HIV Continuum of Care Collaborative

Executive Summary

Provincial Continuum of HIV Care Collaborative

October 1, 2013

Provincial data tells us nearly half of the estimated 9,100 British Columbians known to be living with HIV in BC are not achieving viral suppression to the benefit of the individual and community. This is one of a number of gaps that occurs along the Continuum of HIV Care. And, while progress has been made in improving care and treatment outcomes, it is clear more needs to be done.

On November 19th 2013, the BC Centre for Excellence in HIV/AIDS (BC-CfE) will launch the HIV Continuum of Care Collaborative (the 'Continuum Collaborative'). This initiative will be aligned with the BC Ministry of Health's strategic framework for an AIDS-free generation and will provide important connections between provincial partners in the pursuit of this common aim.

The BC-CfE aims to partner with all health authorities to support multidisciplinary improvement teams to learn, share, and act together. The purpose of the Continuum Collaborative is to close gaps along the Continuum of HIV Care, build capacity for quality improvement, and create a lasting legacy of quality improvement.

The Continuum Collaborative will occur over 15 months with five virtual learning lessons occurring every four to six months at single sites in each health authority. Teams will be required to participate in improvement activities (meeting, reporting, testing changes) and will be supported by Collaborative staff throughout. At the end of the Collaborative, teams will be supported to sustain their performance improvements in the HIV Quality Improvement Network.

Provincial Continuum of HIV Care Collaborative

Concept Paper
October 1, 2013

Despite considerable progress over many years, British Columbians continue to die needlessly from AIDS every year[1]. Less than half of all people living with HIV in BC are actually realizing the life-saving health benefits that come with regular HIV care and treatment (Figure 1). For some it is because they live unaware of their HIV infection (undiagnosed), for others barriers to life-long engagement in HIV care and treatment remain too high to overcome.

In 2009, the Government of British Columbia sponsored the four-year Seek and Treat for Optimal Prevention (STOP) of HIV/AIDS pilot project to test the concept of Treatment as Prevention. This pilot centered in Vancouver and Prince George with a provincial component also occurring with the STOP HIV/AIDS Structured Learning Collaborative.

Much was learned during the pilot project. In particular, the urgent need to expand efforts to improve health outcomes along the Continuum of HIV Care was recognized. On November 30th 2012, the BC Ministry of Health announced a province-wide expansion of STOP HIV/AIDS with HIV-specific funds available for all Health Service Delivery Areas (HSDA). A strategy framework[2] provides guidance to achieve the ultimate goal of an AIDS-free generation. Importantly, the strategy calls for a provincial response to address gaps along the Continuum of HIV Care.

Current Context

Many gaps exist along the Continuum of HIV Care. Provincial data, using the Cascade of Care as a framework to evaluate outcomes along this Continuum (see Box 1), quantifies these gaps (Figure 1).

Box 1: 'Cascade of Care' or 'Continuum of Care', what's the difference?

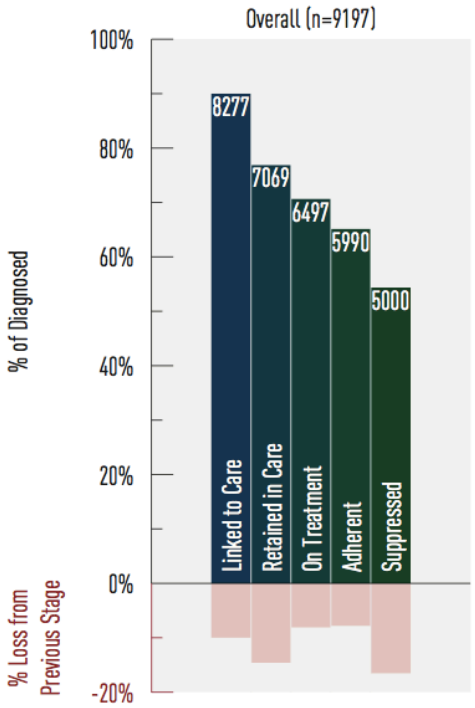
They're really the same thing. In this document we refer to both frameworks. We describe the Continuum of Care (Figure 2) as the main descriptive framework that covers the comprehensive array of care and services including prevention, testing, treatment, and outcomes. By contrast, we invoke the Cascade of Care (Figure 1) to evaluate outcomes along the Continuum of Care.

