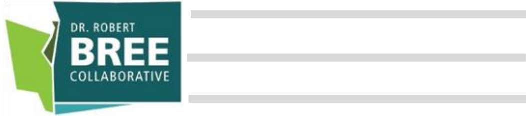

Opioid Use Disorder Treatment Evaluation Framework

Created By: Bree Collaborative staff in collaboration with the Opioid Use Disorder Treatment Evaluation Subcommittee members - Brook Evens, Colin Field, Elizabeth Bojkov, Sarah Halvik, Herber Duber, Tina Seery, Donya Karimi, Petra Eichelsdoerfer, Krista Lynch, Amanda Avalos, Susanne Quistgaard, Nicole St. Clair, Luann Chen

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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 Opioid Use Disorder Treatment.

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**
- **Health ecosystem roles and responsibilities**

Version history

Version	Date	Description	Author
1.0	January 14, 2025	Original draft from subcommittee	See title page

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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.

Opioid Use Disorder (OUD) - A chronic brain disease that involves a problematic pattern of opioid use that causes significant distress or impairment. (generative AI) The chronic use of opioids that causes clinically significant distress or impairment. (Dydyk, Jain, & Gupta, 2024) OUD can include the use of illegal opioids like heroin or prescription opioids like oxycodone.

MCO – Managed Care Organization’s are contracted with the HCA to provide Medicaid plans to eligible Washington State residents.

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

The Bree Collaborative's charge is to develop guidelines for health care topics where there is variation in care or where standards do not yet exist. The primary pathway to implementation is through the Washington State Health Care Authority, which is expected to consider implementing these guidelines into their contracts and programs. Other organizations that serve on the Bree Collaborative Board of Directors are strongly encouraged to implement the guidelines as well and organizations that are not on the Bree board or contracted with Medicaid may also choose to implement these guidelines as appropriate for their organizations.

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 *Opioid Use Disorder Treatment* Guidelines during the life-cycle of the report. This evaluation framework has been developed by the Bree Collaborative Sub-committee of the Opioid Use Disorder Treatment Workgroup.

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, time, resources and available data 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 *Opioid Use Disorder (OUD) Treatment* Report was developed by the Bree Collaborative in 2017 and revisions were undertaken in 2023. The purpose of this revision is to provide updates on best practices as the opioid crisis and treatment for OUD continue to change and evolve.

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 improving **identification, initiation into treatment** and **retention to treatment** for those with OUD. 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 December 3rd, 2024.

The components of this guideline (or intervention) are increases **education** on OUD across the healthcare ecosystem, improvements to **access** to treatment, increased **screening** with a validated instrument across the healthcare ecosystem, increases in **referral to treatment** and/or increases in **evidenced-based treatment** options, changes to **prescribing** standards, and alignment of **measurement** efforts.

Guidelines apply to multiple system actors (clinicians, health plans, correctional institutions, health administration, etc.) that play a part in the identification of patient needs and treatment of OUD.

2. Types of Evaluations

This framework provides guidance for the level and types of evaluations that will assist in the demonstration of the usefulness of the Bree Guidelines. Organizations may 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.

For organizations that are new to evaluations or do not regularly evaluate health care implementations, more information on evaluations: **Evaluation.gov | Evaluation 101**

Table 1. Level and type of evaluations

Level	Type	Audiences

Clinical Assessment	Program and process	Providers, clinics, programs
Organizational Assessment	Program, process, and monitoring	Health system, health plan, facilities
State-wide Assessment	Impact	WA HCA, WA DOH,

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 detailed information and guidance on the types of evaluations different guideline "audiences" or "system actors" should conduct can be found at the beginning of sections 2.2 to 2.5.

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 *Opioid Use Disorder Treatment* guidelines aim to change patient care across three domains – **Identification**, **Treatment initiation** and **Retention to treatment**. In conjunction with the development of the guidelines, a workgroup sub-committee identified metrics that align with these aims:

Metrics to measure changes in standards of care

1. *Identification -*

1a. OUD diagnosis (cascade measure) Percentage of individuals with documented OUD diagnosis (Preferred data source: insurance claim).

