Project Charter:
STOP HIV/AIDS Structured Learning Collaborative

BC Center for Excellence in HIV/AIDS

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British Columbia
Centre *for* Excellence
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ImpactBC
HEALTH IMPROVEMENT ACTION

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STOP HIV/AIDS COLLABORATIVE CORE TEAM

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Misty Bath – Vancouver Coastal Health

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Judy Huska – Impact BC

Dr. Kathy Reims - Faculty

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BACKGROUND

Over the past 20 years, impressive advances in therapeutics for HIV/AIDS care have led to dramatic improvements in the quality and the duration of life for HIV positive individuals (BC Center for Disease Control [BCCDC], 2008). Notably, the revolutionary antiretroviral drug regimens pioneered by researchers at the BC Centre for Excellence in HIV/AIDS (BC-CfE) – known to the medical community as "Highly Active Antiretroviral Therapy" (HAART) or "Combination Antiretroviral Therapy (cART") – has become the international standard for HIV/AIDS care. HAART has resulted in dramatic decreases in the number of AIDS-related deaths, has significantly increased life expectancy for individuals living with HIV/AIDS, and has improved clinical outcomes for thousands of patients. Because of these advances, HIV may now be considered a chronic, manageable condition.

Yet, despite these important advances, HIV/AIDS continues to be a serious public health issue in British Columbia (BC). In 2005, an estimated 8,600 to 12,200 British Columbians were known to be living with HIV/AIDS (Public Health Agency of Canada [PHAC], 2007). At this time, BC is home to the highest HIV/AIDS prevalence rate in Canada – the highest of which occurs in the Vancouver inner-city area (30%) (PHAC, 2008).

Care for HIV-positive individuals is a complex process requiring collaboration among multiple care providers. This is complicated further as providers face numerous obstacles in delivering quality HIV/AIDS care as a result of a variety of social, economic, cultural, and medical challenges. Consequently, providers require effective systems for enhancing access and promoting adherence to therapy among very ill and vulnerable individuals (New York State Department of Health AIDS Institute, 2008).

In February of 2010, after focused efforts by the BC-CfE and the Ministry of Health Services, the province of BC dedicated $48 million over four years to support the "Seek and Treat for Optimal Prevention of HIV/AIDS" (STOP HIV/AIDS) Pilot Project. Under this umbrella, plans to launch a provincial Structured Learning Collaborative were initiated in alignment with the goals of the STOP HIV/AIDS pilot project of reaching and engaging more British Columbians living with HIV/AIDS with better care and access to treatment to significantly reduce the spread of infection.

Increasingly the healthcare community is employing quality improvement frameworks developed by the Institute for Healthcare Improvement (IHI) to address gaps in care. In particular, the Collaborative Method, or the Structured Learning Collaborative (Collaborative) methodology, has been applied in the BC context to improve care for individuals affected by diabetes and congestive heart failure care.

The BC-CfE has sponsored the development of the STOP HIV/AIDS Structured Learning Collaborative to strengthen capacity for quality improvement among local HIV providers across BC, to engage

participating teams in joint quality improvement activities to better coordinate seamless HIV services, and to enhance partnerships across HIV providers and the alignment of quality improvement goals. Efforts associated with the Collaborative are expected to reduce the transmission of HIV, improve health outcomes, reduce morbidity, improve quality of life, and increase patient engagement and involvement in their own care.

KEY PROJECT STAKEHOLDERS

Stakeholder	Title	Program	Responsibility
Dr. Rolando Barrios	Assistant Director, IDC; Principle Investigator	BC Center for Excellence in HIV/AIDS	Clinical lead/champion
Irene Day	Director of Operations	BC Center for Excellence in HIV/AIDS	Sponsor
Cheryl Davies	Vice-President Ambulatory Programs	Oaktree Clinical, Provincial Health Services Authority	PHSA lead
Scott Harrison	Program Director (Acting) Mental Health, HIV/AIDS, Aboriginal Health & Addiction Services	Immunodeficiency clinic /Primary Health Care	PHC lead
Andrew Hughes	CIHS Administrator NOK	Interior Health Authority	IHA lead
Judy Huska	Executive Director, Quality Improvement Action	Impact BC	Quality Improvement lead
Kathy MacDonald	Regional Director Preventive Public Health	Northern Health Authority	NHA lead
Dr. Julio Montaner	Director	BC Center for Excellence in HIV/AIDS	Sponsor
Val Munroe	Operations Director	Vancouver Coastal Health Authority	VCHA lead
Victoria Power	Director, Primary Health Care & Chronic Disease Management	Vancouver Island Health Authority	VIHA lead
Amrit Rai,	Manager, Health Promotion and Prevention (Burnaby) Lead HIV/AIDS, HepC, & BBP	Fraser Health Authority	FHA lead

