

First Episode Psychosis Evaluation Framework¹

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alphabetical)**

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

Opioid Use Disorder 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 First Episode Psychosis.

This evaluation framework includes:

- **definitions and key concepts**
- **principles and standards**
- **information on resources to help align evaluations across system actors**
- **guidelines for setting priorities on what, when and ways to evaluate**
- **system-actor roles and responsibilities**

Document administration

Version history

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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. (Washington State Health Care Authority, 2024)

Substance Use Disorder (SUD) - a treatable mental disorder that affects a person's brain and behaviour, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications. (National Institute of Mental Health, 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 support the implementation of the Bree Collaborative's *First Episode Psychosis (FEP) Guidelines* during the life cycle of the report. This evaluation framework has been developed by the Bree Collaborative Sub-committee of the First Episode Psychosis Workgroup.

This document details the evaluation framework within which the future evaluation[s] of this guideline and any programs developed from its recommendations may be conducted.

Audiences for this framework document may include but are not limited to: Quality Improvement leaders and teams, academic researchers, state agencies conducting outcomes and impact evaluations, staff involved in conducting needs assessments, health system/hospital/clinic administrators. The term "system-actors" is used in sections (?) below in this document in place of the term "stakeholder". These terms apply to any individual or organization that has a role in system-improvement for this topic.

This framework serves two purposes. The first is to inform and align evaluations of the impact of the adoption of the Bree guidelines themselves, in other words, did these guidelines help spread the FEP program to non-Medicaid patient and expand access for Medicaid patients? This document is meant to provide guidance for evaluation alignment across multiple audiences (health plans, health systems, providers, etc.) for the purpose of comparison, and to facilitate state-wide measurement on the progress and outcomes of the adoption of the Bree guidelines. It also provides guidance to researchers to help them understand how the workgroup envisioned measuring change at the community, organization, and population (state) levels.

Organizations conducting implementation projects can benefit from establishing this framework early during the implementation of guidelines to ensure that the programs developed from it are prepared for future evaluations and help 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.

The second purpose of this framework is to provide guidance on how to identify or align with current evaluation services that have experience in evaluating FEP Medicaid programs or how to develop iterative evaluation within a commercial FEP program to maintain fidelity to the New Journey's model.

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 (also referred to as “audiences” in the guideline report).

The *First Episode Psychosis Report* was developed by the Bree Collaborative in 2025. The purpose of the report is to provide guidance to commercial and private payors and providers on how to implement the HCA’s New Journey’s program with fidelity and how to develop the capacity to refer to New Journey’s or other CSC programs that may be developed as a result of these guidelines.

The report was submitted to the Washington State Health Care Authority as part of the Bree Collaborative contract deliverables; however, the purpose of this report is to spread best practices FROM the HCA to the commercial space. 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 overall aim of this report is to make evidence-based coordinated specialty care for FEP a universal health care practice and covered by all payors in Washington State. Screening, early identify, and routing to evidence-based recovery supports for early intervention for FEP should be available state-wide to those who need those services, regardless of their insurance type or ability to pay.

Two of the biggest barriers to reaching this aim and establishing parity between Medicaid and commercial insurers are payment structures in commercial plans and availability of resources (e.g. CSC teams, program slots, etc.). Removal of these types of barriers should be seen as the desired end result of the state-wide implementation of the Bree report.

A gap currently exists between those individuals experiencing FEP that have private insurance compared to those who have Medicaid. Individuals that have commercial insurance in Washington maybe going without FEP services because it’s not covered by their insurance, leading to higher health care costs in the long run. Additionally, people may lose their Medicaid coverage as they “graduate” from an FEP program and move back into the workforce even though they still need coordinated specialty care services after transitioning back into the workforce. Closing this gap should be the main focus of any state-level evaluation and will be the focus of the Bree collaborative’s evaluation for this report.

As coordinated specialty care services are increased in Washington state, the aim is not to “re-create the wheel” in terms of how to measure evidence-based care processes. Thus, part of the purpose of this document is to help evaluators understand how measurement-based care and fidelity reviews are conducted in coordinated specialty care models like New Journeys.

For those that are interested in measuring the usefulness of the Bree report in helping spread a coordinated specialty care model from Medicaid to the commercial space, the Bree

has defined five components of our recommendations. These components are: increases in **education and outreach** on FEP across the healthcare ecosystem, improvements to **screening and diagnosis** for FEP, the development and support of **team-based services & treatment** for FEP, improvements in **transitions of care** between first contact and CSC programs and between CSC programs and return to regular care, changes to **financing** to reduce cost of care to both patients and payors.

The framework for evaluation that has been developed as a part of the evidence-based care that a CSC treatment program provides is nested within the team-based services and treatment component. (see Types of Evaluations below for more information).

2. Types of Evaluations

This framework provides guidance for evaluations that will assist in the demonstration of the usefulness of the Bree Guidelines to make changes in the healthcare ecosystem through the spreading the NJ model of coordinated specialty care for individuals experiencing a first episode of psychosis to private payors and to increase access for patients regardless of their insurance type. It also provides information and support for organizations to measure the effectiveness of the CSC programs that they refer to or stand up within their own organizations. Organizations may use this framework for multiple purposes, including to embed measurement-based care into their CSC programs, assess outcomes of changes made to referral systems or general staff education on CSC programs, 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.

