STOP HIV/AIDS Structured Learning Collaborative

Aim

To engage participating teams in joint quality improvement activities to improve access to high quality HIV care and to advance the health outcomes of people living with HIV/AIDS in British Columbia while strengthening linkages to care and partnerships.

At the end of this Collaborative, the following will have been achieved:

- *Improved access for HIV-infected individuals by increasing the number of patients retained in care*
- *Strengthened partnerships across HIV providers as evidenced by established communication strategies for the purpose of collaboration for quality improvement and care delivery*
- *Routine performance measurements based on standardized indicator definitions and data collection methodologies*
- *Portfolio of successful quality improvement interventions to allow other HIV providers to learn from this Collaborative and to promote peer learning*

Core Domains

The following core domains have been established for this HIV/AIDS Structured Learning Collaborative that serve as an organizing principle framework:

a) Retention in HIV Care

The HIV/AIDS Collaborative will focus on those patients who have been previously in HIV care and are currently lost to follow-up. Special attention will be given to those newly diagnosed, as their initial experience is particularly predictive of their long-term retention in care. Participating HIV teams will re-engage those patients lost to care and learn from them how to best retain other HIV patients.

b) Strengthened Care Partnerships

Providing effective HIV care requires collaboration among multiple care partners. The HIV/AIDS Collaborative focuses on strengthening those partnerships by better coordinating HIV care across medical and service providers, advancing the collaborations among stakeholders to break down the silos of care to benefit individual HIV care, and optimizations of existing partnerships and relationships with community stakeholders.

c) Improved HIV Care

The goal of increasing the capacity for quality improvement is to improve HIV care and ultimately, the health outcomes of HIV-infected individuals. Suggested markers of good HIV care are the following indicators: guidelines-based care, viral load (VL) suppression rates, appropriate medical visit frequencies (i.e. within last 6 months), appropriate antiretroviral regimens, etc.

Milestones

Proposed Date	Description
December 2, 2010	Launch of Collaborative *(1/2-day meeting in Vancouver)*
January 26-27, 2011	Learning Session 1 *(2-day meeting in Vancouver)*
May 25, 2011	Learning Session 2 *(1-day meeting in Vancouver)*
September 28, 2011	Learning Session 3 *(1-day meeting in Vancouver)*
January 25, 2012	Closing Congress *(1-day celebratory meeting in Vancouver)*

Faculty

- Dr. Rolando Barrios - Collaborative Co-Chair
- Christina Clarke - Collaborative Co-Chair
- Dr. Kathy Reims - Faculty, Boulder, CO
- Clemens Steinbock - Faculty, New York, NY
- Judy Huska - Faculty, Impact BC
- Additional faculty TBD

Basic Methodology of a Collaborative

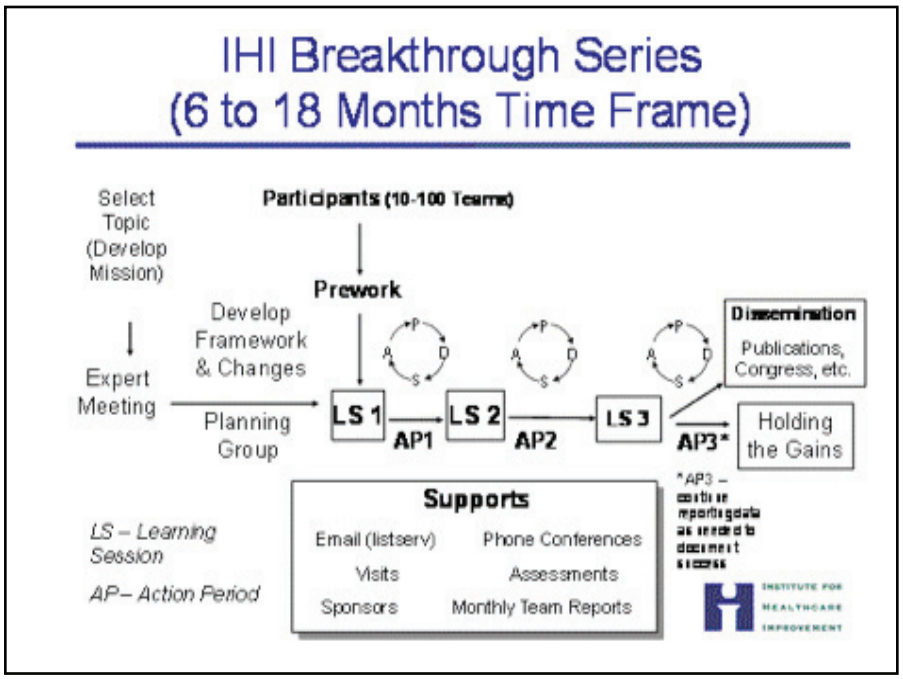
The Collaborative will follow the Breakthrough Series (BTS) Collaborative methodology as developed by the Institute for Healthcare Improvement, and depicted at right. A Structured Learning Collaborative is an organized effort of shared learning by a network of sites to implement best practices and rapidly achieve significant results. The basic structure of this methodology includes four in-person "Learning Sessions" punctuated by active implementation phases referred to as "Action Periods".

