Toolkit for the end+disparities ECHO Collaborative

Your Guide for Participation in the National Quality Improvement Collaborative to Eliminate Disparities in HIV Care

New York State Department of Health AIDS Institute
For Health Resources and Services Administration HIV/AIDS Bureau

HRSA Ryan White HIV/AIDS Program
CENTER FOR QUALITY IMPROVEMENT & INNOVATION

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Toolkit for the
end+disparities ECHO Collaborative

Developed by the
HRSA Ryan White HIV/AIDS Program
Center for Quality Improvement & Innovation

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"*Of all the forms of inequality, injustice in health care is the most shocking and inhumane.*"
Martin Luther King

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I) Collaborative Overview

Executive Summary

The end+disparities ECHO Collaborative, a national quality improvement initiative with participation by Ryan White HIV/AIDS Program (RWHAP) recipients and subrecipients across all RWHAP-funded Parts, focused on reducing disparities by increasing viral suppression rates in four disproportionately affected subpopulations of people with HIV (PLWH): MSM of Color, Black/African American and Latina Women, Transgender People, and Youth. The Collaborative continued the work of the end+disparities Learning Exchange, which was previously managed by the National Quality Center (NQC) and engaged RWHAP recipients from October 2016 through June 2017.

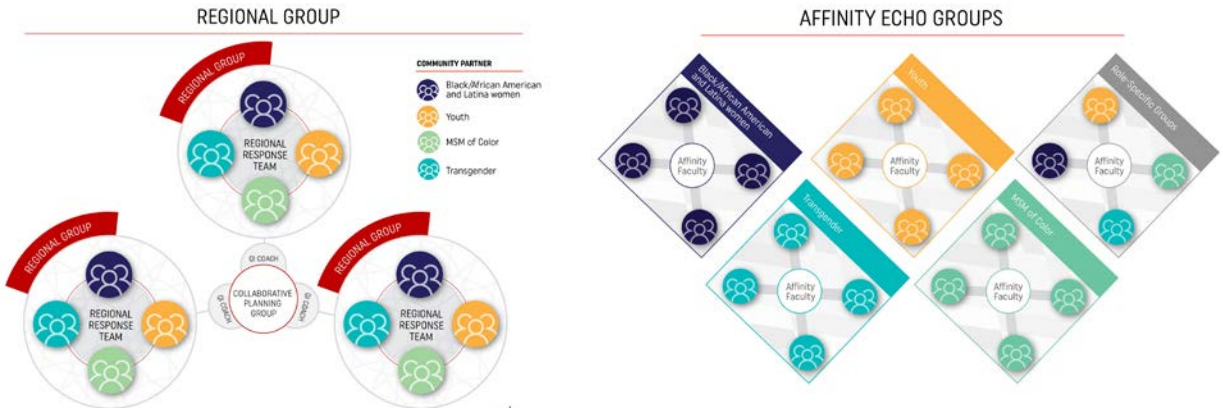
The 18-month long end+disparities ECHO Collaborative, which was managed by the HRSA Ryan White HIV/AIDS Program Center for Quality Improvement & Innovation (CQII), formally known as the National Quality Center (NQC), in partnership with the HRSA HIV/AIDS Bureau (HAB), aimed to decrease the number of people with HIV who were not virally suppressed by 25% by engaging one in three RWHAP recipients across the nation. The underlying framework for this community of practice combined the Institute of Healthcare Improvement (IHI) Breakthrough Series model with elements of virtual case presentations and discussions developed by the Project Extension for Community Health Outcomes (ECHO) at the University of New Mexico, and experiences from past NQC HIV collaboratives.

Mission of the end+disparities ECHO Collaborative

"To promote the application of quality improvement interventions to measurably increase viral suppression rates for four disproportionately affected subpopulations of people with HIV among Ryan White HIV/AIDS Program-funded providers."

RWHAP recipients and subrecipients were encouraged to partner with local HIV providers to form regionally-based improvement groups (**Regional Groups**) and to enroll in the Collaborative. The goal of each Regional Group, which was composed of local HIV providers across all funding RWHAP sources, was to improve the underlying systems of care, monitor viral suppression performance rates, advance regional alignment and communication, and create a sustainable

infrastructure to last well after the formal conclusion of this initiative. In addition, each agency participating in the Collaborative (**Community Partner**) was asked to focus their improvement efforts on one subpopulation (MSM of Color, Black/African American and Latina Women, Transgender People, or Youth) to address viral suppression rate disparities. To facilitate peer learning and exchange, all Community Partners, regardless of their Regional Group affiliation, joined special interest groups (**Affinity ECHO Groups**). Affinity ECHO Groups were based on shared interests, such as selected subpopulations, and helped participants gain improvement insights through content expert perspectives and Community Partner Case Presentations. The ECHO model™, which utilizes virtual case-based communities of practice leveraging video conferencing technology, enables participants to create a vibrant community of learning by eliminating potential in-person meeting barriers.[1]



The first in-person Learning Session (June 2018) brought five members from each participating Regional Group to kick off the national initiative. Three additional virtual Learning Sessions were held at five-month intervals. Regional Group meetings and Affinity ECHO Sessions were interspersed between Learning Sessions. The fourth and final Learning Session took place in-person in September 2019, three months before the end of the Collaborative (December 2019) to celebrate the work completed during this initiative, disseminate best practices, and discuss how best to sustain the communities of practice moving forward. This final Learning Session integrated a virtual audience with the in-person attendees via the Zoom platform. Key activities for participants in this Collaborative included: Pre-Work Activities, Learning Sessions, Regional Group Meetings, Affinity ECHO Sessions, and Data Submissions.

Learn More

One-Page Flyer
Disparities Video
HRSA HIVHAB Invitation Letter/AIDS Bureau Invitation Letter
Kick-Off Sessions Materials
Pre-Work Webinars

[1] Building virtual communities of practice for health. Struminger, Bruce et al. The Lancet, Volume 390, Issue 10095, 632 – 634.

Case for Targeting HIV Disparities to End the Epidemic

Approximately 49.8% of the estimated 1.1 million people with HIV in the United States are not virally suppressed.[2] The statistics of those who make up most of the virally unsuppressed population paint a striking picture of disparities in HIV care, with specific populations – MSM of Color, Black/African American and Latina Women, Youth, and Transgender People – bearing a disproportionate burden of HIV. At 16%, the rate of viral suppression among African American men who have sex with men (MSM) is less than half the rate of viral suppression among White MSM (34%).[3] Among women who are diagnosed with HIV and are within the heterosexual contact transmission risk category, 12.3% of African American women have not achieved viral suppression, compared to 8.2% of Latina women, and 6.8% of White women.[4] A study published in 2013 showed that while the average viral suppression rate for all PLWH is 25%, only 15% of youth are virally suppressed.[5] Although MSM and transgender women have similar CD4 counts at diagnosis, transgender women were found to have delayed linkage to care and lower viral suppression rates than MSM.[6] Data from 2016 indicate that viral suppression in male to female transgender RWHAP clients who have had at least one outpatient ambulatory medical care visit during the calendar year and whose most recent viral load test was <200 copies/mL, the rate of viral suppression is 79%, lower than the rate of 85% among cisgender men, and 84% among women.[7]

The Centers for Disease Control and Prevention (CDC) defines disparities as "differences in health outcomes or health determinants observed between populations."[8] A health disparity population is commonly defined as one in which there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population compared to the health status of the general population. Informant interviews conducted to plan the end+disparities Learning Exchange identified four subpopulations to focus improvement efforts on: MSM of Color, Black/African American and Latina Women, Youth (ages 13-24), and Transgender People.[9] Many of the interviewees recognized that these are not the only disparities that exist in HIV care, but the selection of these groups was seen as a stepping stone to move forward the national dialogue.

The end+disparities ECHO Collaborative focused on these four subpopulations (MSM of Color, Black/African American and Latina Women, Youth (ages 13-24), and Transgender People) because of the extensive literature demonstrating persistent disparities between these subpopulations and the general population, and to align with national HIV public health priorities.

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[2] Zihao, Li, Purcell, D., Sansom, S., Hayes, D., Hall, I. Bradley H, Hall I. Vital signs: HIV Transmission Along the Continuum of Care — United States, 2016. *MMWR*. 2019; 68(11): 267-272.
[3] Rosenberg ES, Millett GA, Sullivan PS, del Rio C, and Curran JW. Understanding the HIV disparities between Black and White men who have sex with men in the USA using the HIV Care Continuum: a modelling study. *Lancet HIV*. 2014;1(3): e112-e118.
[4] Nicole Crepaz, Tian Tang, Viral-load Dynamics Among Persons with Diagnosed HIV—United States, 2014. *Conference on Retroviruses and Opportunistic Infections, Abstract Book*. (2017) www.croiconference.org/sites/default/files/uploads/croi2017-abstract-eBook.pdf
[5] Hall HI, Frazier EL, Rhodes P, Holtgrave DR, Tang T, Gary KM, et al. Differences in human immunodeficiency virus care and treatment among subpopulations in the United States. *JAMA Intern Med*. 2013;173(14):1337-44.
[6] Wiewel EW, Torian LV, Merchant P, Braunstein SL, and Shepard CW. HIV diagnoses and care among transgender persons and comparison with men who have sex with men: New York City, 2006–2011. *Am J Public Health*. 2016;106(3):497-502.
[7] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2016. http://hab.hrsa.gov/data/data-reports. Published November 2017. Accessed Jan 19 2018.
[8] Johnson AS, Beer L, Sionean C, Hu X, Furlow-Parmley C, Le B, et al. CDC health disparities and inequalities report: HIV infection—United States, 2008 and 2010. *MMWR*. 2013;62(3);112-119.
[9] NQC Concept Paper—Developing a Quality Improvement Initiative to End Disparities in HIV Care.

A Literature Review was conducted to make a further case for addressing HIV disparities through this national improvement initiative and a corresponding presentation slide set was developed. These resources are available for participants.

To further inform the development of the end+disparities ECHO Collaborative, CQII solicited input in numerous ways from the RWHAP community, including a national online survey, informant interviews, and focus groups. Participants expressed strong support for a national HIV quality improvement initiative on addressing HIV disparities and provided invaluable insight into how to meet the needs of busy HIV providers throughout the country. Key findings from the 2017 online needs assessment (n=259 individual responses) indicated that approximately 9 out of every 10 survey respondents said they were likely or very likely to participate in this new initiative. The interest in each of the four identified subpopulations was spread relatively evenly; roughly 50% of respondents indicated that they were "Very likely" to choose MSM of Color, Black/African American and Latina Women, or Youth, while 35% responded that they were "Very Likely" to choose Transgender People.

Learn More | Literature Review

Overall Collaborative Goals

The overarching mission of the end+disparities ECHO Collaborative was to "*promote the application of quality improvement interventions to measurably increase viral suppression rates for four disproportionately affected subpopulations of people with HIV among Ryan White HIV/AIDS Program-funded providers.*" The outcome goals of this national initiative were categorized into three different areas: reach, impact, and sustainability.

Goals of the end+disparities ECHO Collaborative
Reach: • One in three Ryan White HIV/AIDS Program (RWHAP) funded-recipients across the United States actively participate in the end+disparities ECHO Collaborative • 30% of all people with HIV cared for by communities served by the Ryan White HIV/AIDS Program are affected by participants of this Collaborative
Impact: • Decrease the number of people with HIV who are not virally suppressed by 25% from baseline reports at the onset of the Collaborative • Over 5,000 additional people with HIV are virally suppressed by the end of the end+disparities ECHO Collaborative
Sustainability: • 90% of regional improvement groups of Ryan White HIV/AIDS Program-funded recipients and subrecipients (Regional Groups) established at the beginning remain active six months after the formal end of the Collaborative (June 2020) • 90% of active Collaborative participants have conducted, documented, and sustained their quality improvement efforts using the knowledge gained in the Collaborative

CQII has partnered with an external evaluator, Abt Associates, to conduct an impact evaluation of CQII and the end+disparities ECHO Collaborative. A quasi-experimental design was employed to see whether the Collaborative achieved the key outcomes of RWHAP services, which include increased viral suppression rates. A written report will be issued to the HIV/AIDS Bureau by June 2020.

An Intermediate Implementation Evaluation was conducted by the Center for Human Services Research at the University at Albany, State University of New York with findings presented on August 30, 2019. The overall purpose of this evaluation was to explore short-term and intermediate outcomes that underlie the end+disparities ECHO Collaborative's theory of change to achieve long-term goals, particularly in terms of participant engagement, activity implementation, and initial progress.

All data related to participation of Community Partners in various Collaborative activities were tracked by CQII and routinely updated, which included participation in Affinity Group Sessions, Case Presentations, data submissions, active Glasscubes use, Regional Group affiliation, etc. These data were openly shared with Regional Group members and forwarded to the CQII evaluator for inclusion in the evaluation efforts.

See Section VIII) Final Results of Collaborative Outcomes for further details about the reach and impact of the end+disparities ECHO Collaborative.

Benefits of Participation

Agencies participating in the Collaborative were referred to as **Community Partners** within this Collaborative framework. These Community Partners benefited from active engagement in this national improvement initiative, as evidenced by:

- Improved viral suppression rates for the entire HIV patient caseload and for the identified disparity subpopulation
- Strengthened clinical quality management (CQM) programs to meet RWHAP CQM expectations
- Strengthened regional partnerships with and harmonization of improvement efforts across local RWHAP recipients and subrecipients across all local RWHAP funding sources
- Increased capacity to detect disparate HIV-related health outcomes for HIV subpopulations using the provided Disparity Calculator
- Increased performance measurement capacity to routinely track agency-specific viral suppression data for strategic planning and quality improvement processes
- Increased performance measurement capacity by routine access to national HIV disparity benchmarking reports that were shared with Collaborative participants
- Increased quality improvement capacity of HIV providers and consumers who have participated in regional quality improvement training opportunities
- Professional quality improvement growth as leaders of Regional Groups and recognition as local quality improvement champions
- Routine access to feedback by nationally recognized quality and content experts and fellow Collaborative participants to advance local improvement efforts

- Opportunities for networking and peer exchanges with fellow Collaborative participants who share similar improvement challenges
- Establishment and continuity of sustainable regional improvement groups of RWHAP recipients and subrecipients beyond the formal Collaborative cycle by implementing formal sustainability strategies
- Routine access to monthly Collaborative announcement letter, which provided data reports, trend analysis, Affinity Session agendas, and special announcements

The investment of time in this Collaborative yielded benefit for patients served by participating agencies and helped participants in aligning with external HIV/AIDS Bureau clinical quality management (CQM) requirements.

Key Definitions

Community Partner	Learning Session
Individual RWHAP recipients or subrecipients participating in the Collaborative; Community Partners included RWHAP-funded agencies that provided direct clinical care or support services, or were regional HIV stakeholders in the Collaborative	In-person or virtual meetings that brought Community Partners together with HIV/AIDS Bureau and CQII representatives, Regional Groups, QI Coaches, and Planning Group members, and other representatives to develop improvement efforts and promote peer exchanges
Regional Group	**Regional Response Team**
Regionally-based improvement group composed of HIV providers (Community Partners) in a respective catchment area (i.e., state, regions within a state, or cross-state areas) who participate in the Collaborative	Community Partners form this group of local quality leaders representing the Regional Group; the Regional Response Teams assume key roles and responsibilities of the Regional Group and include at least one consumer liaison in each team
Affinity ECHO Group	**Affinity ECHO Session**
Special interest groups formed with Community Partners (collaborative participants) regardless of their Regional Group who target the same subpopulation of focus (e.g., MSM of Color), assume similar roles on the Regional Response Team (e.g., Team Leader), or at the community level (e.g., consumer liaisons)	Virtual Affinity ECHO Group meetings focused on one of the disparity subpopulations; these sessions follow the ECHO model™ and include brief didactic presentations by content experts, case presentations by fellow participants (Community Partners), and opportunities for peer sharing and learning
Regional Group QI Coach	**Pre-Work Assignments**
Quality Improvement (QI) expert contracted by CQII to support assigned Regional Groups and Regional Response Teams	Assignments between the enrollment phase and the start of the Collaborative designed to prepare participants for the first Learning Session; these include: familiarization with Collaborative tools, selection of individual subpopulations, identification of Regional Response Team members and roles, drafting of regional aim statement, etc.