The evaluation sub-committee has identified four main purposes for evaluation. To implement and monitor measurement-based care, to support program fidelity reviews, to be used in quality improvement projects, and to identify the population health or state level impacts of the increases in coordinated specialty care access.

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.

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.

More general information on evaluations: [Evaluation.gov | Evaluation 101](#)

2.1 Metrics alignment

The Bree Collaborative evaluation subcommittee has developed a [Theory of Change](#), which illustrates how the work group expects the spread of the NJ program to happen throughout the state's healthcare ecosystem and what high level outcomes and impacts it is expected to have.

Metrics alignment should happen both at the level of the health care ecosystem for (things such as) cost, population health impacts, or effectiveness of Bree guidelines, and at the CSC program level to ensure that programs are meeting evidence-based care standards.

Organizations that are considering using existing evaluation services (such as UW/WSU) should see section 2.2 of this document to determine whether those services are appropriate for your population.

2.2 Program Implementation, monitoring for fidelity, and outcomes

It is proposed that this type of evaluation be conducted by: New Journey's concordant programs/CSC programs

This type of evaluation can answer questions such as “What is the need for First Episode Psychosis services in X population?” or “Did patients, clinicians, or staff receive the right education on their health care options for FEP?” or “what are the outcomes and impacts of the CSC program for individual participants?” “How much fidelity does the program have with New Journeys model?”

Because New Journey's is an evidence-based program, evaluation of the care services is an integral part of the program. Evaluation activities (measured at WSU) and implementation support (measured at UW) already exist at University of Washington/Washington State University for the New Journey's model for Medicaid patients. These activities are paid for through a combination of enhanced rates for Medicaid reimbursement and mental health block grants. Programs that are set up to provide coordinated speciality care (CSC) service to commercial insurance populations should consider using the same program evaluation criteria and measures as those set up for the Medicaid population.

In order to spread the use of coordinated speciality care for FEP to commercial payors, the Bree recommends two approaches. The first is developing referral capabilities or programs to direct individuals to existing CSC services and the second is to stand up treatment programs with fidelity to the New Journey's model or similar CSC models. Both of these approaches should include an implementation evaluation for effectiveness in order to be set up for success and ensure that the program developed has consistency with the New Journey's or CSC models.

Evaluations focusing on referrals to existing systems should aim to measure concepts such as patient experience, outcomes, or impacts for those being referred as well as measuring how many patients that were referred were able to access FEP services. These types of implementation evaluations may be most useful for primary care or other types of non-CSC providers or health plans. Duration of the evaluation may vary; however, organizations should take into consideration the immediacy of the needs associated with a first episode of psychosis and plan their process evaluations accordingly.

As part of the New Journey's model, fidelity to care practices is monitored for team-based care treatment programs, which includes provider education on identification of First Episode Psychosis, patient referrals to appropriate levels of treatment, screening and diagnosis. Organizations wishing to set up a team-based care and treatment program that is consistent with the New Journey's model but receive referrals from other organizations (primary care, health plans,) should include an evaluation of those referral systems in addition to the team-

based care their program provides, to ensure that the New Journey's/CSC model is the appropriate treatment for patients being referred.

This framework has broken implementation evaluations into a pre- and an initial implementation, for clarity. These types of evaluations should aim to allow decision makers to identify early issues regarding program set-up, administration and delivery and take corrective action if necessary.

Evaluation planning should be conducted in parallel with the implementation planning to make sure that all data needs are met, that data is accessible to those conducting the evaluation, and that the evaluation logic matches the goals and activities.

Pre-implementation

The aim of a pre-implementation evaluation is to help organizations who are considering expanding their services to include a CSC model determine the “how” of full implementation and the capacity necessary for the patient population they serve. This kind of needs assessment is fundamental to ensure equity in access while containing costs and properly allocating resources (workforce, training, etc.).

Key risk factors can be identified through claims data, clinical, and administrative data and should include:

- All individuals ages 15-40 with a prior mental health diagnoses in the previous two to five years, including depression/depression with psychotic features, Bi-polar 1 and 2 disorders, psychosis unspecified/not otherwise specified, Schizophrenia spectrum disorders, mania, anxiety and ADHD, Psychosis not otherwise specified, Unspecified psychosis, Brief psychotic disorder, Delusional disorder, Schizophreniform disorder, Schizophrenia, Schizoaffective disorder (bipolar type and depressive type), Bipolar disorder (1 & 2) with psychotic features, Major depressive disorder with psychotic features
 - **F32.3** (Major depressive disorder, single episode, severe with psychotic features) and **F33.3** (Major depressive disorder, recurrent, severe with psychotic features)
 - **F31.5**: Bipolar I, current episode depressed, severe, with psychotic features; **F31.2**: Bipolar I, current episode manic with psychotic features; **F31.0**: Bipolar I, current episode hypomanic; **F31.30–F31.32**: Bipolar I, current episode depressed, mild or moderate; **F31.60–F31.64**: Bipolar I, current episode mixed; **F31.9**: Bipolar disorder, unspecified; **F31.89**: Other bipolar disorder
 - **F29**: Unspecified psychosis not due to a substance or known physiological condition; **F06.2**: Psychotic disorder with delusions due to known physiological condition; **F06.0**: Psychotic disorder with hallucinations due to known physiological condition
 - **F21**: Schizotypal disorder; **F22**: Delusional disorders; **F23**: Brief psychotic disorder; **25**: Schizoaffective disorders
 - **F90.0–F90.9** ADHD; **F40.-, F41.-** Anxiety Disorders
 - **Z03.2**: Encounter for observation for suspected mental/behavioural disorders (e.g., when ruling out schizophrenia)
- All individuals ages 15-40 receiving crisis mental health services within the past 6 months (**codes for specific services to be added**)
- All individuals ages 15-40 with child welfare and criminal justice system involvement within a recent 6-month period. Individuals with a history of reported neglect and abuse prevalence. (**data source recommendations and key terms to be added**)