1b. Assessed for substance use disorder (SUD) using a standardized screening tool (supporting measure) Percentage of individuals who were screened/assessed for SUD using a standardized screening tool. (Preferred data source: clinical data or claims data)

2. *Treatment Initiation –*

2a. Use of pharmacotherapy for OUD (cascade measure) Percentage of individuals with an OUD diagnosis who filled a prescription for or were administered or dispensed an MOUD, overall and by type of MOUD (methadone, buprenorphine, naltrexone). (Preferred data sources: Prescription Monitoring Program (PMP))

2b. OUD provider availability (supporting measure) Number of providers who can prescribe buprenorphine, number of providers who do prescribe buprenorphine, number of opioid treatment programs that dispense methadone and/or buprenorphine. (Preferred data sources: Prescription Monitoring Program)

3. *Treatment retention –*

3a. Continuity of pharmacotherapy for OUD (cascade measure) Percentage of individuals who filled a prescription or were dispensed an MOUD who received the MOUD for at least six months, overall and by type of MOUD (methadone, buprenorphine, naltrexone). (Preferred data sources: Prescription Monitoring Program)

3b. Initiation of OUD treatment and engagement in OUD treatment (supporting measure) Percentage of individuals who initiate SUD treatment within 14 days of an OUD diagnosis. Percentage of individuals who had two or more additional SUD services within 30 days of the initiation SUD treatment encounter. (Preferred data source: clinical data, claims data)

3c. Follow-up after an emergency department visit for substance use (supporting measure) Percentage of emergency department visits for individuals with a principal SUD or overdose diagnosis who had a follow-up visit for SUD within seven days of the visit and within 30 days of the visit (Preferred data source: claims data)

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:

- Include patient goals in measures of patient experience
- 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.

Short-term and medium-term outcomes measures

Increased access to OUD treatment (Examples: Number of new programs to treat OUD, expansion of existing programs by geography, time, capacity, etc., expansion of service types, times, eligibility, expansion of copay reductions or prior authorization reductions.)

Increased number of providers who prescribe MOUD (Fan/PDMP team)

Increased number of individuals with Naloxone (Examples: all persons with OUD have a prescription for Naloxone, Count of Naloxone kit distribution, Percent of incarcerated individuals receiving Naloxone upon release.)

Impact measures (defined on the Washington State Department of Health Opioid Dashboard)

Patient level impact - Reduction in opioid related deaths (Definition: Any Drug – drug overdose deaths cause by acute poisonings. Deaths with any of the following ICD-10 Codes – X40-X44 Accidental poisonings by drugs; X60-X64 Intentional self-poisoning by drugs; X85 Assault by drug poisoning; Y10-Y14 Drug poisoning of undetermined intent.)

System level impact - Reduction non-fatal overdose Emergency Department (ED) visits (Definition: ED visits by Drug Type/Total Number of ED Visits x 10,000 ED visits; instances where suspected drug overdose ED visits have counts less than 10, calculated rates and 95% confidence intervals are considered unstable. Use caution when interpreting these values. Multiple Drug Overdose Visits – suspected multiple drug overdose ED visits are defined as ED visits that were captured by two or more overdoes syndrome definitions. Overdoes syndrome definitions are nationally validated queries that identify suspected overdoes ED visits using a combination of medical diagnosis codes and clinical free text terms. Multiple drug ED visits might involve more substances than just those identified by their respective overdoes syndrome definitions.)

System Level impact - Reduction Emergency Medical Services (EMS) overdose response (Definition: *Opioid Related Responses* – count of individual EMS unit responses to a suspected opioid overdoes incident (may include duplicate incidents reported by multiple responding EMS units. *Suspected Opioid Overdoses* – Count of EMS patient encounters with either a documented improved Naloxone response or a documented opioid impression present in a single patient record. Deduplicated from record count to patient count based on matching incident County, an incident date/time at least 12 hours a part, and at least two of three matching of the following: patient first name, patient last name, and date of birth. *Positive Naloxone Response*: Count of EMS patient encounters where Naloxone was administered to the patient, resulting in an improved patient response. *Opioid Impression*: EMS patient encounters where a suspected opioid overdose was indicated by the EMS provider using any of the following ICD-10 codes in the primary impression, secondary impression, or cause of injury fields; F11, T40.0-T40.4 & T40.6. *Transported to a Medical Facility* – Percent of suspected opioid overdose records indicating that the patient was transported to a medical facility based on the documented type of destination facility.)

2.2 Process evaluations

It is proposed that this type of evaluation be conducted by: all relevant audiences and/or system actors

Process evaluation focuses on implementation details, describing a program's services, activities, policies, and procedures. These types of evaluations can answer questions such as "Is the program reaching its intended participants?" or "How are inputs contributing to program functioning?"

