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HIV Continuum *of* Care Collaborative

BRITISH COLUMBIA
CENTRE *for* EXCELLENCE
in HIV/AIDS

Preparation Resource Manual 2.0

November 2013

The Preparation Resource Manual contains activities and tips to help your team prepare for successful participation in the HIV Continuum of Care Collaborative.

Welcome to the HIV Continuum of Care Collaborative!

We embrace you as leaders in actively advancing healthcare quality improvement across BC!

If this is your first experience in a Structured Learning Collaborative ('Collaborative'), you are likely to feel confused. If you don't even know what a Collaborative is, no problem. Confusion is normal and this manual attempts to help.

In the pages that follow, you will find a number of activities and tips that will help you and your team prepare for successful participation in the Collaborative. From tips on team formation, planning for quality improvement measurement, and ideas for connecting with senior leaders, you should find a variety of resources that will serve you well along the way. In particular, a check-list of activities will help your team get up and running and supplementary materials shed more light on the varied events, activities, methods, and models that are used in the Collaborative.

If at any time you are stuck with questions or in need of assistance, please connect with me. I can be your first point of contact and am committed to helping your team find value and success in the Collaborative.

All the best in your improvement journey and don't forget that we are here to help!

Best regards,

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Overview

The HIV Continuum of Care Collaborative (the 'Continuum Collaborative') is a 15-month initiative that will bring together quality leaders from across BC to work together to close gaps across the Continuum of HIV Care[1].

The Continuum Collaborative uses *Structured Learning Collaborative (SLC)*[2] methodology, developed by the Institute for Healthcare Improvement (IHI), so that participating teams can easily learn from each other and from recognized experts to close gaps in the Continuum of HIV Care.

As a prospective participant, you can expect to learn about current outcomes for British Columbians living with HIV, quality improvement tools and methods, and ideas for closing gaps in care, service, and outcomes. You will be able plan for improvement, test new ideas to improve care and services, develop networks that will further your aims, measure your progress, and share what you learn.

Collaborative staff will coordinate and facilitate a number of events and activities to keep you connected in learning, sharing, and improving. You will have access to expert advisors, regular coaching, and feedback. Likewise, your team will be encouraged to take purposeful steps to sustain the changes that you test and implement over the course of the Continuum Collaborative.

After 15-months, your team will be invited to join the HIV Quality Improvement Network to sustain and spread your performance gains.

Let's Begin!

This manual focuses on preparing you and your team for participation in the HIV Continuum of Care Collaborative. Below you will find a checklist of activities to prepare for successful participation in the Collaborative and a variety of reference materials that will serve you well in your journey. Let's begin!

[1] The Continuum of HIV Care refers to the comprehensive and connected array of health services spanning all levels of intensity of care within the community and health system.

[2] For more information on *Structured Learning Collaborative* methodology, refer to: Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org).

Preparation Checklist

- ☐ **1. Understand Collaborative models, events, and activities**
- ☐ **2. Create your improvement team**
- ☐ **3. Create a plan for patient engagement**
- ☐ **4. Complete and submit team roster sheet**
- ☐ **5. Develop your team's aim statement**
- ☐ **6. Define your population of focus (POF)**
- ☐ **7. Review measurement expectations**

Note: We have sequenced these tasks in a way we believe to be logical; however, we encourage you to read through the whole manual first and complete the tasks in an order that makes sense to you. You may find you have to jump back and forth on some tasks (e.g., step 5 and 6).

1. Understand Collaborative Models, Events, and Activities

The Continuum Collaborative uses *Structured Learning Collaborative (SLC)* methodology, developed by the Institute for Healthcare Improvement (IHI), so that participating teams can easily learn from each other and from recognized experts to close gaps in the Continuum of HIV Care.

An SLC is defined as a "short term (6- to 15-month) learning system that brings together a large number of teams…to seek improvement in a focused topic area."[3] The learning system includes a number of events, activities, and teaches models that facilitate effective change. Here is a high level overview of the models you will learn about and the events/activities that you will become a part of during the Continuum Collaborative:

Introduction to the Collaborative Models

The Model for Improvement[4]

The Model for Improvement is a simple, well-known model for accelerating change and improvement. As participants in the Continuum Collaborative, you will learn about this model and begin to use it to create improvement in your own settings.

Central to the model are three key questions: (1) *What are we trying to accomplish?* (aim); (2) *How will we know that a change is an improvement?* (measures); and (3) *What changes can we make that will lead to an improvement?* (changes). These questions elicit responses to create aims, measures, and a list of changes. The next step in the model is to take the change and test it on a small scale. The model describes a systematic, iterative approach to: plan the change (plan), carry out the plan (do), observe and reflect on the test (study), and then decide if you would like to implement the change, improve upon it, or abandon it altogether (act). This is the PDSA cycle.

➔ More on the Model for Improvement

The Expanded Chronic Care Model (Expanded CCM)

The province of British Columbia has formally adopted the Expanded CCM to guide improvements in primary healthcare. The model builds on the CCM, an evidence-based model for chronic disease management, to incorporate concepts and strategies from population health promotion.[5]

[3] The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org)
[4] Developed by the Associates in Process Improvement. Description available in: Langley J, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. Jossey-Bass, 2009.

The model lists the essential elements within and across health systems and the community that contribute to better health outcomes for populations. These elements include: self-management / develop personal skills, delivery system design / re-orient health services, decision support, information systems, build healthy public policy, create supportive environments, and strengthen community action.

➔ More on the Expanded Chronic Care Model

Introduction to Collaborative Events, Activities, and Structures

The Continuum Collaborative will host and facilitate a number of key events and activities to support learning, sharing, and networking, contributing to the overall purpose of the Collaborative.

Events include the November 19th 2013 Launch, three Learning Sessions, and the Closing Congress. In between these events are Action Periods, which are supported by a number of activities (monthly teleconferences, monthly reporting, quarterly webinars) and structures (listserv, communication emails, and a resource website www.stophivaids.ca) that enhance learning, sharing, connectivity, and improvement.

