STOP HIV/AIDS Structured Learning Collaborative

Change Package Version 2

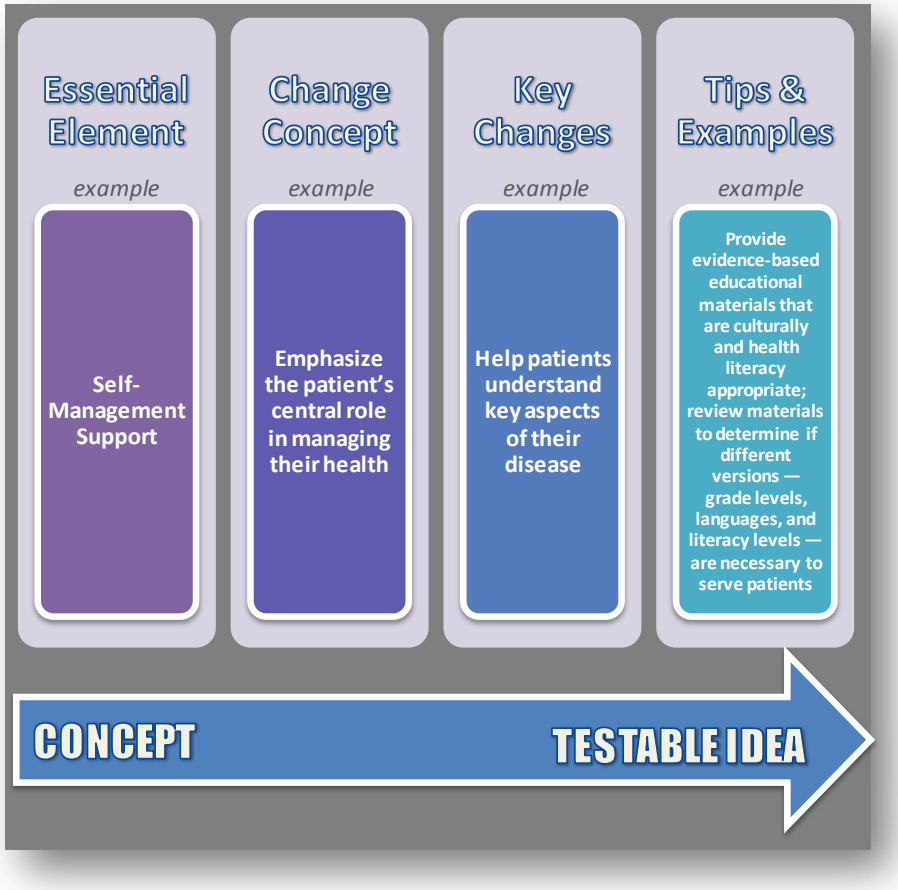
5/25/2011

What is the Change Package?

The change package is a document that contains 'change ideas' that your team can test out in your own practice or program to meet your improvement goals. The ideas in this document are not just your run of the mill ideas; these are 'ideas with a pedigree'! These are evidence based ideas that have been identified by experts and described in literature.

What the Change Package is not…

A collection of pre-packaged solutions ready for implementation. Ideas for change need to be tested in your own unique environment. Through testing, you can refine these change ideas and be certain that they help you to meet your improvement goals.



How is the Change Package Organized?

The Chronic Care Model outlines ***essential elements that are required for a system to deliver high-quality chronic illness care*** (e.g., decision support, self-management support, etc.). Aligned with these *essential elements* are evidence-based ***change concepts***. The change ideas in the Change Package are categorized by these essential elements and change concepts. Of course, concepts are not specific enough to apply in practice. Therefore, ***key changes*** and ***tips and examples*** are aligned with the concepts to provide ideas that can be tested and implemented to improve care for HIV positive individuals.

You will find two parts in the change package. Part I presents the higher level concepts and how each is aligned with the goals of the Collaborative. Part II presents the concepts with more practical information on how and why to test and implement these changes.

So, where do I begin?

You can start anywhere. Read through the change package - what are your practice's strengths and weaknesses? Turn a deficiency in your practice into an opportunity! Start with areas in the change package that your team agrees will generate the highest impact changes. Also, look for changes that are quick wins so that you can generate momentum for further change.

Ultimately, teams should be working in all areas of the change package. Specifically, teams should be testing and implementing changes that cut across all of the *essential elements* of a system that provides high quality chronic illness care.

Orientation

Part 1: Change Concepts & Key Changes

1A) Decision Support

Promote clinical care that is consistent with scientific evidence and patient preference.

