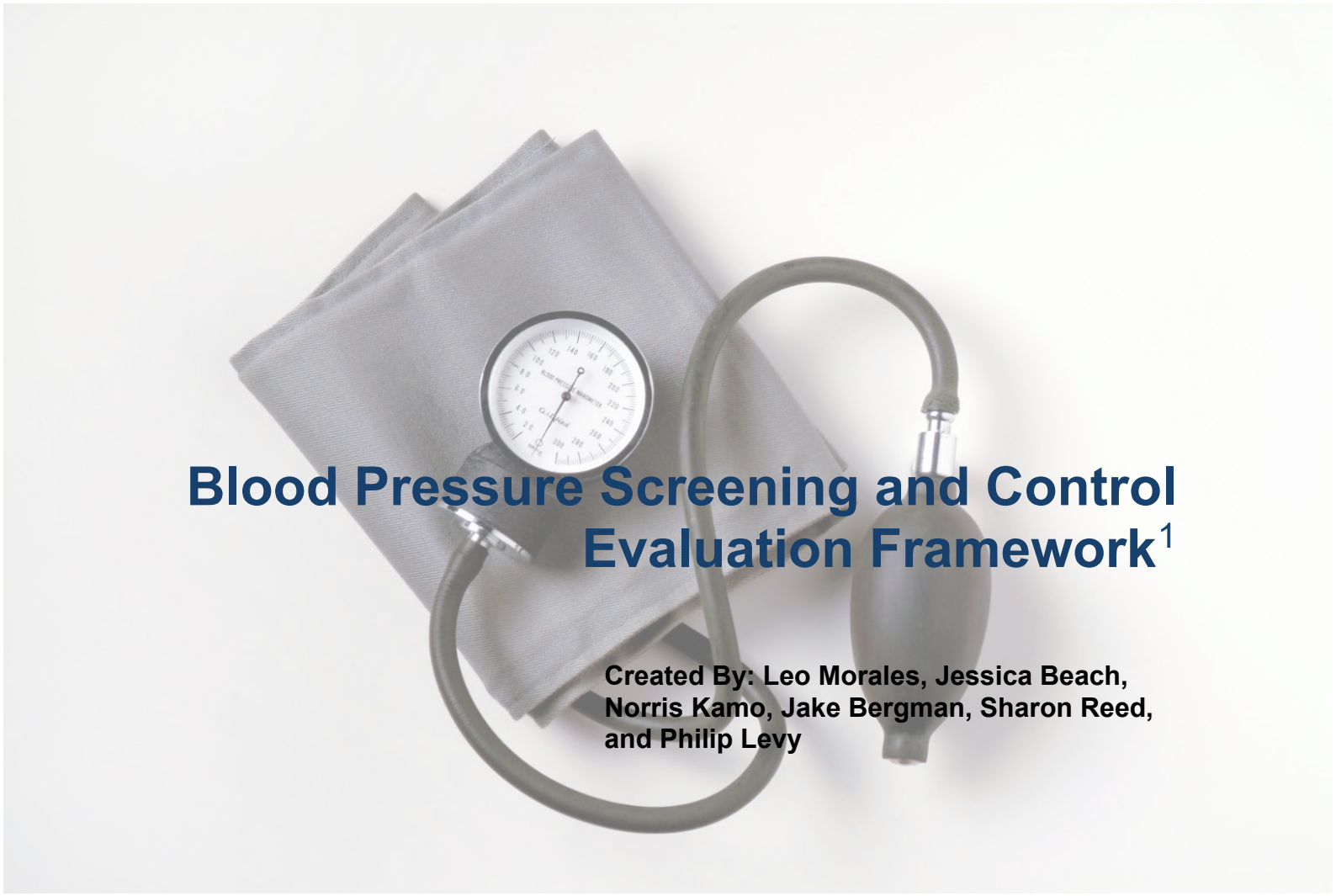

Blood Pressure Screening and Control Evaluation Framework[1]

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[1] Adapted from the Department of Industry, Science, Energy and Resources Evaluation Framework and Evaluation Framework | Better Evaluation

Blood Pressure Control Guidelines

This evaluation framework provides an overall framework for evaluations across different organizations within the Washington State health care system that contribute to patient care for Opioid Use Disorder Treatment.

This evaluation framework includes:

- **definitions and key concepts for measurement**
- **principles and standards for evaluation**
- **Information on resources to help align evaluations across system actors**
- **guidance for setting priorities on what, when and ways to evaluate**
- **Health System roles and responsibilities.**

Document administration

Version history

Version	Date	Description	Author
1.0		Original document	Subcommittee

Contents

Glossary

Accountable Communities of Health - a neutral convener, coordinating body, investor, and connection point between the health care delivery system and local communities. (Washington State Health Care Authority, 2024)

Audience – In Bree reports, an audience is a category of "system-actors". For example, a common audience is "health plans" and a common system-actor would be a specific insurance company.

Care-variation - differences in process of care across multiple clinics, areas, patient groups, insurance types, etc. (Bree Collaborative).

Concordance of care – Organizational and individual activities, interactions, policies and procedures that have a high degree of alignment with best practice recommendations (i.e. for the purposes of this framework best practices are considered to be the Bree Collaborative Guidelines). (Bree Collaborative)

Equity/Equity Lens - A just outcome that allows everyone to thrive and share in a prosperous, inclusive society. (Propel Alanta, 2024) A way of viewing, analysing, or evaluating data that takes vulnerable, disadvantaged, or small groups of people into consideration to assure that all outcomes and impacts are equal (Bree Collaborative).

Evaluation - determination of the value, nature, character, or quality of something. (Merriam-Webster, 2024) A systematic determination and assessment of a subject's merit, worth and significance, using criteria governed by a set of standards. (Wikipedia, 2024)

Guideline – an action to improve health care for a specific health care service

Health Ecosystem - a complex network of all the participants within the healthcare sector. It is a community that consists of patients, doctors, and all the satellite figures who play a role in the medical care received by the patient or their hospital stay. This can include service providers, customers, and suppliers. Recently, the healthcare ecosystem has grown to include electronic health entities and virtual care providers. (Definitive Healthcare, LLC, 2024)

Implementation - the translation of guidelines into practice.

Public Employees Benefits Board (PEBB) Contracts - medical and dental plans that provide health benefits to 222,000 public employees and retirees. (Washington State Health Care Authority, 2024)

Report – A report is multipage document on a health care service

School Employees Benefits Board (SEBB) Contracts - medical, dental, and vision plans that provide health benefits to more than 130,000 employees of the state's school districts and charter schools, as well as union-represented employees of the nine educational service districts. (Washignton State Health Care Authority, 2024)

System-actor – A specific type of organization that participates in health care in some way. Example: X health insurance company, the Washington State Department of Health, a specific provider, etc.