* Dates not yet confirmed.

Launch | November 19th 2013

The Launch is a half-day orientation to the 15-month improvement initiative ahead. Teams will be introduced to the Collaborative aims and steps required to begin measurement and readiness for Learning Session One. The Launch is scheduled for November 19th 2013 (8:30am – 12:30pm) and will mark the beginning of the Collaborative's preparation phase.

[5] Barr VJ, Robinson S, Marin-Link B, Underhill L, Dotts A, Ravensdale D, Salivaras S. The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model. Healthcare Quarterly, 7(1) November 2003: 73-82. Available at: http://www.longwoods.com/content/16763.

Preparation Phase | November 19th 2013 to January 2014

The preparation phase is the time when sites formally establish their improvement team, define their aim statement, begin looking for data sources, and understand the events and activities ahead. This manual focuses on preparation.

Learning Sessions | January 29-30; May 28; September 24th 2014 *dates to be confirmed

Learning Sessions are highly interactive meetings that bring together team representatives in plenary sessions, small group discussions, and team meetings to build networks and learn about best practices for improving HIV care, services, and outcomes. There are three Learning Sessions in the Continuum Collaborative.

Action Periods

Action Periods occur between Learning Sessions. During these times, team members have returned to their home settings and work on testing and implementing ideas acquired from Learning Sessions and other learning and sharing activities. Throughout these periods, teams will actively test changes, will report regularly on their progress, participate in webinars and teleconferences, and receive coaching support and feedback.

Collaborative website

The Collaborative website hosts a calendar of events, resource pages, and a discussion forum. Please use this space to find team resources, recordings of webinars, and information on events. The website is available at www.stophivaids.ca. Login information will be provided to you when your contact information is received on the team roster sheet.

Closing Congress | January 28th 2015 *date to be confirmed

The Closing Congress is similar to Learning Sessions though focuses principally on reflection, celebration, and sharing of the work that has been accomplished over the previous 15-month improvement period. The Closing Congress formally marks the end of the 15-month initiative. After this, teams are invited to join the HIV Quality Improvement Network to sustain and spread.

HIV Quality Improvement Network

A Network of approximately 200 HIV quality improvers that includes interested stakeholders of HIV quality improvement and/or members of past HIV Collaborative teams (from the December 2010 STOP HIV/AIDS Structured Learning Collaborative). The Network is a voluntary and less intensive framework to provide ongoing support to connect, sustain, and spread improvements.

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2. Create your improvement team

What should our team look like? Who should be on our team? These are common early questions and exactly the right questions because getting the right team is critical for change and improvement. Team selection is both an art and a science. While we provide some thoughts on both, your expertise of local factors will be critical to building an effective team.

Building the Team

***Think about the purpose**:* The purpose of the HIV Continuum of Care Collaborative is to close gaps across the continuum so that British Columbians living with HIV are supported to achieve the ultimate treatment goal of viral suppression and to build quality improvement capacity to create a legacy of quality improvement.[6]

Consider the following questions when reflecting on prospective members to advance this purpose:

- What is our current population?
- Who does our service reach?
- What gaps persist along the Continuum of HIV Care?
- Who in our organization is currently involved in these processes in the Continuum?
- Who should be involved in these processes to close gaps and ensure excellence (think about both inside and outside your organization)?
- Who might help us with the process of change and improvement?

***Think about prospective members' characteristics**:* Select each prospective member for their process knowledge, enthusiasm for change, ability to influence peers, and ability to work effectively on a team. Good team members are often respected in their peer groups and adept at listening and communicating effectively.

***Think about diversity of membership**:* Team effectiveness literature shows that member diversity can increase creativity and ability to challenge assumptions; however too much can lead to conflict. Consider a balance of professional backgrounds, job functions, ethnicity, gender, perspectives, culture, age, etc.

***Think about team size**:* In general, teams tend to be more effective when they have between three and eight members. Too many members can increase the complexity of relationships and communication while too few can lead to higher workloads and fewer ideas and perspectives.

***Think about key roles**:* To increase team effectiveness, your team should fill the following key roles (note these roles are not mutually exclusive, one member may align with more than one characteristic):

Key Function	Characteristics and Role	Commitment
Senior Leader	The senior leader has authority to allocate team time and resources and should have administrative authority over areas that may be affected by changes. This individual should be a champion and is responsible for spreading changes.	Encouraged to attend all Learning Sessions (Learning Session one and three at a minimum) and attend periodic team meetings.

[6] For greater detail, see the Concept Paper v6.

Team Leader	The team leader provides day-to-day leadership, coordination, and communication between team members, Collaborative staff, and senior leaders. The team leader should be respected, knowledgeable, and enthusiastic about change.	Should attend all Learning Sessions and team meetings.
Senior clinical champion	Look for senior clinical personnel sought out for their advice, work well with others, and who are not afraid to test change.	The senior clinical champion should attend all Learning Sessions and team meetings.
Clinical, technical and/or process expert	Look for those that know the care processes and subject matter intimately. These individuals may include front office, information systems, lab, medical records, nursing, outreach pharmacy, physicians, and/or quality personnel.	Should attend all Learning Sessions and team meetings.
Person or family member living with HIV/AIDS	It is recommended that every team support one to two clients to participate on their improvement team. PLWHA have intimate knowledge of the user's experience and can help the team to surface assumptions, focus on purpose, and identify practical changes for delivering needs based care and services.	PLWHA are encouraged to attend all Learning Sessions and team meetings. The Collaborative has two-$50 honoraria available per team, per Learning Session, for attending PLWHA members.
Quality Improvement Coach	The quality improvement (QI) coach provides change and QI expertise, guidance, and coaching to support team formation, aims definition, measurement for improvement, testing changes, implementing changes, and sustaining performance improvements. The coach should expect to attend regular team meetings in early months with the aim of building team capacity and autonomy in improvement and change.	Should attend all Learning Sessions and, at a minimum, the first four team meetings.