Learn More | Key Terminologies and Definitions One-Page Flyer

Key Collaborative Phases and Milestones

The end+disparities ECHO Collaborative was divided into four phases, each with a corresponding set of milestones, pictured below. Aside from the Vanguard Meeting, a planning meeting prior to the official beginning of the Collaborative, all other milestones required active participant involvement.

Key Collaborative Phases			
Enrollment Phase: March-April 2018	**Pre-Work Phase:** May-June 2018	**Collaborative Phase:** Jul 2018 - Sep 2019	**Sustainability Phase:** Sep 2019 - Jun 2020
• HRSA/CQII Announcements • Kick-off Sessions • Group Enrollment • Individual Registration	• Initial Regional Group Meetings • Selection of Regional Response Team Members • Drafting of Regional Group Aim Statements • Learning Session 1	• Affinity ECHO Sessions • Viral Suppression Data Submissions • QI Intervention Submissions • Learning Sessions 2-4 • Sustainability Planning	• Viral Suppression Data Submissions • Regional Group Support • Affinity Session Support • Leadership Program • Continued Support for Virtual Technologies

The following table summarizes key milestones for the Collaborative; see the Collaborative Milestone Document for further details:

Key Collaborative Milestones	
Learning Sessions	Regional Group Meetings
2018: June, Nov 2019: Apr, Sep	Starting May 2018
Affinity ECHO Sessions	Viral Suppression Submission Deadlines
2018: Jul, Aug, Sep, Oct, Dec 2019: Jan, Feb, Mar, May, Jun, Jul, Aug, Oct, Nov, Dec	2018: Jul, Sep, Nov 2019: Jan, Mar, May, Jul, Sep, Nov
QI Intervention Submission Deadlines	
2018: Sep, Dec 2019: Mar, Jun, Sep	

Learn More | Making a Mark: Demonstrating Health Impacts H4C Collaborative Report

Overall Expectations for Participation

The following expectations for Collaborative participants were to foster a community of learners, as well as to maximize the Collaborative output to achieve its set of agreed-upon improvement aims. The expectations were organized by the various phases of the Collaborative and by the individual agencies participating in the Collaborative (Community Partners) alongside expectations for regional improvement groups (Regional Group). Further details were provided throughout the document and a checklist of next steps was provided via the Collaborative announcements to all participants; see an example for the months of July and August 2018 through this link.

Community Partner Expectations:

1. Enrollment Phase (~2-3 hours)
    - Participate in the Kick-off Sessions or familiarize yourself with the Kick-off Session slides to introduce participants to the Collaborative
    - Find other local interested RWHAP-funded recipients and subrecipients to form a Regional Group and jointly complete the online Group Enrollment form
    - Register regional agencies of your Regional Group as Community Partners through completing the online Individual Registration forms
2. Pre-Work Phase (~2-3 hours)
    - Gain understanding of the expectations, resources, and meeting structures of the Collaborative
    - Complete Pre-Work Activities
        - Participate in Pre-Work Webinars
        - Identify your subpopulation of focus (MSM of Color, Black/African American and Latina Women, Transgender People, or Youth)
        - Develop an agency-specific Aim Statement
        - Meet with other Community Partners in your Regional Group
3. Collaborative Phase (~6-10 hours monthly)
    - Conduct your quality improvement interventions to reduce disparities for the identified subpopulation
    - Participate in your subpopulation-specific Affinity ECHO Sessions twice a month
    - Present at least one Case Presentation during your Affinity ECHO Sessions and a report-back presentation using provided templates
    - Participate in the routine Regional Group meetings
    - Submit Viral Suppression Data every two months via the online end+disparities Database
    - Submit QI Intervention updates quarterly using a provided template
    - Participate in Learning Sessions every five months
4. Sustainability Phase (6-10 hours monthly)
    - Continue your quality improvement interventions to reduce disparities for the identified subpopulation
    - Incorporate improvements into policies and procedures to sustain the gains achieved by Collaborative participants
    - Participate in Affinity ECHO Sessions of your choosing
    - Participate in the routine Regional Group meetings

Regional Group Expectations:

1. Enrollment Phase (~2-4 hours)
    - Complete the Group Enrollment process and engage other regional Community Partners
    - Coordinate first Regional Group meeting
2. Pre-Work Phase (~2-4 hours)
    - Hold the first Regional Group meeting with support by the assigned Regional Group QI Coach
    - Identify Regional Response Team members
    - Draft a Regional Group Aim Statement
    - Determine who from the Regional Group attend Learning Session 1
3. Collaborative Phase (~1-2 hour monthly)
    - Conduct monthly Regional Group meetings
    - Review viral suppression data submissions by regional Community Partners every two months
    - Review QI Intervention submissions by regional Community Partners quarterly
    - Provide follow-up to Case Presentations by regional Community Partners during Affinity ECHO Sessions

- Provide support to other Regional Group members

4. Sustainability Phase (1-2 hours per month)
   - Conduct monthly Regional Group meetings
   - Review QI Intervention submissions by regional Community Partners quarterly
   - Provide support to other Regional Group members
   - Continue to collect and analyze viral suppression data in your region

Regional Response Team Expectations

1. Pre-Work Phase (~2 hours)
   - Orient to the Regional Response Team concept
   - Identify Regional Response Team members and roles
   - Coordinate travel arrangements for representatives attending Learning Session 1
2. Collaborative Phase (~3 hours monthly)
   - Fill Regional Response Team roles among Regional Response Team members
   - Coordinate routine Regional Group meetings
   - Attend future Learning Sessions
   - Develop a Regional Quality Management Plan
   - Provide at least one consumer training session
   - Provide at least one provider training session
   - Develop strategies to sustain Regional Group efforts beyond the Collaborative
   - Provide assistance to other Regional Group members when needed
   - Coordinate activities with assigned Regional Group QI Coach
3. Sustainability Phase (3 hours monthly)
   - Coordinate monthly Regional Group meetings
   - Implement strategies to sustain Regional Group efforts beyond the Collaborative
   - Provide assistance to other Regional Group members when needed

Network Expectations:

Ryan White HIV/AIDS Program-funded networks, like Part A, Part B, or Part D, play an instrumental role in the implementation of the end+disparities ECHO Collaborative. The following activities provide multiple options for network representatives, even if they do not provide medical care, to be active Community Partners in the Collaborative.

1. Data Collection Reporting
   - Viral Suppression Data Reporting
     - Only those networks that provide medical care are in a position of reporting viral suppression data every other month; in other words, if a network provides non-medical services only, they cannot report viral suppression data
     - Encourage all medical providers in the region to submit their data and assume the role of a facilitator or capacity builder for medical providers by providing support and technical assistance in their performance measurement reporting efforts
     - Coordinate with other medical providers in the jurisdiction who are reporting data to the online end+disparities Database and play an active role in developing the Regional Performance Data Management Plan
   - QI Intervention Reporting
     - Report your improvement efforts every quarter, following the same expectations as other Community Partners
2. Affinity Sessions
   - Like all active Community Partners, identify one Affinity ECHO Group (MSM of Color, Black/African American and Latina Women, Transgender People, or Youth) based on available data; if no medical data are available, such as in networks with supportive services only, use your own preferences and priorities

- Actively participate in the Affinity ECHO Sessions, which include the expectation to present at least one Case Presentation and one report back using the available templates, even if no viral suppression data are available; focus on a challenge, current or planned improvement strategies, or a patient experience representative of a system issue
- Join the Network Affinity Session that is specifically set up for network participants; these monthly sessions specifically support representatives from network programs; discuss the application of the Collaborative to your network models, and provide opportunities for peer sharing

3. Regional Group
   - Actively participate on the Regional Group and in Regional Group meetings
   - Given the role of the network in region, take on a leadership role on the Response Team or actively support the Response Team by convening meetings, provide logistical assistance, conduct regional QI trainings, etc.
   - Encourage all HIV providers in the network to actively participate in the Regional Group
4. Quality Improvement Efforts
   - Conduct meaningful and impactful QI efforts to reduce disparities in your network, regardless of whether you provide medical and/or supportive services
   - Support HIV providers in your network regarding their improvement efforts

Learn More | Collaborative Milestones Document
Key Terminologies and Definitions
Prework Webinars
July and August 2018 Checklist

Enrollment Phase

The HRSA HIV/AIDS Bureau (HAB) Invitational Letter marked the commencement of the Collaborative and began the Regional Group enrollment and subsequent individual recipient/subrecipient (Community Partner) registration process. To introduce the Collaborative, Kick-Off Sessions, virtual webinars explaining the structure of the Collaborative, were held in advance of the enrollment/registration process to introduce RWHAP recipients, subrecipients, and other stakeholders to the structure and purpose of the Collaborative and encouraged participation.

Group Enrollment & Selection Process of Regional Groups

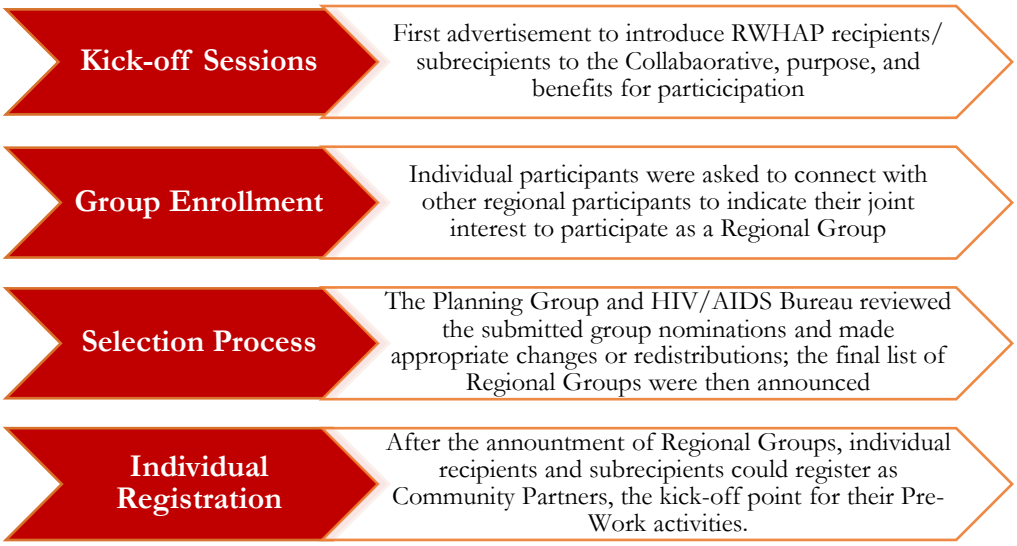
The first phase of enrollment required interested participants to communicate with other RWHAP recipients/subrecipients in their region and submit a regional group nomination. Existing groups of recipients (for instance, Regional Groups, past NQC collaborative teams, etc.) were encouraged to sign-up using the online Group Enrollment Form. Each group completed this form and listed all proposed recipients/subrecipients in the submitted group. The process was designed to encourage local group participation and individual recipients taking initiative to either revisit teams from previous collaboratives or existing regional improvement groups, or to build new networks across regional group members. HIV/AIDS Bureau representatives and Project Officers were encouraged to suggest regional/state teams and encourage their recipients to participate.

Once the Regional Group nominations were submitted, the Collaborative Planning Group and HIV/AIDS Bureau representatives reviewed them to determine the right geographical mix of participants and balance the available resources for this Collaborative. For example, if two small groups signed up in close regional proximity, these groups were merged to form one Regional Group instead of two.

Individual Registration of Community Partners

Once the group enrollment phase was completed and the list of Regional Groups was officially approved, individual RWHAP recipients and subrecipients registered online using the Individual Agency Registration Form. The registration of Community Partners initiates the Pre-Work Phase during which all Collaborative participants were asked to complete a set of Pre-Work assignments before the first Learning Session (June 2018), including the identification of their targeted subpopulation, completion of the technology assessment, and other necessary tasks.

Enrollment and Registration Process



Next Steps

- Learn more about the Collaborative and participate in the Kick-off Sessions
- Garner interest from local HIV providers, recipients and subrecipients and enroll as a Regional Group
- Once the participation of the Regional Group is confirmed, register your individual agency

Learn More | HRSA HIV/AIDS Bureau Invitation Letter
Collaborative Milestones Document
Individual Agency Registration Form
Group Enrollment Form
Kick-Off Sessions Materials

Key Collaborative Contacts

The Collaborative "Planning Group" was a set of individuals who helped plan, develop, and implement the Collaborative and were composed of HIV/AIDS Bureau representatives, faculty members living with HIV, content experts, Regional Group QI Coaches, ECHO representatives, and CQII staff. The Planning Group met virtually on a weekly basis throughout the Collaborative.

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Collaborative Aims

A set of Collaborative Aims were developed to achieve the reach, impact, and sustainability goals of the Collaborative. The following Table outlines the three Collaborative Aims, specific objectives, benchmarks utilized to evaluate their success, and further measurement details.

Aim 1: Increase viral suppression rates for people with HIV by focusing on four disproportionately affected HIV subpopulations and increase the average viral suppression rate across all PLWH served by Collaborative participants		
Objectives	*Benchmarks*	*Measurement Details*
Increase capacity to locally report performance data for disproportionately affected HIV subpopulations	• 75% of active participants use the Disparity Calculator to identify an agency-specific HIV subpopulation one month after Learning Session 1 • 90% of participants submit their viral suppression data for their entire caseload and the identified subpopulation by the end of the third data collection cycle by November 2018	- Bi-monthly viral suppression submissions by Community Partners - Community Partners' Aim Statements - Quarterly QI Intervention update reports
Access to regional benchmarking reports to facilitate peer learning and exchange	• 90% of participants receive regional benchmarking reports after each reporting cycle starting in August 2018, a month after the first data collection cycle • 90% of available benchmarking reports are reviewed during Regional Group Meetings starting in August 2018 • 75% of low performers or non-submitters are followed up by the Regional Response Team or receive additional support starting in August 2018	- Bimonthly Collaborative benchmarking report - Regional Response Team Updates by the assigned Regional Group QI Coach
Access to Collaborative-wide performance data reports	• 90% of participants have access to national benchmarking report starting in July 2018 • 90% of Collaborative-wide QI intervention reports are available within 1 month of the submission deadline starting in October 2018	- end+disparities Database submissions - Quarterly QI Intervention update reports
Aim 2: Implement and document effective improvement activities to reduce gaps in HIV care for disproportionately affected HIV subpopulations		
Objectives	*Benchmarks*	*Measurement Details*
Implement local quality improvement projects	• 75% of participants have a written aim statement within two months after Learning Session 1 • 90% of active participants conduct local improvement efforts regarding the identified subpopulation by the end of the Collaborative • 75% of participants document and report their QI interventions starting with the first reporting cycle in September 2018	- Community Partners' Aim Statements - Quarterly QI Intervention update reports
Increase capacity of participants to reduce disparities for their selected subpopulations	• 90% of participants attend at least 10 subpopulation-specific Affinity ECHO Sessions by the end of the Collaborative • 90% of active participants present at least one Case Presentation during the subpopulation-specific Affinity ECHO Sessions by the end of the Collaborative	- Affinity Case Presentation log
Increase provider quality improvement capacity	• 90% of Regional Groups have at least one provider QI training session to strengthen their QI capacity • 90% of Learning Sessions include provider QI capacity-oriented agenda items	- Learning Session Agenda

	• At least one QI 101 training is provided by CQII by the first Learning Session in June 2018	

Aim 3: Sustain regional quality management networks of cross-Part RWHAP recipients and subrecipients in local improvement groups