Change Concept	Key Changes	Collaborative Goals		
		Retention in care	Partnerships	Improved HIV care
Embed Evidence-based guidelines into daily clinical [1]practice	• Adopt evidence-based practice as standard of care across the practice			✓
	• Employ strategies throughout the practice to ensure evidence-based care is delivered reliably			✓
	• Periodically review current practices and update as needed to align with evolving evidence			✓
Share evidence-based guidelines and information with patients to encourage their participation	• Implement educational strategies to inform and engage patients in guidelines-based care		✓	✓
	• Support engagement of patients in guidelines-based care	✓		✓
Integrate specialist expertise and primary care	• Engage specialists in process of primary care		✓	✓
Use proven provider education methods	• Provide education using problem-based learning			✓

[1] Barr VJ, Robinson S, Marin-Link B, Underhill L, Dotts A, Ravensdale D, Salivaras S. 2003. The expanded chronic care model: integration of concepts and strategies from population health promotion and the chronic care model. Healthcare Quarterly, 7(1), 73-82.

1B) Clinical Information System

Organize patient and population data to facilitate efficient and effective care.

Change Concept	Key Changes	Collaborative Domains		
		Retention in care	Partnerships	Improved HIV care
Provide timely reminders for providers and patients	• Use a registry so that all information is centralized and available for care			✓
	• Leverage prompts and reminders for care at point of service			✓
	• Create outreach and reminder systems to prompt patients regarding recommendations of care due	✓	✓	✓
Identify relevant subpopulations for proactive care	• Create systems to identify patients who are challenged to remain engaged in care or follow care plans	✓		✓
Facilitate individual patient care planning	• Utilize information systems to contribute to shared decision making regarding care			✓
	• Share information with patients regarding current care plan, important care parameters and desired targets	✓	✓	✓
Share information with patients and providers to coordinate care	• Identify patients whose care is shared with other providers to ensure coordination		✓	✓
Monitor performance of practice team and care system	• Periodically compare actual to desired performance for targeted systems of care	✓	✓	✓

1C) Delivery System Design

Assure the delivery of effective, efficient clinical care and self-management support.

Change Concept	Key Changes	Collaborative Domains		
		Retention in care	Partnerships	Improved HIV care
Define roles and distribute tasks among team members	• Match skills to tasks	✓		✓
	• Train staff to optimize skill	✓		✓
	• Cross train staff and leverage multidisciplinary teams	✓		✓
Use planned interactions to support evidence-based care	• Ensure all tasks contribute to evidence-based, patient centered care	✓		✓
	• Plan for patient visits to ensure all recommended care is provided	✓		✓
	• Organize to optimize planned care	✓		✓
	• Provide self-management support to assist patients with evidence-based care recommendations	✓		✓
Provide clinical case management services for complex patients	• Provide coaching, outreach or case management services to meet patient need	✓	✓	✓
	• Provide clinical case management services	✓	✓	✓
Ensure regular follow-up by the care team	• Create systems for systematic identification and outreach for patients due for care or in need of follow up between visits	✓	✓	✓
Give care that patients understand and that fits with their cultural background	• Use materials to communicate with patients that respect differences in health literacy	✓	✓	✓
	• Respectfully address differences in culture regarding provision of care, communication and self-management support	✓	✓	✓
Acknowledge the demonstrated connections between health and the broader social, political, economic and physical environment conditions	• Regularly assess the context of care for individuals and families including social determinants of health	✓	✓	✓

1D) Self-Management Support / Develop Personal Skills

Empower and prepare patients to manage their health and healthcare.

Change Concept	Key Changes	Collaborative Domains		
		Retention in care	Partnerships	Improved HIV care
Emphasize the patient's central role in managing their health	• Help patients understand key aspects of their disease	✓		✓
	• Share recommended care guidelines with patients	✓		✓
	• Provide tools that patients can use to effectively participate in their care	✓		✓
	• Emphasize the importance of general health and healthy behaviors on HIV outcomes	✓		✓
Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up	• Train staff in evidence-based self-management strategies	✓		✓
	• Adopt team roles and work flows that support self-management goal setting	✓		✓
	• Promote systems that support patients to achieve self-management goals	✓	✓	✓
	• Incorporate follow up of self-management goals and creation of new goals into care	✓	✓	✓
	• Encourage patients to include healthy lifestyle self-management goals in addition to HIV specific goals			✓
Organize internal and community resources to provide ongoing self-management support to patients	• Use group visits to support self-management			✓
	• Link with community agencies that promote health and healthy lifestyles	✓	✓	✓
	• Leverage existing resources within the community to support specific patient needs	✓	✓	✓
	• Advocate for additional services that support patient self-management efforts	✓	✓	✓

1E) Health System / Health Care Organization

Create a culture, organization and mechanisms that promote safe, high quality care.