- All individuals ages 15-40 new diagnosis of schizophrenia spectrum disorder or psychotic disorders,
 - ICD 10 codes F20, F21-29
- Social Determinants of Health
 - Housing and economic circumstances - **Z59.0**: Homelessness (crucial for chronic, undertreated psychosis); **Z59.3**: Problems related to living in a residential institution (e.g., group homes); **Z59.5**: Extreme poverty
 - Social Environment - **Z60.0**: Problems of adjustment to life-cycle transitions; **Z60.2**: Problem related to living alone; **Z60.4**: Social exclusion and rejection
 - Up-brining and family - **Z62.820**: Parent-child relational problem; **Z63.0**: Problems in relationship with spouse or partner
 - Other psychological/legal factors - **Z65.1**: Imprisonment and other incarceration

Organizations should also document that they have contacted the Washington State Health Care Authority (HCA) if they are setting up a New Journey's model. Organizations should also notify the HCA if they are setting up a general CSC model. This information will help the State of Washinton measure changes to the capacity for FEP services.

Initial Implementation/Training and implementation support and fidelity monitoring

Those who are interested in “creating” a New Journey’s model team should contact the HCA in order to ensure that the New Journey’s model is adhered to.

Those who are interested in implementing CSC concordant program other than New Journey’s within their own health system should follow the appropriate model and training entity. In general, evaluators should ensure that the following components are included in their evaluation plan:

- Team-based model of care (see [RAISE](#) for example)
- Individualized medical treatment (e.g. medication management)
- Family and patient education (service utilization, family education sessions, handouts being used, or other measures used for the New Journey’s or other CSC models fidelity monitoring)
- Individualized psychotherapy (example: therapist fidelity reviews conducted during fidelity monitoring)
- Supported employment/education (how often individual is in the community doing job development, service utilization, how quickly the employment specialist reaches out to individuals who are ready to go to work/school)
- Peer support services (service utilisation, how often are they meeting someone in the community, chart review, qualitative analysis of notes, etc.)
- Staffing and qualifications (designated FTE for FEP staff for each role, assessing staff qualifications are appropriate for the role)

For Fidelity monitoring, organizations should reference the specific model they are adopting:

- The First Episode Psychosis Services Fidelity Scale 1.0: Review and Update <https://nationalepinet.org/wp-content/uploads/2021/08/The-First-Episode-Psychosis-Services-Fidelity-Scale-1.0-Review-and-Update.pdf>
- On-Track New York <https://ontrackny.org/For-providers/Training-technical-assistance>
- NAVIGATE https://www.navigateconsultants.org/training_and_consulting.html
- EASA <https://easacommunity.org/programs/>

Coordinate speciality care programs that follow the *New Journey's model* should include the following services provided by the treatment team. Nationally, there are codes that pay for all of these components to help payors (i.e. insurance companies) develop a payment model that provides coverage for CSC care models. These codes include:

- Case Management (Could also be a Nurse Care Manager)
- Family Education and support (Program Director position)
- Individual Resiliency Training (i.e. Psychotherapy)
- Medication management geared towards individuals with FEP
- Supported Education & Employment (Note: national codes don't have rates)
- Peer support

The following codes are used to pay for the work:

- H2041 & H2042 (not active in Medicaid, but commercial can use it)
- T2022-HT & T2023-HT (Washington State- Medicaid)

The Service Encounter Reporting Instructions (SERI) guide for Medicaid or insurance billing can be used as an additional resource: <https://www.hca.wa.gov/assets/billers-and-providers/seri-v2025.pdf>

Some examples of codes used in Medicaid are listed below:

SERVICE CODE Medicaid	
90846	Family psychotherapy without patient present
90847	Family psychotherapy (conjoint psychotherapy) with patient present
90837	Psychotherapy, 60 minutes with patient and/or family member.
H0031	Mental health assessment, by non-physical
90849	Multiple family group psychotherapy
90791	Psychiatric diagnostic evaluation
H0046	MH Services NOS
99214	Medication Management
H2015	Community support services
99213	Medication Management
H0036	Psychiatric supportive treatment
H0023	Engagement and outreach
H0023	Supported employment
90792	Psychiatric evaluation w/ medical services