[1] In 2011, there were 59 HIV-related deaths reported by the Vital Statistics Agency. Data available from http://www.vs.gov.bc.ca/stats/annual/2011/

[2] From Hope to Health: Towards an AIDS-free Generation. Available from: http://www.health.gov.bc.ca/library/publications/year/2012/from-hope-to-health-aids-free.pdf

Gaps widen increasingly as one follows outcomes along the Continuum towards the desired end points of virologic suppression and ultimately best individual and population health. Additionally, these gaps are found to be more significant for specific subpopulations, including women, injection drug users, and Aboriginal persons.

Figure 1: Estimated Cascade of Care for BC Overall[3]



The gaps highlighted across the Continuum of HIV Care persist for many reasons, some of which include stigma, lack of coordination between service providers, systems not adequately designed to meet patient needs, or slow uptake of best-available evidence. The Continuum Collaborative aims to enhance the ability of HIV providers and persons living with HIV to apply quality improvement methods and best-available interventions to close gaps across the Continuum of HIV Care.

[3] HIV Monitoring Quarterly Report for British Columbia, Second Quarter 2013. Available at: http://stophivaids.ca/about-stop-hivaids/updates/

Our Purpose

Towards the vision of an AIDS-free generation in British Columbia and in alignment with the STOP HIV/AIDS provincial initiative (Hope to Health), the BC Centre for Excellence in HIV/AIDS (BC-CfE) is sponsoring the HIV Continuum of Care Structured Learning Collaborative (the 'Continuum Collaborative').

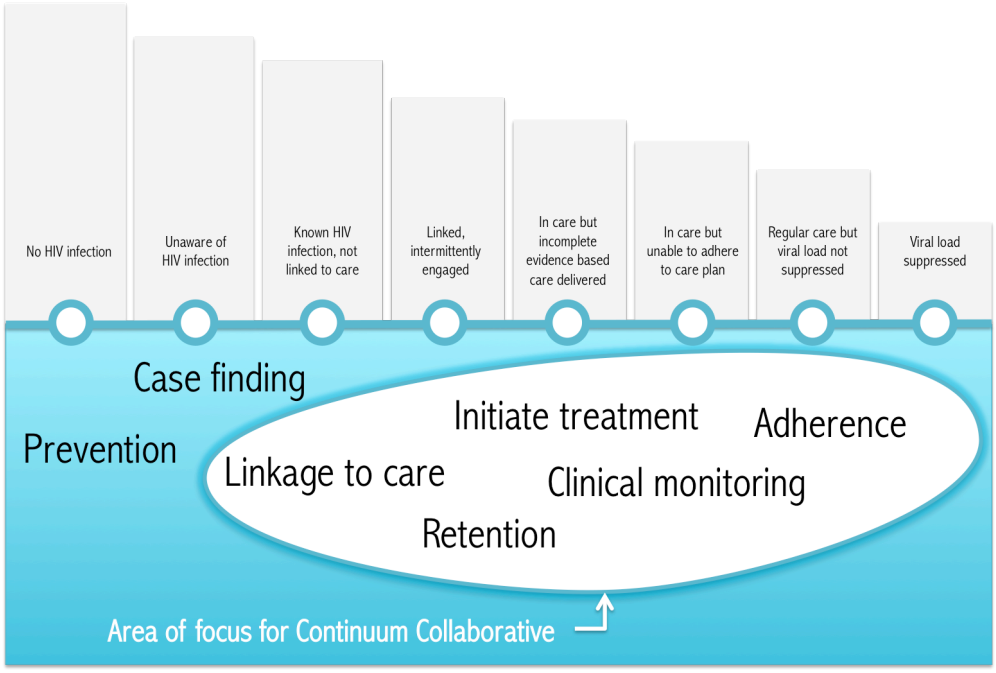
The BC-CfE will partner with all health authorities to support multidisciplinary improvement teams (inclusive of people living with HIV and diverse patient care and support team members):

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 better 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.