COLLABORATIVE GOALS

The aim of the STOP HIV/AIDS Structured Learning Collaborative is to improve access to high quality HIV/AIDS care and to improve health outcomes for people living with HIV/AIDS in BC while strengthening linkages to care and partnerships. At the end of this Collaborative, the following will have been achieved:

- Improved access for HIV-positive 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 formalized collaboration for quality improvement
- Unified quality improvement activities across all participating HIV provider teams to benefit those patients served by these providers
- Routine performance measurements based on standardized measure 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

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

a) ***Retention in HIV Care*** **-** Retaining HIV patients in care is a key theme in 'STOP HIV/AIDS' and represents an important aspect in providing high quality HIV/AIDS care. The HIV/AIDS Collaborative will focus on those HIV patients who have been previously in HIV care and are currently lost to care. 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/AIDS care requires collaboration among multiple care partners. The STOP HIV/AIDS Collaborative focuses on strengthening these partnerships through improved coordination of HIV care across medical and service provider domains. This will advance collaboration among stakeholders to break down silos of care thereby benefitting individual HIV care and optimizing 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.

Formalized measures will be provided to reflect each of these core domains. These measures will be designed to guide teams through their quality improvement journey by providing them with practical information on starting points, goals and progress along the way. When HIV providers work in partnership towards these goals, they have the potential to strengthen their individual programs and speed the pace of improvement by working collectively towards common priorities to improve the overall quality of HIV/AIDS care for patients in British Columbia.

STOP HIV/AIDS COLLABORATIVE CORE MEASURES

*Please see the *STOP HIV/AIDS Guide to Measurement* document for additional details on the measures listed below.

Detailed descriptions for the Core Collaborative Measures are presented in the following table:

#	Core Measure	Objective	Suggested Target	Numerator	Denominator
1	**HIV Primary care visits**	To determine the proportion of patients engaged in standard care	> 95%	Total number of those in the denominator who had at least one visit to a HIV primary care provider in the past 4 months	Total number of active HIV patients included in the Population of Focus
2	**HIV Viral load**	To determine the proportion of patients receiving standard of care laboratory monitoring, can also be used as a proxy for engagement in care	> 95%	Total number of those in the denominator who had at least one HIV plasma Viral Load (pVL) test in the past 4 months	Total number of active HIV patients included in the Population of Focus.
3	**Antiretroviral Therapy (ART) uptake among those unequivocally in need of ART**	To determine the proportion of patients who urgently require ART and are receiving HIV-related care that are actually NOT being prescribed ART	> 95%	Total number of those in the denominator who are currently taking ARV	Total number of active HIV patients included in the Population of Focus known to have had a CD4 cell count <200 cells/mm^3
4	**Achieving maximal HIV virologic control if prescribed ART**	To determine the proportion of patients on ART who are being successfully treated	> 95%	Total number of those in the denominator who have a pVL less than 200 copies/mL at last pVL measure	Total number of active HIV patients included in the Population of Focus who have been on ARV for six months or more
5	**Patient Experience**	below	>90%	Sum of all responses that were Excellent and Very Good for respective question 1 through 4.	Sum of all responses from the respective question, 1 through 4 from the patient access survey.