Active implementation/ Measurement Based Care

Measuring and monitoring fidelity to the CSC and New Journey's models is part of the active implementation to ensure that the program continues to be evidence-based. Consider EPINET as a resource for measurement-based care or WSU core assessment battery <https://nationalepinet.org/core-assessment-battery-cab/>

Those who are interested in implementing a referral process to existing CSC teams should consider the following when evaluating the effectiveness of their screening and referral activities:

- Measurement of referring provider education for FEP resources, patient identification, and appropriate patient routing
- Measurements of referring providers and staff trained on “how to” for referrals (in-service or annual trainings)
- Number of patients referred to a CSC program and who were able to enter treatment

Strong recommendations:

- Reference New Journey's manuals to define team roles, responsibilities, and FTE
- Use Bree score cards as a resource to plan evaluation of pre- and initial implementation (found in our [Implementation Guide](#))
- Leverage existing resources at the University of Washington and Washington State University as resources to plan evaluation of pre- and initial implementation.

Soft recommendations:

- Training institutions and educational organizations should establish relationships with health care institutions for the purposes of evaluation.

2.3 Health System Process Evaluations

It is proposed that this type of evaluation be conducted by: Academic training or educational organizations, health plans, health systems, behavioural health agencies/clinics,

These types of evaluations can answer questions such as “How have commercial healthcare system and/or payors implemented the New Journey's model?” or “Is it financially sustainable?”

Organizations that are engaged in direct patient care and care financing are the primary focus for recommendations on health system process evaluations.

Organizations that are not directly involved in patient care should consider evaluating the programs or vendors in their networks.

The following table summarizes the measurement concepts for system actors across the components of the report.

Measurement concepts across system actors

Domain	Delivery System (CSC/Providers)	Health Plan (Payors)	Employer (Purchasers/Workforce)
Access to Care	Time from onset to CSC entry (DUP); % linked to CSC within 7 days post-hospitalization	% of members with new psychosis diagnosis linked to CSC within 30 days; network adequacy	% of employees with covered access to CSC/early psychosis services
Engagement & Retention	% attending of scheduled CSC visits in first 6 months; dropout rates	Claims-based follow-up after hospitalization (7 & 30 days); psychotherapy adherence	Utilization of EAP or behavioural health benefits; employee self-reported ease of access
Clinical & Functional Outcomes	Symptom reduction (PANSS, BPRS); functioning (WHODAS, SOFAS); quality of life (QLS)	Population-level improvements in functioning/claims-based proxies (e.g., reduced acute care utilization)	Return-to-work rates; job stability among those with FEP
Recovery & Patient Experience	Patient-reported recovery (RAS, PROMIS); care transitions (CTM-15)	Satisfaction with behavioural health care; patient-reported outcomes	Employee survey data on stigma, recovery support, and accommodations
Physical Health Integration	% receiving metabolic screening (BMI, HbA1c, cholesterol, BP)	Claims for physical health monitoring among members with psychosis	% employees receiving preventive health visits after FEP diagnosis
Utilization & Cost	ED visits, readmissions, hospital length of stay	Inpatient admissions per 1,000; ED use; high-cost episode reduction	Disability claims, absenteeism, presenteeism, health care costs
Fidelity to CSC Model	Scores on FEPS-FS or NAVIGATE fidelity assessments	Use of fidelity monitoring program	Benefit design alignment with evidence-based CSC programs; fidelity monitoring programs
Equity	Stratification of outcomes by race, ethnicity, gender, geography	Plan-level equity dashboards; parity compliance monitoring	Workforce equity metrics (benefit access and utilization by subgroup)

Strong recommendations:

- Collaborate with the University of Washington and Washington State University.

2.4 Evaluating Public Health Impact

It is proposed that this evaluation be conducted by: State agencies, payors, academic researchers,

A system-wide evaluation relies on rigorous methods to determine the population level outcomes and impacts associated with a specific intervention compared to the usual standard of care or the usual care pathways. A system-wide evaluation can help answer the question, “What is the impact on patients or regular health care services (such as ER usage) associated with the spread of CSC services to commercially insured populations?”

The Bree Collaborative mission is to improve the quality of patient care and patient outcomes in Washington State, to that end, the measurement of the population health outcomes and impacts associated with the implementation of Bree guidelines adoption on *First Episode Psychosis* should be undertaken by system actors (usually state agencies) across Washington State.

Although these guidelines address a small population in Washington, we expect that the outcomes and impacts of using an evidence-based treatment model will have profound impacts on individuals' quality of life and on decreases in overuse of other services which do not substantially contribute to the resolution of psychosis (ER capacity, hospital beds). Outcomes and impact evaluations can be conducted for the purpose of population health at the organisational, regional, or state levels.