1. Background and Overview

1.1 Introduction

This Evaluation Framework outlines future evaluation activity that is intended to measure the uptake, concordance of care, outcomes, and impacts of the Bree Collaborative's *Blood Pressure Screening and Control* Guidelines during the life-cycle of the report. This evaluation framework has been developed by the Bree Collaborative Sub-committee of the Blood Pressure Screening and Control Workgroup. This is a living document. Please check back for updates.

This document details the evaluation framework within which the future evaluation[s] of this guideline may be conducted. Establishing this framework early in your organizations implementation life cycle ensures that the programs developed from it are prepared for future evaluations and helps instil an evaluative mindset from the outset. The framework provided by this document should be referred to during the implementation process and used to inform the drafting of an evaluation plan by each organization. It is recommended that it be reviewed periodically or in response to significant program, regulatory, or environmental events.

While this framework is expected to inform the evaluations outlined herein, the evaluations themselves may deviate from this framework based on input from various collaborators and interested parties and the program's evaluative needs at the time of each evaluation. This document is meant to provide alignment across multiple audiences for the purpose of comparison and to facilitate state-wide measurement on the progress and outcomes of the adoption of the Bree guidelines.

The framework provides guidance for different types of evaluations at different levels across the healthcare ecosystem. It details the reasons behind recommendations for particular types and timings of evaluation activities, makes recommendations for types of evaluations by audience, identifies domains for the development of evaluation questions, and identifies the data which should be available, or which will have to be collected to answer these questions.

This framework has been prepared by taking into account the strategic importance of the guidelines and the expected level of resourcing for evaluations at each organization, other initiatives that may affect implementation of the guidelines, and important contextual factors across the state.

1.2 Guideline overview

A **Bree Report** is defined as *a multipage document on a health care service, identified by Bree members as needing improvement that provides information and guidelines for actions different audiences can take within the health care ecosystem to improve the health of that chosen report topic*. A report may also be referred to as an **intervention** for the purposes of evaluation. A **Bree Collaborative Guideline** (previously called a recommendation in earlier Bree reports) is defined as *an action to improve health care for a specific health care service*. Reports include multiple guidelines for many different system-actors.

The *Blood Pressure Control* Report was developed by the Bree Collaborative in 2025. These guidelines were submitted to the Washington State Health Care Authority for the purpose of implementation as part of their Medicaid and other contracting activities with the intention of

reducing the **variation in care for blood pressure control**. The report was also published to the Bree Collaborative website for the purpose of implementation by Bree Collaborative members and by health care providers, purchasers, payors and community partners in general, in Washington State. The guidelines report was released on January 27th, 2026 and will be updates as necessary.

The components of this guideline (or intervention) are increases **blood pressure screening** for all people in Washington State, to improvements to **measurement accuracy** through training and public education, to improve **blood pressure management** through team-based care and access management plans and programs, to support **Quality improvement programs** and to increase **financing** of primary care interventions.

Guidelines apply to multiple system actors (clinicians, health plans, correctional institutions, health administration, etc.) that play a part in screening and treatment for blood pressure control.

2. Types of Evaluations

This framework provides guidance for the types of evaluations (e.g. community, organizational, and impact) that will assist in the demonstration of the usefulness of the Bree Guidelines. Organizations may also use this framework to improve their process of care, identify pinch-points or lessons learned, assess outcomes of changes made, monitor state-wide progress on the goals of the guidelines, and/or determine the impact of guidelines adoption on their patients' health, workforce, costs, etc.

As equity is an important part of the Bree Collaboratives' work, strategies and activities to improve equity should be included in any type of evaluation. More information on equity focuses specific to the guidelines can be found throughout this document.

More information on evaluations: **Evaluation.gov | Evaluation 101**

Information about what types of evaluations different guideline "audiences" or "system actors" should conduct can be found at the beginning of sections 2.2 to 2.5.

Other ways the Bree Collaborative support evaluations?

Many of the Bree Collaborative resources and supports for evaluation are referenced throughout this document. These include, but are not limited to, the *Implementation Guide*, the *Survey Bank*, the *Question Bank*, the *Measurement Bank*, the *Evaluation Tool Depot*, and *case study development* support. Bree staff can offer guidance on using our resources or provide one-on-one help to develop evaluations aligned with the implementation of our guidelines. Individuals wishing to receive assistance in using this framework or other resources offered by the Bree can reach out to: breecollab@gmail.com or knicholas@qualityhealth.org.

2.1 Metrics alignment

One of the intentions of this framework is to help organizations across the health care ecosystem align how they measure activities, outputs, outcomes and impacts associated with the implementation of the guidelines. The Bree Collaborative *Blood Pressure Screening and Control* guidelines aim to improve blood pressure **screening, diagnosis, control,** and to

reduce population level variation in blood pressure screening and management. The Workgroup sub-committee has identified metrics that align with these aims:

Process measures

BP Screening CMS QM 317 - Percentage of patient visits for patients aged 18 years and older seen during the performance period who were screened for high blood pressure AND a recommended follow-up plan is documented, as indicated, if blood pressure is elevated or hypertensive.

Denominator: All patient visits for patients aged 18 years and older at the beginning of the performance period

Exclusion: Patient has an active diagnosis of hypertension prior to the current encounter

Patients aged ≥ 18 years at the beginning of the performance period (G9744)

AND

Patient encounter during the performance period (CPT or HCPCS): 90791, 90792, 92002, 92004, 92012, 92014, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92546, 92622, 92625, 97802, 97803, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99236, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99424, 99491, D3921, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, G0101, G0270, G0402, G0438, G0439

WITHOUT

Telehealth Modifier (including but not limited to): GQ, GT, FQ, 93, POS 02, POS 10

Numerator: Patient visits where patients were screened for high blood pressure AND have a recommended follow-up plan documented or referral, as indicated, if the blood pressure is elevated or hypertensive

Blood Pressure (BP) Classification **–** BP is defined by four (4) BP reading classifications: Normal, Elevated, First Hypertensive, and Second Hypertensive Readings

- Normal BP: Systolic BP (SBP) < 120 mmHg AND Diastolic BP (DBP) < 80 mmHg
- Elevated BP: SBP of 120-129 mmHg AND DBP < 80 mmHg
- First Hypertensive Reading: SBP of >= 130 mmHg OR DBP of >= 80 mmHg without a previous SBP of >= 130 mmHg OR DBP of >= 80 mmHg during the 12 months prior to the encounter
- Second Hypertensive Reading: Requires a SBP >= 130 mmHg OR DBP >= 80 mmHg during the current encounter AND a most recent BP reading within the last 12 months SBP >= 130 mmHg OR DBP >= 80 mmHg

BP Referrals -

Percent of patients who were screened and referred if they had a blood pressure reading of SBP >= 130 mmHg OR DBP >= 80 mmHg or greater

Percent of patients who are screened and experiencing a hypertensive emergency that are provided emergency services

Community level screening evaluation measure concepts:

- How many community screening/education events were held, over what period of time
    - Characterize educational materials: non-English and translation assessment, reading level (MS word has the Flesch-Kincaid Grade Level and Flesch Reading Ease score), assessed for culturally appropriateness
    - Characterize staff at event: bilingual, interpreters provided, licensure,
- How many people were screened in total in the same time period
    - Characterization of screening events, ex: location, settings, times/days (ex: in consideration of employed individuals, individuals with transportation issues, handicapped accessible)
    - Characterize patients who were screened: language, R/E, age, gender, zipcode/Social Vulnerability Index (SVI) measure, rural status (Rural-Urban Continuum Codes RUCC Index from UW) https://depts.washington.edu/uwruca/
    - How many people indicated that they have their own BP cuff or machine?
- Was individualized counseling provided
    - How many people received individualized counseling
- Of those who were screened, total number were identified with (high BP by stage), over the same time period
- Of those identified with hypertension,
    - how many were referred back to their usual source of care
    - were referred to new care (based on cut/off)
    - how many had insurance
    - currently receiving treatment (e.g. taking medication),
    - have a usual source of care,
    - when last seen
    - was anyone sent to urgent care or ER for treatment
- Of those who were referred, how many entered care
    - At your organization, follow-up with individual (considering sampling)

Patient Experience Measures

The Bree Collaborative will be posting patient experience surveys, measurement methodologies, and structured interview questions in our **Survey Bank** to help align patient experience measures as they are developed by partner organizations and agencies.

For those organizations that are developing their own patient experience evaluation tools, the National Institute of Health has published a **literature review** for the purpose of identifying existing quality measures and gaps in measurement of patient experience.

Strong recommendations:

- Document providers use of shared decision making with patients.
- Include patient goals in measures of patient experience
- Provide patient logs, cards, or other documentation of the BP at time of screening or appointment
- Include qualitative methods in patient experience measurements

- Share patient experience evaluation surveys, methods, and results with the Bree Collaborative OR use surveys and tools shared with the Bree in your own evaluation work

Soft recommendations:

- Consider using CAHPS patient experience surveys to better understand patient perspectives on clinical interactions.

Long-term outcomes measures

Percent of people with high hypertension diagnosis AND an individualized, documented management plan

Percent of visits for Hypertension where a Prevent calculator for cardiovascular disease risk calculations was used

Patient who receives shared decision making and documentation for blood pressure control for individualized blood pressure target

Increase in patient self-monitoring and reporting of home blood pressure values

Patients self-efficacy in blood pressure management (see diabetes self-efficacy tool)

Percent of patients with:

- *a 1-month follow-up visit after high blood pressure diagnosis or referral*
- *a 3-6 month follow-up visit after start of treatment for patients to determine blood pressure control and escalate or begin medication if necessary*
- *Percent of patients who can self-monitor*

Impact measures

The Bree Collaborative work group recognizes that best practices for target blood pressure may change over time or be different for different groups (ex: older individuals). With that in mind, the workgroup recommends the following metrics, *with the caveat* that these metrics are subject to change and providers should follow the current best practice recommendations.

Current recommendations are listed below AHA/ACA guidelines. Updated definitions of these measures should be followed if updates are made by the measure steward.

NCQA/HEIDS 0018 Controlling High Blood Pressure (CBP) - The percentage of patients 18 – 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. (NOTE: See Process measures section for more information on Blood Pressure (BP) Classification and consider stratifying this measure by control classifications.)

OR

CMS165v11

Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period. (NOTE: See Process measures section for more information

on Blood Pressure (BP) Classification and consider stratifying this measure by control classifications.)

BOTH of these measures should be stratified by race/ethnicity, age, geography or other SDOH factors to measure disparities

Population level increase in annual BP Screenings

2.2 Community Level Evaluations

Information for this type of evaluation is relevant for organizations that implement community screening initiatives, activities, programs, or that provide community care.

These types of evaluations can answer questions such as "is there an increase in access?", "Is the program reaching its intended participants?" or "Is the program acceptable to the community of focus"?

Organizations that are engaged in direct patient care and care financing are the primary focus for community level evaluation recommendations for the *Blood Pressure Screening and Control* guidelines. The goal of the report at the community level is to increase the number of people who "know their number" and the objectives are to provide more people with education and information about hypertension and to increase access to blood pressure screening.

Evaluations can be useful to share your success and lessons learned with others and might focus on one or more of the following:

- Funding - Demonstrate impact to funders, or seek support for continuing the program
- Spread - Gather information on the approach that can be shared with others or to help determine if an approach would be appropriate to replicate in other locations with similar needs
- Barriers and facilitators – highlight solutions to overcome some of the barriers that the Bree report highlights, including care transitions, care coordination, access to primary care, patient education, underinvestment in environmental supports, culturally and linguistically appropriate services, medication refill policies, cost sharing, preauthorization, etc.

In order to align with Bree Collaborative recommendations, Community level evaluations should aim to measure the expansion of screening settings (e.g. at events, in pharmacy, etc.), the reach of their initiatives or programs (e.g. the number and percentage of patients in the target population, screened, referred to care, number receiving educational information, etc.) and patient experience (e.g. is the program acceptable to the target population, did it help people get screened, do people know their numbers, are more people able to self-manage their blood pressure.)

Creating surveys to evaluate community screening

Many toolkits exist to help organizations set up community-based screening events such as the South East London ICS or Providence's instructions on how to set up blood pressure

screenings for faith-based communities, however there are no standard questionnaires for patient assessment and few examples to leverage.

Types of questions to include in a screening event form are questions about current care, such as “are you currently in care, are you on medications, when was your last appointment, etc.; questions about how to follow up with them or documenting appointments made at the point of screening (same day, next day, etc.); and including meta data such as (name, age, etc.). It is recommended that surveys include information on equity items such as geography, race/ethnicity, preferred language, etc.

Organizations are able to draw examples from the Bree Collaborative Survey Bank or submit compete surveys or individual questions to the Survey Bank or the Survey Question Bank, respectively.

One example of an on-line fillable form to provide to patients as a “hypertension screening card” can be found HERE.

Strong recommendations:

- To measure fidelity or programs or initiatives with Bree recommendations, use the Bree score card (in our **Implementation Guide**)
- Use Bree Survey Question bank to align patient experience survey and research questions across multiple stakeholders
- Include an equity perspective in the evaluation planning
- Focus on threshold for referral (e.g., refer to emergency room for hypertensive crisis (SBP>180 with target organ damage), refer to primary care for SBP >/=130))

Soft recommendations:

- Leverage Module 4 of the RHIhub Community Health Toolkit https://www.ruralhealthinfo.org/toolkits/rural-toolkit/4/program-evaluation
- Leverage other, alternative evaluation frameworks when designing interventions that include under-represented groups (example: “Pulling Together for Wellness” Indigenous evaluation framework)

Data source recommendations:

Event surveys, patient surveys, administrative event planning data and documents, EHR data

2.3 Organizational Level Evaluations

Information for this type of evaluation is relevant to health care providers, health care payors, self-insured organizations, health plans

Program (summative) and process evaluations assesses the effectiveness of the processes and the final outcomes, determining whether a program achieved its goals. This type of evaluation can answer questions such as “Did participants experience the desired outcomes?” or “What changes were made to improve the quality of the program?”