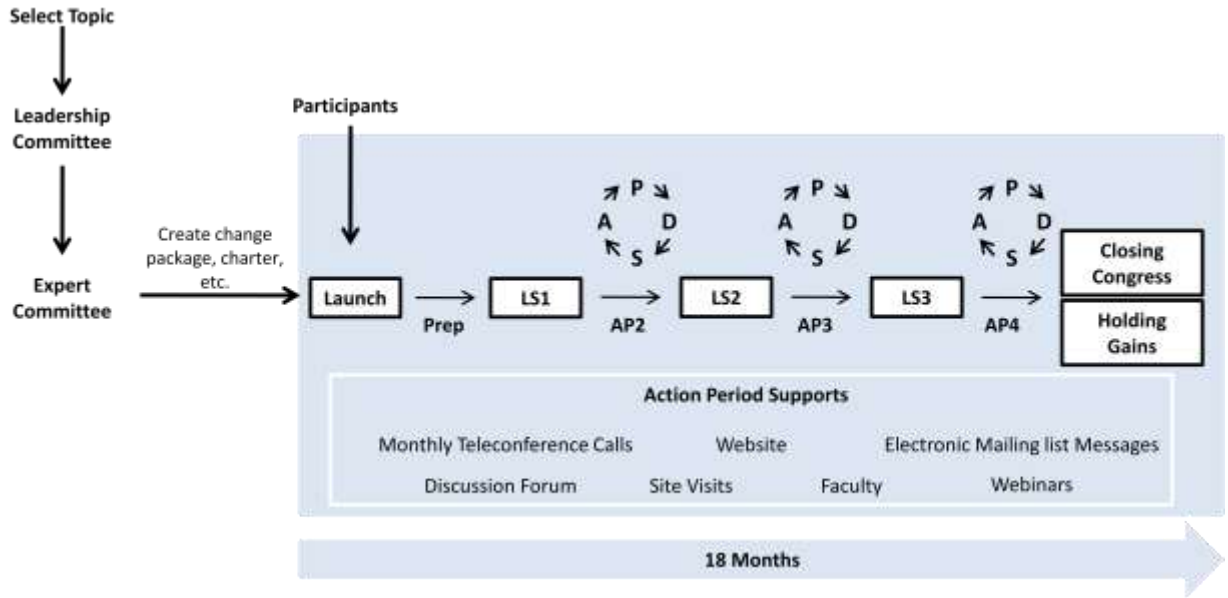
5	Patients have valuable insight into the quality and process of care that is provided for them. You can choose to measure patient feedback specific to access to care by using the Patient Access Survey attached to this document . This survey can be completed at the time of the visit to give a real time measurement of satisfaction. **See Appendix B for Patient Access Survey** **Question # 1.** How would you rate your satisfaction with getting through to the office (either by phone or in person)? Objective: To determine the level of satisfaction with the office (either by phone or in person)? Numerator: Sum of all responses that were Very Good or Excellent on question 1. Denominator: Sum of all responses from question 1 on the patient access survey. **Question # 2.** How would you rate your satisfaction with the length of time you waited to get your appointment? Objective: To determine the level of satisfaction with the waiting time to see a clinical provider. Numerator: Sum of all responses that were Very Good or Excellent on question 2. Denominator: Sum of all responses from question 2 on the patient access survey. **Question # 3.** How would you rate your satisfaction with the personal manner of the person you saw today (courtesy, respect, sensitivity, friendliness)? Objective: To determine the level of satisfaction with the care provided. Numerator: Sum of all responses that were Very Good or Excellent on question 3. Denominator: Sum of all responses from question 3 on the patient access survey. **Question # 4.** How would you rate your satisfaction with the time spent with the person you saw today? Objective: To determine the level of satisfaction with the time spend by the provider with the patient Numerator: Sum of all responses that were Very Good or Excellent on question 4. Denominator: Sum of all responses from question 4 on the patient access survey. **Question # 5.** Did you see the clinician, or staff member, that you wanted to see today? Objective: To determine the level of satisfaction with continuity of care provided by the team. Numerator: Sum of all responses that were Yes. Denominator: Sum of all responses (yes + no) for question 5.

COLLABORATIVE METHODOLOGIES

Over the next 18 months, a diverse set of Collaborative teams from across the province will work in partnership to improve access to high quality HIV care and to advance the health outcomes of people living with HIV/AIDS in BC. Participants will learn and implement innovative, evidence-based practices to achieve and hold gains in these improvement areas.

The STOP HIV/AIDS Collaborative will follow the Breakthrough Series (BTS) Collaborative methodology developed by the Institute for Healthcare Improvement (IHI) (depicted below). This will be an organized effort of shared learning by a network of approximately 30 teams, from across BC, purposely working together over the course of 18 months. Throughout the Collaborative, it is expected that team participants maintain continual contact with each other and with Faculty members through a Virtual Community of Practice which includes monthly teleconference calls, electronic mailing list messages, an interactive discussion forum, emails, webinars, and website access. This will create a community of learning in which teams collaborate with each other to discuss common issues, share ideas, and spread best practices.