Building the high performing team

To get the best out of your team, use best practices for team development and team process. While it is the team leader that oversees and ensures proper team development and team process, all members should do their part to contribute to an effective team:

1. Ensure all members are valued for their contributions

It is everyone's responsibility to create an open, respectful, and productive team environment where the contributions of all members are heard, respected, and considered. All members should avoid interrupting others and long digressions. Members should also be encouraged to speak freely, ask questions, and explore the contributions of others.

2. Keep language clear and simple

This is an important, though surprisingly challenging, principle to follow. All members should strive to avoid using acronyms and jargon. Everyone can help out with gentle reminders and by asking fellow teammates to explain further when needed.

3. Divide and conquer

Ultimately, the team leader is responsible for coordinating meetings, taking care of administrative details, orchestrating team activities, overseeing outputs, documenting the project, meeting timelines, and acting as a liaison between the team and the organization. However, effective leadership isn't about doing everything; rather it is about drawing on the strengths of all members and sharing the load. All members should make a priority effort to assist when needed and complete tasks in a timely fashion.

4. Adhere to best practices for running effective meetings:

To respect the time of all members and to get the most out of your meetings, we suggest you start and end meetings on time, use and adhere to agenda, take minutes, and rotate the responsibilities for facilitating, agenda setting, and minute taking. Evaluate the effectiveness of each meeting e.g., did everyone feel heard? Did we accomplish our objectives? Etc.

All members should make a priority effort to attend all meetings, be on time, and communicate effectively. The team leader should lead a conversation on member expectations. Members should be involved in the discussion, understand expectations, and agree on remedies for members not meeting expectations.

5. Have patience

New teams experience some hallmark stages of team development on their way to becoming a high-performing team. Members will feel different thoughts and emotions and it will be important for all members to recognize these stages so that they do not detract from the important work of the team. These stages include:

Stage 1 Orientation	Stage 2 Dissatisfaction	Stage 3 Resolution	Stage 4 Production
Eager, high expectations	Discrepancy between hopes and reality	Decreasing dissatisfaction	Excited about participation
Anxiety about fit and expectations	Dissatisfied with dependency on authority	Resolving discrepancies between expectations and reality	Working collaboratively and inter-dependently
Testing situation and figures	Angry about goals, tasks, and action plans	Resolving animosities and polarities	Feeling team strength
Assessing authority and hierarchy	Feeling confused or incompetent	Developing harmony, trust, support, and respect	Showing high confidence in accomplishing tasks
Needing to find a place and establish oneself	Negative about leaders and/or teams	Developing self-esteem and confidence	Sharing leadership
	Competing for power and/or attention	Being more open and giving more feedback	Feeling positive about task successes
		Sharing responsibility and control	Performing at high levels
		Using team language	

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3. Create a plan for patient engagement

Benefits of patient participation

Involvement of persons living with HIV (PLWHIV) in the improvement process has many benefits[7]:

- **Provide perspective.** PLWHIV provide valuable firsthand knowledge about issues that many people and families living with HIV/AIDS face on a daily basis. PLWHIV can add critical perspectives on improvement planning and execution.
- **Reality check.** PLWHIV help keep the team focused and on track by reminding them of key issues facing PLWHIV and their families, and sharing experiences in seeking and obtaining services.
- **Help in needs assessment**. PLWHIV can help ensure that needs assessments consider the needs of PLWHIV from differing populations and geographic locations, including those receiving care and those not in care.
- **Identification of service barriers**. PLWHIV can identify service barriers that may not be evident to others and can help plan to overcome those barriers.
- **Outreach.** PLWHIV can help identify ways to reach PLWHIV communities that have unmet needs for services.
- **Quality.** PLWHIV can give direct feedback on opportunities and imperatives for improving the quality of specific services.
- **Community liaison**. PLWHIV can provide an ongoing communications link with the community. They can bring community issues to the improvement team and care information to the community.

Plan for Engagement

All teams should develop a plan or strategy for patient participation. Effective planning involves determining the appropriate level and duration of engagement for your engagement (see resources below to support you). A helpful framework for your plan is to address the five Ws: **Who, What, Where, When Why, How**?

[7] Benefits adapted from the HRSA's HIV/AIDS Programs: Ryal White HIV/AIDS Program Part A Manual. Section VI. Planning Council Operations: PLWHA/Consumer Participation Available at: http://hab.hrsa.gov/tools2/PartA/index.htm.

How?

Different levels of engagement, different goals in mind

There are many different ways to engage patients and to increase patient participation. Below is a framework that shows how different types of participation serve different functions:

	Inform	Consult	Involve	Collaborative	Empower
Patient Participation goal	Providing patients with balanced and objective information to assist them in understanding problems, changes, and/or solutions.	Seeking patient feedback on analysis, changes, and/or proposed decision.	Working directly with patients throughout the process to ensure that patient-centred issues and concerns are consistently understood and considered.	Partnering with patients in each aspect of decisions including the development of alternatives and the identification of preferred solutions.	Placing final decision-making control in the hands of patients.
Sample tools and methods	Fact sheets Websites Open houses	Public comment Focus groups Surveys Public meetings	PLWHA on team Workshops Deliberate polling	Patient advisory committees Consensus-building Participatory decision-making	Citizen juries Ballots Delegated decisions

Adapted from the International Association for Public Participation's spectrum of engagement framework. More information is available at:
http://www.impactbc.ca/sites/default/files/resource/n354_ipcc_ppe_framework_final.pdf

Return to checklist ⏎

4. Complete and submit the team roster sheet

When you have assembled your team, please complete the following fields and send them to the Collaborative project director. These individuals will be signed up for the listserv (connect with fellow improvers), mailing list (get updates on events and activities), and given a username for the Collaborative website (for resources created during the Collaborative www.stophivaids.ca).