Change Concept	Key Changes	Collaborative Domains		
		Retention in care	Partnerships	Improved HIV care
Visibly support improvement at all levels of the organization, beginning with the senior leader	• Increase awareness and engage senior leaders in improvement activities		✓	
	• Ensure senior leaders "own" the improvement efforts		✓	
	• Link improvement goals to the organization's vision, mission and goals		✓	
Promote effective improvement strategies aimed at comprehensive system change	• Integrate Collaborative Models (Model for Improvement and Chronic Care Model) into the "fabric" of the organization		✓	
	• Define roles and accountability for quality improvement (QI) activities			✓
	• Use evidence-based QI methodology			✓
Encourage open and systematic handling of errors and quality problems to improve care	• Create a process for active reporting of errors and quality problems			✓
	• Address errors and quality problems through system redesign			✓
Provide incentives based on quality of care	• Measure quality by using a valid and trusted set of performance indicators			✓
	• Use performance indicators to reward teams for reaching quality goals			✓
Develop agreements that facilitate care coordination within and across organizations	• Promote multidisciplinary teamwork in care of patients			✓

1F) Community Linkages

Mobilize the community to meet needs of patients.

Change Concept	Key Changes	Collaborative Domains		
		Retention in care	Partnerships	Improved HIV care
Build healthy public policy	• Advocate for policies that support health equity and improved health outcomes for patients with HIV		✓	✓
Create supportive environments	• Work together at the community level to ensure essential support services are accessible		✓	✓
	• Share key documents across agencies		✓	✓
Strengthen community action	• Conduct a quality improvement project to streamline care processes		✓	✓
	• Promote regional collaboration		✓	✓
	• Develop resource management strategies to mutually benefit programs		✓	✓

Part 2: Change Concept, Key Change, Tips & Examples from Literature & Practice

2A) Decision Support *Promote clinical care that is consistent with scientific evidence and patient preference*

Change Concept	Key Change	Tips & Examples from Literature and Practice
Embed evidence-based guidelines into daily clinical [2]practice	Adopt evidence-based practice as standard of care across the practice	• Identify widely-respected current guidelines for the treatment of HIV/AIDS and co-morbid conditions and share with all medical providers • Use locally adapted evidence-based guidelines that include standardized severity assessment and intensification of care • Involve a provider champion and end-users in adapting guidelines[3] - develop consensus on guidelines and involve influential naysayers in the process of adapting the guidelines for "buy in" • Customize guidelines for the clinic, within the boundaries of the evidence; speed up the process by consulting with clinics that have already customized guidelines • Set clear expectations and timelines for guideline adaptation, review, and adoption • Include evidence summaries that accompany good guidelines to facilitate discussion • Conduct a baseline chart audit to benchmark your current practice against agreed-upon guidelines

	Employ strategies throughout the practice to ensure evidence-based care is delivered reliably	• Use flow sheets, pathways, or checklists to embed guideline-based care into daily practice and into the registry system. For example:
		  ○ Use encounter forms and protocols to highlight needed services
		  ○ Develop a flow sheet through consensus building and testing that consolidates all pertinent clinical information – engage end-users in development and testing
		  ○ Embed the flow sheet into work flows (e.g., try different ways of inserting the flow sheet into the patient record)
		  ○ Have patients complete assessment tools prior to visit
		• Use prompts and reminders to drive guideline-based care, monitor clinical status, monitor medication use, etc. – make them difficult to ignore and reduce reliance on memory
		  ○ Establish screening alerts for specific patient needs such as adherence training and secondary prevention tests
		• Standardize protocols
		  ○ Develop consensus protocols for common concerns
		  ○ Use standardized phone or e-mail follow-up protocols to identify patients needing stepped-up care, such as calling people after emergency visits
		  ○ Use standing orders to assure delivery of evidence-based interventions and prevent errors (e.g., develop standing orders for immunizations and labs for patients)

[2] Barr VJ, Robinson S, Marin-Link B, Underhill L, Dotts A, Ravensdale D, Salivaras S. 2003. The expanded chronic care model: an integration of concepts and strategies from population health promotion and the chronic care model. Healthcare Quarterly, 7(1), 73-82.

[3] Davis DA, Taylor-Vaisey, A. 1997. Translating guidelines into practice: A systematic review of theoretic concepts, practical experience and research evidence in the adoption of clinical practice guidelines. Can Med Assoc J. 157(4): 408-16.