Objectives	*Benchmarks*	*Measurement Details*
Engage RWHAP recipients and subrecipients in regional improvement groups	• 90% of all RWHAP recipients within the catchment area of a Regional Groups are active members of the Regional Group as evidenced by attending Regional Group meetings • 100% of Regional Groups have an updated contact list of RWHAP recipients with identified key contacts (e.g., leader, data person, QI coordinator, medical provider) one month after Learning Session 1	- Contact list of Regional Group participants - Regional Group attendance records
Actively align regional quality improvement efforts	• 100% of Regional Groups have a Regional Response Team in place one month after the first Learning Session in June 2018 • 90% of Regional Groups have monthly meetings with participation of its members to foster cross-Part alignment, partnership and collaboration among regional RWHAP recipients starting in July 2018 • 90% of Regional Groups improve their cross-agency collaboration, using the Regional Group Assessment Tool by the end of the Collaborative	- Regional Response Team Updates by the assigned Regional Group QI Coach - Listing of Regional Response Team roles and responsibilities - Regional Group Assessment Tool
Sustain regional and local improvement efforts beyond the Collaborative	• 100% of Regional Group participants have routine access to virtual communication platforms during and after the Collaborative • 90% of all Regional Groups have written strategies to sustain their Regional Group beyond the formal Collaborative by Learning Session 4 in September 2019 • 90% of Regional Groups remain active six months after the formal end of the Collaborative in June 2020 • 90% of Community Partners continue their local improvement efforts after the formal end of the Collaborative in June 2020	- Regional Group Sustainability Strategies
Increase the QI capacity of consumers to be meaningfully involved in improvement activities	• 90% of Regional Groups have at least one active consumer liaison representative on their Regional Response Teams by Aug 2018 • 90% of Regional Groups have one QI training session dedicated to helping consumers to build their capacity by the end of the Collaborative • 75% of Learning Sessions include consumer-oriented agenda items • At least 5 Consumer Affinity Sessions are held throughout the Collaborative allowing consumer liaisons to share experiences and build their QI capacity	- Listing of Regional Response Team roles and responsibilities - Learning Session Agenda

Key Definitions

Disparity Calculator	QI Intervention
An Excel spreadsheet to assist in the decision-making process of Community Partners on which	A change in some aspect of the system or process with the goal of increasing the quality of care of clients and improving health outcomes

disparity subpopulation to work on based on locally available viral suppression data	
Viral Suppression Data	**Benchmarking Report**
Every other month, each Community Partner submits their viral suppression data (HAB viral suppression measure definition: National Quality Forum #: 2082) for a) all PLWH receiving HIV care (entire HIV caseload); and b) the participant-selected disparity subpopulation	Viral suppression data are collected and submitted to allow comparisons across Regional Teams; these benchmarking reports are immediately available in the online end+disparities Database; a detailed benchmark report is issued by CQII within one month after the submission deadline for Community Partners
Regional Group Assessment Tool	**Community Partner Reporting Form**
A tool used to assess the level of interaction, performance, and communication between Community Partners of a Regional Group across Parts	A template used by each Community Partner to document their improvement journey and QI project development, as well as outcomes and conclusions

Learn More | Key Terminologies and Definitions

Technologies

App - A smartphone app that was accessible online at **enddisparities.CQIIApp.org** was created to support end+disparities ECHO Collaborative participants. The application, specifically designed for this initiative, allowed participants to access meeting calendars with corresponding documents, reminds participants of events, and provided a medium to connect with other Community Partners, their Regional Group, and other participants of the Collaborative. However, there was minimal uptake by participants for the App, and it was eventually discontinued.

Constant Contact - Online marketer utilized to communicate with end+disparities ECHO Collaborative participants. Monthly announcement letters, which included data reports, upcoming events, deadlines, and Affinity Session topics. This platform was also used for special announcements, such as to promote quality improvement trainings, upcoming Learning Sessions.

Glasscubes - A password-protected online forum (called Glasscubes and accessible at **CQII.Glasscubes.com**) was created for registered users of the Collaborative to share QI resources to maintain a library of documents relevant to the Collaborative. Each Regional Group managed their own Glasscubes workspace and posted documents relevant to the work being done in their group. This site provided a platform for discussion of recent Affinity Sessions, posting of additional resources, and reinforced the virtual learning community. A list of didactics that were presented during the 18-month campaign can be found at end+disparities ECHO Collaborative Didactics.

Poll Everywhere - Poll Everywhere is a real-time web, SMS, and Twitter polling service that lets users submit votes or comments online and can be integrated into a PowerPoint slide. The program was used successfully both within Affinity Group Sessions, as well as during in-person trainings and Learning Sessions.

Website - CQII established an online presence dedicated to this Collaborative to publicly disseminate its content to all RWHAP recipients, regardless of their participation in this initiative.

To leverage existing resources, the end+disparities website (at enddisparitiesExchange.org) was transitioned to TargetHIV. The URL for the new website is **enddisparities.org** and is housed on the TargetHIV website.

Zoom - Virtual communication technologies played a key role in this Collaborative, since they were used throughout all Collaborative activities, including Affinity ECHO Sessions and virtual Learning Sessions. To increase accessibility for Community Partners who could not physically attend meetings, a video conferencing service, called Zoom, was used. Participants were expected to have access to a webcam. Zoom is an online video conferencing software that is compatible with a variety of different operating systems, including OS, Android, Windows, and telephone services. The software is HIPAA compliant and enables up to 500 participants to join. The ECHO model™ utilizes this software because of its ease of use and accessibility – it works well in low bandwidth. Zoom is also available for Regional Groups through June of 2020, to facilitate local communications. Please refer to the Zoom Set Up Guide for further instructions on how to use Zoom for this Collaborative.

Next Steps

- Log-in into Glasscubes and set up your Regional Group page for your own regional use
- Become familiar with Zoom, the virtual communication platform for this Collaborative, and use your web camera

Learn More | end+disparities ECHO Collaborative Website
Zoom Set Up Guide

How to Reach CQII for Assistance

To facilitate assistance for this Collaborative, the following email address was established by the HRSA Ryan White HIV/AIDS Center for Quality Improvement & Innovation (CQII) and could be accessed by all Collaborative participants:

CollaborativeSupport@CQII.org

CQII provided the contact information below:

New York State Department of Health AIDS Institute
90 Church Street, 13th floor
New York, NY 10007-2919
212.417.4730 (main)
212.417.4684 (fax)
www.CQII.org
Info@CQII.org

If additional individualized technical assistance by RWHAP recipients or subrecipients were needed that fell outside of the Collaborative work, a technical assistance request was made to the HIV/AIDS Bureau using the Technical Assistance (TA) Request Form.

Learn More / HRSA HIV/AIDS Bureau CQM Technical Assistance Referral Form

Frequently Asked Questions	
I am the only organization in my region who wants to participate. Can I enroll?	How many regional HIV providers do I need to enroll locally in our Regional Group?
No. One of the underlying premises of the Collaborative is to create and foster regional improvement efforts; try to get others involved in your region to participate and enroll as a team.	We hope to have at least 5 recipients join each Regional Group.
Do all participating agencies in a region need to choose the same subpopulation?	Can I select more than one subpopulation?
No. A Regional Group does not select one subpopulation for the entire region; each Community Partner can choose their own subpopulation.	No. To participate in all the activities of the Collaborative, including QI Intervention Submissions and Viral Suppression Data Submission, only one subpopulation is selected.
Can I participate in the Affinity ECHO Sessions but not in my Regional Group?	Can I choose which Collaborative activities we want to participate and which not?
No. The expectations for the Collaborative include your participation in both activities; this will allow you to better reach the goals of the Collaborative.	No. All Community Partners are expected to participate in all Collaborative activities and complete their assignments; the Collaborative is based on the premise – all teach, all learn, all improve
Can participation in the Collaborative help me to meet HIV/AIDS Bureau clinical quality management expectations?	Who should I talk to get individual advice about my participation in the Collaborative?
Yes. The successful participation in the Collaborative will certainly help you and your agency to meet the HIV/AIDS Bureau clinical quality management (CQM) expectations.	You can email us at CollaborativeSupport@CQII.org, reach the Regional Group QI Coach assigned to your Regional Group, or schedule an Office Hours appointment with CQII staff to help you.

II) Pre-Work Activities

The first two phases of the end+disparities ECHO Collaborative included the Enrollment Phase (March-April 2018) and the Pre-Work Phase (May-June 2018), which included the first face-to-face Learning Session (June 2018). Every participant in the Collaborative, as well as Regional Groups and Regional Response Teams were expected to complete their assigned Pre-Work tasks. The following table lists these Pre-Work expectations; all tools and resources are described at the end of the document.

Community Partners

Community Partner Pre-Work Activities and Resources			
Enrollment Phase (Mar-Apr 2018)			
Activity	*Objective*	*Tool/Resource*	*Due Date*
Learn about the Collaborative	To understand the overarching goals, benefits, and expectations of the Collaborative To learn about the end+disparities ECHO Collaborative framework	• Kick-Off Sessions • Collaborative Flyer • Disparities Video • end+disparities Website • Collaborative Toolkit	Mar-Jun 18
Understand the Registration Process	To understand the enrollment process and the expectations to recruit fellow HIV providers across all Parts regionally	• Collaborative Toolkit • Enrollment and Registration Zoom Session • Enrollment and Registration Slides • Office Hours	Mar-Apr 18
Enroll as a Regional Group and Register as a Community Partner	To become an active participant in the end+disparities ECHO Collaborative	• Group Enrollment Form • Individual Registration of Community Partners Form • Office Hours	Mar-May 18
Pre-Work Phase (May-Jun 2018)			
A) Set-up a Team and Provide Contact Information	To set-up a local improvement team To share the most accurate agency, contact information of staff involved in the Collaborative and a description of the agency, including HIV patient caseload	• Contact Information Template • Individual Registration of Community Partners	Mar-Jun 18
Complete a Technology Assessment	To better understand what data systems are used to track local performance data To ascertain access to webcams and experience with Project ECHO	• Technology Assessment Survey	Mar-Jun 18
B) Identify One Disparity Subpopulation	To focus local quality improvement efforts to reduce HIV disparities To select the most appropriate subpopulation-specific Affinity ECHO Group using the provided Disparity Calculator	• Disparities Calculator • Disparities Calculator Guide • Collaborative Toolkit • Pre-Work Webinar • Office Hours	Apr-Jun 18

C) Develop a Community Partner Aim Statement	To set individual agency-specific improvement goals To track improvement progress over time	• Developing Aim Statement Session • Community Partner Aim Statement Template/Sample • Pre-Work Webinar • Office Hours	Apr-Jun 18
Develop Quality Improvement and Technology Capacity	To strengthen the quality improvement capacity To become familiar with the virtual communication tools used in the Collaborative, including Zoom	• QI 101 Training • Zoom Technology Introduction • Office Hours	Apr-Jun 18
Participate in first Regional Group Meeting	To become an active member of the Regional Meeting	• Regional Group Guide • Regional Group QI Coach Participation at Regional Group Meetings	May-Jun 18
Prepare for first Learning Session	To take advantage of the first in-person Learning Session	• Collaborative Toolkit • Getting Ready for Learning Session Collaborative Toolkit	Jun 18

A) Establishing Local Community Partner Improvement Teams

The success of regional improvement efforts is dependent on the success of each local Community Partner and its improvement efforts. As a result, it is critical that each agency establishes a local improvement team. The collective efforts of all local improvement teams in the region have the most potential for a measurable impact.

Local improvement teams, the agency-specific vehicles of quality improvement activities, meld together the skills, experiences, and insights of different staff. Successful teams have clear aims to guide their activities, the necessary resources to complete the local improvement work, support by senior leaders, and the willingness of team members to learn from each other and maintain open communication with the quality management committee, staff, and consumers. These teams are most effective when they are well connected and integrated into the agency's clinical quality management committee.

Each agency improvement team will vary in size and composition. Effective team functioning becomes everyone's responsibility. Each team, however, needs a quality improvement leader who understands the improvement process, members who are familiar with the process to be improved, and a liaison to report their activities to the Response Team. Consider the following **suggestions** for inclusion on your local improvement team:

- Include representation from the clinical quality management committee
- Ensure that all key functions and department of the agency are represented
- Involve an agency leadership representative on the team
- Include an engaged consumer on the team and be proactive preparing the consumer

The agency quality improvement leader serves as the driving force to build effective relationships between team members and ensures everyone understands the team's assignments and how the local agency efforts connect with regional improvement efforts, represented by the Regional Group. The agency quality improvement leader ensures team members know each other and recognize how members can complement each other through their expertise and perspectives. The leader or co-

leaders represent the agency and communicates with the Response Team and become an important link between the local and regional improvement efforts.

Once local improvement teams are established, each team starts their own improvement journey with the following milestones:

- Set local improvement goals by writing a Community Partner Aim Statement
- Conduct improvement activities to meet the local and regional improvement needs
- Collect performance data and track improvement efforts over time

Next Steps

- Set-up your local improvement team at your agency – June 2018
- Register and share your contact information
- Complete the technology assessment to learn more about your needs – June 2018
- Identify your representatives and participate in the Regional Group meeting

Learn More | Community Partner Aim Statement Template and Sample
Individual Agency Registration Form
NQC Cross-Part Quality Management Guide
HIVQUAL Workbook
Technology Assessment

B) Identify One Disparity Subpopulation

The cornerstone of this Collaborative was the expectation that each Community Partner identified and selected one disproportionately affected HIV subpopulation: MSM of Color, Black/African American and Latina Women, Transgender People, and Youth.

The selection of the subpopulation by each agency determined:

- Participation in the subpopulation-specific Affinity ECHO Groups to gain improvement insights through content expert perspectives and Community Partner Case Presentations
- Viral suppression data reporting for the identified subpopulation in addition to the entire HIV caseload
- Local quality improvement project to address HIV disparities

To detect disparate HIV-related health outcomes and to select the most appropriate subpopulation, we recommended that each Community Partner utilized the provided Disparities Calculator. Each agency determined its subpopulation of choice, independent from other agencies within a Regional Group.

The Disparities Calculator is a pre-programmed tool, initially used in the end+disparities Learning Exchange to help participants identify their disparity population. The calculator helped participants determine where their greatest disparities were among the populations they served. It is based on statistical calculations used by the Supreme Court of the United States in determining disparate impact (the study of whether the effect of a policy or system of policies results in discrimination or disparity as proven by math). The Disparities Calculator was used as a decision-making tool and one

of the many sources of information that should have been considered when selecting a subpopulation of interest. The calculator may have reported more than one disparity population, in which case, individual agencies were encouraged to consider its needs when selecting the targeted subpopulation. Please note that it was not required to report the detailed results using the Disparities Calculator but rather the decision by the agency which HIV subpopulation had been determined to be the focus for this Collaborative. A Disparity Guide is also available to provide additional assistance.

Required data elements to use Disparity Calculator:

- Your name, agency, reporting date, and the date range included in your report
- Overall viral suppression numerator and denominator data for your total HIV service population
- Segmented viral suppression numerator and denominators for the identified disparity subpopulation

The Disparities Calculator has five tabs:

- Instructions: descriptions of each tab and instructions on how to enter data
- Statistics Basics: refresher on statistics and terminologies used in the calculator
- Data Entry: the single place to enter data in the calculator
- Summaries: dashboard of final calculation results for quick sharing and discussion
- Analyses: background statistical processes and values that inform the summary dashboard for sharing with leaders and decision makers

All mathematical methods have limitations that are important to understand when using these tools. Remember – this Disparities Calculator is a guide to assist participants in their efforts to select the most appropriate HIV subpopulation and did not singlehandedly determine their subpopulation of focus as other internal and external factors, such as local priorities, number of patients served in each subpopulation, or ability to maximize impact, were considered.

In case the Disparity Calculator did not yield any measurable or significant disparities, Community Partners needed to look at internal and external public health priorities or preferences by staff and consumers served by the Community Partner to determine one Collaborative HIV subpopulation.

Next Steps

- Get access to and familiarize yourself with the Disparity Calculator
- Enter your viral suppression data into the Disparity Calculator – May/June 2018
- Identify your disparity subpopulation as your focus for the Collaborative – June 2018

Learn More | Disparity Calculator
Disparity Calculator Guide

C) Developing a Community Partner Aim Statement

Each local Community Partner was asked to write an aim statement to define their direction and scope of their improvement work to be reached at the end of the Collaborative, and to strategize about key tasks and timelines ahead of them. The **Community Partner Aim Statement** was due

within one month of Learning Session 1 and was reported in the designated Glasscubes folder. The agency-specific improvement team reviewed its own performance data and the regional improvement goals and allowed for flexibility in setting agency-level goals. For those agencies that already surpassed national benchmarks, a higher local goal may have been set. Other agencies set local goals that were more realistic for their current system.

An aim statement serves as a local blueprint. Its completion is important to clarify and focus the agency's direction and scope of work. It also creates a standard document for communicating what the improvement work in the Collaborative was, what it intends to accomplish, when it is likely to be completed, and who was responsible for its implementation.