Organizations that are engaged in direct patient care and care financing are the primary focus for process evaluation recommendations, although all audiences that are implementing the *Opioid Use Disorder Treatment* Guidelines should consider conducting post-commencement evaluation.

Goals of the Bree guidelines on OUD treatment are to support a medication first approach and the long-term goals are to improve identification, initiation into treatment, and retention to treatment. To those ends, organizations should consider these goal as they develop their process evaluation.

Generally speaking, process evaluations should focus on the initial implementation of the program to allow decision makers to identify early issues regarding program administration and delivery and take corrective action if necessary.

Process evaluation planning should be conducted in parallel with the implementation planning to make sure that all data needs are met, and that the evaluation logic matches the goals and activities. Duration of a process evaluation may vary depending on design, audience type, and scope of the implementation; however, organizations should take into consideration the immediacy of the risk associated with opioid use and plan their process evaluations accordingly.

Strong recommendations:

- Use Bree score cards (score cards can be found in the OUD Treatment section of our **Implementation Guide**)
- Use Bree Survey Question bank to align survey and research questions across multiple stakeholders
- Use one or more of the evaluation components outlined in this framework in section 1.2 (i.e. education, access, etc.)
- Include an equity perspective in process evaluation planning

Soft recommendations:

- Include patient experience in process evaluation planning

2.3 Program Evaluation

It is proposed that this type of evaluation be conducted by: Academic training (colleges, certifications, internships, etc.), health plans, health systems, treatment facilities, correctional facilities, and other care facilities.

Program evaluation or a summative evaluation assesses 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?"

This framework assumes that organizations involved in direct patient care will have an established quality improvement program for OUD treatment outcomes or that they will

include an OUD treatment component in their existing quality improvement work that serves the same purpose as process and program evaluation.

The Bree guidelines on OUD treatment also recommends that organizations with an educational focus (i.e. academic institutions for clinician training) conduct a program evaluation to measure the success of their post-service trainings and to measure trainee attitudes towards substance use disorders. In doing so, this evaluation may be able to assess changes in the knowledge capacity of clinicians entering the workforce or receiving ongoing training.

Strong recommendations:

- Training institutions should establish relationships with health care institutions (e.g where graduates are interned or working) for the purposes of evaluation
- Include an equity perspective in the program evaluation plan

Soft recommendations:

- Organizations that provide training to their employees as part of the guideline's implementation work may want to implement an iterative program evaluation process.

2.4 Monitoring

It is proposed that this evaluation be conducted by: health plans, health systems, and public health agencies.

This evaluation type should focus on monitoring variation in standards of care for OUD treatment to address equity, to identify gaps in the care system (e.g. areas or populations in Washington State or clinics within health systems), and to establish benchmarks for standards of care at a system-level or state-wide level.

Organizations with population health focus should consider conducting a monitoring evaluation plan for the purposes of policy or program modifications and accountability. *Direct care organizations may include some aspect of monitoring in their programs; however, this section is primary addressing system-wide (i.e. a health plan network or a health system) and state-wide (i.e. public health agencies) monitoring.*

In doing so, this type of evaluation activity may be able to support impact evaluations and help assess the performance of the guideline's recommendations in achieving its goals (increased screening, initiation to treatment, retention to treatment) at a system or state-wide level.

Strong recommendations:

- Washington State should implement a tracking system using the standards of care metrics outlined in section 2.0 with data collected from the preferred data sources, for Medicaid, at a minimum.

Soft recommendations:

- Health care systems should monitor their progress on the guideline goals by using standards of care metrics.
- The Washington State Health Care Authority should consider using the identified standards of care metrics in VBP programs.

2.5 Impacts

It is proposed that this evaluation be conducted by: State Agencies

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. The charge of the Bree Collaborative is to develop guidelines to be submitted to the HCA for implementation into their programs and contracts, however this report covers recommendations for additional state agencies as well.