		• Monitor the effectiveness of encounters and the frequency of missed clinical tasks to understand gaps in care ○ Have providers abstract a random sample of their own charts to understand the gap between known good practice and actual practiceTry to integrate the chart audit with development of the registry • If a team is already practicing evidence-based medicine, use the team members to spread the word. If a team is not practicing this way, have them visit another clinic that is
	Periodically review current practices and update as needed to align with evolving evidence	• Routinely review and update guidelines for care (suggested annually or as new guidelines are published) • Widely communicate practice changes and impacts on daily work flows to all staff • Change policies and procedures to fully integrate the changes into clinical practice
Share evidence-based guidelines and information with patients to encourage their participation	Implement educational strategies to inform and engage patients in guidelines-based care	• Post information about guidelines in the clinic lobby and other public places • Make follow-up calls (using the registry) to determine if the patient followed through • Develop "patient-friendly" guideline handouts or wallet cards and distribute them to patients • Review a customized care pathway with patients as part of action planning - give patients a handout that reviews their prevention and ongoing care standards • Use protocols that are worksheets for clients to keep • Review all client education literature in the office for accuracy, consistency with guidelines and acceptability to patients • Provide BC HealthGuide for the nurses and clients. http://bchealthguide.org/ • Provide links to BC HealthFiles online to patients. http://bchealthguide.org/ • Review public domain websites and recommend one to patients • Develop an organized approach to link patients to easily accessible, scientifically accurate information
	Engage patients to ensure they understand the impact of healthy living on their condition and encourage patients to make healthy choices that promote wellness	• Survey patients about their knowledge of disease processes • Be sensitive to the cultural environment of the patient and family (see Delivery System Design for delivering culturally competent care) • Have providers reinforce "patient expectations": clarify the patient's role in making sure recommended tests and examinations are completed according to the guideline • Include "patient expectations" as part of all support groups and public presentations
Integrate specialist expertise and primary care	Engage specialists in the process of primary care	• Establish a service agreement and protocol for specialists to support primary care • Request that specialists designate a "specialist on-call" for brief phone consults to primary care • Invite specialist to spend a half day doing mini-clinics with primary care teams
Use Proven provider education methods	Provide education using problem-based learning	• Encourage physicians to attend a Continuing Medical Education course on evidence-based medicine with interactive components • Establish bimonthly case conferences using the common cases • Use academic detailing (group or 1:1 educational outreach) to provide updates on clinical topics[4] • Target educational opportunities based on performance

[4] Pearson S-A, Ross-Degnan D, Payson A, Soumerai SB. 2003. Changing Medication Use in Managed Care: A Critical Review of the Available Evidence. Am J Manag Care, 9(11), 715-731.

2B) Clinical Information Systems

Organize patient and population data to facilitate efficient and effective care

Change Concept	Key Change	Tips & Examples from Literature and Practice

Provide timely reminders for providers and patients	Use a registry so that all information is centralized and available for care	• Visit a center with a well-implemented patient registry
		• Choose or develop an electronic or manual registry
		  ○ Electronic registries should allow for flexible data handling and reporting, easy extraction of patient information, easy information transfer between systems (e.g., lab, appointments, etc.)
		  ○ Manual methods: develop a card file or notebook to track patient information
		• Include staff members from all positions in the planning of the registry and data elements (e.g., providers, information systems administrators, case managers, etc.)
		• Use a template to document how the data elements were established so that new staff can replicate the process
		• Regularly audit and maintain the accuracy of the registry – develop a standard process for updating
		• Organize permissions in electronic systems to optimize staff contributions to care and maintain patient confidentiality

	Leverage prompts and reminders for care at point of service	• Before a visit, print out current information from the registry • Customize initial intake and annual assessment forms to include clinical reminders for providers and nursing staff • Use patient treatment record forms that include services needed at time of visit (include a flow sheet to help monitor clinical data and track trends; Insert screening alerts for providers (e.g., for Pap smears, PPDs)
	Create outreach and reminder systems to prompt patients regarding recommendations of care due	• Create electronic links between the registry and mailing programs • Periodically query the registry to generate lists of patients who have missed or are overdue for a service to initiate follow-up
Identify relevant subpopulations for proactive care	Create systems to identify patients who are challenged to remain engaged in care or follow care plans	• Categorize the population living with HIV/AIDS to identify special needs (e.g., HAART-naïve or experienced, ethnicity, language, insurance, needs/limits, homelessness) • Use the registry to generate lists of high-risk patients for specialized care and follow-up (e.g., query hospitalized in past month; CD4 counts under 200; on HAART with detectable viral loads; women with abnormal Pap smears; hepatitis B or C co-infection; tuberculosis co-infection; chemical dependency)

Facilitate individual patient care planning	Utilize information systems to contribute to shared decision making regarding care	• Use patient treatment record forms that include services needed at time of visit:
		  ○ Include a flow sheet to help monitor clinical data and track trends
		  ○ Insert screening alerts for providers (e.g., for Pap smears, PPDs)
		  ○ Before a visit, print out current information from the registry

	Share information with patients regarding current care plan, important care parameters and desired targets	• Use registry to create a take-home patient summary sheet • See also self-management support
Share information with patients and providers to coordinate care	Identify patients whose care is shared with other providers to ensure coordination	• Query patients and providers and other staff regarding information that would be useful for them
Monitor performance of practice team and care system	Periodically compare actual to desired performance for targeted systems of care	• Use the registry to report both client-specific and clinic/program-wide data – monitor progress over time • Report findings in provider meetings to share successful strategies and support compliance with standards of care - show blinded or unblinded comparison data to motivate providers • Send progress reports to leadership and all team members • Periodically evaluate clinical performance within context of community demographics or disease markers • Periodically consider new strategies or services by conducting a community needs assessment

