree reports - Organizations that are members of the Bree Collaborative or that participate regularly in the development of the reports cited awareness as a barrier less often than those that did not. Internal awareness was more of an issue for reports with broad scopes that were not hospital specific, but the process of evaluation generated interest and enthusiasm for implementation work among those organizations that are not members or do not regularly participate on work groups. *Opportunity: to include smaller, rural, and behavioral health organizations in guideline development, implementation, and evaluation activities. Opportunity: plan a social media strategy to promote Bree guidelines that includes the awards program.*
2. Data collection – There is a clear gap in the use of data for analytics and reporting that affects organization's ability to implement quality improvement programs that align with Bree guidelines. *Opportunity: to align metrics and develop supports, methods, and infrastructure for data reporting that both eases the burden of collection and increases the availability and credibility of data.*
3. Future Bree Collaborative Work – The Bree will use this data throughout 2024-2025 to develop and inform a guideline revisions process and to support new topic selections and the workgroup process.
4. Implementation support – Although the Bree has limited resources for implementation support, this is an important area of opportunity. In 2022 the Bree Hired one FTE to work on implementation. Throughout 2022-23 staff at the Bree worked on mechanisms to support implementation, including the development of action collaboratives, strengthening partnerships for implementation, improvements to webinars, creation of learning labs, the development of an implementation guide and creation of implementation awards. *Opportunity 1: in addition to this work there is an opportunity to encourage implementation through more outreach to small clinics and rural area and by supporting the development of business cases for the report recommendations.*
5. Evaluation planning – Evaluation of the Bree Collaborative's primary lever of change, the Washington State Health Care Authority, using the same methods as the evaluation of health plans proved to be inadequate for validity and consistency. The evaluation tools need further development and validation in order to better capture a true measure of implementation.

Opportunity 1: The Bree and the HCA should work together more closely to design an appropriate evaluation on shorter time-frames (e.g 1-4 years after report releases). Opportunity 2: the Bree should develop methods for creating evaluation plans and tools in parallel with the work groups to improve validity, reliability, specificity, and acceptability of the evaluations.

SUSTAINABILITY

Among the organizations that participated in both the 2016 and the 2023 evaluations, sustainability was demonstrated across eight reports and improvements occurred for 6 of the 8 reports that they were previously evaluated on. Score changes are likely due to slight variations in evaluation methodology, however the organization with the most variation between 2016-2023 also reported major restructuring during this period. In spite of this, they were able to sustain practices on the majority of the reports that were evaluated and saw the biggest drop due to non-response from clinical staff during the 2023 evaluation period.

CONCLUSIONS

During the process of recruiting for this evaluation it became clear that most organizations are interested in implementing or have implemented Bree Collaborative reports, however process data remains difficult to collect. Overall, for those who are implementing the guidelines, they demonstrate the most robust fidelity when there are other initiatives that support the work. For reports that have been adopted, sustainability is the norm. Most organizations that participated are working towards better measurements for health equity, but struggle with analytics. Health plans have more capacity to implement best practices from Bree guidelines than health care delivery organizations, likely because guidelines for health care delivery are more complex and require more time, staffing, and funding.

There remain multiple opportunities for the Bree Collaborative to leverage, including improvements in the Bree process, strategies to help improve data collection and transparency, and increased capacity for implementation support and evaluation.

Appendices

Appendix A – 2023 Evaluation Participants

A1.1 – Health Systems

Multi-Hospital System	Number of Hospitals in system	Number of beds in system	Percent of WA State All beds	non-hospital services owned or affiliated with system	Number of physicians and physician assistants employed/affiliated with system

MultiCare (MC) (not-for-profit	MC Auburn MC, Auburn (195 licensed, 165 staffed Beds) Pierce County MC Capital MC Olympia (107 licensed, 88 staffed beds) Thurston County MC Covington MC (58 licensed/56 staffed beds) King County MC Deaconess Hospital, Spokane (388 licensed, 279 staffed beds) Spokane County MC Good Samaritan Hospital, Puyallup (425 licensed, 394 staffed beds) Pierce County MC Mary Bridge Children's Hospital (Childrens), Tacoma (82 licensed, 82 staffed beds) Pierce County MC Tacoma General/Allenmore Hospital, Tacoma (581 licensed, 451 staffed beds) Pierce County MC Valley Hospital, Spokane Valley (123 licensed, 123 staffed beds) Spokane County MC Yakima Memorial, Spokane Valley (226 licensed, 226 staffed beds) Yakima County MC Navos BH Hospital (Navos West Seattle Campus), Seattle (psych) (70 licensed, 70 staffed beds) King County Wellfound BH Hospital,46 Tacoma (psych)47 (120 licensed, 120 staffed Beds) Pierce County	•341 ICU •1,342 acute care •293 psych •109 other •2,085 staffed •2,344 licensed	ICU: 19.67% •Acute: 14.64% •Psych: 23.31% •SNF: N/A •Alcohol: N/A •Other: 37.46% •Staffed:16.34% •Licensed:15.50%	•Primary care •Urgent care •Pediatric care •Specialty services including MCBH Network; MC Indigo, Mary Bridge Health Network, Pulse Heart Institute, MC Rockwood Clinic (multi-specialty) •Telehealth	Physicians:1,072 •Physician assistants: 161