Step 1: Fill out the following table
Step 2: Copy and paste (or recreate fields) in an email with subject: "team roster". Send to cclarke@cfenet.ubc.ca

Team Roster Sheet (Complete and return to cclarke@cfenet.ubc.ca)		
Name of practice(s) or organization(s) on team		
Team name (if different from organization)		
Address		
Phone		
Member name	Team member title	Email
	Sr. Leader	
	Day-to-day leader (key contact for team)	
	Sr. Clinical Champion	
	Person living with HIV/AIDS (PLWHA)	
	Quality improvement coach	
	Clinical/Technical Expert	

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5. Develop your team's aim statement

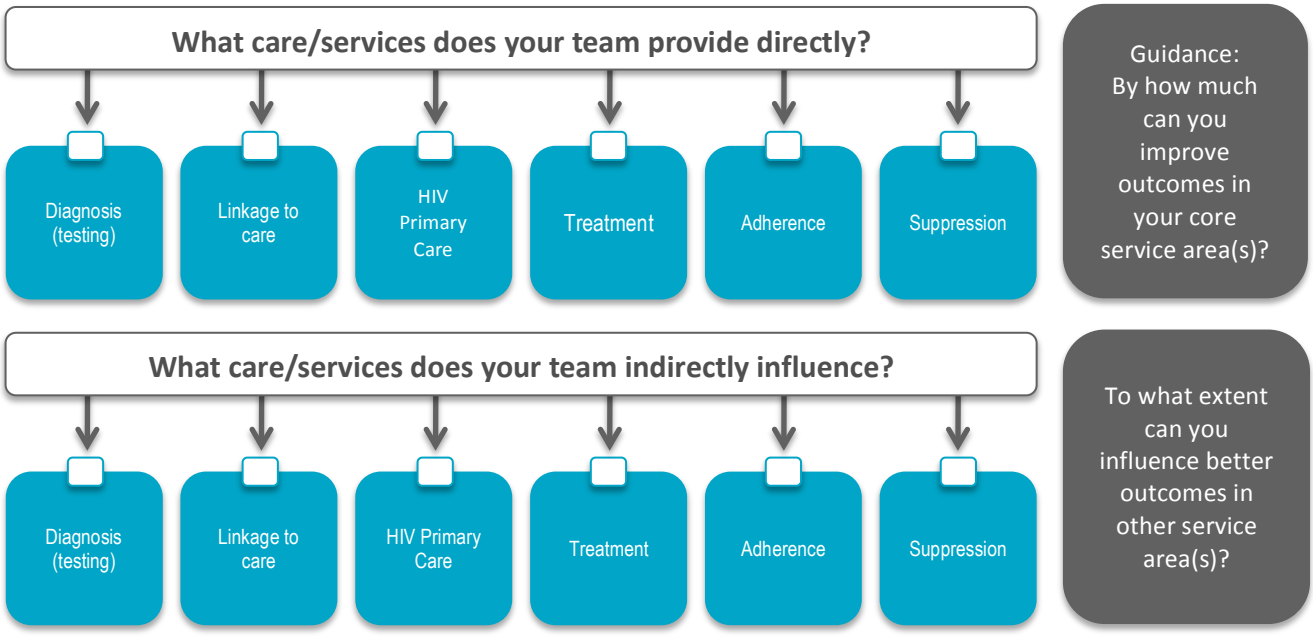
An *aim statement* is your team's most clear statement of purpose. Your team should devote early efforts to crafting an effective aim statement. When defining your aim, consider:

1 Alignment with the purpose of the Continuum Collaborative

Review the purpose of the Collaborative. Align your aim with the purpose to get the most out of participation (copied from the Continuum Collaborative concept paper):

1. Close gaps across the Continuum of HIV Care so that British Columbians living with HIV are supported to achieve the ultimate treatment goal of viral suppression to the benefit of the individual and the community,
2. Build capacity for quality improvement among people living with HIV and diverse patient care and support team members to facilitate measurable improvements and to improve staff/client satisfaction, and
3. Create a lasting legacy of quality improvement that routinely advances health outcomes, continuously meets the needs of people living with HIV, and is supported by sustainable quality improvement teams.

2 The care and services that you can influence and improve



3 Needs within your Population of Focus

Examine population data within your organization. What are the priority gaps that your population faces along the HIV Continuum of Care? Refer to the section on defining population of focus.

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Pro-tips for an effective aim statement

✔ **Involve your senior leaders**

Engage your senior leaders in the process of aim development to align your aim with organizational objectives.

✔ **Be as clear and specific as possible**

Teams will have a clear picture of the changes that need to be made if the aim is unambiguous and clearly stated. Include which changes you think will be most important for your defined POF. Include numerical targets (by how much?) and a timeline for achieving your goals (by when?).

✔ **Include additional guidance**

What is in scope, out of scope? Describe any other partners that you plan to engage (e.g., community support organizations, AIDS Services Organizations, clinics with whom you will liaise, etc.). Include specific strategies that your organization will follow. Include anything that you think is useful for guiding your team and making sure your path is clear.

✔ **Revisit your aim statement often**

Expect your aim statement to change over time, especially as you gather new information and learn more about closing gaps.