The following measurement concepts should be used to help determine the impact of increases in capacity and access to CSC services for FEP:

- Reduction in ER and in-patient usage for those receiving CSC aligned services and treatment
- Decrease in out-of-pocket costs for patients/total cost of care for FEP (see section 2.5 for more information)
- Increase/decrease in patient functioning, comparing those who have received CSC service to those who have not
- Fewer people moving from commercial plans to Medicaid for FEP services

Strong recommendations:

- Include community or individual benefits, such as increase/decrease in justice involvement, homelessness, social services use, school interventions, employment, other patient experience and patient reported outcomes, etc.
- Include a care-variation lens (Note: care-variation refers to differences in access, intensity, and quality of care across multiple clinics, areas, patient groups, insurance types, etc.)
- Use Bree score cards to measure differences in program services or program models when comparing organizations or areas as a counterfactual (e.g. usual standard of care, usual care pathway).

2.5 Evaluating Cost of Care

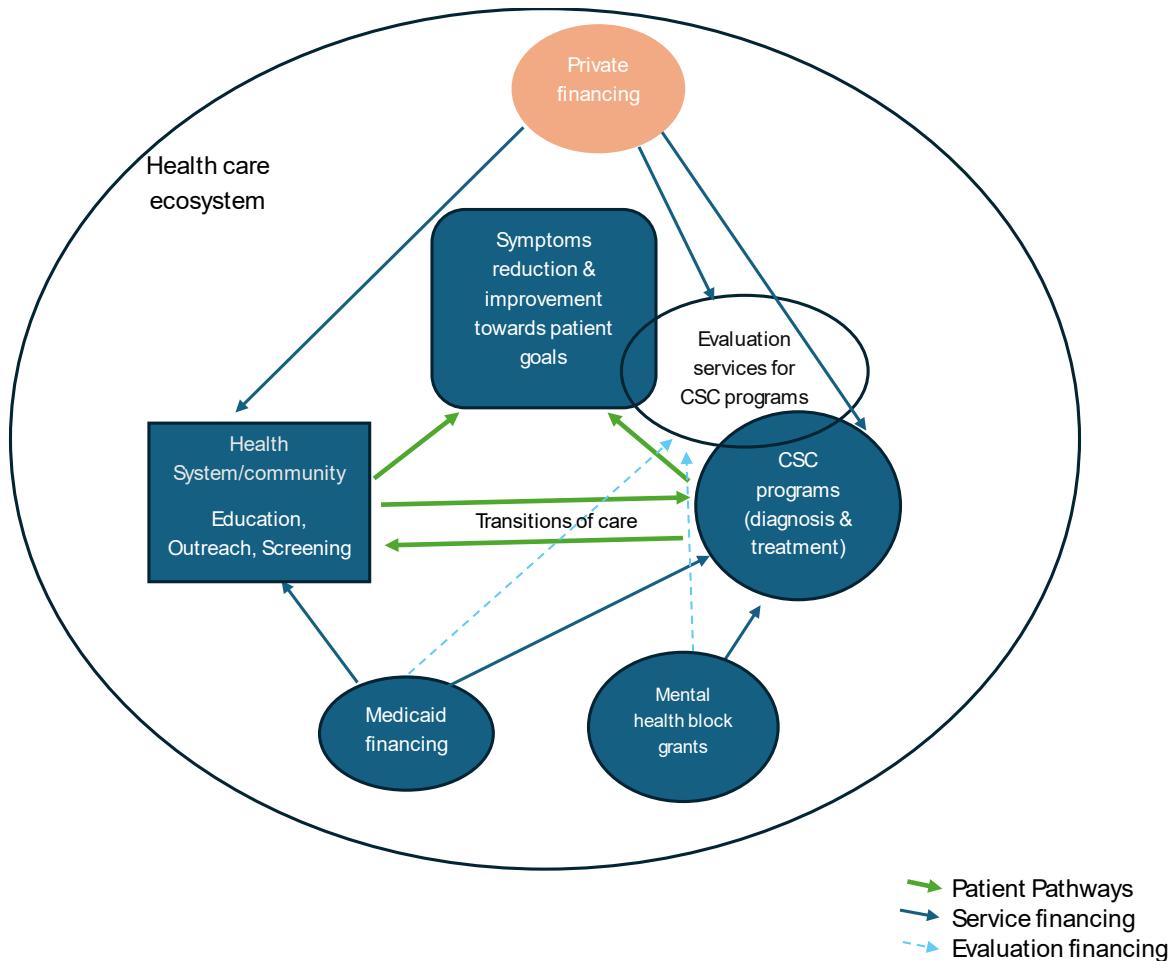
It is proposed that this evaluation be conducted by: State agencies, payors, and direct patient care organizations.

A cost of care evaluation relies on rigorous methods to determine the costs associated with a specific intervention compared to the usual standard of care or the usual care pathways. A cost of care evaluation can help answer the question, “What is the value of the program?”

The Bree Collaborative aims to improve health care affordability in Washington State, to that end, the measurement of the cost of care associated with the implementation of Bree guidelines adoption on *First Episode Psychosis* should be undertaken by system actors across Washington State. Figure 1 (below) provides a visual representation of how the

workgroup envisions private financing for the expansion of FEP services to the private insurance sector to work across the health care eco-system in Washington State.

Figure 1.



The Foundation for Health Care Quality and the Bree Collaborative offer collaborative evaluation tools that can be useful for cost-of-care evaluations. These tools include our Collaborative [Survey Bank](#), [Survey Question Bank](#), and [Measurement Bank](#). These tools allow organizations to share homegrown measures, patient surveys, provider surveys, etc. without any associated fees or proprietary restrictions.