To that end, the measurement of the impact of guidelines adoption on opioid mortality, morbidity, and EMS services should be jointly undertaken by the HCA, DOH, and Division of Behavioural Health Recovery. In addition, these state agencies and divisions may want to include adoption of the guidelines by Cascade Care Plans in an impact evaluation. These types of evaluations can answer questions such as “What is the overall impact of the implementation on patients?” or “what is the impact of the implementation on state services?” and should consider assessing the impact of the Bree guideline’s adoption on one or more of the following measures:

Reduction in opioid related deaths (patient impact)

Reduction in non-fatal overdose ED visits (long-term outcome OR system impact)

Reduction EMS overdose response (long-term outcome OR system impact)

Some primary assumptions to consider for an impact evaluation is that these guidelines may have been implemented in other lines of business withing the MCOs and that patients may move between private and public insurance schemes during the implementation phase. Therefore, the Bree recommends an intention-to-treat approach.

Because the purpose of the Bree is to increase quality, address variations in care, and reduce health care costs, organizations that conduct impact evaluations may want to include a cost benefit analysis in their evaluation plans.

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.)
- Use Bree score cards to measure concordance with guidelines when assessing plans, programs, or organizations

Soft recommendations:

- Include cost benefit analysis in impact evaluation planning

3. Evaluation Alignment

3.1 Guideline logic

At the heart of each guideline is a 'theory of change' (Appendix A) by which workgroup members determine the outcomes 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.

The Bree Collaborative offers evaluation resources, including our **Evaluation Tool Depot,** to assist with the development of logic models. 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.

3.2 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.

3.3 Evaluation Matrix

The Bree has created an evaluation matrix to align audience specific recommendations with audience specific objectives, component specific goals, and recommended metrics to measure success for each component, including recommended data sources so that guideline components can be measured in a common manner.

The Evaluation Matrix can be found HERE

3.4 Data Matrix

The Bree has included a sample data matrix and strongly recommends it's 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.

4. 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, we are interested in how organizations translate our guidelines into their own context or setting and what the results of their implementation are.

4.1 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 *Opioid Use Disorder Treatment 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
  - DBHR
- Health plans
- Health care purchasers/employers
- Health care systems
  - clinics
  - clinicians
- Behavioural health
  - Clinics
  - clinicians
- Community Organizations
  - Community Pharmacists/ off-site OTPs (define)
  - OUD treatment programs/facilities
- First responders/EMS

Table 4.1.1 below outlines broad roles and responsibilities for system-actors with regard to the OUD treatment 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 (universally promote employee understanding of behavioural health benefits, universal communication around services offered, behavioural health-related components in employee wellness programs, reduce employment barriers).

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 regulations/licensing Public Health support

	Grant funding/other funding
Health Plans	Provide adequate coverage for patients for OUD screening and treatment Provide adequate funding for (aka VBP) Provide adequate networks for care Data transparency/sharing
Employer/Purchasers	Develop requirements for plans that are purchased Implementation of recommendations to support patients in the work environment
Health Systems, providers	Care coordination Care pathways Provide treatment aligned with best practices Data Transparency/sharing
Behavioural Health Organizations/providers	Care coordination Care pathways Provide treatment aligned with best practices Data Transparency/sharing
Community Organizations	Care coordination Data Transparency/sharing
Academic Institutions/education programs	Provide adequate understanding of best practices for OUD Treatment in training programs
Emergency Services	Provide treatment aligned with best practices

It is the responsibility of each organization to ensure that their evaluations are overseen by a governance body and a management team. It is not within the scope of this framework to define how each individual organizations evaluations should be designed and governed; however, this framework sets out some general information, in sections 3.2 through 3.5, for governance bodies and management teams 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.*

4.2 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, substance use, and 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**
- **Include patient safety considerations**
- **Adhere to HIPAA requirements**

The OUD treatment guideline specifically notes that "many individuals with opioid use disorder are protected by the Americans with Disability act as OUD is considered a disability which substantially limits major life activities", thus evaluation plans should consider some measurement of access for those with an existing OUD diagnosis (i.e. do your changes make it easier for those with life limits – homelessness, incarceration, transportation issues, etc. - from their OUD use to get screened, enter treatment and stay in treatment?).

Strong recommendation:

- Organizations should include equity considerations for one or more of the following groups in their evaluation plan: adolescents, individuals who are or have recently been incarcerated, pregnant people and post-partum individuals, and older adults (65+).
- Organizations should assess solutions to addressing stigma and bias against those with OUD.