Figure 2: Continuum of HIV Care with Collaborative Area of Focus



Measures and targets will be refined after gathering more information from health authorities and prospective teams.

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 load suppression and to reduce HIV transmissions to others, as evidenced by:***

Aim	Benchmark	Reporting
Linkage: Increase the number of HIV-infected individuals linked to HIV care	Improve linkage by 5% (~50); 10% (~95); 25% (~237); 50% (~475); 75% (~712)?	Monthly by teams
Retention: Increase the number of HIV-infected individuals retained in ongoing HIV care	Improve retention by 5% (~160); 10% (~319); 25% (~798); 50% (~1,595); 75% (~2,393)?	Monthly by teams
On ART: Increase the number of HIV-infected individuals on ART	Improve treatment uptake by 5% (~223); 10% (~445); 25% (~1,111); 50% (~2,221); 75% (~3,332)?	Monthly by teams
Adherence: Increase the number of HIV-infected individuals who are ART adherent	Improve adherence by 5% (~244); 10% (~487); 25% (~1,218); 50% (~2,435); 75% (~3,653)?	Monthly by teams
Suppression: Increase the number of HIV-infected individuals who are viral load suppressed	Improve adherence by 5% (~295); 10% (~590); 25% (~1,475); 50% (~2,950); 75% (~4,425)?	Monthly by teams
Patient experience: Increase positive experiences reported by recipients of care	For example, my HIV provider really knows me as a person[4]	Monthly by teams
Care coordination: Increase the effectiveness of handoffs between health care providers		Monthly by teams

[4] Flickinger, TE et al. Higher quality communication and relationships are associated with improved patient engagement in HIV care. *Acquir Immune Defic Syndr*, 2013; 63(3):362-366.

2. ***Build capacity for quality improvement among HIV providers and clients a like to facilitate measurable improvements and to better staff/client satisfaction, as evidenced by:***

Aim	Benchmark	Reporting
HIV providers have the capacity for quality improvement	• 200 HIV providers have increased their quality improvement capacity by successfully attending a quality improvement training session • 80% of all training participants rated the quality improvement training as useful and applicable for their work environments • 80% of all training participants have applied all/parts of the training content in their HIV programs	Quarterly, Collaborative staff
Clients have the capacity for quality improvement	• 50 individuals living with HIV have been trained in quality improvement ('client training') • 80% of all client training participants rated the quality improvement training as informative and practical • 50% of all client training participants are involved in some quality improvement aspects, i.e., member of a QI team	Quarterly, Collaborative staff

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, as evidenced by:***

Aim	Benchmark	Reporting
Regional HIV cascades are routinely available to local HIV providers to identify gaps in HIV care	• 100% of participating sites received a local cascade data to inform them about their regional HIV Care Continuum	Quarterly, Collaborative staff
HIV providers routinely measure key HIV indicators and use the findings to initiate improvement activities	• 90% of participating sites submit their Collaborative indicators every reporting period	Monthly, Collaborative staff
	• 80% of participating sites have improved their performance scores, comparing the baselines data with subsequent data submissions	Annual, Collaborative staff
HIV providers have established quality improvement teams to advance HIV care	• 100% of participating sites have established a written aim statement based on local priorities • 100% of participating sites have established local QI teams to improve prioritized aspects of HIV care	Annual, Collaborative staff

Changes

Two categories of changes provide guidance to participating teams and to Collaborative staff to realize the aims of the Continuum Collaborative:

Category I: Scripted moves

Scripted moves are changes guided by best-available evidence and organized by patient segments. Taken together, these changes can be tested and implemented by teams to close gaps across the Continuum of HIV Care.

Category II: Collaborative activities

Collaborative activities include all activities designed and delivered by the planning group to support teams to carry out improvement. These activities are designed to support teams to apply the scripted moves to close gaps across the Continuum of Care within the context of health authority and guidance . These activities have been shaped by health authority and provincial guidance and drivers (see box 2).