An aim statement typically includes:

Problem Statement

- Use concrete terms—terms that clearly describe the problem to be addressed
- Include quantifiable numbers that indicate the current level of performance
- Be relevant to HIV care and services provided by the agency
- Focus on the subpopulation of choice for this Collaborative

Improvement Goal

- Effective teams work with clearly defined SMART goals (specific, measurable, assignable, realistic, time-related)
- Set the goals and then continue making changes until the level is reached at which the effort expended is too great for the gain

Below are links to locate the Community Partner Aim Statement Template and a completed sample. The aim statement may evolve and change over time as new information and data results become available or additional knowledge is gained. Consider the aim statement as a 'living document.'

Learn More | Community Partner Aim Statement Template and Sample
NQC Cross-Part Quality Management Guide
HIVQUAL Workbook
Pre-Work Webinars

Next Steps

- Get access to and familiarize yourself with Community Partner Aim Statement Template and completed samples – June 2018
- Develop a Community Partner Aim Statement with your local improvement team and upload to Glasscubes – June/July 2018
- Identify your representatives and participate in the first Regional Group meeting
- Prepare for the first Learning Session

Regional Response Team

Regional Response Team Pre-Work Activities and Resources			
Enrollment Phase (Mar-Apr 2018)			
Activity	*Objective*	*Tool/Resource*	*Due Date*
Understand the Regional Group Concept	To understand the Regional Group framework To understand the roles and responsibilities of the Regional Response Team	• Regional Group Guide • Collaborative Flyer • Collaborative Toolkit	Mar-Jun 18
Learn about the Group Nomination Process	To understand the enrollment process and the expectations to recruit fellow HIV providers across all Parts regionally	• Collaborative Toolkit • Kick-off Sessions and Slides • Office Hours	Mar-May 18
Pre-Work Phase (May-Jun 2018)			
Meet as a Regional Group for the First Time	To establish the Regional Group Meeting To select the Regional Response Team and assign roles and responsibilities	• Regional Group Guide • Regional Group QI Coach Participation at Regional Group Meetings • Office Hours	May-Jun 18
D) Develop a Regional Group Aim Statement	To set regional improvement goals To track improvement progress over time	• Pre-Work Webinar • Regional Group Aim Statement Template • Regional Group Aim Statement Sample • Regional Group QI Coach • Learning Session 1 • Office Hours	Apr-Jun 18
Prepare for first Learning Session	To take advantage of the first in-person Learning Session To assess the regional alignment of improvement efforts across Community Partners To arrange travel logistics to attend in-person Learning Session 1 for Regional Response Team members	• Collaborative Toolkit • Pre-Work Webinars and slides • Regional Group Assessment Tool	Jun 18
Developing a Data Submission Plan	To create a streamlined process to collect all data from agencies within a Regional Group.	• Collaborative Toolkit • Regional Group QI Coach • Office Hours	

D) Developing a Regional Group Aim Statement

In addition to aim statements developed by each Community Partner, each Regional Group was asked to draft a Regional Group Aim Statement describing the current status quo and what each Regional Group intended to accomplish at the end of the Collaborative with a focus on cross-part alignment, regional coordination of QI activities, and harmonization of improvement efforts. It clarified the group's direction and scope of work.

Key components of the Regional Aim Statement were the following:

- **Problem Statement**: A brief description of why the regional improvement work that will be pursued is necessary.
- **Goal Statement**: A set of two to three concrete smart objectives that address what is being targeted, when an improvement will be seen, how much improvement can be anticipated, and who this improvement effects.

The objectives listed in an aim statement were expected to be SMART **(specific, measurable, assignable, realistic, time-related)**. All Community Partners in the Regional Group should have been involved in this process. The Regional Group Aim Statement should have been completed after the first Learning Session and is submitted to the group's assigned Regional Group QI Coach through the appropriate Glasscubes folder.

Links to the Regional Group Aim Statement Template and completed sample are listed below. Remember that this document can change over time.

Next Steps

- Set-up your Regional Group and meet – your assigned Regional Group QI Coach can help you
- Familiarize yourself with the Aim Statement Template and provided samples – May/June 2018
- Jointly develop your Regional Group Aim Statement and upload to Glasscubes – June 2018
- Prepare for the first Learning Session – June 2018

Learn More | Regional Group Aim Statement and Template
Pre-Work Webinars
NQC Cross-Part Quality Management Guide
HIVQUAL Workbook – Page 98-102
One-Page Flyer

Key Definitions

Group Enrollment	Individual Registration
The first phase of enrollment: an online registration is used to confirm the interest of regional RWHAP recipients and subrecipients in forming an improvement group and participating as a Regional Group in the Collaborative; each submission is reviewed and approved by the HIV/AIDS Bureau	The second stage of enrollment: after the Regional Groups are finalized, individual RWHAP recipients and subrecipients register online as Community Partners to participate in the Collaborative and are registered with their designated Regional Group
Community Partner Aim Statement	**Regional Group Aim Statement**
A document, developed by each Community Partner, describing the current status quo and what each Community Partner intends to measurably accomplish at the end of their improvement work (i.e., viral suppression goal for one of the selected subpopulations); it clarifies and focuses the team's direction and scope of work	A document, developed by each Regional Group, describing the current status quo and what each Regional Group intend to accomplish at the end of their improvement work (i.e., further alignment across Parts); it clarifies and focuses the group's direction and scope of work

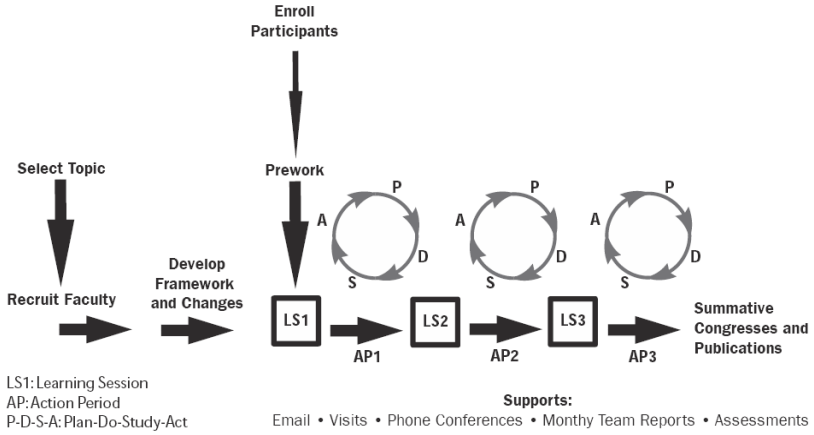
Frequently Asked Questions	
Where can I learn more about each Pre-Work activity?	How can I get further assistance to meet the various Pre-Work activities?
Identify on the Pre-Work Activities Table the resources you need to learn more about the activities.	Reach out to your assigned Regional Group QI Coach, schedule an Office Hour to guide you through the process, or email CollaborativeSupport@CQII.org.
Do I need to develop a Community Partner Aim Statement in addition to the Regional Group one?	Can I skip some of the Pre-Work activities?
Yes. These Aim Statements fulfill different purposes for your local and regional improvement work.	Unlike the end+disparities Learning Exchange all participants in this Collaborative are expected to complete all activities, including, Pre-Work activities to maximize the benefits of the Collaborative.

III) Learning Sessions

Peer learning presents a vital opportunity for HIV providers to draw on the clinical quality management (CQM) expertise of fellow providers and is a powerful mechanism for accelerating improvement efforts.[10] Collaborative learning[11] is a proven way to address the ever-increasing complexities of gaining knowledge and expertise in health care, as well as the application of this knowledge in real world situations. Quality improvement collaboratives use evidence-based frameworks to create learning communities that are designed to achieve rapid scale-up of improvement across health care facilities.

The Institute of Healthcare Improvement (IHI) developed the Breakthrough Series in 1994 to help health care organizations make "breakthrough" improvements in quality while reducing costs.[12] The Breakthrough Series model is based on the following premise: sound science exists, but much of this science lies fallow and unused in daily work. There is a gap between what providers know and should do, and what providers actually do. [13] [14] The Breakthrough Series model has been successfully applied nationally by the NYSDOH in six national collaboratives since 2004.

Breakthrough Series Model



Following the IHI Breakthrough Series model, the Learning Sessions allowed for routine meeting points for participants, while the action periods between Learning Sessions weree used by participants to carry out their local improvement activities, routinely report standardized Collaborative measures and QI interventions, and participate in the twice-a-month Affinity Group ECHO Sessions.

The Learning Sessions for this end+disparities ECHO Collaborative were designed to bring all participants together with HIV/AIDS Bureau and CQII staff, Regional Group QI Coaches, Planning Group, Affinity Group Faculty, and other representatives to receive guidance, develop improvement plans for action, and promote peer learning and exchange. These Sessions took place

[10] Dudgeon D, Knott C, Chapman C Et al. Development, Implementation, and Process Evaluation of a Regional Palliative Care Quality Improvement Project. J Pain Symptom Manage. 2009; 38: 483-95.
[11] Bruffee, K., Collaborative Learning. Baltimore. The Johns Hopkins University Press. 1993.
[12] Institute for Healthcare Improvement. The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. 2003. Available at http://www.ihi.org/IHI/Results/WhitePapers.
[13] Baker GR: Collaborating for improvement: The Institute for Healthcare Improvement's Breakthrough Series. New Med 1:5–8, 1997.
[14] Plsek PE: Collaborating across organizational boundaries to improve the quality of care. Am J Infect Control 25:85–95, 1997.

every five months beginning in June 2018. While registration was not required to participate in the Learning Sessions, an early request for identification of interest for various breakout sessions was collected in order to ensure proper staffing for each topic. Due to room size limitations for the first and last face-to-face Learning Sessions, the number of representatives from each Regional Group was limited.

Learning Session Logistics

Learning Session	*Logistics*	*Participants*	*Date*
Learning Session 1	• 2-day face-to-face meeting • Location: Bethesda, MD • Estimated 100 participants • Logistical support was provided to attend	• 5 Representatives from each Regional Group • Extended Planning Group • Affinity Faculty Members	June 13-14, 2018
Learning Sessions 2 and 3	• 2-day virtual sessions; 4-5 hours each • Regional Response Team members were encouraged to be present in the same location • Estimated 100-150 participants	• Community Partner Representatives • Regional Response Team members • Expanded Planning Group	Nov 5-6, 2018 Apr 25-26, 2019
Learning Session 4	• 2-day face-to-face/virtual meeting • Location: Bethesda, MD/Zoom • Estimated 110 (80 participants in-person and 30 participants virtual) • Logistical support was provided to attend in-person • Last Learning Session focused on sustainability and helped transition this Collaborative	• 3-5 Representatives from each Regional Group • Planning Group • Affinity Faculty Members • Virtual session ran parallel to the in-person meeting with a modified agenda	Sep 24-25, 2019

Three previous publications by the New York State Department of Health (NYSDOH) might be helpful for your participation in the Collaborative, the links are at the end of this chapter:

- Planning and Implementing a Successful Learning Collaborative: This Guide provides an overview how to plan and implement an HIV collaborative and is based on previous experiences by the National Quality Center (NQC).
- NQC Cross-Part Guide: A publication by the NQC how to work across various RWHAP Parts and build synergies to benefit the care of people with HIV.
- Making a Mark: Demonstrating Health Impacts H4C Collaborative Report: This publication by NQC outlies the most recent NQC collaborative and demonstrates the impact of this collaborative.

Virtual Learning Sessions

Four Learning Sessions were held every five months between the active periods of the Collaborative. The second and third Learning Sessions were conducted virtually using the same virtual platform (Zoom) as for the Affinity Group Sessions. All Collaborative participants were invited to attend and approximately 120 participants attended. Each session was two-days long and spanned 4-5 hours each day. A central virtual "room" held all participants for plenary sessions, while smaller breakout

sessions (a Zoom functionality) was used to increase interactivity among participants and to bring participants of similar needs together. The fourth and final Learning Session combined both in-person as well as a virtual component that ran parallel to the in-person activities.

Using a Webcam when Joining Virtual Learning Sessions

It is was critical that each participant in the Collaborative, including Community Partners, Faculty members, and CQII staff, joined the virtual Learning Sessions using a web camera. Seeing the various participants on the screen helped to maximize the opportunity to create a virtual community of learners. Here are a few scenarios that could have prevented a participant from using a webcam and how to overcome them:

Barriers and Potential Solutions to Using a Webcam	
I don't have a webcam.	I have a webcam on my computer/laptop, but I don't know how to get it to work.
CQII will provide you with a webcam, if needed, for the duration of the Collaborative so that you can virtually join the Learning Sessions. Simply send CQII an email and we will send one webcam per agency with the understanding that the camera is returned at the end of the Collaborative.	First, contact your IT department and ask to help you. It is an expectation for this Collaborative to join our virtual Learning Sessions and to use a webcam. CQII will try to assist you to the best of our abilities to help us. Set-up an Office Hour appointment.
I use a webcam, but it is not working with Zoom.	We are not allowed to install webcams on my computer.
First, check out the Zoom website at www.support.zoom.us to address the problem. Contact CQII and we will try to troubleshoot the issue with the help of our colleagues at ECHO.	Try the following options: - use a laptop with a camera - arrange to meet as a group/team in a location where a webcam is available - meet with colleagues who have working cameras - use your mobile device, including your phone If no other options exist, dial-in by using the provided phone number and meeting code since we do not want you to miss the important sessions.

Learn More | [Planning and Implementing a Successful Learning Collaborative]
[Making a Mark: Demonstrating Health Impacts H4C Collaborative Report]
[NQC Cross-Part Quality Management Guide]

Next Steps

- Determine in your Regional Group who will attend the first Learning Session – May/June 2018
- Prepare for Learning Sessions and share with local and regional improvement teams – May/June 2018
- Ensure that your webcam is working and join our virtual sessions – July 2018

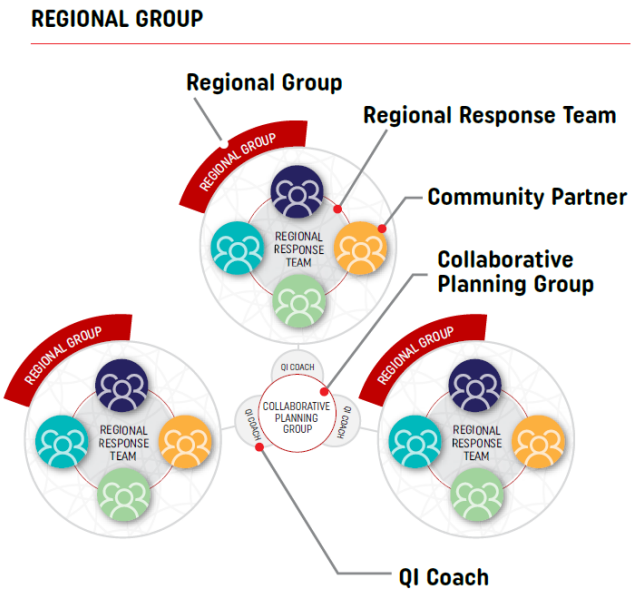
Frequently Asked Questions	
Can every Community Partner attend the first Learning Session in June 2018?	Can every Community Partner attend the Learning Sessions 2 and 3?
No. Only a representative group of each Regional Group is invited to attend the face-to-face Learning Session.	Yes. In fact, all Community Partners should plan to attend these virtual Learning Sessions.
Will I be reimbursed for attending Learning Session 1?	Does each Learning Session include agenda items related to consumer involvement?
Yes. CQII will reimburse you for travel expenditures and arrange lodging if no other financial support is available.	Yes. We made the commitment to include the voices of people with HIV in many aspects of the Collaborative, including the Learning Sessions.

IV) Regional Groups

The end+disparities ECHO Collaborative model used a combination of successful elements of past HIV/AIDS Bureau Collaboratives, the recent Learning Exchange, and the ECHO model™ to create an innovative framework to achieve the aims of this national improvement effort. Regional Group, a concept previously utilized with success, are composed of RWHAP-funded recipients and subrecipients (Community Partners) in their respective catchment area, such as the state, regions within a state, or cross-state areas.

The purpose of the Regional Group was to build regional quality improvement capacity, provide support for other Collaborative activities, and create a sustainable regional quality improvement network. Each Regional Group was led by a group of its Community Partners who are on the Regional Response Team with the support of an assigned QI Coach. Regional Groups meet monthly and their meetings are facilitated by the Regional Response Team.