2C) Delivery System Design

Assure the delivery of effective, efficient clinical care and self-management support

Change Concept	Key Change	Tips & Examples from Literature and Practice
Define roles and distribute tasks among team members	Match skills to tasks	• Develop job descriptions that optimize scopes of practice • Create organizational chart to visually illustrate roles and tasks
	Train staff to optimize skill	• Provide in-service training to staff to understand important aspects of HIV care • Emphasize to all team members their role's impact on care • Educate providers on each member's role in providing care
	Cross train staff and leverage multidisciplinary teams	• Use a multidisciplinary approach to group visits; include pharmacy, nursing, and case management staff • Ensure that patients are continually connected to a multidisciplinary team through phone calls, reminders, urgent appointments, and planned visits • Include all staff in case conference rounds
	Ensure all tasks contribute to evidence-based, patient centered care	• Standing orders do not replace planned visits. Make sure orders include: annual vaccines (e.g., influenza vaccines), annual procedures (e.g., Pap smears and PPDs), quarterly phlebotomy for routine blood tests, CD4 count, and viral load testing

Use planned interactions to support evidence-based care	Plan for patient visits to ensure all recommended care is provided	• Identify HIV/AIDS patients coming in for an appointment the next day or week • Look at registry data and identify needs on a flow sheet or visit note • Assign staff to identify gaps in care prior to visit • Plan the visit, including who will perform assessments, make referrals, and generate self-management goals • Implement standardized protocols and standing orders as appropriate (e.g., labs, immunizations, annual assessments) • Use quick team meetings (huddles) to facilitate planned care • Train staff in the planned visit approach (a planned medical visit should contain an assessment, review of therapy, review of medical care, self-management goals, problem solving, and follow-up planning, including the plan for the next visit)
	Organize to optimize planned care	• Conduct a time study to understand ideal visit length • Map the journey of the patient tracking the flow of information, supplies, technical aspects of care, and the patients experience with care from the perspective of the patient • Standardize exam room layout and supplies – ensure rooms are stocked prior to use • Eliminate the need for patients to move between examining rooms for different parts of their visit • Conduct a walk-through of your own facility as well as other facilities
	Provide self management support to assist patients with evidence-based care recommendations	• Design systems to support self-management for patients including goal setting. Include specifics about responsibilities, work flows, documentation and follow up
Provide clinical case management services for complex patients	Provide coaching, outreach or case management services to meet patient need	• Include a case management section in the medical record-to-record case management interventions related to ARV management • Reorganize medical records to better coordinate information about ARV management, such as lab values, ARV medications, adherence assessment information, case management notes, etc. • Partner with other organizations as needed to ensure adequate case management services for patients served
	Provide clinical case management services	• Determine availability of clinical case management services • If clinical case management services are available, assure that complex patients receive these services; if clinical case management services are not available, review roles and tasks and distribute them amongst the team • Have social workers and nurses learn problem-solving therapy and send patients who need further assistance to them. (http://impact-uw.org/) • Connect with existing health services (i.e., Home Health) to explore opportunities to redeploy these resources into case management (Fraser Health)
Ensure regular follow-up by the care team	Create system for systematic identification and outreach to patients due for care or in need of follow up between visits	• Plan the follow-up approach, including who will contact patients, how, and when • Use phone, outreach workers, and mailings for follow-up • Ask patients for best methods and times to follow up for check-back visit, pharmacy refills, etc. • Develop scripts/algorithms for phone follow-up; this can enable some MAs/HAs/LPNs to perform follow-up usually accomplished by RNs

		• Track patients lost to follow-up via their case managers
Give care that patients understand and that fits with their cultural background	Use materials to communicate with patients that respect differences in health literacy	• Use the American Medical Foundation's "Help Your Patients Understand"[5] • Use the "close the loop" strategy for ensuring good communication. ("We just talked about your new medication. Tell me what you heard so I can see if I made it understandable.")[6]
	Respectfully address differences in culture regarding provision of care, communication and self-management support	• Train staff in communication techniques with patients of different cultures • Train providers in how to use interpreters effectively with the training video available from Cross Cultural Health Care Program[7] • Use "World's Apart" Curriculum to raise awareness of cross-cultural issues[8] • Solicit patient and family preferences
Acknowledge the demonstrated connections between health and the broader social, political, economic and physical environment conditions.	Regularly assess the context of care for individuals and families including social determinants of health	• Use standardized assessment tools to assess for insecurities such as food or homelessness. • Refer patients to additional support services such as food banks, housing support • Coordinate with other agencies to support transportation needs