Box 2: Guidance and Organizational Drivers

The following strategic directions from the Ministry of Health and guidance from health authorities will be incorporated into the planning and delivery of the Continuum Collaborative:

All health authorities are accountable for goals laid out in the Hope to Health strategic framework: The Continuum Collaborative endeavors to support health authorities in achieving focused goals laid out in the strategic framework. Focusing on known and newly diagnosed, the Collaborative seeks also to complement concurrent testing initiatives by building system capacity to receive newly diagnosed with high-quality HIV care.

All health authorities are facing travel restrictions outside health authority boundaries: The Continuum Collaborative will support virtual learning sessions aiming to foster provincial collaboration, learning, and sharing.

A number of activities are already underway related to monitoring and evaluating: The Collaborative endeavors to integrate available indicators and data definitions (e.g., from provincial HIV monitoring and evaluating committee) to the fullest extent possible to ensure alignment and avoid duplication of efforts.

I. Scripted Moves

These are ideas and strategies to improve care in each of the key segments addressed in the HIV Continuum of Care Collaborative. These ideas are intended to be adapted to different contexts and should serve as a springboard for other ideas to improve care across the Continuum.

Known HIV infection, not linked to care	**Linked, intermittently engaged**	**In care but incomplete evidence based care delivered**	**In care but unable to adhere to care plan**	**Regular care but viral load not suppressed**	**Viral load suppressed**
Patient-centric support at diagnosis	Importance of the first care encounter	Decision support tools for practice teams	Registry tracking and proactive planned care	Adherence support	Ongoing monitoring of important care milestones
Ready access: every door is the right door	Respect for patient priorities	Educational support for care teams	Case managers	Protocol for assessing resistance and changing ART regimens	Ongoing support for continued engagement in care
Outreach and accompaniment	Pacing – respect where people are and what they can do	Protocols and standardization of key care guidelines	Linkages to/coordination with addiction services, mental health agencies	Behavioral health consultation	Anticipate challenges and provide additional support as needed
Strong patient engagement skills practiced	Establishment of trusting relationships embedded in care	Telehealth	Linkages to/coordination with community support agencies	Peer support	Bolster support networks to meet whole-person needs of individuals
Opportunities and support for trusting relationships	Quality information	Planned care with registry support	Detailed care plan shared by all delivering care, supporting care and patient	Multidisciplinary case conferences	
Standardized processes for linkage that incorporate options for patients	Linkages to community supports as appropriate	Dedicated processes for special needs populations: substance abusers, mentally ill, migration, transient, homeless, corrections, limited capacity to comprehend disease and treatment	Work with community agencies to address social determinants	Pharmacy support for medication evaluation	
	Cultural safety	Outreach for care gaps	Multidisciplinary case conferences	Decision support for non-responders	
	Confidentiality – systems to protect especially in small or rural communities	Case management for selected populations	Pharmacy support: side effect mitigation, adherence tips, drug interactions	Telehealth and expert consultation	
	Ready access to support and information, including after hours	Self-management support: health literacy, adherence, action planning, support for behavioral change	Respect for patient preferences, shared decision making for treatment options	Respect for patient preferences, shared decision making for treatment options	
		Assess and eliminate policy barriers	Check-in after ART start to assess side effects and problem solve		
		Offer additional information, apps, et al. to increase patient's ability to engage in care	Engage family and other caregivers as patient deems appropriate		