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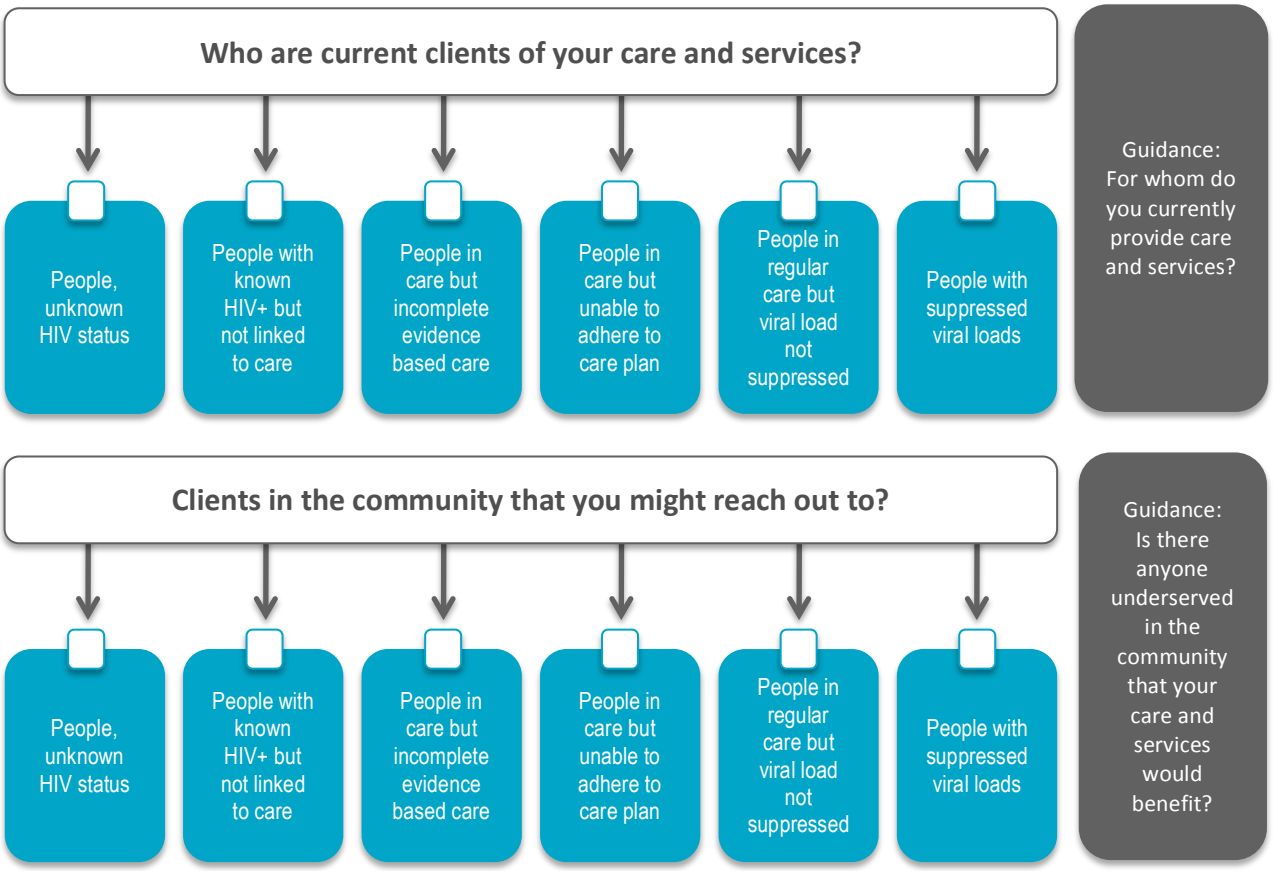
6. Define your population of focus (POF)

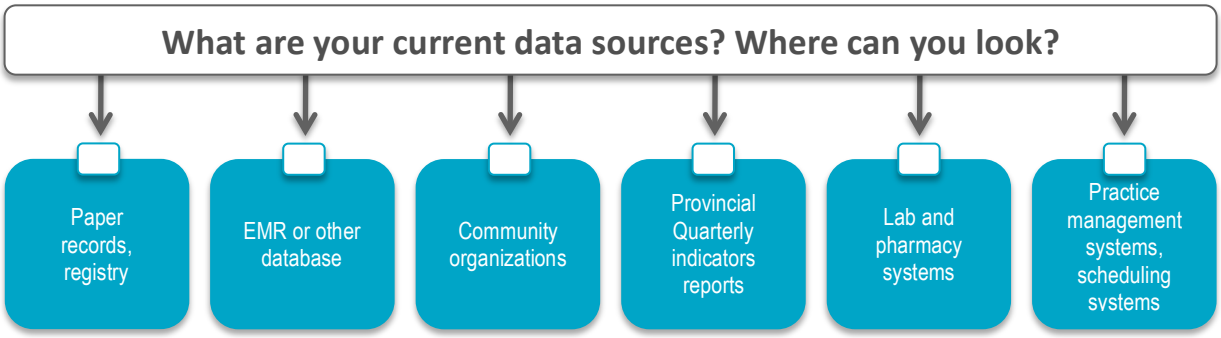
Your POF is the population of clients for whom your team will base what it is that you want to accomplish (aim) and for whom you will measure key quality indicators. To help you get started thinking about your POF, consider your reach:

1 What is the current and possible reach of your care and services?



2 What do you understand about this population?

Where to look? Think about what information or records you currently collect, receive, or have received. Consider:



Other sources? _____

3 Create a list

1. Look at records dating back three years.
2. Review all HIV patients that have been a recipient of your service.
3. Exclude any that have clear documentation of having *Moved or Gone Elsewhere* (MOGE), including:
   - Documentation of transfer of care (e.g., request for records from another primary care provider)
   - Documentation of death
   - Documentation of moved without local forwarding address.

   Special note: you may find that some clients receive service/care from other external clinics/practices. Do not exclude these clients from your POF if there is not clear MOGE documentation. Instead, you may find that these shared care arrangements are prime targets for improvement.
4. You have described your initial POF (this may change).

Example to demonstrate this process:

You work in a clinic that provides HIV primary care. You look into your paper records, dating back three years, and find that 105 individuals have sought care at your clinic over this time. You also find that 30 have transferred care to another provider, 5 have passed away, and there are 8 you're not really sure what happened to.

You determine that your POF is:

> List = 105; MOGE = 30 + 5 = 35
>
> POF is 105 – 25 = 70

The 8 clients you're not sure what happened to remain in your POF.

When you look into care for your POF, you find that:

> 10 clients unsuppressed, 8 not on treatment, and two have poor adherence

You think that these will be prime gaps to improve and they should be reflected in your aim.

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7. Review measurement expectations

Measurement is an investment of time but it is an important and worthy investment. Simply put, we must measure things to know if they are getting better or worse.