2D) Self-Management Support / Develop Personal Skills

Empower and prepare patients to manage their health and healthcare

Change Concept	Key Change	Tips & Examples from Literature and Practice
Emphasize the patient's central role in managing their health	Help patients understand key aspects of their disease	• Provide evidence-based educational materials that are culturally and health literacy appropriate; review materials to determine if different versions — grade levels, languages, and literacy levels — are necessary to serve patients • Recommend support groups and web sites that can provide additional support • Teach clients to evaluate medical information for themselves[9] • While working with a client, say, "HIV is a serious ongoing health problem. We are here to provide the best care for your condition, but you are the day-to-day manager of the condition."
	Share recommended care guidelines with patients	• Share graphs that plot the CD4 count and viral load with the patient • Review ideal care for HIV so that the patient understands the expected frequency of visits, laboratory work and the importance of monitoring even though they may not feel different

[5] http://www.ama-assn.org/ama/pub/category/8115.html
[6] Schillinger D, Piette J, Grumbach K et al. 2003. Closing the loop. Physician communication with diabetic patients who have low health literacy. Arch Intern Med, 163, 83-90.
[7] http://www.xculture.org/cultcompprograms.php
[8] Available from Fanlight Productions, 4196 Washington Street, Boston, MA 02131, 1 800 937-4113, www.fanlight.com.
[9] http://www.nlm.nih.gov/medlineplus/understandingmedicalresearch.html

	Provide tools that patients can use to effectively participate in their care	• Use evidence-based shared decision making strategies to involve patients in their care • Provide contact information and instructions for urgencies and questions • Collaboratively set treatment goals and share progress toward goals with patient: lab values, weight, blood pressure, etc.
	Emphasize the importance of general health and healthy behaviors on HIV outcomes	• Provide information and support to patients to optimize healthy behaviors: healthy eating, active living, safety, avoidance of substances including drugs, tobacco and excess alcohol, stress reduction and emotional linkages to friends and family
Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up	Train staff in evidence-based self-management strategies.	• Train staff in evidence based self-management support skills such as stages of change, how to set specific goals with patients and how to measure confidence
	Adopt team roles and work flows that support self-management goal setting	• Decide who ,what, when, where and how self-management goals will be set • Allow patient to direct the self-management goals • Encourage patient to involve family and friends as appropriate to support achieving self-management goals
	Promote systems that support patients to achieve self-management goals	• Use tools such as bubble diagrams to support patients in choosing self-management goals • Evaluate strategies to support patients between visits to support achievement of self-management goals: phone calls, peer network, health coach, case manager • Systematically evaluate patients who struggle with achieving self-management goals: look for issues with literacy, challenges with psychosocial issues or lack of confidence
	Incorporate follow up of self-management goals and creation of new goals into care	• Document an HIV goal contract or promise that includes specifics such as self-monitoring, guidelines for treatment, and an assessment of the patient's confidence level, anticipated barriers and problem solving strategies Discuss self-management goal at every visit – help problem solve, reframe goals or create new goals
	Encourage patients to include healthy lifestyle self-management goals in addition to HIV specific goals	• Encourage patients to choose areas that are of interest to them – healthy eating, physical activity, stress reduction, et. al. and support their efforts to make healthy changes
	Use Group visits to support self-management	• Offer group visits to patients • Let the group determine the content of sessions. Leaders can monitor the content to ensure that critical information is covered • Use lay people as leaders • Incorporate education, peer networking and self-management goal setting into group visits
Organize internal and community resources to provide ongoing self-management support to patients	Link with community agencies that promote health and healthy lifestyles	• Develop a resource manual for existing support services - share resources with patients as appropriate • Consider HIV-specific support such as pharmacy, support for dealing with serious illness, etc as well as more general support such as nutrition classes, physical activity clubs, stress reduction classes and more
	Leverage existing resources within the community to support specific patient needs	• Encourage patients to participate in community services that would support their self-management goals • Create formalized agreements with agencies that can augment professional support for patients such as behavioral counseling, case management, housing assistance, transportation assistance, etc. • Link with agencies who can help patients with health system navigation as needed
	Advocate for additional services that support patient self-management efforts	• Evaluate additional self-management needs of patients and advocate for development of services to support

2E) Health System / Health Care Organization

Create a culture, organization and mechanisms that promote safe, high quality care.