The primary aims of the *Blood Pressure Screening and Control guidelines* are to help individuals across Washington state (and beyond) identify elevated blood pressure and risks of elevated blood pressure and to understand how to manage it, with the support of health care providers, if necessary. Specific clinical guidance on how to manage patients and specific goals for blood pressure control are beyond the scope of the report and organizations should refer to reliable and valid clinical recommendations from state, regional, national or international bodies. Organizational evaluations should be conducted with these aims and limitations in mind.

Care and care financing organizations should consider the primary goal to get patients more involved in their own care, thus long-term outcome measures or impact measures should reflect this.

Organizations may also consider including an impact measure that quantifies a reduction in high blood pressure for those who receive care, however the primary purpose of this type of measure should focus on reduction in disparities. Evaluators should be aware that state and national guidelines on a measure of optimal care may change after the release of the *Blood Pressure Screening and Control* report and follow clinical guidelines as the evolve.

Organizational level evaluations should consider including one or more of the following focus areas to evaluate:

- Staff training – See the TargetBP guidelines for measurement of activities
- Individual patient focus – to determine if the program or process address patient-specific factors such as patient measurement supports, health literacy, knowledge about hypertension and its management, and self-efficacy in adopting healthy behaviors, and adhering to medications, or if patients have a guideline aligned validation visit for their machine, etc.
- Health system program or process focus – to determine if implementing these guidelines improved the healthcare system processes, team-based care, pharmacist-led medication management, and use of technology in quantifiable ways.
- Cost/benefit – Organizations that conduct impact evaluations may want to include a cost benefit analysis in their evaluation plans to make a “business case” for their screening and community activities that may not be directly reimbursed. Consider looking at cost/benefit in terms of whether the investments in community care result in reductions in cost or relative benefit in:
    - Upstream utilization
    - Adverse patient outcomes
    - Disparities in care processes or patient outcomes

Strong recommendations:

- Bree score card (in our **Implementation Guide**)
- Use the American Heart Association BP Pillars of Evidence-Based Activities to assess your processes https://targetbp.org/awards/
- All audience members should consider using geography, income, race and ethnicity, language, and/or disability status as stratifiers for examining the outcomes to examine important variations.

Soft recommendations:

- The Bree Collaborative encourages the use of the blood pressure control metrics in Washington State Health Care Authority VBP programs (see impact measures section).

Data Source recommendations:

- patient records
- administrative data
- claims data or other cost data

2.4 Regional and State Level Evaluations

It is proposed that this evaluation be conducted by: public health agencies (including ACH's), health plans, health systems, and EMS.

An impact evaluation relies on rigorous methods to determine the changes in outcomes which can be attributed to a specific intervention based on cause-and-effect analysis. (American University, 2024)

The Bree Collaborative aims to improve the quality of patient care, patient outcomes and affordability in Washington State, to that end, the measurement of the impact of guidelines adoption on blood pressure control associated mortality, morbidity, and should be undertaken by regional and state level system actors.

Impact evaluations should seek to compare impact measures after guideline implementation to a prediction of what would have happened (a counterfactual) in absence of guideline adoption. These types of evaluations can answer questions such as "What is the overall impact of the program on the larger community?", "In what ways does the program contribute towards the overall wellbeing of the population?" "What was the Population Attributable Fraction (PAF) for reduction in adverse events associated with a reduction in hypertension prevalence (number needed to treat)?"

Organizations such as Accountable Communities of Health, large health systems or health plans, may also want to consider conducting an impact evaluation that assesses the impact on their patient population. This type of evaluation should assess the impact of the guideline's adoption on one or more of the following measures:

- Patient experience – patient self-management
- Blood pressure control based on current recommendations
- Reduction in disparities for BP control

If direct care organizations or care financing organizations choose to conduct an impact evaluation, they should consider answering the questions such as "In what ways does the program contribute to advancing our organization's mission (to improve health)?"

Strong recommendations:

- Include an equity lens in impact evaluations
- Include a care-variation lens in impact evaluations (Note: care-variation refers to differences in process of care across multiple clinics, areas, patient groups, insurance types, etc.)

- Washington State should continue to use R/E stratifications for blood pressure control measure which is included in the Common Measure Set.
- Use Bree score cards to measure concordance of care when comparing organizations or areas a counterfactual

Soft recommendations:

- Include cost/benefit analysis in impact evaluation planning

2.5 Guideline logic

At the heart of each guideline is a 'Theory of Change', or TOC, (Appendix A) which helps all audience types visualize how the workgroup members imagined the changes that will occur across the healthcare ecosystem as a result of their recommendations. It describes a chain of results flowing from the buy-in, resource utilization and capacity building, to affect medium to long-term outcomes that result in an impact for patients and services in Washington State. Each organization can use this to help develop a TOC specific to their organization or project that is well aligned with the intent of the workgroup.

The purpose of the evaluation recommendations in this report is to provide evidence as to whether or not the implementation of these recommendations has resulted in the theorized change.

The Bree Collaborative offers evaluation resources, including our **Evaluation Tool Depot,** to assist with the development of organization-level logic models which should describe how each system-actor's implementation will result in the intended changes. Organizations logic models can focus evaluation questions on outcomes and processes of interest that are appropriate for their services. They can clarify the policy and program intentions and clarify alignment between activities and objectives.

Other resources for developing logic models include evaluation question guidance (section 2.7), the evaluation matrix (section 2.8), and common contextual factors (section 3.3) included in this document.

2.6 Evaluation questions

Across the lifetime of these guidelines, evaluations need to include a range of questions that promote accountability, address gaps in care, and promote learning from system-actors experiences.

The Bree has identified four main **domains** for systems transformation in our *Roadmap to Health Ecosystem Improvement* which can be used to help develop evaluation questions which are appropriate to inform the effectiveness and impact of our guidelines: *equitable care, integrated/holistic care, data usability and transparency, and financing.* In addition to these "pillars of transformation", the roadmap identifies **levers of change** which can also be used to develop evaluation questions. They include *clinical workflows, transparent reporting, education, patient engagement, coordination, contracts and networks, legislation and regulation, organizational policy changes, and data infrastructure.*

To support alignment, the Bree Collaborative has developed a **Survey Question Bank** which can be used to share evaluation questions across organizations participating in

evaluation. Although still in its infancy, the Question Bank can be built out by participants through submission of their research questions or survey questions. Organizations may also draw from the question bank to help develop evaluations that are comparable across multiple organizations, sectors, areas, or populations.