Because the FEP report is intended to spread the New Journeys model or similar CSC models from the Washington State Health Care Authority (HCA) to the private and commercial sectors, the (HCA) or other agencies in the State of Washington should consider assessing the impacts of increased services for patient in Washington on the costs associated with their own program.

An example of cost of care evaluation: [An Economic Evaluation of Coordinated Specialty Care \(CSC\) Services for First-Episode Psychosis in the U.S. Public Sector](#)

Cost of care metrics should include the goals that are similar to the goals of the New Journey's model, such as:

- Costs or savings associated with reduction in ER visits or hospitalizations
- Long-term costs or savings associated with increases/decreases in patient functioning
- Social programs expenditures/decreased use of social services
 - How many people in the CSC model are engaged in competitive employment
- Increases/decreases in coverage for FEP

Strong recommendations:

- Include community costs such as increase/decrease in justice involvement, homelessness, social services use, school interventions, etc.
- Include a cost-variation lens (Note: cost-variation refers to differences in costs of care across multiple clinics, areas, patient groups, insurance types, etc.)
- Use Bree score cards to measure differences in program services or program models when comparing organizations or areas as a counterfactual (e.g. usual standard of care, usual care pathway).

2.6 Guideline logic

At the heart of each guideline is a ‘theory of change’ (Appendix A) by which workgroup members determine the outcomes and impact sought and how that change can be achieved across the healthcare ecosystem. This theory of change describes how the implementation of the Bree Guidelines contributes to 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.

To help interested parties measure the outcomes and impacts of *our guidelines*, the Bree Collaborative offers evaluation resources, including our **Evaluation Tool Depot**. The Evaluation Tool Depot contains links to free, open-source software, templates, and educational resources for evaluation planning, cultural considerations, qualitative data collection and more. It is designed to help organizations that have limited access to professional evaluators or small staff.

The Bree Collaborative recommends that organizations develop a logic model specific to their program or project. Organizational-level logic models can focus evaluation questions on Education and outreach, screening and referral, services and treatments, transitions of care, or cost of care that are appropriate for their line of business. 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.

2.7 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](#). This roadmap can be used to help develop evaluation questions that are appropriate to inform the effectiveness and impact of our guidelines. These domains are: *equitable care, integrated/holistic care, data usability and transparency, and financing*. In addition to these domains or “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 of questions to be answered by evaluations, the Bree Collaborative has developed a [Survey Question Bank](#). This resource can be used to share evaluation questions across multiple stakeholder organizations. 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.

Note that not every evaluation should address all the 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.

2.8 Data Matrix

This framework included a sample data matrix strongly recommends that it be used to document data sources. The data matrix can help identify the data sources that will be used to gather data to complete each metric, identify which metric(s) answers which evaluation question, and determine the frequency at which data collection and analysis is needed.

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

Generally speaking, the Bree Collaborative submits its reports to the Washington State Health Care Authority (HCA) so that they can 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. However, the First Episode Psychosis guidelines are intended to spread the New Journeys Program FROM the HCA to commercial and private payor and providers, making private payors and providers the primary audience (or role) and the HCA the secondary audience.

The reports provide guidance for system actors (see section 3.1) to help them implement the recommendations made by the workgroup. The Bree defines implementation as the “translation of guidelines into practice”. For the purposes of evaluation, we are interested in WHO uses our reports, HOW they 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, its 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 FEP report 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
 - Washington State Department of Health
 - OSPI
- Health plans
- Health care purchasers/employers
- Health care systems
 - Primary care clinics
 - » Clinicians, prescribers, nurses, LCSW, educational vocational specialists
 - Hospital systems
- Behavioural health agencies
 - Clinics
 - Clinicians, prescribers, LCSW, educational vocational specialists
- Community Organizations
 - Schools
 - Academic institutions

Table 4.1.1 below outlines broad roles and responsibilities for system-actors with regard to the *First Episode Psychosis guidelines* which we feel will transform the health care system in terms of FEP services. 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 (flexible work arrangements, access to support groups, policies for leave, aligned EAP, vendor choices).

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	Education and convening SMEs Data sharing/transparency/requirements New Journey's Program management
Health Plans	Provide adequate coverage for patients for coordinated speciality care services for FEP Provide adequate networks for CSC Provide case management services Data transparency/sharing
Employer/Purchasers	Ensure CSC services are included plans that are purchased Implementation of recommendations to support patients in the work environment
Health Systems, providers	Clinician education Patient Screening Provide treatment aligned with best practices Support care transitions Data Transparency/sharing
Behavioural Health Organizations/speciality care teams	Patient Identification Provide treatment aligned with best practices Supporting transitions of care Data Transparency/sharing
Academic Institutions/education programs	Provide adequate understanding of best practices for FEP in clinician training programs Support referral pathways Staff training

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 or identification of comorbidities or substance use or ensure that standards for the ability to consent are thoroughly reviewed and ethical standards are applied where necessary or appropriate. These standards should include, at a minimum:

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

When evaluation plans include patient level data, special care needs to be taken to protect individual data. Individuals experiencing first episode psychosis may require extra precautions in term of consent for including their sensitive information in evaluations or research. Additionally, FEP is a relatively rare condition and ethical standards for dealing with small numbers (data masking, etc.) needs to be take into consideration.