Change Concept	Key Change	Tips & Examples from Literature and Practice
Visibly support improvement at all levels of the organization, beginning with the senior leader	Increase awareness and engage senior leaders in improvement activities	• Update senior leaders with routine performance data reports; provide ongoing and routine updates (performance data, meeting minutes, survey results, narratives) to them and give information that can be presented on your behalf at the executive/board level. • Invite senior leaders to attend site visits, routine staff meetings, improvement committee meetings – allow them to meet staff and understand you context for improvement activities • Invite senior leaders to attend a consumer focus group to better understand client & community needs • Develop sr. leader specific storyboards to highlight successes, the business case, and successful QI work • Provide references of other senior leaders who have undertaken the same effort • Advocate for senior leader support to make QI a core budget priority
	Ensure senior leaders "own" the improvement efforts	• Establish a senior leaders committee or invite senior leaders to QI team meetings • Use performance data to ask for support and make them 'uncomfortable' with the current status quo • 'Recruit' senior leaders from other departments to join your routine QI meetings and highlight alignment across programs • Include senior leaders in grant applications so that they have a stake in the success • Ask senior leaders for some opening remarks on upcoming organizational priorities • Inform and update senior leaders on clinical and QI priorities in order to develop their hands-on knowledge of methodology and QI infrastructure • Make quality improvement a routine agenda item on executive and board meetings
	Link improvement goals to the organization's vision, mission and goals	• Link improvement work, measures, and outcomes to organizational strategic plans and goals • Adopt language from strategic plans and align with improvement goals • Provide reports and feedback by using graphs and trends over time that will assist senior leaders with communication and advocacy • Help senior leader in determining the "value" of improving chronic illness care (e.g., quality recognition, increased productivity/efficiency, business case, more patients, and important community linkages that can provide needed services and resources)
Promote effective improvement strategies aimed at comprehensive system organization	Use evidence based QI methodologies	• Integrate collaborative models (Model for Improvement and Chronic Care Model) into the "fabric" of the organization • Standardize QI activities across the organization
	Embed the voice of consumers and patients in QI efforts	• Create suggestion boxes and review as a group; track suggestions and follow-up activities over time • Make consumers part of ongoing improvement activities • Recruit 2 patients to become members of the QI team and actively support them in their roles • Develop a buddy system of patients to inform others about improvement activities • Make a consumer a board member

	Define roles and accountability for QI activities	• Provide routine QI training to all staff and focus on new employees • Recruit clinical quality champions who are enthusiastic for quality improvement and respected by other clinicians; consider rotating the role of physician champion to avoid burnout • Make quality improvement a routine expectations for all staff members • Ensure supports, operations and HR policies are designed to sustain improvement: recruiting, job descriptions, performance evaluations, policies and procedures • Engage all staff in at least one improvement project over the course of one to two years
	Use effective communication strategies for internal and external stakeholders	• Understand the data! Know what the issues/barriers are, and present them in an objective manner that invites the senior leader to contribute. • Keep it simple! Provide a simple, straightforward report that everyone can understand. Avoid being too technical or too clinical. • Quote patients' own words or reactions whenever possible, or discuss provider satisfaction • Display a sign that states: "For further information, contact xxxxx" • Promote improvement activities on the waiting room bulletin board or in newsletter. Assign a team member to post changes monthly
	Create a system of care that promotes a continuum of care	• Develop consistent intake and/or standard eligibility processes for all providers • Engage all providers to participate in developing a standard continuum of services to reduce duplication of services and to address gaps in service • Create a flowchart to show the various constituencies, their connections and potential barriers and gaps • Develop method to describe and depict this system and engage all clients in this system of care • Develop a referral flow chart for all patients from community services, including counseling & testing, to primary medical care • Develop and adopt consistent standards of care across programs
Encourage open and systematic handling of errors and quality problems to improve care	Create a process for active reporting of errors and quality problems	• Conduct staff surveys to identify key priorities for improvements across departments • Avoid blaming individuals for errors or quality problems, look to the systems • Make staff accountable for reporting of performance
	Measure quality by using a valid and trusted set of performance indicators	• Use process measures, such as percentage of kept appointments or number of adherence interventions, and outcome measures, such as CD4 count or viral load, to inform care • Selected staff members double-check quality of their data and compare to system reports of data • Have staff members participate in selection and definition of measure • Ensure that the improvement team knows how to graph and display measurable progress
	Address errors and quality problems through system redesign	• Base your decisions to target improvement efforts on your data • Routinely share performance data with all staff in the organization
	Integrate performance measurement into existing data collection systems	• Use the existing Clinical Information System and integrate QI measures to collect performance data about cost and outcomes
Provide incentives based on quality of care	Highlight quality champions and make them visible	• Develop an annual quality award program and highlight the winners • Conduct routine storyboard presentations in common hallways for staff and patients to see the progress across the entire hospital • Develop a routine Quality Newsletter and highlight success stories