Evaluation questions for each evaluation type can be developed to align with this roadmap and with the guideline logic and should form the basis of an evaluation plan and the Terms of Reference.

Note that not every evaluation should address all the evaluation question domains, or all of the levers of change (paragraph 2 section 2.7) identified by the Bree– they may be spread out across different audience or system-actor organizations, or across different types of evaluations such as monitoring and impact evaluations.

2.7 Data Matrix

The Bree has included a sample data matrix and strongly recommends its use to document data sources so that evaluation results can be compared across health ecosystem actors.

An example of the Data Matrix can be found in Appendix B and a fillable template can be found in the Bree Collaborative Implementation Guide.

3. Roles and standards

The Bree Collaborative submits it's reports to the Washington State Health Care Authority (HCA) to consider them for use in designing Medicaid contracts, PEBB and SEBB contracts, and for general implementation at the HCA or in Accountable Communities of Health programs. Guideline reports are also posted on our website and disseminated to other system actors for the purposes of implementation.

The reports provide guidance for system actors (see section 3.1) to implement. The Bree defines implementation as the "translation of guidelines into practice". **For the purposes of evaluation, the Bree Collaborative is interested in how organizations translate our guidelines into their own context or setting and what the results of their implementation are.**

3.1 Roles and responsibilities

The Bree uses the term "Audiences" or "System-actors" in place of the term "stakeholders" for clarity. There may be one or many different organizations within an audience category (for example, there will be multiple "health plans" but only one Washington State Department of Health) or there may be multiple audiences within a single organization (for example, a health system, it's associated clinics or hospitals and the clinicians). Finally, some organizations may play more than one role (for example, the HCA is both a purchaser and a government agency, or a health system may choose to evaluate both its patient care activities and the purchasing for its employees' health insurance plans).

There are many system-actors with roles in implementing and evaluating the *Blood Pressure Screening and Control Guidelines* across Washington State in order to affect and measure

changes to care processes, financing, and outcomes across the health care eco-system. These are:

- Washington State Agencies/State Organizations
  - Health Care Authority
    - » Accountable Communities of Health
  - Department of Health/Local Health Jurisdictions
  - DBHR
- Health plans
- Health care purchasers/employers
- Health care systems
  - Health care professionals/primary care providers
  - Health care teams
  - Quality improvement teams
- Community Organizations
  - Community Pharmacies
- Dental Clinics/Dentists

Table 4.1.1 below outlines broad roles and responsibilities for system-actors with regard to the *Blood Pressure Screening and Control* guidelines. Further details about the exact actions that should be taken to align policies, procedures, and programs with Bree guidelines can be found in the Bree collaborative score cards which are located in the **Implementation Guide**. For example, any employer that has implemented the Bree guidelines should evaluate the extent to which their organizations have implemented the recommended supports for patients in the work environment (benefits design, wellness fairs or on-site screenings, policy and program changes, vendor evaluation and performance guarantees, etc. – see the guidelines report or score cards for full list).

Table 4.1.1: Roles and responsibilities in the health care ecosystem

Each organization has different roles and responsibilities as system-actors within a health care eco-system that provides quality care to patients. The roles and responsibilities of different organizations as defined by these guidelines are outline in the table below:

System actor role	Responsibility
State organizations	Purchasing for MCOs Data sharing/transparency/requirements Changes to approved drug lists Public Health support Convening for and promoting health education
Health Plans	Provide adequate coverage for patients Provide adequate funding for (aka VBP) Provide adequate networks for care

	Member outreach
Employer/Purchasers	Develop requirements for plans that are purchased Implementation of recommendations to support patients in the work environment
Health Systems, providers	Provide screening and treatment aligned with best practices Data Transparency/sharing Patient outreach Community coordination
Dentists/Dental Clinics	Provide screening aligned with best practices Coordinate with primary care Data Transparency/sharing
Community Organizations	Care coordination Data Transparency/sharing

It is the responsibility of each organization to ensure that their evaluations are overseen by a governance body. It is not within the scope of this framework to define how each individual organizations evaluations should be governed; however, this framework sets out some general information, in sections 3.2 through 3.5, for governance bodies to consider when designing their evaluation and for organizations to consider when establishing their governance body. At a minimum, the governance body should include representation by the program's policy and delivery teams. Observers or subject matter experts from other areas should also be invited to participate as required.

As part of their evaluation plan, organizations should consider including a table, similar to table 4.1.1 above, of internal roles and responsibilities as part of their evaluations which include who is responsible for the following: *Agree to the Terms of Reference and evaluation plan, provide feedback on the evaluation report, chair of the governance group to sign off on the final evaluation report, provide evaluation guidance and input to evaluation plan, draft the evaluation Terms of Reference and evaluation plan for the evaluation; Conduct, manage, or advise on evaluation activity as required; Provide program data and guidance on program administration and delivery as required; and Provide data and input as required.*

3.2 Ethical Standards and Cultural Considerations

Equitable care is one of the pillars of the Bree Collaborative's *Roadmap to Health Ecosystem Improvement* and, as a matter of course, the Bree Collaborative encourages all implementation and subsequent evaluation work to consider an equity lens. Organizations may refer to the Foundation for Health Care Qualities web page for further guidance when planning an evaluation: https://www.qualityhealth.org/equity/

Evaluations involving the measurement of vulnerable groups, groups with specific cultural considerations, or individuals with barriers to their ability to consent should be thoroughly reviewed and ethical standards should be applied where necessary or appropriate. These standards should include, at a minimum:

- **The use of an IRB, when appropriate**
- **Patient safety considerations**
- **HIPAA requirements**

Each evaluation should be overseen by a governance body established by the organization. It is not within the scope of this framework to define how each individual organizations evaluations should be governed; however, this framework sets out some general information, in this section, through 3.5, for governance bodies to consider and for organizations to consider when establishing their governance body. At a minimum, the governance body should include representation by the program's policy and delivery teams. Observers or subject matter experts from other areas should also be invited to participate as required.

Strong recommendation:

- Organizations should leverage the Bree Collaborative's Social Need and Health equity report to ensure ethical standards are being met when collecting social needs data.

3.3 Common Contextual Factors

Because the *Blood Pressure Screening and Control* guidelines are designed to be implemented by organization across the state, there will be common contextual factors that they should consider in their evaluation work in order to illustrate how the interact with the recommendations or how the context of implementation influences the adaptation of the guidelines for particular settings or populations. The Bree has identified a set of contextual factors that all organizations should consider however, each organization should research their own settings for additional contextual information such as population demographics, organizational size, etc.

Strong recommendations:

Organizations should consider, at a minimum, the following contextual factors when planning their evaluations:

- Washington State geography – urban or rural designations as defined by HRSA https://www.hrsa.gov/rural-health/about-us/what-is-rural/data-files
- Workforce availability – Health Professional Shortage Areas as defined by HRSA https://data.hrsa.gov/tools/shortage-area/hpsa-find
- Data capacity – internet accessibility and other data infrastructure as defined by the Washington State Office of Broadband https://www.commerce.wa.gov/wsbo/fcc-broadband-map/
- SDOH prevalence – area deprivation indices, food deserts, etc.
- Population demographics – race/ethnicity, languages, age, etc.