The following illustration demonstrates the composition and support of Regional Groups:



Regional Group Overview

Each Regional Group was supported by an assigned Regional Group QI Coach and was asked to:

- Convene monthly meetings with the Regional Group members or a representative group (such as members of the Regional Response Team); the Regional Group decided attendance requirements for its individual Community Partners and whether the meeting was conducted virtually or in person
- Develop a routine process to update development of the Regional Group and share information with participants in the region
- Gather regional Viral Suppression Data and QI Intervention submissions and share benchmark reports within their constituencies
- Review performance data (viral suppression and QI interventions) from all Community Partners
- Prepare for upcoming Learning Sessions and related assignments

- Conduct Regional Group assessments using provided standardized assessment tools every five months
- Refer Community Partners to regional quality champions and other resources, or to assigned Regional Group QI Coach when in need; requests for technical assistance should be made to the HRSA HIV/AIDS Bureau if additional support is needed
- Aid and support to Community Partners, including following-up on individual Case Presentations from subpopulation-specific Affinity ECHO Sessions
- The estimated monthly time commitment for a Community Partner to participate in a Regional Group ranged between 1-3 hours per month

Regional Response Team Overview

The Regional Response Team assumed key roles and responsibilities of the Regional Group and was representative of the Community Partners in the Regional Group.

- Approximately 5-8 individuals participated on a Regional Response Team
- Each individual Regional Group identified the roles their Regional Response Team should have and identify Regional Response Team members to assume them [see below]
- The Team Leader facilitated the Regional Group meetings and represented the Regional Group to other stakeholders; a co-leadership model was encouraged
- Regional Response Team members or representatives from the Regional Group were asked to attend the initial in-person Learning Session in June 2018
- The estimated monthly time commitment for a Regional Response Team member ranged between 2-3 hours a month

Regional Group QI Coach

Each Regional Group was assigned a QI Coach, a quality improvement expert contracted by CQII or CQII staff with extensive expertise in quality improvement. Regional QI Group Coaches provided support to the Regional Group through the following activities:

- Support the Regional Response Team in facilitating meetings and ensuring the Regional Group members communicate and work effectively as a team
- Prepare their Regional Group for Learning Sessions
- Prepare their Regional Group for performance data and QI Intervention updates
- Provide feedback after Viral Suppression Data submissions, and QI Intervention submissions

The following paradigms helped Regional Group QI Coaches in their efforts to support the assigned Regional Groups. The focus of the Regional Group QI Coaches was on

- Supporting the Regional Response Team/Regional Group NOT necessarily the individual Community Partners
- Being a catalyst to the Regional Group NOT the 'hands-on manager' for the group; in the end the Collaborative promotes a sustainable regional quality management infrastructure going forward
- Understanding that the time commitment by the Regional Group QI Coach per Regional Group changes over time from being more involved in the beginning to being less involved once the groups are established and fully functional
- Meeting the individualized needs of each Regional Group by treating each group differently based on their team composition, dynamics, and prior experiences as a Regional Group

- Referring individual agencies to CQII/HIV/AIDS Bureau when for further technical assistance when individual Community Partner needs are beyond the scope of involvement of the Regional Group QI Coach

On average, each Regional Group QI Coach spent

- up to 10 hours per Regional Group per month, which was broken down by
  - 2-3 hours/per month for prep/participation in the monthly Regional Group meetings
  - 3-4 hours/per month for assistance to Response Team Members
  - 2-3 hours/per month for reviewing documents/providing feedback
  - 2 hours/per month for documenting activities related to the Collaborative
- 4 days for one in-person trip to the Regional Group to support the Regional Group (details are to be worked out)

The following table, Regional Group Activities, outlines the various key activities. Details related to each activity are described below in this document and are linked to the name of the activity in the following table. Each tool and its location can be found on the Index of Resources and Forms in the Appendix.

Regional Group Activities			
Collaborative Phase (Jul 2018-Sep 2019)			
Activity and Link	***Objective***	***Tool/Resource***	***Due Date***
A) Finalize the Regional Response Team	To create an effective Regional Response Team To finalize the roles and responsibilities of the Regional Response Team	• Regional Group QI Coach • Collaborative Toolkit • NQC Cross-Part Guide – Chapter 2 • Office Hours	Jul-Aug 18
B) Establish Monthly Meeting Schedule for the **Regional Group**	To establish a routine meeting schedule for the Regional Group	• Collaborative Toolkit • NQC Cross-Part Guide • Monthly Agenda Items Suggested by CQII/Regional Group QI Coach • Office Hours	Jul 18-Dec 19
C) Collect and Review Data Submissions from Community Partners	To better understand local performance data and use their findings for quality improvement To aid individual agencies	• Collaborative Toolkit • Pre-Work Webinar 1 • Learning Session 1 • Regional Group QI Coach Participation at Regional Group Meetings • Data Liaison Affinity ECHO Sessions • Office Hours	Jul 18 -Dec 19
D) Write a Regional Quality Management Plan	To establish a functional regional structure to support local improvement efforts	• NQC Cross-Part Guide – Chapter 4 • NQC Part B Guide – Section 3 • HIVQUAL Workbook – Step 1 • Office Hours	Apr-Jul 18
E) Outline Regional Sustainability	To establish a functional regional structure to support local improvement efforts	• NQC Cross-Part Guide – Chapter 9 • HIVQUAL Workbook – Step 6 • Office Hours	Aug-Dec 19

F) Conduct Training Opportunities for Providers **and Consumers**	To further build capacity for quality improvement among regional providers and consumers	• CQII.org website with training slides and training guides • Regional Group QI Coach • Office Hours	Aug 18-Dec 19

A) Finalize the Regional Response Team Membership

The Regional Response Team was a self-organizing, peer-driven group comprised of members representing different provider types, agencies, funding streams, and localities across the region. This team created an opportunity for members to work together on specified Collaborative goals and be the liaison between RWHAP recipients/subrecipients in the region, assigned Regional Group QI Coach, CQII staff, and other participating Regional Response Teams. Regional Groups were expected to establish a plan to select their Regional Response Team at the first Learning Session. Though not all Community Partners attended the first Learning Session, all members of Regional Groups were encouraged to help select their Regional Response Team through participating virtually in this portion of the Learning Session, if possible.

The objective of the Regional Response Team was to establish a cross-Part quality management infrastructure with the aim of improving and streamlining communication among participating agencies and to build a sustainable regional infrastructure well beyond the Collaborative, while focusing on cross-Part alignment, regional coordination of QI activities, and harmonization of improvement efforts. Though each Response Team was encouraged to develop its own managerial structure, every team was expected to:

- Regularly schedule team meetings (via teleconference, web conferencing, in-person if possible) to jointly achieve the goals of the Collaborative
- Develop routine processes to update and share information with Collaborative participants in the region and with other Regional Response Teams
- Gather Viral Suppression Data and QI Intervention submissions from Community Partners in their Regional Group and share benchmark reports on the progress of the Collaborative work within their constituencies
- Refer Community Partners to identified quality champions in the region and other resources, if assistance is needed or requested, or to aid Community Partners under the guidance of the assigned Regional Group QI Coach

Below are some suggestions for lead functions on the Regional Response Team. The group should allow itself the flexibility to modify these roles or add new roles so that participants can contribute their expertise and talents in a way that is most beneficial.

Additionally, the Regional Response Team composition should be reinforced with a variety of skills that contribute to a well-rounded, highly competent membership. These skills need to include clinical expertise, social service support experience, and consumer perspective. Technical writing skills, statistical expertise, and administrative abilities will all contribute to a high functioning organization. Representation of all RWHAP Parts and geographic areas is crucial. Membership evolution over time should be anticipated.

Regional Response Team Lead Functions

Roles	Skill Set	Responsibilities
Team Leader	This is an energetic, confident person who believes in the success of the Collaborative. This person can lead without leading. This person is willing to provide ongoing support and encouragement to all participants. This is an open-minded person, sensitive to the needs of all Regional Response Team members and respectful of all viewpoints. The identification of a Co-Leader(s) or Assistant Leader(s) may be needed or desired.	• Plans and conducts Regional Response Team meetings, sets agendas, and guides discussion • Coordinates Regional Response Team activities and ensures that timelines are met • Maintains and updates the Collaborative calendar of activities • Monitors the virtual office repository on Glasscubes and ensures that appropriate notices, reports, and events are posted • Works closely with Regional Response Team members by providing support and linking them with any additional resources or experts that they may need to fulfill their roles • Provides a point of communication between Regional Response Team members and the Collaborative Planning Group • Speaks on behalf of the Regional Group's participation in the Collaborative and broadcasts the team's successes outside of the geographic catchment area • Participates in monthly Response Team Leader Affinity Sessions
Data Liaison	This person has a broad understanding of data, data management, and data analysis that extends beyond the use of one single database. This person understands universally how data are recorded and used, and how data can drive improvement. This person has a solid understanding of the HIV/AIDS Bureau measures – numerators, denominators, inclusions, and exclusions.	• Accepts and responds to questions Community Partners might have about how they are reporting Viral Suppression data or how the data elements are defined • Helps to assure that all agencies are reporting Viral Suppression data in a standard method so that the aggregation of data across all databases and all agencies is meaningful • Helps assess the needs of the agencies regarding data collection and reporting, and recommends training topics • Monitors online data reporting system and routinely retrieves aggregated and trended reports to share with the rest of the group • Works closely with the Quality Improvement Liaison, sharing information and recommendations for improvement • Participates in monthly Data Liaison Affinity Sessions when additional support is needed for the data collection process
Communicator (Public Relations Manager/Alignment Officer)	This person is tactful, diplomatic, non-judgmental, upbeat, and positive. This person is respectful of other people's time and energy and can communicate effectively and efficiently.	• Compiles and maintains an updated contact list for all participating agencies • Develops positive working relationships with the persons responsible for participation at each agency • Develops or oversees the development of regional storyboards to be shown at Learning Sessions • Strives to ensure active and meaningful participation of agencies and provides "nudges" when data reports are due or late

		• Disseminates information, training aids, newsletters, project reports, and other relevant information to all agencies via email or Glasscubes • Has the potential to suggest partners, linking those agencies with a level of skill in a specific area with an agency that is struggling in that same area
Trainer	This person is comfortable speaking to groups of people and is adept at assessing needs. This person is familiar with authorities/experts in the region and can engage them in training efforts when needs are identified. The person is familiar with quality improvement methodologies and tools and has prior training experiences.	• Shares training resources to the Communicator for Collaborative-wide distribution or posting on Glasscubes • Conducts or organizes at least one provider QI training and manages the training logistics with support from others within the Regional Group and CQII • Conducts or organizes at least one consumer QI training and manages the training logistics with support from other within the Regional Group and CQII
Secretary/Recorder	This person can capture the thoughts of participants and organize ideas in writing. This person is a good listener and assures that everyone's ideas are heard and understood, and has sound writing skills.	• Records minutes at meetings and submits them to the Communicator for distribution or posting • Provides a review of all reports submitted by the Regional Response Team • Helps draft the Regional Group Aim Statement, collecting input from members of the Regional Group • Serves as the lead for the creation of the regional Quality Management Plan, helping to organize its development and blend contributions from various members • Takes the organizational responsibility for the construction and dissemination of a potential regional newsletter to broadcast upcoming events, deadlines, highlights of accomplishments made so far • Submits progress reports as needed
Quality Improvement Liaison	This person has experience working with multidisciplinary teams. This person has skills in strategizing and evaluation, utilizes a creative/inventive thought process, and is non-judgmental and non-critical in nature. This person is familiar with quality improvement methodologies and tools, and how to establish local quality improvement teams.	• Is available to assist all Community Partners within the Regional Group in the development of their Aim Statements and Plan-Do-Study-Act (PDSA) cycles • Offers assistance to Community Partners in the design and implementation of local improvement efforts, when needed • Coordinates the Case Presentation follow-up presentations during Regional Group meetings • Assist with QI Intervention submissions of regional participants • Shares successful strategies with other interested members of the Collaborative

Consumer Liaison	Ideally, the individual already has experience participating on planning boards or other committees and communicating with or advocating for other HIV patients. This person is comfortable communicating with consumer and provider communities of medical care and social service support and has at minimum a basic understanding of quality improvement concepts and RWHAP funding structures.	• Provides a personal perspective on the implementation of improvement strategies and the challenges and barriers that consumers face in obtaining high quality care • Serves as a liaison between the Regional Response Team members, peers, and other councils and boards, and shares information, concerns, and successes between these entities • Educates peers and other council and board members on the goals and progress of the Collaborative • Where needed, speaks to groups of consumers or providers encompassing the entire Collaborative catchment area or leads discussions during consumer tracts at Collaborative-wide meetings • Participates in Consumer Affinity Sessions

More | NQC Cross-Part Quality Management Guide

B) Establish Monthly Meeting Schedule for the Regional Group

The Regional Group had flexibility in determining its meeting structure and attendance requirements to meet the needs of its membership. CQII provided each Regional Group their own unique Zoom log in for their use until June 2020. The Regional Group decided whether to conduct meetings in person or virtually through the Zoom platform. There was no strict format Regional Groups were expected to follow, but meetings should meet the requirements of the following checklist:

- Meet monthly
- Prepare team members for Viral Suppression and QI Intervention submissions
- Provide feedback on Viral Suppression and QI Intervention submissions
- Discuss the benchmarking report
- Prepare for other meetings including Learning Sessions and Affinity ECHO Sessions

Each month, CQII or the assigned Regional Group QI Coach forwarded suggested agenda items to facilitate the agenda development process and alignment with upcoming Collaborative activities. Review the Detailed Calendar document to see suggested Regional Group Meeting agenda items.

Learn More NQC Cross-Part Quality Management Guide

C) Collect and Review Data Submissions from Community Partners

The Regional Group played an important role in collecting the various data elements from regional Community Partners and reviewing the data results. As outlined in the data collection plan, each Community Partner was expected to submit one standardized measure (viral suppression) for two different patient groups (entire HIV caseload and identified subpopulation) every other month staring July 2018. These data were then complied in a benchmark report, which tracked each Regional and Affinity Group's improved viral suppression rates over time and shared the benchmark report one month after the submission deadline in the Collaborative announcement.

CQII also provided a detailed data report for each Regional Group after each data submission, which allowed them to identify local Community Partners who were struggling with their quality improvement efforts. In addition, each Community Partner are asked to report their improvement activities and interventions to reduce HIV-related disparities every three months beginning in September 2018 by submitting the Community Partner Reporting form. The development of Regional Group activities was captured in the Regional Group Response Team report, which was completed by the Regional Group's assigned coach and submitted every three months.

The Regional Group are expected to

- Provide support to other regional Community Partners in their efforts to submit their Viral Suppression data and QI Intervention data
- Review regional benchmarking report findings after each submission cycle, by accessing the online end+disparities Database, and discuss with other regional Community Partner the implications for moving forward

The Regional Response Team Data Liaisons were also asked to join their counter parts from other Regional Teams to form the Data Liaison Affinity Group. These monthly virtual meetings, facilitated by a CQII consultant, allowed them to share their experiences and best practices.

Learn More | Viral Suppression Submission

D) Write a Regional Quality Management Plan

A quality management plan is a written document that outlines how the Regional Group wants to organize itself, including a clear indication of responsibilities, regional improvement aims, performance measurement strategies and goals, and alignment of local improvement efforts. There was no strict format each Regional Group's Quality Management Plan to follow. Regional Groups were expected to develop a Regional Quality Management Plan or adopt existing regional plans by updating them to reflect the participation in the Collaborative. The following components might be part of the written Regional Quality Management Plan and serve as a checklist:

- ☐ **Regional Improvement Aims**
  - Select a few measurable and realistic improvement goals - utilize the aims outlined in the Regional Group Aim Statement
  - Describe shared vision to which all other activities are directed; assume an ideal world and ask yourselves, "What do we want to be for our clients and our community?"
  - Establish thresholds where the region wants to be
- ☐ **Regional Quality Management Infrastructure**
  - Detail the regional quality management infrastructure – utilize the outline describing the Regional Group and Regional Response Team
  - List internal and external stakeholders and specify their engagements in the Regional Group
  - Define the roles and responsibilities of key persons, organizations, and major stakeholders and clarify their expectations
  - Document who attends Regional Group meetings, who chairs the meetings, and who coordinates the related activities
- ☐ **Performance Measurement and Reporting**
  - Describe who is accountable for collecting, analyzing, and reviewing performance data results and for sharing benchmarking reports – utilize the outline in the Regional Performance Data Management Plan

- Identify indicators to determine the performance of local HIV providers across the region
- Include strategies on how to report and disseminate results and findings; communicate information about quality improvement activities to address identified gaps
- Evaluate the effectiveness of the infrastructure to decide what improvements are needed to further advance the regional infrastructure

☐ **Capacity Building**

- Describe opportunities for QI capacity building among providers and consumers
- Outline how to share best practices for QI performance measurement and QI activities
- Provide technical assistance on QI and performance measurement

Learn More | NQC Cross-Part Quality Management Guide—Chapter 4
NQC Part B Guide—Section 3e
HIVQUAL Workbook – Step 1

E) Outline Regional Sustainability Strategies

One of the major goals of the end+disparities ECHO Collaborative was to create regional improvement networks that remained active at least six months after the end of the Collaborative (June 2020). The Regional Groups form the basis of these regional improvement networks.