4.3 Common Contextual Factors

Because the *Opioid Use Disorder Treatment* 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 – Opioid settlement dollars, treatment facility distribution, etc.
- Workforce – 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/

4.4 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

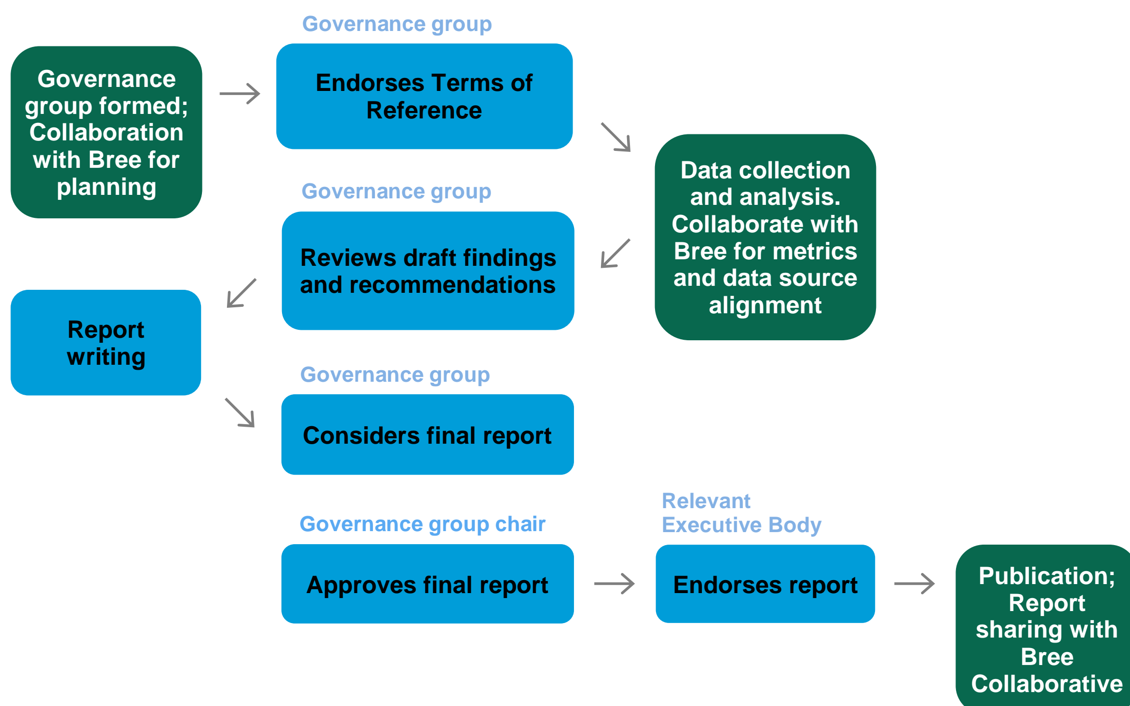


Table 4.2.1: Creating a timeline that considers other initiatives

Organizations using this framework should create a timeline for evaluation that considers alignment with the Washington State Opioid and Overdose Response Plan, the Medicaid Transformation Project 1115 waiver, other federal and local opioid response initiatives and recommendations for other system-actors in the Bree Guidelines for OUD Treatment. 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
Washington State Opioid and Overdose Response Plan	2021	
Medicaid Transformation Project	June 2023	June 2028
HRSA's Rural Opioid Treatment and Recovery Initiative	2024	
NIH HEAL Initiative	2022	
SAMHSA updated regulations on OTPs	2024	

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. to inform a timeline for implementation and evaluation.

The Bree collaborative is supporting timeline alignment through their Reporting Initiative, which is set to launch in January of 2025. 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 or across the state have also adopted or are in the process of implementing the *OUD Treatment Guidelines.* Please visit the **Evaluation Homepage** on our website for updated information on this initiative.

4.5 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 implementing the guidelines.

Specific methodologies for evaluations should be agreed by the governance body and the management team 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

4.6 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	Low quality evaluation report; failure to meet	Likely	Fewer organizations are willing to conduct	Substantial/ High	Bree staff to consult on the evaluation design and

undertake the evaluation	timeframes; stakeholder dissatisfaction; damage to reputation of the organization		evaluations; effects of guidelines across the health care eco-system has gaps in knowledge		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

Dydyk, A., Jain, N., & Gupta, M. (2024). *Opioid Use Disorder*. Retrieved October 24, 2024, from https://www.ncbi.nlm.nih.gov/books/NBK553166/

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

National Institute of Mental Health. (2024, October 24). *Substance Use and Co-Occurring Mental Disorders*. Retrieved from nimh.nih.gov: https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health