3.4 Timelines

Figure 4.2.1 outlines the general sequence of events for each evaluation and identifies three points at which organizations should consider coordination with the Bree Collaborative: during the evaluation planning process, during the initial data collection process, and to submit a copy of the final evaluation.

Organizations may also consider closer partnerships with the Bree for evaluation support, or with the Foundation for Health Care Quality, for leveraging data from other programs within

the Foundation such as OB COAP, CBDR, or Smooth Transitions. In such cases, organizations may want to adjust their evaluation timelines to align with the Bree's awards or reporting initiatives or with FHCQ programs data collection schedules.

Figure 4.2.1: Collaboration with the Bree

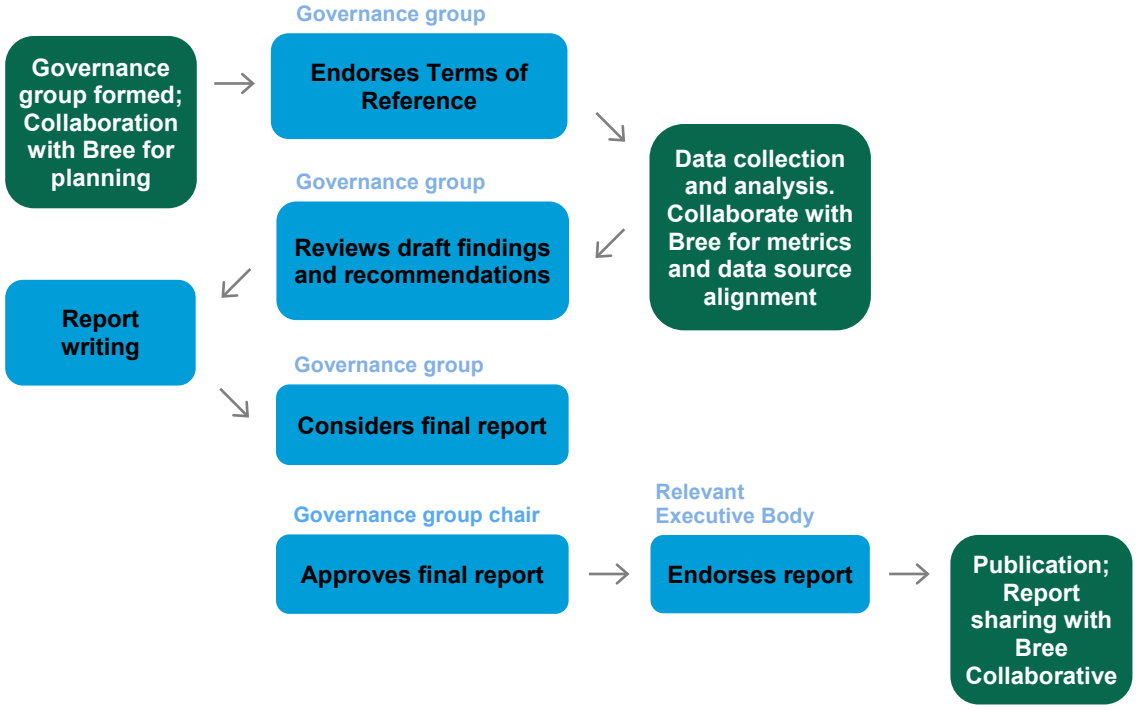


Table 4.2.1: Creating a timeline that considers other initiatives

Organizations using this framework should create a timeline for evaluation that considers alignment with the Medicaid Transformation Project 1115 waiver, other federal and local opioid response initiatives and recommendations for other system-actors included in the Bree Guidelines. For example, health systems may want to consider developing a timeline that considers required reporting for state initiatives.

The timeline for organizational level evaluations should be detailed enough to help individuals external to the organization put the evaluation into a state-wide context.

Initiatives	Start	End
Rural Health Transformation Project		
NCQA ECQM proposed measure change		
Target BP - AHA		
Puget Sound – AHA local projects or funding support		

Timelines for evaluation should also consider the goals of the guidelines (Identification, initiation to treatment, retention to treatment), and other organizational-internal recommendations such as infrastructure or training recommendations, etc.

The Bree collaborative is supporting timeline alignment through their Reporting Initiative. This initiative will result in a map of organizations with lists of Bree guidelines that they have

adopted or are in the process of implementing. This initiative can help you align your evaluation work with others by being able to see what other organizations in your area have also adopted the *Blood Pressure Screening and Control Guidelines.* Please visit the **Evaluation Homepage** on our website for updated information on this initiative.

3.5 Methodologies

Mix of methods, both quantitative and qualitative, should be used to gather evidence to answer the evaluation questions in order to provide a full picture of patient, staff, and other collaborators experiences, in addition to outcomes and impact data, depending on the type and number of evaluations each organization wishes to conduct. Methodologies should support, at least in part, an understanding of concordance of care with Bree recommendations and/or should aim to quantify the outcomes and impact of using the guidelines.

Specific methodologies for evaluations should be agreed by the governance body prior to the commencement of each evaluation.

Strong recommendations: Evaluations are expected to include in whole or part -

- Bree Collaborative Score Cards to support process or program evaluations;
- Desktop research: a systematic review of program documents which may include program guidelines, executed grant agreements, program logic, policy papers, and program reporting and procedure manuals. This may also include a review of relevant reports and existing data;
- Leveraging of other Foundation for Health Care Quality programs (e.g. OB COAP, Health Equity, Patient Safety), where applicable
- Data sampling, where applicable

Soft recommendations: Evaluations may include the following -

- Literature review: a systematic review of similar programs run in other jurisdictions, reviews or evaluations of similar programs, and relevant journal research articles or media reports (with caution)
- Semi-structured interviews with a range of stakeholders which may include face-to-face, telephone, or video-conferencing, etc.
- Surveys
- Economic profiling of the organization and region
- Case studies of selected projects or patient cases

3.6 Risks and limitations

When developing an evaluation[s] using this framework, organisations should consider the following risks and limitations as they pertain to demonstrating concordance of care, outcomes, or impacts associated with the implementation of the Bree Guidelines on *Blood Pressure Screening and Control*:

- Availability of resources and skills to conduct the evaluation/s

- Availability and quality of data from internal and external sources
- The burden/cost of collecting robust data
- Proportion of the program or initiative that can be directly contributed to the Bree Collaborative Guidelines and the difficulties or limitations of quantifying guidelines contributions
- Generalizability of the evaluation

These risk and limitations are ones that have been identified by the Bree as the primary one's pertaining to guideline adoption.