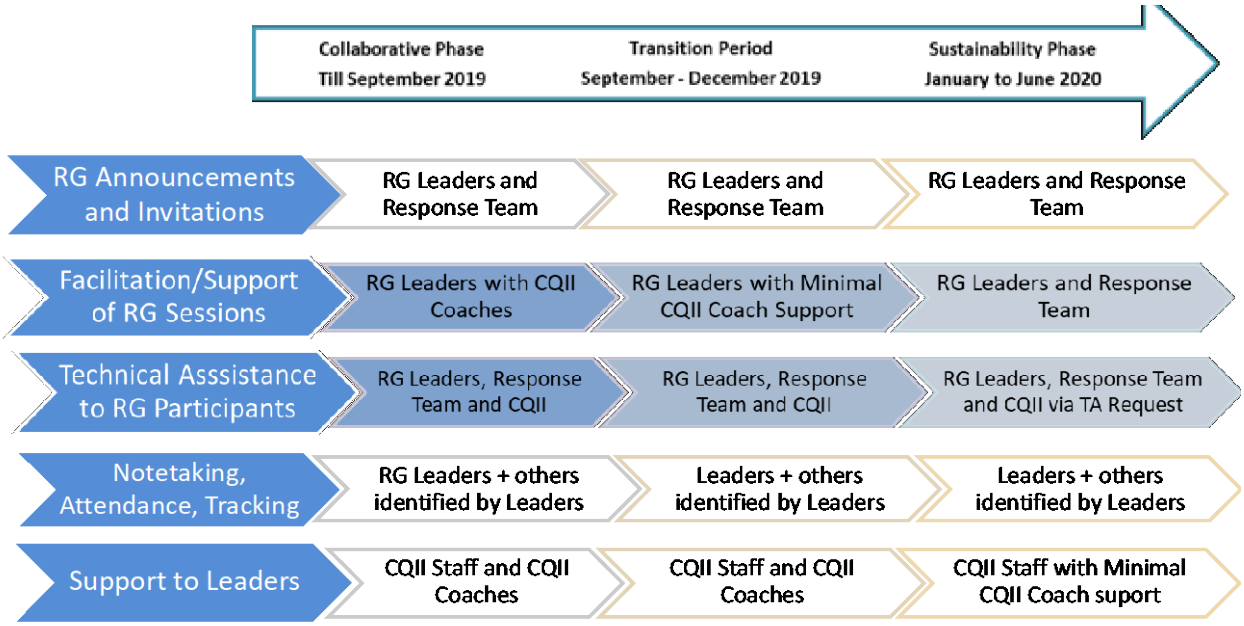
To ensure that the efforts of the Regional Group and its Regional Response Team continued beyond the Collaborative it was important to outline **Sustainability Strategies** that were integrated into the written Regional Group's Quality Management Plan. While there was no strict format, each Regional Group was expected to consider the following questions:

- **Regional Response Team Infrastructure**
  - How often will the Regional Group meet moving forward?
  - Will the Regional Response Team leadership change?
  - Will the Regional Response Team membership change?
  - How will potential turnovers of members be addressed?
- **Engagement of Community Partners within Regional Group/Regional Response Team**
  - How will routine communications between the Regional Response Team and Community Partners be ensured moving forward?
  - How will regional leaders be engaged to continue the efforts of Regional Group?
- **Performance Measurement**
  - How frequently are members of the Regional Group expected to report their Viral Suppression data going forward?
  - Who will review the submissions and generate aggregated reports?
  - What will be done with the data after every submission cycle?
- **Capacity Building**
  - How will the team help continue building QI capacity for providers and consumers?
  - Who will lead these capacity building efforts?

A goal of the end+disparities ECHO Collaborative was for at least 90% of the Regional Groups to be sustained for a minimum of 6 months beyond the end of the Collaborative (through June 2020). The following table illustrates key components of the Regional Group Transition Plan for Sustainability. There are three time periods described: the Collaborative Phase, the Transition Phase, and the Sustainability Phase. The Collaborative Phase includes the active period of the Collaborative and the full support for all Regional Groups by their respective QI coaches. During the Transition

Phase, the responsibility for supporting the Regional Groups will gradually shift to members of the Regional Response Team (previously described). Finally, during the Sustainability Phase, the Regional Group leaders were expected to support their Regional Group members, including data submissions, improvement efforts, and Affinity Groups independent of CQII administration.

Regional Group Transition Plan for Sustainability



Learn More | NQC Cross-Part Quality Management Guide—Chapter 9
HIVQUAL Workbook – Step 6

F) Conduct Training Opportunities for Providers and Consumers

A gap among recipients and subrecipients related to their capacity for quality improvement still exists. This Collaborative provided opportunities to increase the quality improvement capacity of HIV providers and consumers. One of the expressed goals of the Collaborative was for each Regional Group to conduct at least:

- one quality improvement training dedicated to HIV providers: and
- one training to consumers to help them build their capacity.

These trainings should have been designed to meet the individual training needs of participants. It was recommended that no-cost surveying options, such as SurveyMonkey, were utilized in assessing the needs of the participants.

Support by the assigned Regional Group QI Coach, Planning Group, and/or CQII peer consultants was available to fulfill these expectations. Slide presentations on key QI topics, needs assessment surveys to evaluate local improvement needs, and other training materials were available, if requested.

A training log, as well as a Regional Group meeting attendance log should have been maintained by the Regional Response Team to allow tracking of training activities and reported when Regional Group updates were submitted.

G) Regional Group Expectations for Network Agencies

The following Regional Group expectations were for network agencies, like Part A, Part B, and potentially Part D:

- **Participate in the Regional Group and Regional Group Meetings:** Network agencies should attend Regional Group Meetings based on the meeting structure decided upon by the Regional Group.
- **Take a Role in the Regional Response Team:** Given the role of the network in region, Community Partners from network agencies should take on a leadership role on the Response Team or actively support the Response Team by convening meetings, providing logistical assistance, or through conducting regional QI trainings, etc.
- **Encourage all HIV providers in the network to actively participate in the Regional Group**

Learn More | NQC Cross-Part Quality Management Guide—Chapter 9
NQC Subcontractors Guide –Section 2
HIVQUAL Workbook
NQC Part B Guide—Section7

Next Steps

- Finalize the Regional Response Team membership and build team cohesion – June/July 2018
- Establish monthly meeting schedule for the Regional Group – June 2018
- Draft a Regional Quality Management Plan to outline the necessary infrastructure – August 2018
- Plan local training opportunities for providers and consumers

Key Definitions

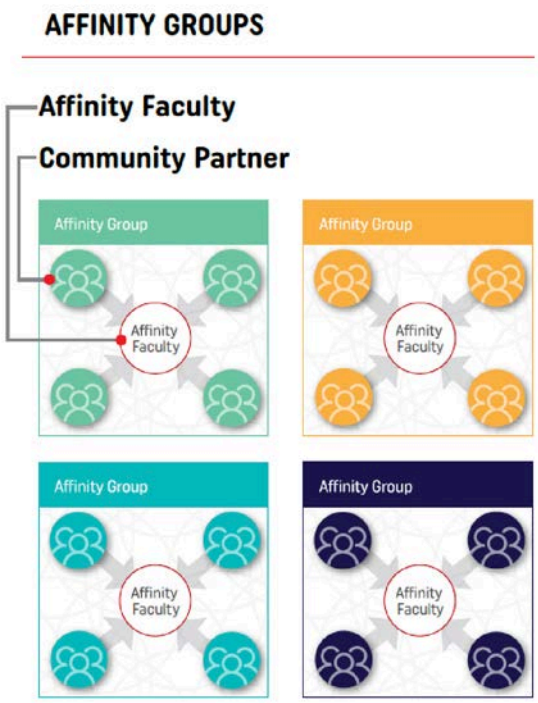
Regional Group	Regional Response Team
Regionally-based improvement group composed of HIV providers (Community Partners) in a respective catchment area (i.e., state, regions within a state, or cross-state areas) who participate in the Collaborative	Community Partners form this group of local quality leaders representing the Regional Group; the Regional Response Teams assume key roles and responsibilities of the Regional Group and include at least one consumer liaison in each team
Regional Group QI Coach	**Regional Group Aim Statement**
Quality Improvement (QI) expert contracted by CQII or CQII staff to support Regional Groups and Regional Response Teams	A document, developed by each Regional Group, describing the current status quo and what each Regional Group intend to accomplish at the end of their improvement work (i.e., further alignment across Parts); it clarifies and focuses the group's direction and scope of work

Frequently Asked Questions

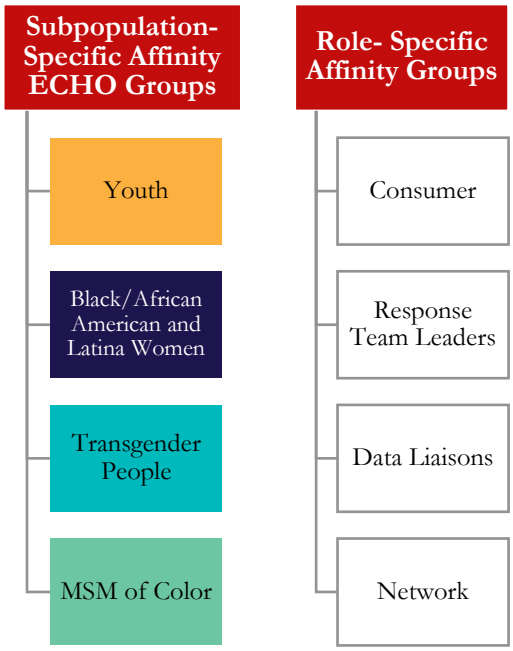
Can all Community Partners in my Regional Group take a Regional Response Team role?	How many people from my organization are expected to attend the Regional Group meetings?
It is up to the Regional Group to determine the size and mix of its Regional Response Team membership. Our advice is to keep the membership small and effective.	The Regional Group should determine the membership and size of the group. Keep in mind that the inclusion of various organizational representatives will result in further engagement and ownership of the success of the Regional Group.
Can we adjust the roles on the Regional Response Team?	Is the Regional Quality Management Plan different from my agency quality management plan?
Yes. Be flexible and decide what works for your group. You can decide to have co-leads for each position, rotate certain functions, add functions that others have not considered yet.	Yes. The Regional Quality Management Plan outlines the activities across all programs in a region and how to align local improvement activities.
Should we integrate the Sustainability Strategies into the Regional Quality Management Plan?	The members of my Regional Response Team do not have previous experience collecting data or conducting a QI training. Who can help us?
Yes. In the past, teams have used their sustainability plans into the existing Regional Quality Management Plans by adding an additional section on sustainability. It is important to highlight steps how to sustain the momentum from the Collaborative going forward.	You have multiple resources available to you. First, reach out to your assigned Regional Group QI Coach to provide the necessary support. Secondly, email CQII staff at CollaborativeSupport@CQII.org or make an Office Hours appointment to seek assistance by CQII staff. Consider the further assistance of your HIV/AIDS Bureau Project Officer or make a formal request for technical assistance from the HIV/AIDS Bureau.

V) Affinity ECHO Groups

The end+disparities ECHO Collaborative combined traditional elements of the IHI Breakthrough Series model with the ECHO model™. To achieve the aims of the national improvement effort, Community Partners from across different Regional Groups were invited to join Affinity Groups and attend each group's virtual Affinity ECHO Sessions using the Zoom platform to create a virtual learning community modeled after tele-ECHO session developed by Project ECHO.



The purpose of the Affinity ECHO Groups was to facilitate peer learning and exchange across all Community Partners, to gain subpopulation-specific improvement insights through learning from content experts, people with HIV, and discussions generated in these sessions. The Affinity ECHO Sessions were facilitated by Affinity Group Faculty, a group of individuals who organize, develop content, and provide guidance for these sessions.



There were two types of Affinity ECHO Groups:

- **Subpopulation-specific Affinity ECHO Groups**, which targeted the same disparity subpopulation
- **Role-specific Affinity Groups**, which supported Community Partners who had similar roles in the Collaborative

Through the enrollment process, each Community Partner identified one HIV disparity subpopulation to focus their improvement efforts. These choices allowed CQII to assign each Community Partner to a subpopulation-specific Affinity ECHO Group. Each Community Partner joined one subpopulation-specific Affinity ECHO Group. CQII identified individuals with specific roles within the Regional Group and assigned them to the appropriate role-specific Affinity Groups.

One-time observers at Affinity Sessions were welcome to attend. If you participated more frequently, each participant was asked to assume all expectations for active participation, including case presentations, based on the 'all teach, all learn, all improve' premise.

While each of the Sessions described above built upon a virtually based community of learners, modifications to the original ECHO model were made. The subpopulation-specific Affinity ECHO

Groups were most closely aligned with the original model. A didactic presentation and case presentations and feedback from both the community and content experts were included. The role-specific Affinity ECHO Sessions (except for the Consumer Liaison group, which followed the original ECHO model) utilized the shared community of learners approach, without the didactics and case presentations.

Using a Webcam when Joining Zoom

It was critical that each participant in the Collaborative, including Community Partners, Faculty members, and CQII staff, joined the various Zoom-based Affinity ECHO Sessions using a web camera. Seeing the various participants on the screen helped to maximize the opportunities to create a virtual community of learners. Here were a few scenarios that could have prevented a participant from using a webcam and how to overcome them:

Barriers and Potential Solutions to Using a Webcam	
I don't have a webcam.	I have a webcam on my computer/laptop, but I don't know how to get it to work.
CQII will provide you with a webcam, if needed, for the duration of the Collaborative so that you can virtually join the Learning Sessions. Simply send CQII an email and we will send one webcam per agency with the understanding that the camera is returned at the end of the Collaborative.	First, contact your IT department and ask to help you. It is an expectation for this Collaborative to join our virtual Learning Sessions and to use a webcam. CQII will try to assist you to the best of our abilities to help us. Set-up an Office Hour appointment.
I use a webcam, but it is not working with Zoom.	We are not allowed to install webcams on my computer.
First, check out the Zoom website at www.support.zoom.us to address the problem. Contact CQII and we will try to troubleshoot the issue with the help of our colleagues at ECHO.	Try the following options: - use a laptop with a camera - arrange to meet as a group/team in a location where a webcam is available - meet with colleagues who have working cameras - use your mobile device, including your phone If no other options exist, dial-in by using the provided phone number and meeting code since we do not want you to miss the important sessions.

A) Subpopulation-Specific Affinity ECHO Sessions

Subpopulation-specific Affinity ECHO Sessions were attended by the Community Partners and Affinity Faculty belonging to the same Affinity ECHO Group. The Affinity Faculty were a team of content experts, including people with HIV, and CQII staff/consultants who support the meeting. People with HIV who participated on the sessions were originally referred to as "population experts", but as the importance of their lived experience was more fully appreciated, they were eventually recognized as full faculty members.