Teams

The Collaborative Steering Group aims to engage between 20 and 25 teams to participate in the first wave HIV/AIDS Collaborative. These teams will include between 3-6 members each from a wide variety of disciplines, including physicians, nurses, nurse practitioners, medical office assistants and other allied health professionals.

Infrastructure Support

- *Monthly conference calls for all clinical teams with Collaborative Faculty*
- *Quality improvement coaching*
- *An e-mail Listserv and Virtual Community of Practice*



Collaborative Expectations

Organization/Team	Responsibilities
Health Authorities	• Have a Quality Improvement Coordinator available to assist each clinical team in designing and implementing practice redesign, using recognized improvement methodology to consider the following: • *What are we trying to accomplish?* • *How will we know that a change is an improvement?* • *What changes can we make that can lead to an improvement?* • Reimburse between 3-6 members per team for travel expenses and backfill • Set aside discretionary funding, as appropriate, to assist teams in addressing gaps that are uncovered as a result of the Structured Learning Collaborative (i.e. need for additional staff, access to HA services, etc.) • Enable the collection and sharing of data and learning with other clinical teams and overall project leadership group
B.C. Centre for Excellence in HIV/AIDS	• Provide logistic costs associated with up to four learning sessions per Collaborative; including venue, speaker fees, materials, etc. (excluding reimbursements to team members for travel, accommodation, or backfill) • Establish, with Impact BC, a Structured Learning Collaborative Core Team consisting of Project Director, Clinical Director, and Quality Improvement Faculty • Plan, design, and maintain a Virtual Community of Practice that coordinates aspects of the Structured Learning Collaborative • Finalize and distribute HIV Primary Care Guidelines • Provide quarterly reports to Leadership Committee
Participating clinical teams	• Perform pre-work activities to prepare for the first Learning Session, including conference call(s), self-assessment(s), development of an aim statement • Form a local team of HIV providers to participate in all Collaborative activities based on roles/functions suggested by the Collaborative • Attend 4 face-to-face Collaborative meetings in Vancouver, BC that are between 1-2 days in length • Align the goals of the Collaborative with local work priorities • Perform tests of changes that are aligned with the goals of the Collaborative and have the potential for widespread implementation of improvements • Collect well-defined indicator data that relate to their aim statement at least monthly and openly share them for the duration of the Collaborative • Report to Collaborative Steering Group monthly on the team progress using a provided reporting format, including details of changes/improvements made, challenges faced and data to support these changes, both during and between Learning Sessions • Share their data and successes with other teams to promote peer learning • The Collaborative will include a wide variety of participants, including several teams working in partnership with a patient's most responsible provider to ensure appropriate and comprehensive care delivery
Collaborative faculty	• Provide quality improvement frameworks, such as the Model for Improvement and Breakthrough Series Collaborative Model, to structure this Collaborative • Provide guidance and feedback to participating teams and offer suggestions for improvement based on reported data and progress reports • Offer coaching to participating teams • Facilitate Collaborative face-to-face meetings and conference calls • Provide sound ideas to test for improvements in quality of care in alignment with the goals of this Collaborative • Provide communication strategies to keep participants connected during the Collaborative