		• Write up successful improvement stories and highlight the impact on patients' quality of life
	Use performance indicators to reward teams for reaching quality goals	• Clinical teams are rewarded for using registry, holding planned visits and setting goals • Team members are recognized for quality improvement efforts: promotions, public recognition, additional professional opportunities
Develop agreements that facilitate care coordination within and across organizations	Identify key stakeholders that are instrumental to provide high quality HIV care	• Ask providers to identify common medical and non-medical providers that are providing care outside the agency • Conduct a brainstorming session during regular staff meetings with all staff to identify medical and non-medical providers that are providing care outside the agency • Conduct a focus group with patients to identify other medical care and service providers that patient frequent attend • Develop a contact list with detailed information about type of service • Develop how many patients are shared between the HIV agency and each external care/service organization
	Envision an improved health care system	• Develop a shared vision for improving quality across providers • Map the health care system, including key stakeholders and their roles; mapping "who does what" will inform all stakeholders as well as identify holes and duplications in service provision • Develop a work plan for sustaining and spreading work for the provider-based teams • Have provider-based teams regularly present their quality improvement projects to all providers • Identify the major gaps in the health care system using data and epidemiologic information from planning sources • Establish a communication system to convey progress on quality improvement efforts for all stakeholders
	Coordinate care and services within and across agencies	• Use tracking database to identify patients who are using multiple agencies and generate reports to avoid duplication of services, assure ongoing treatment and care • Increase opportunities for primary care providers and case managers to consult on cases • Link care and support services providers to reach out to patients and increase retention • Provide technical assistance to assist with data linking, so that if a client accesses any service, they can be encouraged to get into care • Work with correctional agencies to coordinate patients' continuity of care and to ease transition of patients from prison to parole and immediately into care • Sponsor training/learning Collaboratives that cross the prevention/care cultural divide to improve coordination between these services, especially relating to partner notification and linkage to testing and care • Develop a system for smooth and efficient referrals to specialty care • Coordinate care for complex populations such as the dual or triple diagnosed • Improve level of service based on acuity (better job assessing need), by a joint team (nurse and social worker) acuity determination • Improve linkages between CBOs and health care providers to get people in care/retained in care • Improve/decrease length of time between testing positive and first lab work/medical appointment by using a case manager/peer counselor first response team • Help patients address concrete needs – transportation/child care to facilitate medical appointment-keeping i.e. link service and care programs
	Establish cooperative relationships with other	• Form formal relationships with key stakeholders to achieve a shared compelling vision by aligning and leveraging resources

	organizations, facilities, and providers	• Create agreements to share data and coordinate patient care • Develop written transition plans for care transitions: changes of providers or care facilities • Promote multidisciplinary teamwork in care of patients
	Form Formal Relationships with Key Stakeholders to Achieve a Shared Compelling Vision by Aligning and Leveraging Resources	• Meet with the external care/service organizations • Formalize the relationship by developing a common vision and ask each party to sign the vision statement • Develop and sign a memorandum of understanding (MOU) to outline roles and responsibilities • Invite external agency to attend staff meetings and present their services to staff • Ask external agencies to attend QM committee meetings
	Develop outcome measures across programs	• Plan how to align and link data to programmatic goals and objectives: • Ensure that data systems capture outcome measures • Ensure that outcome data/metrics are consistently collected and validated as close to point of service as possible • Use logic models to select outcomes evaluate successes • Assure that outcome metrics serve multiple purposes (quality improvement, grant reporting and evaluation)

2F) Community Linkages

Mobilize the community to meet needs of patients.

Change Concept	Key Change	Tips & Examples from Literature and Practice
Build healthy public policy	Advocate for policies that support health equity and improved health outcomes for patients with HIV	• Needle exchange • Create out policies for opt out testing
Create supportive environments	Work together at the community level to ensure essential support services are accessible	• Successful program development following a needs assessment process
Strengthen community action	Conduct a quality improvement project to streamline care processes	• Initiate a QI project that will benefit both partnering agencies/practices that overlap through shared populations • Comprise QI team by engaging staff from both agencies • Engage and educate community stakeholders on the work of the quality improvement effort • Raise community awareness about quality efforts; examples might include community focus groups, short surveys or suggestion boxes that outline the areas of focus and welcome ideas from the community • Create community resource lists for use by patients, families, and provider teams

	Promote regional collaboration	• Hold local or regional meetings with stakeholders centered on common cross-cutting issues • Create a workgroup with the participants for QI across programs • Convene a regional meeting/conference for the purpose of identifying gaps in funding and establishing service priorities • Form a regional collaborative and have monthly phone calls to discuss common issues • Convene a representative group of consumers to advise state on alignment of care and support systems • Seek joint funding/programming across agencies
	Develop Resource Management Strategies to Mutually Benefit Programs	• Map community resources and establish linkages between provider based teams and community resources • Seek joint funding/programming across agencies to maximize resources • Combine local/regional buying power of like groups when negotiating prices and other purchases such as laboratory services and testing supplies • Create unit of service reimbursement for all services (including case management) • Negotiate best prices for services with all vendors
	Share key documents across agencies	• Create a portable medical record the patient can use that is Web linked and enables communication across the delivery system • Create a virtual office that communicates to key stakeholders quality improvement efforts and results • Create an web site for storage of common documents, meeting announcement and agendas, useful forms, and shared improvement data • Develop a central registry system tracking key outcomes • Connect case management and referral specialists to the registry in order to track patients across the care system • Standardize information systems for data reporting and sharing of information