Affinity Faculty Roles				
Facilitator	**Content Experts**	**Content Presenter**	**Coordinator**	**Technology Support**
• Facilitates discussion during Affinity ECHO Sessions • Provides support to Community Partners who present their Case Presentation • Helps the Affinity ECHO Group consolidate feedback on Case-Presentations	• Helps develop a curriculum for Affinity ECHO Sessions with CQII staff support • Presents didactic portion at Affinity ECHO Sessions • Recruits Content Presenters as Content Presenters (guest speakers) for topics when needed • Coordinates with CQII to include additional Content Presenters for topics across all four Affinity Groups • Content Experts have expertise in HIV care through either working directly in the field or through shared lived experiences	• Delivers specialized content on topics relevant to the Affinity ECHO Groups in coordination with the Content Expert	• Coordinates Zoom invitations and reminders • Assists in scheduling additional planning meetings for the Affinity Faculty • Schedules Community Partner Case-Presentations • Reviews Case-Presentation forms created by Community Partners • Follows up with presenting Community Partners' QI Coaches on their Case Presentation	• Present during all sessions to provide Zoom Technology support • Helps faculty utilize polling features and software • Records the didactic element of the session • Monitors the chat room for questions • Takes minutes for the sessions

Session Structure and Meeting Times

Each of the four subpopulation-specific Affinity ECHO Groups (MSM of Color, Black/African American and Latina Women, Transgender People, or Youth) met virtually twice a month starting in July 2018. The frequency of the sessions was revaluated by Affinity Faculty members of each group after the first three months of the Collaborative. Each meeting was 60 minutes long. The meeting cycle for each of the Affinity Groups is listed below:

- **MSM of Color:** First and Third Tuesdays of each month beginning on July 17th | 12:30 – 1.30 pm ET
- **Black/African American and Latina Women:** First and Third Tuesdays of each month beginning on July 17th | 1-2 pm ET
- **Youth:** Second and Fourth Tuesday of each month starting July 10th | 12 – 1 pm ET
- **Transgender People:** Second and Fourth Tuesday of each month starting on July 10th | 1:30 – 2:30 pm ET

While the content focus may differ among the four subpopulation-specific Affinity ECHO Sessions, the sessions had the same agenda and learning structure. All Affinity ECHO Sessions had a shared set of "Ground Rules" that were developed to create comfortable spaces of learning. The rationale behind these rules and terminology used in this Collaborative can be found in the document "Documenting Culturally Sensitive and Gender Affirming Ground Rules."

Subpopulation-Specific Affinity ECHO Session Agenda			
Agenda Item	*Details*	*Lead*	*Length*
Introduction	• Facilitator welcomes participants and sets tone for Session • Facilitator provides overview of session • Brief participant introductions • Engages the audience; potentially using polling questions to interact with participants	Facilitator	~10min
Didactic Presentation	• Content Expert or Content Presenter prepares a 10-minute presentation on a pre-determined topic and include 3-4 discussion/polling questions • The didactic element is presented by the Content Expert or, if the Content Expert or Content Presenter is not available, by the Facilitator • Discussion facilitated by Facilitator	Content Expert, Content Presenter, or Facilitator	~15min
Case Presentation	• Community Partners present their Case Presentation with a focus on challenges and "asks" from fellow peer providers; a template (including a completed sample) and a slide template are provided in the Appendix • To encourage learning beyond the Session, the Faculty provides 1-3 follow-up recommendations to the Community Partner during the session, which is used by the Coordinator to create a document for use by the Community Partner	Community Partner	~15min
Discussion	• Facilitator, with assistance by the Content Expert and Population Experts, poses discussion questions to engage the session participants in response to content and Case Presentation • To engage the audience, previously submitted questions/polls by Content Expert or Community Partner presenter are utilized, as well as live polling and use of chat rooms are encouraged	Affinity Faculty	~15min
Wrap Up	• Facilitator summaries the key points made in the Session • Action items from the discussion are summarized	Facilitator	~5min

Didactics

The didactics were recorded across all Affinity Sessions by CQII. Close to 100 didactics were archived on Glasscubes for Collaborative participants. The list of didactics can be found at end+disparities ECHO Collaborative Didactics.

Community Partner Case Presentations at Affinity ECHO Sessions

Affinity Groups may have different mechanisms for collecting submissions and how the faculty expects Community Partners to prepare for the session. The following outlines the expectations Community Partners were expected to meet. Community Partners received a copy of the slides that

were presented during the Affinity ECHO Session 1-3 days before the actual session. Individuals attending the Affinity ECHO Session were encouraged to review the slides before the meeting to encourage maximum discussion.

Each Community Partner was expected to present at least one Case Presentation during a session through the course of the Collaborative. Case Presentations were fifteen-minute long presentations in which Community Partners reflected on their own agency's performance. They were designed to promote peer sheering, build capacity, learning in real life situations, and help Community Partners receive feedback on their improvement work. These presentations allowed for each Community Partner to receive individualized advice based on the unique needs of their agency allowing the Collaborative to address the diversities and complexities of issues faced by participants. Presentations for Affinity ECHO Sessions may have focused on one of the following areas related to the Community Partners' identified subpopulation:

- One system-wide challenge or barrier
- A current or planned quality improvement intervention
- Best practices or lessons learned based on current or recent quality improvement efforts
- Single patient experience (no patient identifiers) to illustrate the effects of a system issue

To assist Community Partners in developing their Case Presentations a standardized Case Presentation Slide Template was provided with completed samples. The following suggested timeline provided a framework for Community Partners to prepare for and follow-up on their Case Presentation.

Case Presentation Timeline	
Timeline	**Action**
Start of Collaborative (at least 4 weeks before Case Presentation)	**Community Partner**: Sign-up for the date of an Affinity ECHO Session from your Affinity Group that you are available. Please email the Coordinator of your Affinity Group to confirm dates.
2 weeks before Case Presentation	**Community Partner**: Send a draft of Case-Presentation slides to the Affinity Faculty Coordinator **Coordinator:** Review all slides for PHI and collect additional feedback from Affinity Faculty members if necessary.
1 week before Case Presentation	**Community Partner**: Receive comments from Affinity Faculty and make necessary adjustments
1 day before session	**Coordinator: Send finalized Affinity ECHO Session slides to all members of Affinity ECHO Group.**
Day of Case Presentation	**Community Partner**: Present Case-Presentation slides during Affinity ECHO Session; take notes about recommendations and feedback by Affinity Faculty and peer participants **Affinity Faculty**: Provide 1-3 follow-up recommendations to the Community Partner during the Case Presentation.
3 days after Case Presentation	**Coordinator:** Send consolidated notes from discussion and additional resources to Community Partner who presented as well as members of the Affinity Group.
3 or more months after the Case Presentation	**Community Partner:** scheduled a "report back," and completed the associated template to be presented during an Affinity Session to provide an update on their improvement project.

As indicated above, a "report back" presentation was expected at least three months after each Case Presentation. This follow-up presentation provided the Affinity Group members with additional information of activities after the initial Case Presentation and included changes in viral suppression data since the onset of the improvement project.

Attendance at each of the Affinity ECHO Group sessions was recorded in the iECHO program. A spreadsheet of dates, topics, and presenters was developed to keep track of each Session. Copies of the Case Presentation PowerPoint slides and follow-up presentations have been cataloged.

Storyboards

Each of the end+disparities ECHO Collaborative participants were encouraged to submit a Storyboard to capture and visually display key aspects of their improvement projects. A slide template was developed by the Faculty for Community Partners to submit their nominations for inclusion in Learning Session 4. After the review of all submissions and selection by CQII, CQII staff 'converted' the slides into a Storyboard using an agreed template for further input and feedback by the selected submitters. The final Storyboards were professionally printed by CQII and brought to the Learning Session for presentations by the Community Partners at the HRSA/HAB headquarters. Subsequently, each Storyboard was presented on a national webinar on December 11 and 12, 2019 to reach a wider audience.

Affinity ECHO Group Expectations for Network Agencies

The following Affinity ECHO Group expectations were for network agencies, like Part A, Part B, and potentially Part D:

- **Identify a Subpopulation to join an Affinity ECHO Group:** Like all active Community Partners, every network agency registered in the Collaborative must identify one Affinity ECHO Group (MSM of Color, Black/African American and Latina Women, Transgender People, or Youth) to join based on available data; if no medical data are available, such as in networks with supportive services only, select a group that aligns with the priorities of your agency.
- **Participate in Affinity ECHO Sessions and present one Case Presentation:** Every network agency should actively participate in their selected subpopulation's Affinity ECHO Sessions. During the Collaborative every Community Partner is required to present one Case Presentation using the provided template. If no viral suppression data are available; focus on a challenge, current or planned improvement strategies, or a patient experience representative of a system issue
- **Join the Network Affinity Group and attend Network Affinity Sessions:** This role-specific Affinity Group is specifically designed to support network participants. These monthly sessions provide a forum to discuss the application of the Collaborative to network models, and provide opportunities for peer sharing

 Learn More | Case Presentation Template
Case Community Partner Report Back Template Report Back Template

Quality Improvement 'One Step at a Time' Training

A four-session quality improvement training was designed for Collaborative participants who were new to quality improvement, had issues with staff turnover, or were referred for additional training

because of their low viral suppression data submitted via the online end+disparities database. The class included training on the Model for Improvement, PDSAs, Drilling Down the Data, Fishbone diagrams, Flowcharts, and Driver Diagram. Each participant was given homework assignments, which were reviewed at the beginning of each class session. The capstone project for the course was a case presentation from each student in their respective Affinity Group. Three sessions of this class were presented with approximately 30 individuals completing the class.

Leadership Program

The CQII Leadership Program is a capacity building and sustainability approach for end+disparities ECHO Collaborative members who are interested in enhancing their individual skills to take on a co-facilitation role in the Collaborative Affinity Group Sessions. The group meets monthly to learn about facilitation techniques and to complete a related professional development curriculum. Their involvement has resulted in enhancing their capacity to facilitate virtual Affinity Sessions, strengthened the voices of HIV providers in improvement discussions, and has led to improved sustainability, as these individuals are positioned to become future faculty members of Collaborative Affinity Sessions. The capacity building and mentoring efforts by CQII will continue through June 2020 with the hope that the CQII Leadership Program participants will continue their efforts throughout this period and beyond.

Next Steps for Community Partners

- Become familiar with the Zoom platform and ensure that your webcam is working – June 2018
- Put the Affinity ECHO Session schedule in your calendar for the entirety of the Collaborative – June 2018
- Schedule your Case Presentation to showcase your improvement work – June 2018
- Prepare your Case Presentation using the provided template and refine based on input by faculty

B) Role-Specific Affinity Sessions

Unlike subpopulation-specific Affinity ECHO Session, role-specific Affinity Sessions were designed to provide support to individuals involved in specific activities associated with their role in the Collaborative. These sessions did not follow the ECHO model™ used in the subpopulation-specific Affinity ECHO Sessions, specifically no didactic presentations and no Case Presentations. Each Affinity Session facilitator could develop their own session agenda with the input by the Affinity Session participants.

The following table lists role-specific Affinity Groups and the function they serve in Collaborative participation.

Role-Specific Affinity Groups

Group	Function	Participants	Frequency
Consumer Affinity Group	• Support the needs of consumers within the Collaborative	- Consumer liaisons on Regional Response Teams	Monthly

	• Allow consumers or consumer advocates to network and share their perspectives • Build their capacity for quality improvement	- Consumers or consumer advocates from Community Partners - CQII Facilitator	
Response Team Leader Affinity Group	• Support Regional Response Team Leaders in meeting their responsibilities • Provide opportunities for peer sharing	- Response Team Leaders - CQII Facilitator - HAB	Monthly
Data Liaison Affinity Group	• Support Data Liaisons on the Regional Response Teams • Provide opportunities for peer sharing • Answer technical questions related to data submissions	- Response Team Data Liaisons - CQII Facilitator	Before Every Submission Cycle
Network Affinity Group	• Support representatives from network programs • Discuss the application of the Collaborative to their network models • Provide opportunities for peer sharing	- Part A/Part B Recipients - CQII Facilitator	Monthly

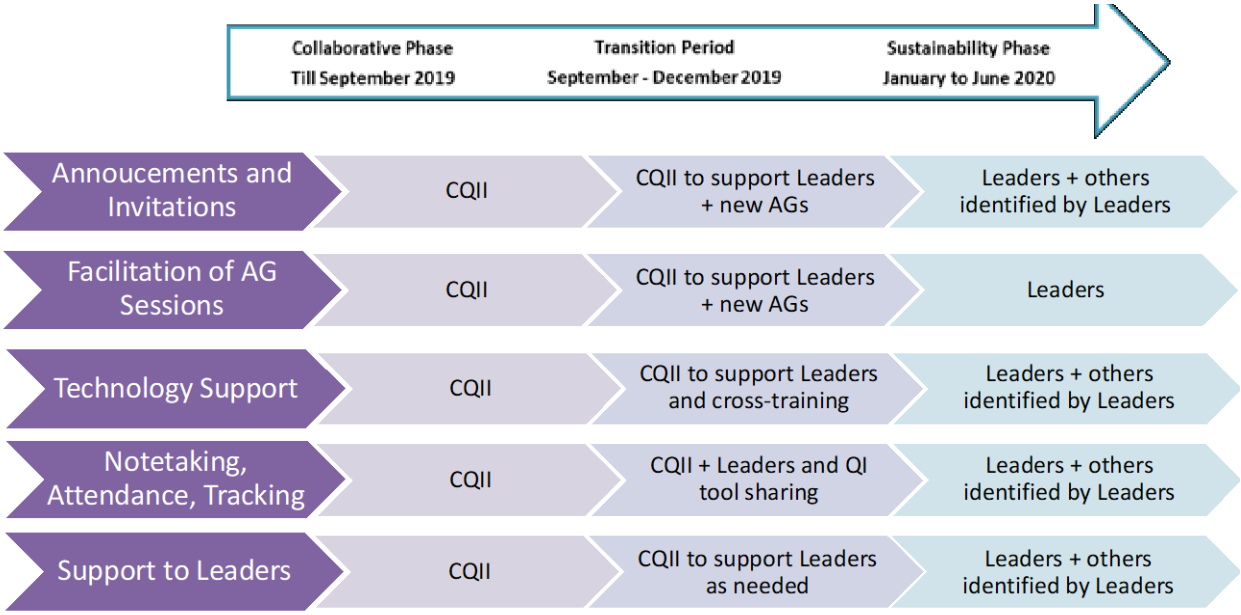
Next Steps

- Ensure that your role-specific Affinity ECHO Sessions are scheduled in your calendar
- Share your insights with your peers on the Affinity ECHO Sessions

Affinity Group Transition Plan for Sustainability

Affinity Sessions may be continued beyond the duration of the Collaborative. Sessions may continue independent of CQII by participants of the Leadership Program. The Affinity Sessions are supported by the Regional Group structure and include a subpopulation focus that is pertinent to the local community. The following chart illustrates key components of the Affinity Group Transition Plan for Sustainability. The Collaborative Phase includes the active period of the Collaborative with the full support by CQII for all Affinity Groups. During the Transition Phase, some of the responsibility for organizing and facilitating the Affinity Groups falls on members of the Leadership Program. Finally, during the Sustainability Phase, the Leadership Program members are expected to maintain their Affinity Groups independent of CQII administration.