University of Washington (UW) Medicine Private Non-Profit and Public	UW Medicine/Harborview Medical Center, Seattle (413 Licensed, 412 Staffed Beds) King County US Medicine/Valley Medical Center, Renton (341 Licensed, 330 Staffed Beds) King County UW Medicine/UW Medical Center, Seattle (810 licensed, 476 staffed beds) King County	•248 ICU •883 acute care •84 psych •3 other •1,218 staffed •1,564 licensed	•ICU: 14.30% •Acute: 9.64% •Psych: 6.68% •SNF: N/A •Alcohol: N/A •Other: 1.03% •Staffed: 9 or 55.05% •Licensed:10 or 3.02%	Primary care (25) •Urgent care (5 •Telehealth	Physicians: 1,741 •Physician assistants: 120
Virginia Mason Franciscan (VMF) (not-for-profit) CHI: Catholic	VMF Health St Anne Medical Center, Burien (133 licensed, 115 staffed beds) King County VMF Health St. Anthony Hospital, Gig Harbor (112 licensed, 112 staffed beds) Pierce County VMF Health St. Clare Hospital, Lakewood (106 licensed, 102 staffed beds) Pierce County VMF Health St. Elizabeth Hospital, Enumclaw (38 licensed, 25 staffed beds) King County VMF Health St. Francis Community Hospital, Federal Way (124 licensed, 124 staffed beds) King County VMF Health St. Joseph Medical Ctr, Seattle (374 licensed, 362 staffed beds) King County VMF Health St. Michael Medical Center, Silverdale (336 licensed, 248 staffed beds) Kitsap County Virginia Mason Franciscan Health/Virginia Mason Franciscan Health Rehabilitation (60 licensed, 60 staffed beds) Pierce County Virginia Mason Medical Center, Seattle (371 licensed, 272 staffed beds) King County	•154 ICU •1,176 acute care •35 SNF •55 other •1,420 staffed •1,654 licensed	• ICU: 8.88% •Acute: 12.83% •Psych: N/A •SNF: 16.06% •Alcohol: N/A •Other: 18.90% •Staffed:11.13% •Licensed:	•Primary care, •Cardio-vascular health •Digestive health, Neuro spine, etc. •Telehealth	Physicians:1,142 •Physician assistants: 194

Kaiser Permanente	Ballard Medical Center (Pharmacy) Bellevue (Urgent Care, Pharmacy) Bellevue – Factoria Medical Center (pharmacy) Bellingham Medical Center (Pharmacy) Bothell – Northshore Burien (pharmacy Everett Medical Center (pharmacy) Federal Way Gig Harbor Medical Office Kent Medical Center (pharmacy) Lynnwood Medical Center (pharmacy) Marysville – Smokey point Medical Center (pharmacy) Olympia Medical Center (Pharmacy, Urgent Care) Olympia – West Olympia Medical Center (pharmacy) Overlake Hospital Medical Center (Emergency care) Port Orchard Medical Center (pharmacy) Poulsbo Medical Center (Pharmacy) Puyallup Medical Center (pharmacy) Redmond at Riverpark (pharmacy) Renton Medical Center (pharmacy) Seattle – Central Hospital (after hours, pharmacy, urgent care) Seattle – Ballard Seattle – Capitol Hill Campus (Urgent Care, Pharmacy Seattle – Northgate (pharmacy) Seattle – Rainier Medical Center (pharmacy) Seattle – South Lake Union Medical Office Silverdale Medical Center, other (eye care, rehab pharmacy) Spokane – Kendall Yards Spokane – Lidgerwood (pharmacy) Spokane – Riverfront Spokane – South Hill Medical Center (pharmacy Spokane – Veradale Medical Cener (pharmacy) Tacoma - Steel Street Medical Center (pharmacy)			Integrated primary care, vision, specialty care, behavioral health, urgent care, pharmacy, and hospital care	1,047 physicians and 1,634 nurses

	Tacoma Medical Center (eye care, pharmacy)				