The Bree Collaborative and the Foundation for Health Care Quality seek to mitigate some of these risks or limitations by offering resources for control of data collection limitations, data sharing limitations, and metrics and methodological alignment limitations that are found throughout this framework and in Bree and Foundation for Health Care Quality programs.

Table 4.4.1: Risks and controls

Risk	Results	Likelihood	Consequence	Rating	Control
Insufficient resources to undertake the evaluation	Low quality evaluation report; failure to meet timeframes; stakeholder dissatisfaction; damage to reputation of the organization	Likely	Fewer organizations are willing to conduct evaluations; effects of guidelines across the health care eco-system has gaps in knowledge	Substantial/ High	Bree staff to consult on the evaluation design and methods; resources (templates, trainings, etc.) for implementation and evaluation planning; partnerships with other health system actors.
Inadequate data to support analysis	Inadequate evidence to support findings; low quality evaluation report; stakeholder dissatisfaction; damage to reputation of organization	Possible	Understanding of guideline impact is reduced or incomplete	Substantial/ High	Agreed evaluation matrix identifying objectives, goals, and metrics; data collection methodology (e.g. score cards); partnerships with other health system actors.
Inability to untangle impacts of other initiatives	Lack of clear impact; diluted/ exaggerated impact	Almost Certain	Inability to quantify the exact contribution of the Bree Collaborative work to system-wide changes	Minimal/ Medium	Identification of common contextual factors; timeline alignment with other initiatives
Generalizability of evaluations	Fragmented evidence; evaluations irrelevant for state or nation-wide use	Possible	Inability to spread Bree best practices	Moderate/ High	Survey question bank; evaluation framework;

Each organizations' evaluation governance body should be responsible for monitor the evaluation closely to ensure that these and other emerging risks are managed effectively. Table 2.4.2 defines the risk ratings used above. Table 2.4.2 defines the risk ratings used above.

Table 4.4.2: Risk ratings

Likelihood rating	Consequence rating				
	Insignificant	Minimal	Moderate	Substantial	Severe
Almost certain	Minor	Medium	High	Very high	Very high
Likely	Minor	Medium	Medium	High	Very High
Possible	Low	Minor	Medium	High	Very High
Unlikely	Low	Minor	Minor	Medium	High
Rare	Low	Low	Minor	Medium	High

References

American University. (2024, 10 31). *What is Impact Evaluation?* Retrieved from programs.online.american.edu: https://programs.online.american.edu/online-graduate-certificates/project-monitoring/resources/what-is-impact-evaluation

Definitive Healthcare, LLC. (2024, October 24). *Healthcare Ecosystem* . Retrieved from definitivehc.com: https://www.definitivehc.com/resources/glossary/healthcare-ecosystem

Merriam-Webster. (2024, October 24). *Evaluation*. Retrieved from Merriam-Webster.com Dictionary: https://www.merriam-webster.com/dictionary/evaluation

Propel Alanta. (2024, October 24). *How we define equity*. Retrieved from letspropelatl.org: https://www.letspropelatl.org/define-equity

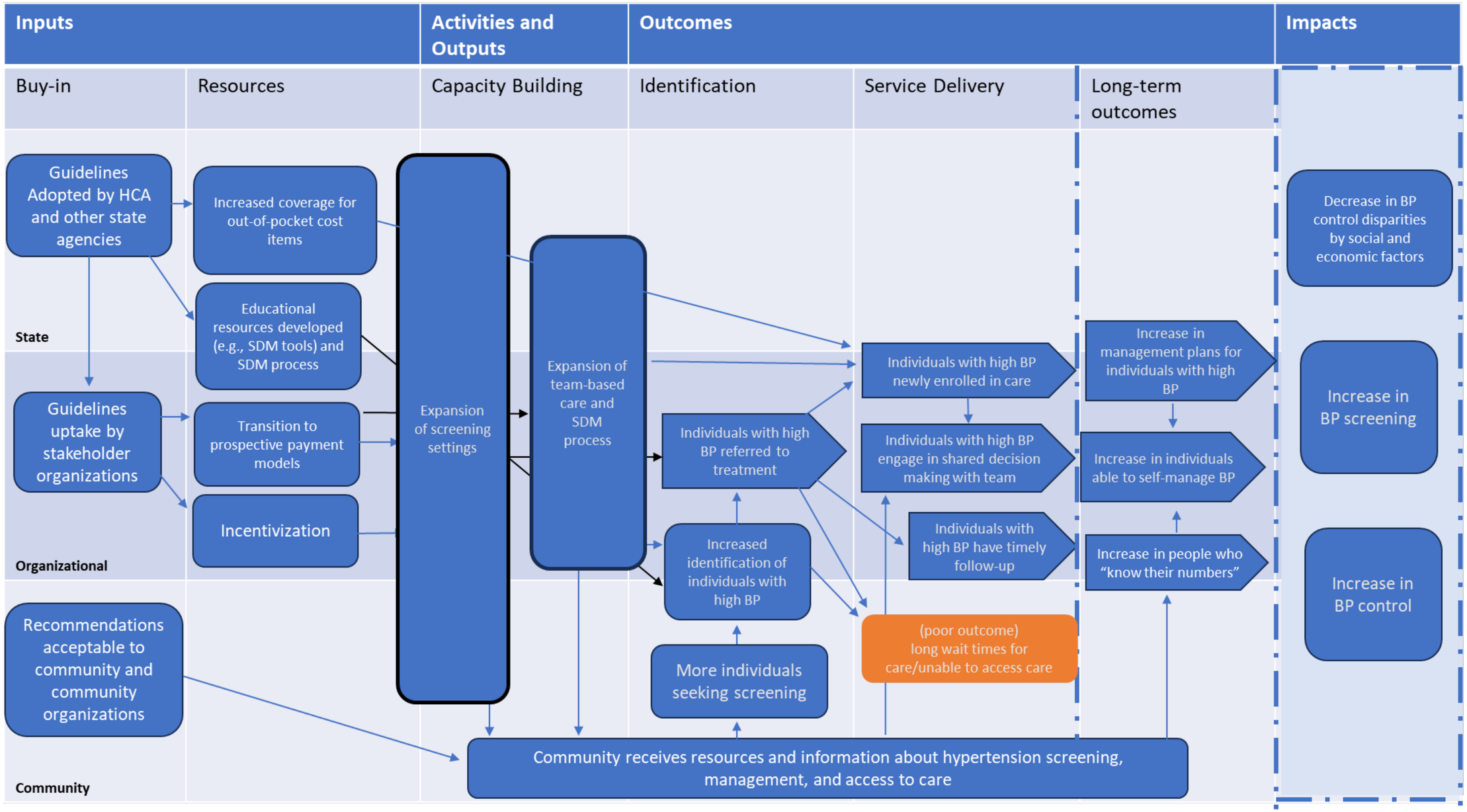
Washignton State Health Care Authority. (2024, October 24). *School Employees Benefits Board (SEBB) Program*. Retrieved from hca.wa.gov: https://www.hca.wa.gov/about-hca/programs-and-initiatives/school-employees-benefits-board-sebb-program

Washington State Health Care Authority. (2024, October 24). *Accountable Communities of Health (ACHs)*. Retrieved from hca.wa.gov: https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/accountable-communities-health-achs

Washington State Health Care Authority. (2024, October 24). *Public Employees Benefits Board (PEBB) Program*. Retrieved from hca.wa.gov: https://www.hca.wa.gov/about-hca/programs-and-initiatives/public-employees-benefits-board-pebb-program

Wikipedia. (2024, October 24). *Evaluation*. Retrieved from Wikipedia: https://en.wikipedia.org/wiki/Evaluation

Appendix A Theory of Change



Appendix B Data Collection Matrix

This template is for guidance only and provides generic examples of questions and indicators that your evaluations may consider. A fillable template can be found in the Bree Collaborative Implementation Guide.