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 include equity considerations for one or more of the following stratifications in their evaluation plan: gender, race/ethnicity, income or employment status, educational status.
- Organizations should assess solutions to addressing stigma and bias against those with psychosis.

3.3 Common Contextual Factors

Because the *First Episode Psychosis* 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 they influence 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>
- Financial/capacity resource allocations –treatment facility distribution, etc.
- Workforce – Health Professional Shortage Areas as defined by HRSA <https://data.hrsa.gov/tools/shortage-area/hpsa-find>
- Telehealth 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/>

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 Washington State Health Care Authority, for leveraging data.

Figure 4.2.1: Collaboration with the Bree

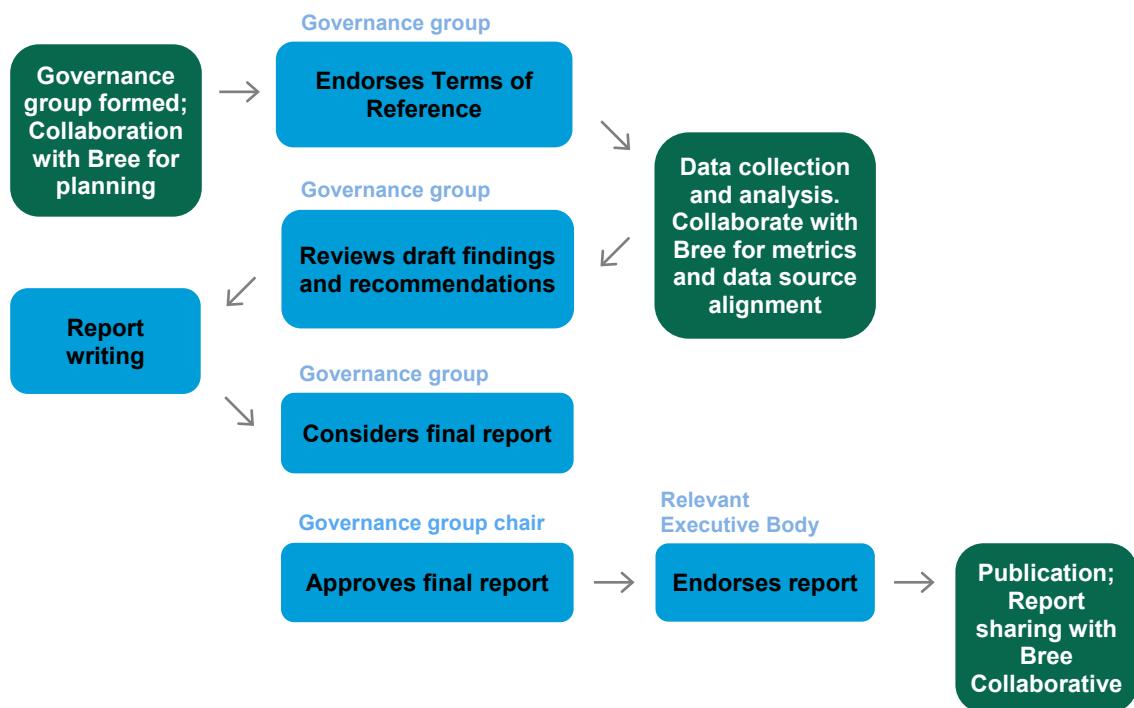


Table 4.2.1: Creating a timeline that considers other initiatives or priorities

Organizations using this framework should create a timeline for evaluation that considers alignment with both internal and external initiatives, as well as with recommendations for other system-actors in the Bree Guidelines for *First Episode Psychosis*. For example, health systems may want to consider developing a timeline that considers major purchaser or payor implementation schedules.

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 Program	2026	TBD
Medicaid Transformation Project	June 2023	June 2028

Timelines for evaluation should also consider the goals of the guidelines (spreading New Journey's concordant programs/CSC programs to commercially insured populations, increasing the capacity for referral to programs modelled on New Journey's/CSC) and other organizational-internal recommendations such as infrastructure or training recommendations, etc.

The Bree collaborative can support timeline alignment through their Reporting Initiative. This initiative will result in an annually updated map of organizations that are implementing specific Bree reports and provide a general definition of “partial” or “full” implementation.