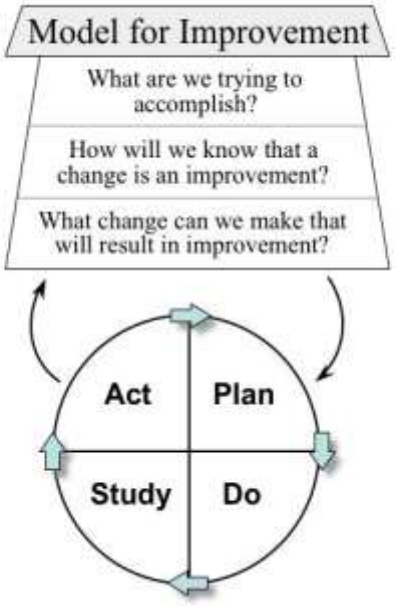
The basic structure of the Collaborative methodology has been adapted for the STOP HIV/AIDS Structured Learning Collaborative to include an in-person Launch where stakeholders and team representatives will assemble to commence Collaborative preparatory work (i.e., defining team membership, crafting improvement aims, collecting baseline measures, creating storyboards, etc.). Subsequently, experts will share approaches to system change and ideas for change at the first in-person "Learning Session" (LS). Each LS will be followed by "Action Periods"(AP) where teams are supported in actively testing and in implementing changes in care processes using the Model for Improvement (described below).



STOP HIV/AIDS Structured Learning Collaborative structure adapted from: The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement, IHI Innovation Series White Paper. Boston: Institute for Healthcare Improvement; 2003

Each Collaborative team will create an improvement aim guided by the Model for Improvement (the "Model"). Teams will define answers to the three key questions within the Model. Specifically, these are:

1) ***What are we trying to accomplish?*** (Aim) Here, participants determine which specific outcomes they are trying to change through their work.
2) ***How will we know that a change is an improvement?*** *(Measures)* Here, team members employ appropriate measures to track their success.
3) ***What changes can we make that will result in improvement?*** *(Changes)* Here, teams identify key changes that they will actually test.



Langley, Nolan, Nolan, Norman, & Provost. The Improvement Guide 2nd Edition, San Fransisco, Jossey-Bass Publishers; 2009.

When teams have selected changes, rapid cycle testing of these changes using a sequence of planning (P), doing (D), studying (S), and acting (A) is to be applied to guide improvement. Employing PDSA Worksheets, teams can design tests of change to achieve their defined aims.

The Collaborative is supported by:

Steering Committee	Meet twice annually to review progress and address provincial level policy concerns.
Leadership Committee	Meets four times annually to provide leadership support for the development, implementation, and evaluation of the STOP HIV/AIDS Pilot Project.
Collaborative Core Team	Meet twice monthly (or as needed) to discuss ongoing operational issues, provide policy support to the individual collaborative teams, and linking program delivery to provincial level monitoring of HAART roll out.
Expert Advisory Group	An expert group of individuals in HIV/AIDS care and quality improvement. This group meets at the start of the Collaborative to develop Collaborative content and design and may be consulted on an as need basis thereafter.
Project Secretariat	Includes the Collaborative Director, the Medical Director, and Administrative Assistant.
Community of Practice	All members of the Collaborative teams.

COLLABORATIVE EXPECTATIONS

Health Authorities will:

- 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

The BC Centre for Excellence in HIV/AIDS will:

- Provide logistic costs associated with up to four learning sessions per Collaborative including venue costs, 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 will:

- Perform preparation activities to prepare for the first Learning Session, including attend teleconference 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 Planning 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 Faculty will:

- Provide quality improvement frameworks, such as the Model for Improvement and Breakthrough Series Collaborative Model, to structure the 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

PRELIMINARY MILESTONE SCHEDULE

Key Collaborative Milestones	Date
Expert Meeting	September 23, 2010
Learning Session 0 (Launch)	December 2, 2010
Collaborative teams complete preparation	January 25, 2010
Learning Session 1	January 26-27, 2011
Learning Session 2	May 25, 2011
Learning Session 3	September 28, 2011
Evaluation Reports	Ongoing
Closing Event and Harvesting Session	January 25, 2012

SIGNATURES

Name	Position/Title	Signature	Date
Dr. Julio Montaner	**Project Sponsor** (required)		
Irene Day	**Project Sponsor** (required)		
Dr. Rolando Barrios	**Collaborative Medical Director**		
Judy Huska	**Impact BC Executive Sponsor**		
Christina Clarke	**Project Director**		

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