Evaluation Questions	Data: What to collect? When to collect it?				Data source: WHERE is it? HOW to collect it? WHO is responsible? ARE permissions required?
Questions	**Indicators**	**Metrics/Measures**	**Context**	**Data Frequency**	**Recommended data source**
Process/structural improvement					
What changes were made to patient identification policies or process?	Difference between previous and Bree aligned policies or procedures	TBD by evaluator	See Section 3.3	Aligned with clinical considerations; aligned with other initiatives (see section 3.4)	Who: TBD Policies; workflows; QI programs; patient records;
What changes were made to the treatment initiation process?	Difference between previous and Bree aligned policies or procedures	TBD by evaluator	See Section 3.3	Aligned with clinical considerations; aligned with other initiatives (see section 3.4)	Who: TBD Policies; workflows; QI programs; patient records;
What changes were made to polices or process for measuring blood pressure?	Difference between previous and Bree aligned policies or procedures	TBD by evaluator	See Section 3.3	Aligned with clinical considerations; aligned with other initiatives (see section 3.4)	Who: TBD Policies; workflows; QI programs; patient records;
What changes were made clinician/patient/staff education?	Difference between previous and Bree aligned policies or procedures	TBD by evaluator	See Section 3.3	Aligned with clinical considerations; aligned with other initiatives (see section 3.4)	Who TBD Policies; workflows; QI programs; patient records;
What changes were made to patient access to services?	Difference between previous and Bree aligned policies or procedures	TBD by evaluator	See Section 3.3	Aligned with clinical considerations; aligned with other initiatives (see section 3.4)	Who: TBD Policies; workflows; QI programs; patient records;
What changes were made to data sharing policies or processes?	Difference between previous and Bree aligned policies or procedures	TBD by evaluator	See Section 3.3	Aligned with clinical considerations; aligned with other initiatives (see section 3.4)	Who: TBD Policies; workflows; QI programs; patient records;

What changes were made to financial contracts or coverage policies?	Difference between previous and Bree aligned policies or procedures	TBD by evaluator	See Section 3.3	Aligned with clinical considerations; aligned with other initiatives (see section 3.4)	Who: TBD Policies; workflows; QI programs; patient records;
Effectiveness					
How effective were care coordination activities?	Before/after implementation of Bree guidelines	TBD by evaluator	See Section 3.3	Point in time measures from PDSA; Aligned with the evaluation timeline	Who: TBD Patient records; EHRs; QI programs; patient satisfaction surveys;
How effective was shared decision making?	Before/after implementation of Bree guidelines	TBD by evaluator	See Section 3.3	Point in time measures from PDSA; Aligned with the evaluation timeline	Who: TBD Patient records; EHRs; QI programs; patient satisfaction surveys;
Outcomes					
What were the outcomes of screening activities?	Before and/or after implementation of Bree guidelines	See section 2.1 for definitions	See Section 3.3	Point in time measures from PDSA; Aligned with the evaluation timeline	Who: TBD Patient records; EHRs; QI programs; patient satisfaction surveys; See section 2.1
What were the outcomes of referrals?	Before and/or after implementation of Bree guidelines	See section 2.1 for definitions	See Section 3.3	Point in time measures from PDSA; Aligned with the evaluation timeline	Who: TBD Patient records; EHRs; QI programs; patient satisfaction surveys; See section 2.1
How many patients had BP management plans?	Before and/or after implementation of Bree guidelines	See section 2.1 for definitions	See Section 3.3	Point in time measures from PDSA; Aligned with the evaluation timeline	Who: TBD Patient records; EHRs; QI programs; patient satisfaction surveys; See section 2.1
Cost/Benefit ratio?	Before and/or after implementation of Bree guidelines	TBD by evaluator	See Section 3.3	Aligned with the evaluation timeline	Who: TBD Billing records; patient records; budgeting records; See section 2.1
Impact of Guidelines					
Increase in BP control	Before/after implementation of Bree Guidelines	See section 2.1 for definitions	See Section 3.3	Aligned with clinical considerations and evaluation timeline (Monthly, bi-monthly, quarterly, bi-annually, annually)	Who: TBD Patient records, surveillance data
Decrease in BP control disparities by social and economic factors	Before/after implementation of Bree Guidelines	See section 2.1 for definitions	See Section 3.3	Aligned with clinical considerations and evaluation timeline (Monthly, bi-monthly, quarterly, bi-annually, annually)	Who: TBD Patient records, surveillance data

Increase in BP screening	**Before/after implementation of Bree Guidelines**	**See section 2.1 for definitions**	**See Section 3.3**	**Aligned with clinical considerations and evaluation timeline (Monthly, bi-monthly, quarterly, bi-annually, annually)**	**Who: TBD** **Patient records, surveillance data**
Other patient benefits (economic, health, etc.)		**TBD by evaluator**	**See Section 3.3**	**TBD**	
Lessons Learned					
Barriers and facilitators		**TBD by evaluator**	**See Section 3.3**	**Post evaluation**	**Who: TBD** **Surveys; structured interviews; program documents;**
“Pinch-points”		**TBD by evaluator**	**See Section 3.3**	**Post evaluation**	**Who: TBD** **PDSAs, surveys, structured interviews, Key informant interviews**
Other Information:	**What are you going to track?** **The concept that will help answer the question**	**How are you going to track it?** **How the concept will be measured**	**What will the indicators be compared to?** **For example:** • **specified target values** • **baseline values** • **a relevant benchmark or standard** **a comparison group of comparable non-participants**	**How often will the indicators be collected?** **For example:** • **Weekly** • **Monthly** • **Quarterly** **Annually**	**Program management team via program administrative data. This includes application forms, funding agreements, progress/completion reports, fees collected number of recipients etc. Policy team via program policy documents, media reports, etc. Evaluator via program documentation and/or literature reviews in collaboration with program/policy teams** **Evaluator via internal or external surveys or interviews and comparative data in collaboration with program/policy teams, data professionals, linked datasets or others as required**