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

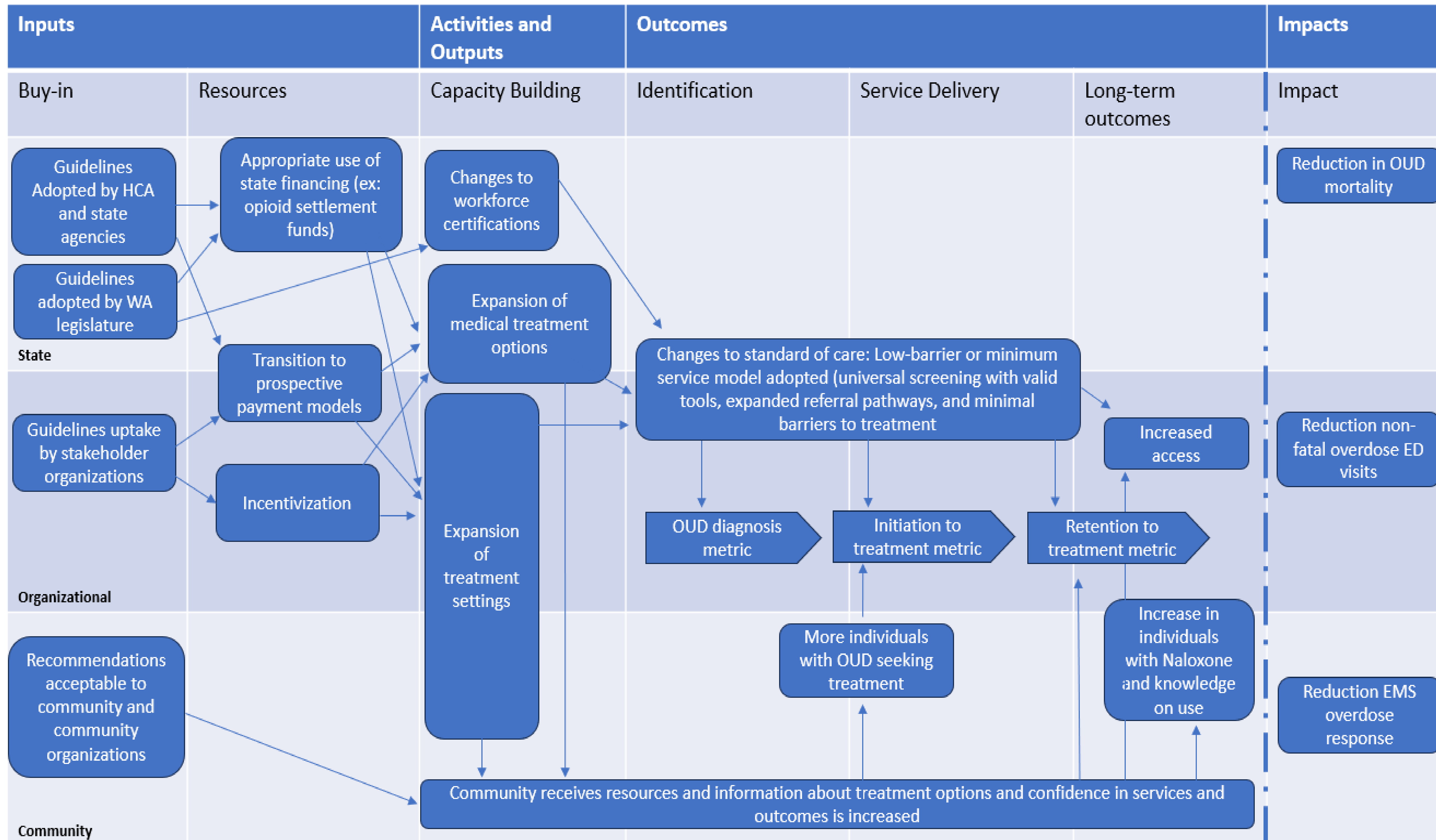
Washigngton State Health Care Authority. (2024, October 24). *School Employees Benefits Board (SEBB) Program*. Retrieved from hca.wa.gov: https://www.hca.wa.gov/about-hca/programs-and-initiatives/school-employees-benefits-board-sebb-program

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 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 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 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
What are you going to track? The concept that will help answer the question	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 are you going to track it? How the concept will be measured	What are the factors that might influence this data? Examples: rural areas, cultural context, language, hours of operation.	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