A1.2 – Clinics and independent hospitals

Clinics/Independent hospitals	Sites	Services	Physicians and Physicians Assistants
HealthPoint	19 sites https://www.healthpointchc.org/find-clinics	Integrated primary care, behavioral health, dental, pharmacy, school-based care, urgent care, community services	148 doctors and providers
Everett clinic and Polyclinic	30 sites	Primary Care, urgent care, specialty and surgical care, advanced imaging, virtual care, lab services	
Arbor Health Morton Hospital	Critical Access Hospital Morton Clinic Mossyrock Clinic Randle Clinic	Hospital inpatient services, outpatient services, imaging, lab, rehab services, social services, sleep medical center, behavioral health, infusion services, respiratory therapy, women's health, wound care, podiatry, family medicine, ER	31 doctors and providers

A1.3 – Health Plans

Health plan name	Holding company	Clinical Services	Contract with HCA
Kaiser	Kaiser Foundation Group	Permanente Medical Groups (including acquiring Group Health Cooperative of Puget Sound Kaiser Permanente Central Hospital Clinics and offices throughout the state Lab services	Yes
United Healthcare of Washington	United Health Group	Optum Health: Polyclinic Northwest Physicians Networks Everett Clinic* Monarch Health Refresh MH Prospero (home health) Landmark (home health agency) LHC (aging in place services)	Yes
Community Health Plan of Washington	none	Affiliated with Federally Qualified Health Centers	Yes

Appendix B – 2016 Survey results

Health Plans	Barriers

Avoidable Hospital Readmissions	2.7		• Sufficient Market Share/Volume • Burden/ease of collecting or obtaining data • Business case or evidence of economic reward
Obstetrics	2.0		
Addiction/Dependence Treatment	1.9		
End of Life Planning	1.8		
Opioid Prescribing	1.7		
Oncology Care	1.4		
Low Back Pain	1.2		
Prostate Cancer Screening	0.7		
Value based payment	*Bundled Payment*	*Warranty*	
Coronary Artery Bypass Graft	0.4	0.2	
Lumbar Fusion Surgical	0.7	0.4	
Total Knee/Hip Replacement	1.0	0.6	
Other	1.0	0.7	
Hospitals			
Avoidable Hospital Readmissions	1.6		
Obstetrics	2.8		
Addiction/Dependence Treatment	1.4		
End of Life Planning	2.2		
Opioid Prescribing	2.5		
Oncology Care	2.1		
Low Back Pain	2.0		
Prostate Cancer Screening	2.3		
Value based payment	*Bundled Payment*	*Warranty*	
Coronary Artery Bypass Graft	2.2		
Lumbar Fusion Surgical	1.9		
Total Knee/Hip Replacement	2.3		
Medical Groups			
Avoidable Hospital Readmissions	2.5		
Obstetrics	2.8		
Addiction/Dependence Treatment	1.4		
End of Life Planning	1.7		
Opioid Prescribing	1.8		
Oncology Care	2.2		
Low Back Pain	1.8		
Prostate Cancer Screening	1.6		

Appendix C - List of organizations responding to the Health System Survey.

Evergreen Health Care, Educational Service District 105, United Health Care, UW Medicine, Carelon, Fred Hutch Cancer Center, Polyclinic, Swedish, Everett Clinic, Proliance Surgeons, Virginia Mason Medical Center, Catholic Charities Eastern Washington, Multicare, Olympic Area Agency on Aging, Stapleton Integrative Psychotherapy, Tri-cities Community Health, HealthPoint, Community Health Plan of Washington, Arbor Health,

Appendix D – Health System Survey questions

Brief Survey	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
QF1a) The use of the guidelines increased my/our understanding of the topic.					
QF1b) The use of the guidelines increased my/our confidence in decision making.					
QF1c) The patient recommendations provided our patients with increased knowledge about the topic.					
QD3a) I/we could easily identify appropriate goals from the Bree guidelines.					
QD3b) I/we would easily identify the objectives needed to reach goals in the Bree guidelines.					
QC5a) The overall costs of the implementation project(s) were worth the benefits.					
QC5b) Any increases in workforce costs or workloads to implement guideline(s) was in proportion to the benefits.					
QC5c) The cost of implementing the guideline(s) was reasonable for our facility or organization.					
QS11a The use of the guidelines increased my/our UNDERSTANDING of what data should be captured and shared with others on my/our team.					
QS11b From my perspective, the use of the guidelines guidelines increased our organizations ABILITY to implement data sharing solutions with other partners.					
QS11c The use of the guidelines increased our organizations ABILITY to implement analytics capabilities.					
QS11d The goals for REFERRALS were were clear.					
QS12a The goals for DATA TRANSPARENCY (such as sharing information with patients) were clear.					
QS12b The goals for DATA STANDARDIZATION were clear.					
QS13a The goals for DATA AGGREGATION capabilities were clear.					
QS13b The goals for DATA COLLECTION were clear.					

QS13c The goals for POPULATION HEALTH MANAGEMENT were clear.					

Appendix E – Roadmap