Measurement Expectations

After the first Learning Session in January 2014, all teams will be required to regularly collect and report *numerical and qualitative data* for the duration of the 15-month Collaborative. This will include between *four and six numerical quality improvement indicators*. The specific indicators that you will collect and report will depend on your team's improvement focus along the HIV Continuum of Care (see 'Measurement Package' below). The Collaborative Leadership will work with each team to ensure that measurement is meaningful for the services provided and the population served.

From these reports, each team will receive custom coaching, feedback, and encouragement from experts in HIV quality improvement. Teams will also be asked to share their reports with the Collaborative community and experts will use the volume of reports to design relevant learning activities and to connect different teams working on similar issues.

Measurement Package

At the first Learning Session, all teams will receive a ***Measurement Package;*** a document containing specific indicators, definitions, indicator options (where applicable), and other key information for measurement.

For now, you may wish to familiarize yourself with other current approaches to measuring the quality of HIV care, services, and outcomes. For example, the *cascade of care* is a common approach to measure outcomes along the Continuum of HIV Care. Indicators aligned with the cascade are available in the Provincial STOP HIV/AIDS Quarterly Monitoring Reports, which includes a number of population level indicators.[8] Likewise, the STOP HIV/AIDS Structured Learning Collaborative required five standard measures, which may be also useful for some teams (see table below for example):

STOP HIV/AIDS Collaborative Core Measures provided here for example only:

STOP HIV/AIDS Collaborative Indicator	Definition	Target
Engagement in care	The proportion of HIV clients with at least two HIV primary care visits with a primary care team member (60 days apart, or more) in the past 12 months	95%
Plasma viral load testing frequency	The proportion of HIV patients with at least one pVL test in the past 6 months	95%
ART uptake among unequivocally in need	Proportion of HIV clients in the POF known to have had a CD4 cell count <200 cells/mm3on ART and currently on ARTs	95%
ART uptake	Proportion of HIV patients in the POF on ART	95%
Achieving maximal virologic control if prescribed ART	Proportion of HIV clients in the POF achieving virologic control (pVL <200 copies/ml) among those clients on ART for 6 months or more	95%
Patient Experience	Survey instrument	

[8] The Quarterly STOP HIV/AIDS Monitoring Reports are available on line and can be downloaded at http://stophivaids.ca/about-stop-hivaids/updates/.

Some Principles of Measurement for Improvement

- The objective of measurement for improvement is to learn and improve. It is different from other types of measurement (i.e., for the purposes of research or accountability[9]) because measurement for improvement is designed to speed up improvement. Data should be useful, not perfect.
- When it comes to measurement, we don't want to re-invent the wheel. As much as possible, we will suggest relevant indicators that are already well established.
- Improvement indicators are designed to tell you if you are progressing in achieving your aim. For that reason, indicators are designed to align with your aims. For example, if you are seeking improvements in linkage to care, you will measure key processes and outcomes related to linkage.

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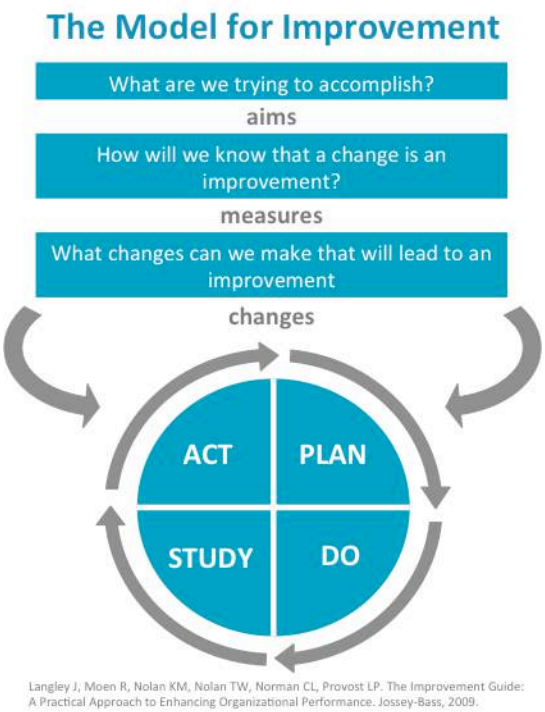
[9] For a more robust discussion on the distinction between measurement for improvement, research, and accountability see Solberg LI, Mosser G, McDonald S. The three faces of performance measurement: improvement, accountability, and research. Jt Comm J Qual Improv. 1997 Mar;23(3):135-47.

Reference 1: The Model for Improvement



The improvement model is based on three fundamental questions:

1. What are we trying to accomplish?

The first question is meant to establish an aim to make explicit what the team is trying to accomplish. The aim should be aligned with the Collaborative.

An effective aim is clear and unambiguous. Try using the mnemonic SMART to create an effective aim: specific, measureable, actionable, realistic, and time-bound). See further direction in section 5, develop your team's aim statement.

2. How will we know that a change is an improvement?

All improvement requires change, but not every change will result in improvement. So, we must measure things to know if they are getting better or worse. When we measure for improvement, we seek useful data not perfect data. In the Collaborative we encourage the use of a standard family of measures. This is so that we can learn together about improvement and so that we don't have to each re-invent quality indicators.

3. What changes can we make that will result in an improvement?

What can you do to achieve your aim? What changes will be needed to your current processes for coordinating and delivering care and services? Changes ideas come from evidence, people living with HIV, other industries, and peers in improvement. The Collaborative will provide a compendium of evidence-based and experience-based ideas for changing care and services along the Continuum of Care.

4. Plan, Do, Study, Act Cycle (PDSA Cycle)

Changes can look pretty shiny on paper; however, sometimes these changes can fail to translate into improvement. Therefore, it is a good strategy to test an idea before committing to it (implementing). The PDSA cycle is a systematic, iterative testing approach. The approach helps teams to plan for the change (what are we going to do, where?), do the change (try it out as you planned it), study the effects of the change (what was observed, anything unexpected?), and then act on what you observed:

- adapt (improvement observed, time to implement), or
- adopt (shows promise but back to drawing board for another PDSA), or
- abandon (just not going to work).