This initiative to help you align your evaluation work with others by showing what other organizations in your area have also adopted the *(FEP) 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:

- Use Bree Collaborative Score Cards to support process or program evaluations.
- Use 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;
- Leverage other Foundation for Health Care Quality programs (e.g. Health Equity, Patient Safety), where applicable
- Report adoption of guidelines to the Bree Collaborative Reporting Initiative
- Use data sampling, where applicable

Soft recommendations: Evaluations may include the following -

- Surveys
- Economic profiling of the organization and region

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 OUD Treatment:

- 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;
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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

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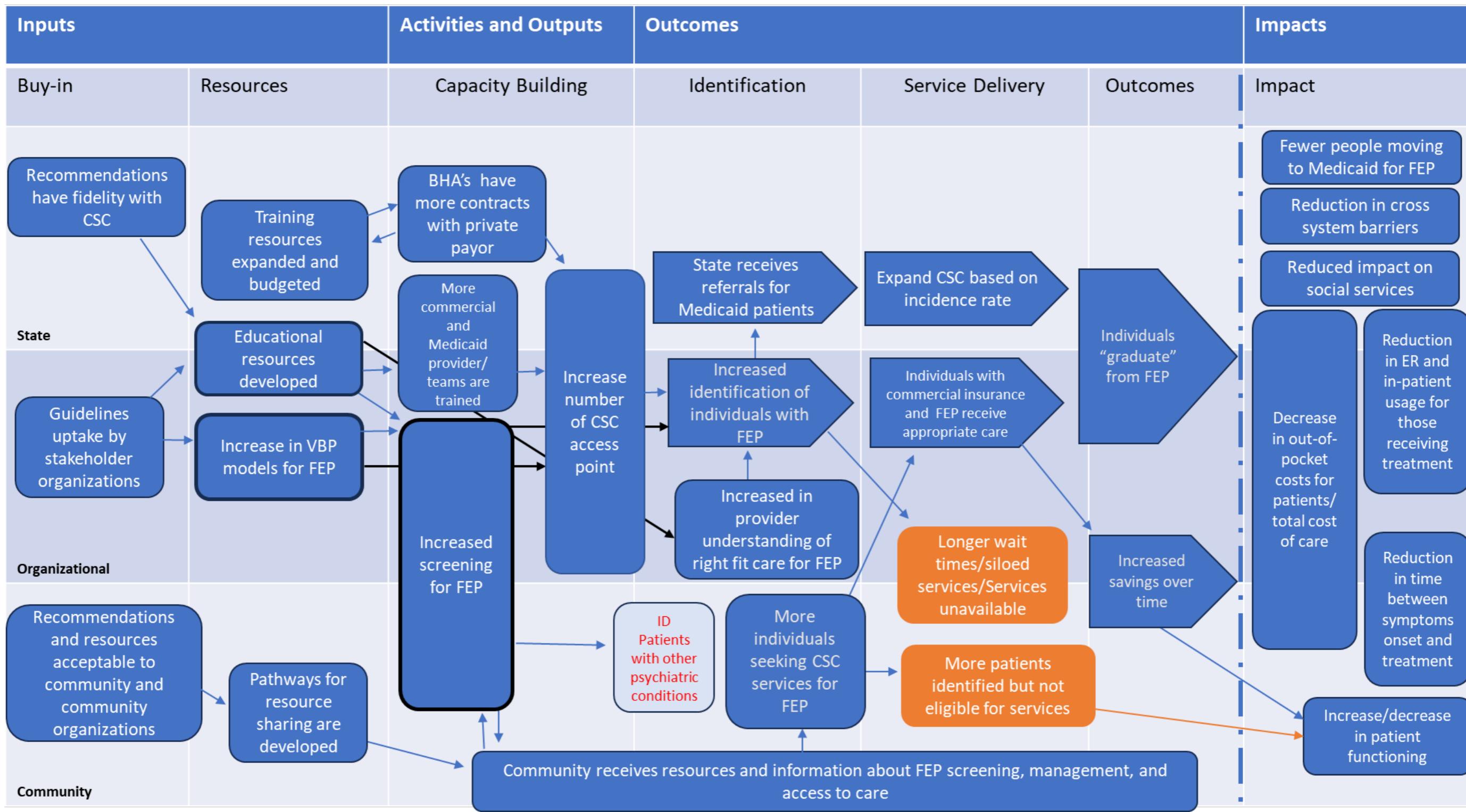
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Appendix A Theory of Change



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 policies or process for prescribing and continuation of pharmacotherapy?	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	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;

	policies or procedures				
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 for screening, initiation to treatment, and retention to treatment?	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 peer support for initiation to treatment and retention to treatment?	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	Identification metrics, section 2	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 initiation to treatment activities?	Before and/or after implementation of Bree guidelines	Initiation to treatment metric, section 2	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 retention to treatment activities?	Before and/or after implementation of Bree guidelines	Retention to treatment metric, section 2	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					
Reduction EMS overdose response	Before/after implementation of Bree Guidelines	See section 2.5 for definitions	See Section 3.3	Aligned with clinical considerations and evaluation timeline (Monthly, bi-monthly, quarterly, bi-annually, annually)	Who: TBD (EMS data); DOH
Reduction in opioid related deaths	Before/after implementation of Bree Guidelines	See section 2.5 for definitions	See Section 3.3	Aligned with clinical considerations and evaluation timeline (Monthly, bi-monthly, quarterly, bi-annually, annually)	Who: TBD DOH
Reduction in non-fatal overdose ED visits	Before/after implementation of Bree Guidelines	See section 2.5 for definitions	See Section 3.3	Aligned with clinical considerations and evaluation timeline (Monthly, bi-monthly, quarterly, bi-annually, annually)	Who: TBD EHR's; DOH
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: <ul style="list-style-type: none">• 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: <ul style="list-style-type: none">• 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