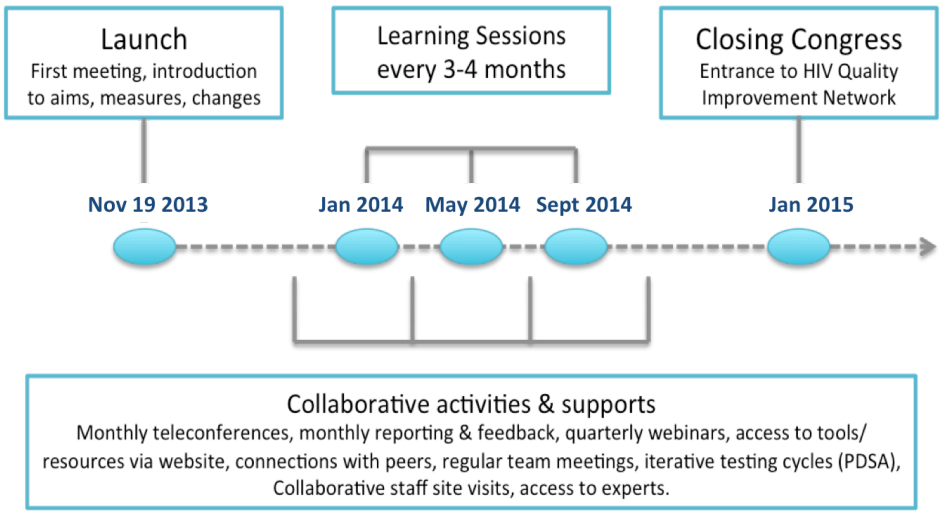
II. Collaborative activities

The Continuum Collaborative will follow the Institute for Healthcare Improvement's (IHI) Breakthrough Series Collaborative methodology to close gaps along the Continuum of HIV Care.

All health authorities are invited to participate and are encouraged to partner locally with internal and external partners to achieve the aims of the Continuum Collaborative. Local or regional level teams will be invited to participate through their health authorities.

The Continuum Collaborative will be a 15-month initiative launching on November 19th 2013 for 15 months, with virtual learning sessions occurring every four to six months and with regular webinars. This will begin a period of planning and organization (Figure 3). The Collaborative will hold its first learning session in January.

Figure 3: Prospective Collaborative Events and Activities



When all participating sites/teams are identified by health authorities, each team will be asked to complete several activities in anticipation of a successful launch:

- Form an improvement team with guidance provided in the preparation manual
- Begin collecting data for key indicators described in the measurement package
- Draft a charter or aim to articulate individualized goals in alignment with overall aims
- Submit a team roster including with member names and contact information
- Schedule a first team meeting to discuss team formation, data, and meeting times

During the Collaborative, all teams will take part in virtual Learning Sessions every four to six months and maintain continual contact with each other and planning group members. Over time, a community of learning will develop in which teams will collaborate to share good ideas and best practices, as well as raise issues and lessons learned.

Finally, the HIV Continuum Collaborative will share findings and achievements with other regions, provinces and stakeholders to facilitate widespread national improvement efforts.

Expectations

To ensure immediate initiation and active participation in Collaborative activities, the following expectations are outlined for participating:

Health authorities:

- Establish local or regional quality improvement teams
- Understand each team's contribution along the Continuum of HIV Care and review regional Cascade of HIV Care data quarterly
- Support each team to dedicate time to quality improvement activities including attending virtual learning sessions, monthly quality meetings, data tracking and reporting, testing and implementing changes, etc.
- Provide liaison support for coordinating virtual learning sessions with Collaborative staff including room booking, technical support, and facilitation support at learning sessions

Participating teams:

- Create a quality improvement team that meets regularly to plan and discuss quality improvement activities including team formation, measurement, reporting, testing changes, implementing changes, etc.
- Understand your team's contributions to the Continuum of HIV Care and develop data systems to understand your current performance in areas within which your team contributes
- Develop an aim statement aligned with the Collaborative aims and program specific goals
- Initiate quality improvement change cycles focusing on relevant aspects of the Continuum of HIV Care
- Report monthly on Collaborative measures relevant to program and goals
- Report a monthly narrative describing quality improvement activities
- Develop a plan for patient involvement and/or include at least one patient on your quality improvement team
- Have at least three team representatives attend virtual learning sessions
- Have at least one team representative attend improvement activities between learning sessions including monthly teleconferences and quarterly webinars

Collaborative staff:

- Facilitate and produce monthly teleconferences, quarterly webinars, and other learning activities to facilitate team success
- Respond to monthly data and narrative reports with guidance and feedback
- Provide a dedicated website to post information pertinent to the Collaborative and to disseminate Collaborative findings and news
- Facilitate and coordinate all virtual learning sessions using existing Health Authority or UBC videoconferencing infrastructure
- Provide quality improvement training for all participants including HIV providers and clients