Return ⏎

Reference 2: The Expanded Chronic Care Model (Expanded CCM)

The Chronic Care model (CCM) is an evidence-based model that describes important elements of a healthcare system that contributes to high quality systems that produce better patient outcomes.[10] The Expanded CCM builds on this model, incorporating concepts and strategies from population health promotion.[11]

The province of British Columbia has formally adopted the Expanded CCM to guide improvements in primary healthcare. The model specifically identifies essential elements of a health system and community that contribute to better health outcomes for its population.

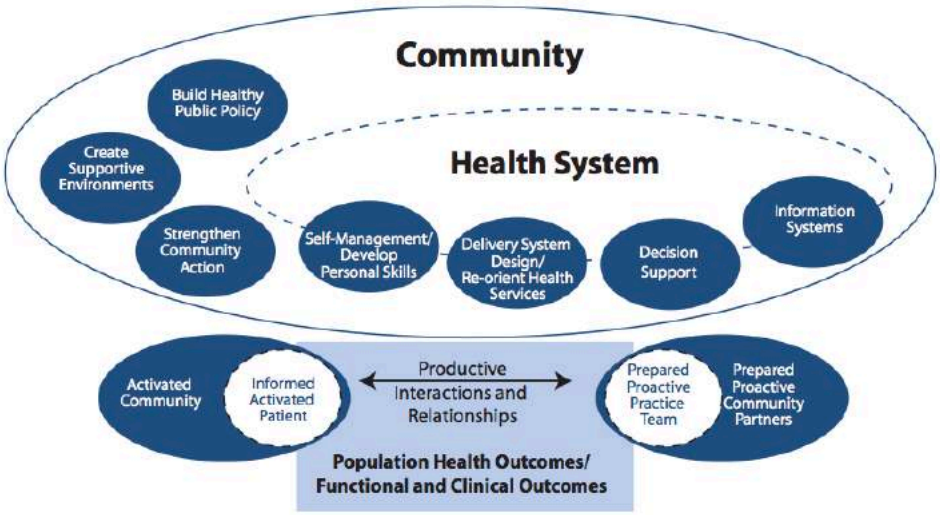
The model is represented in the image below. It shows health systems (individual healthcare organizations) as entities within the community. Both play a role in promoting the flow of ideas, resources, and people. The following are elements of the Expanded CCM:

- Self-management / Develop personal skills: The health system and community supports and coordinates self-management in coping with chronic conditions and supports the development of personal skills for health and wellness.
- Delivery System Design / Re-orient Health Services: The health system and community work to support individuals and communities in holistic ways (e.g., advocacy on behalf of vulnerable populations, emphasis on health, quality of life, and clinical outcomes).
- Decision Support: Integrate evidence-based guidelines for care, treatment, being well, and staying healthy into daily practice (e.g., use flow sheets that synthesize evidence-based treatment guidelines, develop health promotion and prevention best-practice guideline).
- Information Systems: Develop information systems based on patient populations to provide relevant client, community, and contextual data for decision-making.
- Build Healthy Public Policy: Development and implementation policies designed to improve population health to foster greater equity in society and increase the availability of safe and healthy goods, services, and environments.
- Create Supportive Environments: Contribute to strategies that foster conditions for optimal levels of health in social and community environments based on evidence that describes the significant impact of social supports on overall health and quality of life.
- Strengthen Community Action: the health system works with and mobilizes the community to set priorities and achieve goals that improve the health of the community. Public participation is key to removing barriers to health living.

[10] The model is based on the "Chronic Care Model" used by a national program in the United States called Improving Chronic Illness Care (ICIC). This program is based at the McColl Institute for Healthcare Innovation at the Group Health Cooperative of Puget Sound.

[11] Barr VJ, Robinson S, Marin-Link B, Underhill L, Dotts A, Ravensdale D, Salivaras S. The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model. Healthcare Quarterly, 7(1) November 2003: 73-82.

Figure 2. The Expanded Chronic Care Model: Integrating Population Health Promotion



Created by: Victoria Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts & Darlene Ravensdale (2002) Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001). "Does the Chronic Care Model also serve as a template for improving prevention?" *The Milbank Quarterly*, 79(4), and World Health Organization, Health and Welfare Canada and Canadian Public Health Association.(1986). Ottawa Charter of Health Promotion.

Available at: http://www.primaryhealthcarebc.ca/pdf/eccm_article.pdf.

Return ⏎

Glossary of Terms and Concepts

Action Period

Action Periods occur between Learning Sessions. During these times, team members have returned to their home settings and work on testing and implementing ideas acquired from Learning Sessions and other learning and sharing activities. Throughout these periods, teams will actively test changes, will report regularly on their progress, participate in webinars and teleconferences, and receive coaching support and feedback.

Aim or Aim statement

A written statement of purpose that is specific, measurable, actionable, realistic, and time-bound. The aim statement may also include guidance such as a general description of the work, the population of focus, and the numerical goals. At the end of your improvement effort, your aim statement should help you to determine if you have been successful.

Annotated Run Chart

A line chart that shows data plotted over time (i.e., time is the x-axis) with annotations (small notes) that links qualitative descriptions of changes to the times at which they occurred on the plot. This allows the viewer to connect changes made with specific results.

Champion

An individual in the organization who believes strongly in quality improvement and is willing to work with others to test, implement, and spread changes. Teams need at least one clinical champion. Champions in other disciplines who work on the process are important as well. This champion should have a good working relationship with colleagues and with the day-to-day leader(s) described below, and be interested in driving change in the system.

Change Concept

A general idea for changing a process, usually developed by an expert panel based on literature and practical application of evidence. Change concepts are usually at a high level of abstraction, but evoke multiple specific ideas for how to change processes. "Simplify," "reduce handoffs," "consider all parties as part of the same system," are all examples of change concepts.

Change Idea

An actionable, specific idea for changing a process. Change ideas can be tested to determine whether they result in improvements in the local environment (e.g., simplify the process for data entry by having front desk staff enter visit information daily from a duplicate copy while the original is filed in the chart).

Change Package

A compilation of evidence-based and experience-based ideas for changes that are aligned with the aims of the Collaborative.

Closing Congress

The Closing Congress is similar to Learning Sessions, though focuses principally on reflection, celebration, and sharing of the work that has been accomplished over the previous 15-month improvement period. The Closing Congress formally

marks the end of the 15-month initiative. After this, teams are invited to join the HIV Quality Improvement to sustain and spread improvements.

Collaborative (aka Structured Learning Collaborative)

A systematic approach to healthcare quality improvement in which organizations and providers test and measure practice changes, then share their experiences in an effort to accelerate learning and widespread implementation of best practices. "Everyone teaches, everyone learns."

Collaborative Leadership and Faculty

Staff and experts that coordinate the events and activities of the Collaborative and provide teaching and coaching to participating teams.

Collaborative Team (a.k.a. improvement team)

All individuals from the participating organizations that drive and participate in the improvement process. This team coordinates and actively participates in the improvement process and supports representatives to attend the Collaborative Learning Sessions and other learning activities.

Collaborative Director

Person responsible for many of the day-to-day activities of the Collaborative, including meetings, materials, conference calls, website, reports, and information management.

Data Collection Plan

A specific description of the data that the team will collect, the frequency of data collection, data sources from which data artifacts will be obtained, and key roles and responsibilities to oversee data collection, reporting, and analysis. More will be provided in the Measurement Package.

Day-to-Day Leader or Key Contact

This person manages the team, arranges meetings, assures tests are being completed, and data are collected. The day-to-day leader will be the critical driving component of the team. It is important that this person understand not only the details of the system, but also the various effects of making change(s) in the system. This individual also needs to be able to work effectively with all members of the team. The day-to-day leader will be the "key contact" at your organization. This individual should be responsible for coordinating communications between the team, the Sponsorship Team and staff.

Early Adopter

In the improvement process, the opinion leader within the organization who brings in new ideas from the outside, tries them, and uses experiences with positive results to persuade others in the organization to adopt the successful changes.

Early Majority/Late Majority

The individuals in the organization who will adopt a change only after it is tested by an early adopter (early majority) or after the majority of the organization are already using the change (late majority).

Expanded Chronic Care Model

A model that represents the ideal system of healthcare for people with chronic disease and an approach to re-designing healthcare to mirror that ideal system. The model describes a number of key elements of this

system that occur in the health system and the community: self-management / develop personal skills; delivery system design / re-orient health Services; decision support; information systems; build healthy public policy; create supportive environments; and strengthen community action.

Implementation

Implementation is a process in which a change is made a permanent part of the system. During this process, organizations will formally adopt the change, communicate it widely, change job descriptions, codify the change in policy, etc. Changes should only be implemented after they have been successfully tested and there is a high degree of belief that the change will bring about improvement.

Information Systems (IS)

Refers to the information system of an organization, usually the computerized information system. a

Key Contact

The individual on the team who takes responsibility for maintaining communication between the team and the Collaborative staff, including reporting monthly and disseminating information to team members.

Learning Session

Learning Sessions are highly interactive meetings that bring together team representatives in plenary sessions, small group discussions, and team meetings to build networks and learn about best practices for improving HIV care, services, and outcomes. Teams leave these meetings with new knowledge, skills, and materials that prepare them to make immediate changes. There are three Learning Sessions in the Continuum Collaborative.

Listserv

An automatic mailing list. When e-mail is addressed to a LISTSERV mailing list, it is automatically broadcast to everyone on the list. The result is similar to a newsgroup or forum except that the messages are transmitted as e-mail and are therefore available only to individuals on the list.

Measure (a.k.a. quality indicator, improvement measure)

A focused, reportable unit that will help a team monitor progress towards achieving their aim. The Collaborative will describe the measures and strategy for measurement in the Measurement Package.

Measurement Package

A key document that describes the shared measurement system so that all teams can align their efforts in the pursuit of the common Collaborative aim. The document defines measures (or quality indicators) that will be required for each team based, and others that will be optional. Other useful information will be provided for collection and reporting.

Model for Improvement

An approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of proven and effective changes. The model includes the use of “rapid-cycle improvement,” successive cycles of planning, doing, studying, and acting (PDSA cycles).

PDSA Cycle

A systematic and iterative approach to testing out a change, which includes four phases: Plan, Do, Study, and Act. At the end of each cycle, teams will chose to adopt, adapt, or abandon the change.

Population of Focus (POF)

The population of clients for whom your team will base what it is that you want to accomplish (aim) and for whom you will measure key quality indicators.

Preparation

The time between the Launch and the first Learning Session when sites prepare for participation in the Collaborative. During this time, sites will formally establish their improvement team, define their aim statement, begin looking for data sources, and understand the events and activities ahead.

Run Chart

See "annotated run chart."

Senior Leader

The senior staff member or executive in the practice/organization who supports the team and controls all the resources employed in the processes to be changed. The senior leader works to connect the team's aim to the organization's mission, provides resources for the team, and promotes the spread of work of the team to other sites, providers, and conditions.

Spread

The intentional and methodical expansion of the number and type of people, units, or organizations using the improvements. The theory and application comes from the literature on the concept of Diffusion of Innovation.

Team

See 'Collaborative team'.

Technical Expert

The team member in the organization who has a strong understanding of the processes to be improved and changes to be made. A technical expert may also provide expertise in process improvement, data collection and analysis, and team function.

Test

A small-scale trial of a new approach or a new process. A test is designed to learn if the change results in improvement, and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA cycles.

Website

The Collaborative website hosts a calendar of events, resource pages, and a discussion forum. Please use this space to find team resources, recordings of webinars, and information on events. The website is available at www.stophivaids.ca. Login information will be provided to you when your contact information is received on the team roster sheet.