Affinity Group Transition Plan for Sustainability



Affinity Faculty Members

Affinity Faculty Contact Information (Table 4)			
Youth			
Facilitator	Adam Thompson	a.thompson@kennedyhealth.org	864-354-8468
Content Expert	Dr. Jeffrey Birnbaum	Jeffrey.Birnbaum@downstate.edu	917-692-7812
	D'Angelo Keyes	mrkeyes326@gmail.com	773-366-4683
	Dottie Rains	DottieDowdell@gmail.com	609-213-5830
	Jordan Delfyette	jpd221@njms.rutgers.edu	347-209-8233
Coordinator	Jennifer Lee	Jennifer.Lee@health.ny.gov	(212) 417-4696
Technology Support	Tai Sampeur	taina.sampeur@health.ny.gov	(212) 417-4730
Black/African American and Latina Women			
Facilitator	Lori DeLorenzo	loridelorenzo@comcast.net	540-951-0576
Content Expert	Dr. Kathleen Clanon	Kathleen.Clanon@acgov.org	510-612-5548
	Kneeshe Parkinson	blessingsoflove39@gmail.com	314-612-0423
	Vanessa Johnson	vjohnson.ribbon@gmail.com	301-768-2852
	Dawn Trotter	dtrotter@evergreenhs.org	716-308-9579
Coordinator	Jennifer Lee	Jennifer.Lee@health.ny.gov	(212) 417-4696
Technology Support	Kehmisha Reid	kehmisha.reid@health.ny.gov	(212) 417-4554
MSM of Color			
Facilitator	Barbara Boushon	boush@frontier.com	608-838-6259
Content Expert	Dr. Latesha Elopre	lelopre@uabmc.edu	205-975-2457
	Joey Pons	joeypons@gmail.com	787-672-7929
	Rene Vega	rvbdta@aol.com	213-245-4153
	Daniel Grier	daniel@birminghamaidsoutreach.org	205-305-7211
Technology Support	Tai Sampeur	taina.sampeur@health.ny.gov	(212) 417-4730
Coordinator	Chuck Kolesar	Chuck.Kolesar@health.ny.gov	(212) 417-4768
Transgender			

Facilitator	Dr. Brian Wood	bwood2@uw.edu	206-459-6410
Facilitator	Jane Caruso	janecaruso2@gmail.com	267-229-9022
Content Expert	Dr. Corinne Heinen	cheinen@uw.edu	206-817-5474
	Cecilia Chung	cecilia@transgenderlawcenter.org	415-902-0216
	Lailani Muniz	lailani.m.10458@gmail.com	347-370-2127
	Teo Drake	teo.drake@gmail.com	860-917-7137
Technology Support	Kehmisha Reid	kehmisha.reid@health.ny.gov	(212) 417-4554
Coordinator	Jennifer Lee	Jennifer.Lee@health.ny.gov	(212) 417-4696
Consumer Affinity Group			
Facilitator	Deloris Dockrey		
Coordinator	Jennifer Lee	Jennifer.Lee@health.ny.gov	(212) 417-4696
Regional Response Team Leader Affinity Group			
Facilitator	Clemens Steinbock	Clemens@CQII.org	212-417-4730
Network Affinity Group			
Facilitator	Chuck Kolesar	Charles.Kolesar@health.ny.gov	212-417-4730
Data Liaison Affinity Group			
Facilitator	Debbie Eisenberg	disenbe@gmail.com	
Coordinator	Chuck Kolesar	Charles.Kolesar@health.ny.gov	212-417-4730

Key Definitions

Affinity ECHO Group	Affinity ECHO Session
Special interest groups formed with Community Partners (collaborative participants) who target the same subpopulation of focus (e.g., MSM of Color), assume similar roles on the Regional Response Team (e.g., Team Leader) or at the community level (e.g., consumer liaisons)	Virtual Affinity ECHO Group meetings focused on one of the disparity subpopulations; these sessions follow the ECHO model™ and include lessons by content experts, case presentations by fellow participants (Community Partners), and opportunities for peer sharing
Affinity ECHO Group Faculty	**Facilitator**
Each subpopulation-specific Affinity ECHO Session is supported by a group of experts who are responsible for planning the content, review of case presentations, and facilitating their respective Affinity ECHO Sessions; membership of the Affinity ECHO Group Faculties is comprised of CQII consultants and staff, Population Experts, and HHIV/AIDS Bureau representatives	Individual contracted by CQII to plan, coordinate, and facilitate Affinity ECHO Sessions; these individuals are part of the Affinity ECHO Group Faculty
Content Expert/Faculty	**Case Presentation**
Individuals with significant content expertise related to a specific disparity subpopulation; individuals may include medical professionals or quality improvement experts. Each Affinity Faculty has content experts who are living with HIV to ensure the consumer perspective is active in all discussion.	Presented by each Collaborative Partner during Affinity ECHO Sessions at least once throughout the Collaborative to promote peer sharing and build local improvement capacity; a standardized case presentation template, slide set, and completed sample are provided

Frequently Asked Questions	
Can I join more than one Affinity ECHO Group?	When should I conduct my Case Presentation and when do I select the date?
You can only join one subpopulation-specific Affinity ECHO Group. You are invited to join other role-specific Affinity Groups if it matches your interests and roles in your agency and Regional Group.	The first Case Presentations will be held in July 2018. We encourage you to schedule your presentation early to maximize the benefits of the learning environment created by Affinity ECHO Sessions.
Do I receive feedback prior to the Case Presentation?	What should I do with the feedback in response to my case presentation?
Yes. We developed a timeline to submit your draft slides to the Faculty several weeks before to allow you to incorporate their feedback. Use the template and completed sample to make it easier for you and your agency.	We encourage you to incorporate the recommendations you received. Later in the Collaborative cycle, we will ask you to present your Case Presentation follow-up to your Regional Group and give an update what you have done with the information.

VI) Viral Suppression Performance Measurement Reporting

The end+disparities ECHO Collaborative was about improvement of care for people with HIV, not performance measurement. However, measurement played an important role throughout the initiative. Measurement of viral suppression data helped participants to evaluate the impact of changes made to improve the quality and systems of care. Always remember that measurement should be designed to accelerate improvement, not slow it down.

Routine performance measurement reporting by Collaborative participants centered on one standardized measure (viral suppression) for two different patient groups (entire HIV caseload and identified HIV subpopulation). Each participating Community Partner was expected to submit their performance data every other month via the online end+disparities Database beginning in July 2018; see Data Reporting Table.

The facilitate the regional data collection efforts and ensure consistencies across all participating providers, each Regional Group was asked to develop a written Regional Performance Data Management Plan, which outlines the data collection expectations and roles.

Performance Measure

The Collaborative adopted the HIV/AIDS Bureau (HAB) viral suppression measure definition (National Quality Forum #: 2082): percentage of patients, regardless of age, with a diagnosis of HIV with an HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year.[15]

[15] https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/coremeasures.pdf

Performance Measure: HIV Viral Load Suppression

National Quality Forum #: 2082

Description:	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year
Numerator:	Number of patients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year
Denominator:	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year
Patient Exclusions:	None
Data Elements:	1. Does the patient, regardless of age, have a diagnosis of HIV? (Y/N) a. If yes, did the patient have at least one medical visit during the measurement year? (Y/N) i. If yes, did the patient have a HIV viral load test with a result <200 copies/mL at the last test? (Y/N)

Every other month, each Community Partner was asked to report viral suppression data for

a) all HIV patients receiving HIV outpatient ambulatory health services in a 12-month measurement period (**entire HIV caseload**); and
b) all HIV patients identified in the participant-selected disparity subpopulation who receive HIV outpatient ambulatory health services in a 12-month measurement period (**HIV subpopulation**).

Each Regional Group needed to decide on the criteria for defining people with HIV receiving HIV outpatient ambulatory health services (for instance, RWHAP eligible scope versus all clients) and outline these criteria in a Regional Performance Data Management Plan. The following data points were required to be submitted by Community Partners using the online end+disparities Database at each data submission deadline using a rolling measurement year (see Data Reporting Table):

- Numerator and denominator for entire HIV caseload
- Numerator and denominator for identified HIV subpopulation

Data Reporting Timeline

The following table outlines the due dates (the third Friday in each reporting month) to submit the viral suppression data and corresponding 12-month measurement periods for each reporting cycle:

Report Due Dates	12-Month Measurement Period
July 20, 2018	May 1, 2017 – April 30, 2018
September 21, 2018	July 1, 2017 – June 30, 2018
November 16, 2018	September 1, 2017 – August 31, 2018
January 18, 2019	November 1, 2017 – October 31, 2018
March 15, 2019	January 1, 2018 – December 31, 2018
May 17, 2019	March 1, 2018 – February 28, 2019
July 19, 2019	May 1, 2018 – April 30, 2019
September 20, 2019	July 1, 2018 – June 30, 2019
November 15, 2019	Sep 1, 2018 – August 31, 2019

end+disparities Database

All data submissions were made to an online Collaborative database, called end+disparities Database, at **database.enddisparities.org**, which was adapted from the previous in+care Campaign. Each Community Partner submitting performance data was instructed to set-up a user account (one per agency) and reported the numerator and denominator data for both patient populations (entire HIV caseload and identified HIV subpopulation) according to the agreed-upon Regional Performance Data Management Plan. In addition, participants were asked to enter short statements to describe confidence in the data they submitted, including challenges, such as lab reporting errors or complications to access all patient data.

Here are a few features of the online Collaborative database:

- Easy to use platform that has been previously and successfully utilized by a national HIV improvement initiative
- Immediately trends entered performance over time
- Allows to group all Community Partners in a Regional Group to produce a single regional performance score
- The benchmarking functionality compares all submissions by participants in the Collaborative, top 10% and top 25% performers across all submissions, and stratification by Part, state, or facility type
- Gives your Response Team Data Liaison and assigned Regional Group QI Coach access to look at individual local performance data and across a region, and ability to download the data for further analysis

Each Community Partner was asked to set up one account per agency to avoid double entry and reporting. The Data Liaison on the Response Team and the assigned Regional Group QI Coach were given the appropriate access in the online database to look at performance data across a region. Each user of the database had routine access to their own performance data reports and trends over time, aggregated Regional Group benchmark reports, and other national benchmarking reports.

Deduplication of Local Data Submissions

To aggregate the viral suppression data across a Regional Group, all local submissions by Community Partners needed to be unduplicated, unless regional, real-time databases existed to draw the information. Please note that individual patient data were not unduplicated across agencies. However, individual patient data were unduplicated when individual Community Partners report their own data.

The Regional Response Team developed a methodology to assure that each organization's performance data were only counted once regardless of the number of Parts through which they were funded (either directly by HIV/AIDS Bureau or by another Ryan White HIV/AIDS Program recipient). For example, an organization that is a Part C/D recipient as well as a Part A/B subrecipient would only have their performance data counted once for each measure in a regional benchmarking report. Part A or B recipients with subrecipients, which provide HIV primary care, needed to collect performance data from their subrecipients.

Each Regional Group had multiple options to ensure that each facility data was only counted once:

a) Option A: Each Community Partner, regardless of their funding stream, that provides HIV medical outpatient care in the region submits their performance data in accordance with the Collaborative expectations directly to the online database

Considerations:

- All HIV providers are only counted once
- The actual scores for Part A, Part B, and others need to be aggregated based on local funding streams after all data are reported
- The recipients may not necessarily know right away which of the subrecipients have reported or not

b) Option B: All regional RWHAP-funded recipients with no other RWHAP subrecipient funding streams report their performance data directly in the online database AND all RWHAP-funded subrecipients report their performance data to their recipient funder who reports the aggregated performance data directly in the online database; be aware that each subrecipient with multiple funding streams can only be counted once

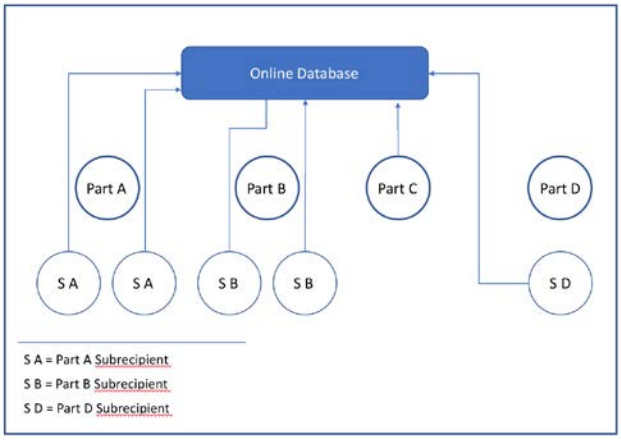
Considerations:

- A clear data reporting hierarchy needs to be developed and communicated to all regional Community Partners before data are reported either to the database or to the recipient
- In case of subrecipients with multiple funding streams, the actual scores for Part A, Part B, and others need to be aggregated after all data are reported

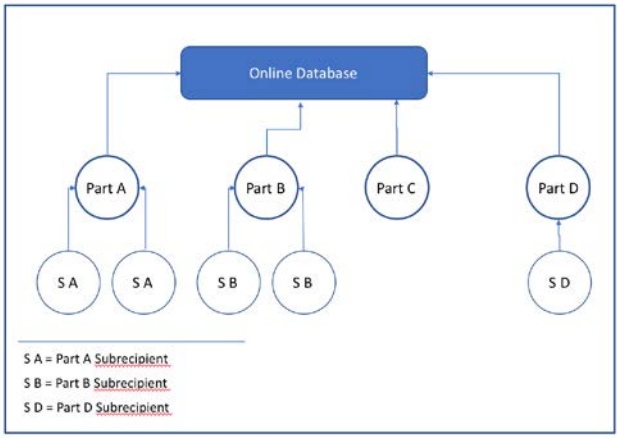
c) A hybrid solution agreed upon by the Response Team based on local funding streams and preference

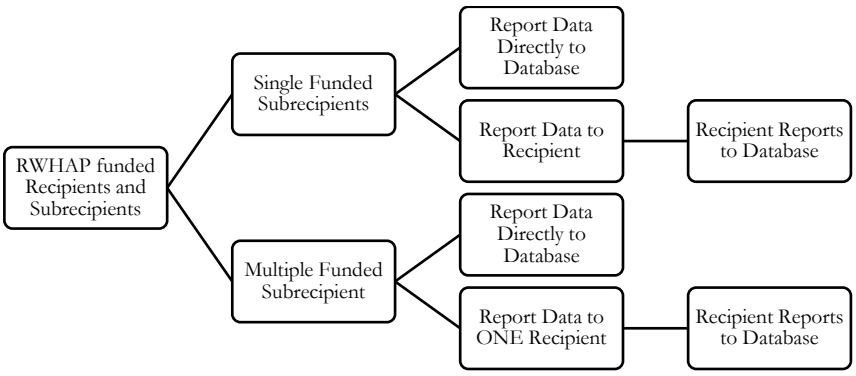
The following illustration outlines the first two options:

Option A



Option B





Each Regional Group was asked to develop their own Regional Performance Data Management Plan to outline how data were reported across the region safeguarding that each facility is only counted once, definitions to ensure alignment of data collection efforts by all regional Community Partners, and the necessary roles and responsibilities.

Network Agency Expectations

Only those networks that provide medical care were in a position of reporting viral suppression data every other month; in other words, if a network provided non-medical services only, they could not report viral suppression data. Therefore, we suggested network participants to do the following:

- Encourage and assist all medical providers in the region to submit their data by providing support and technical assistance in their performance measurement reporting efforts
- Play an active role in developing the Regional Performance Data Management Plan

Regional Performance Data Management Plan - Guiding Questions

The following questions were intended to guide the thought process by the Regional Response Team in developing the written Regional Performance Data Management Plan. The purpose of this Plan was to outline how performance data were routinely reported from all HIV agencies across the region, data results are tabulated and analyzed, benchmark reports are generated and shared, and how the roles and responsibilities were distributed. This plan was an integral part of the overall Regional Quality Management Plan.

This list of questions was not all-encompassing but aimed to identify key issues regarding regional data collection efforts and to shape the development of the Regional Performance Data Management Plan. While the Collaborative Faculty did not propose a specific format, a sample was suggested below to allow each region to uniquely articulate their performance measurement strategies. A starting point for any plan was an accurate listing of all local HIV providers, their funding streams, and where data was reported to by local Community Partners.

Guiding Questions to develop your Regional Performance Data Management Plan:

- Which agencies are providing Ryan White HIV/AIDS Program-funded HIV ambulatory medical care in your region?
    - For each agency, which Ryan White HIV/AIDS Program funds do they receive?
    - Which Ryan White HIV/AIDS Program Part are they a subrecipient of?
    - Who will serve as a data contact at each agency?
- What is hierarchy for reporting local Collaborative performance data across your region?
    - To whom are recipients and subrecipients reporting their data?
- How will your Response Team review and analyze data submitted by HIV providers?
    - How do you plan to deduplicate the data collected at the agency level (i.e., agencies that receive funding through Ryan White Parts)? Note that you are not excepted to deduplicate patient-level data.
    - Who is responsible on the Response Team for data collection, review, and reporting? Note that this task may be too large for the Data Liaison to handle alone.
    - What mechanism will you use to communicate results? Via Glasscubes, emails to Community Partners, newsletter, etc.?
- How do you plan to schedule key activities for the submission of viral suppression data by local Community Partners?

  - What guidance and support will you give to agencies regarding data collection and submission?
  - How do you prepare benchmarking reports? What template are you considering?
  - What process will you have to disseminate your regional data to local agencies?
- What type of data will be shared back to local Community Partners?
  - How will you share aggregated data from the entire Regional Group? Do you want to include aggregated data from each Part?
  - Will you share individual data from each Community Partner? If so, blinded or unblinded?
  - Do you consider using benchmark reports? What data will you include (i.e., top percentiles, Parts, other Regional Groups)?
- How will you use the benchmark reports to initiate improvement activities?
- What are the roles and responsibilities in the data management efforts?
  - Who is responsible for data collection efforts at each agency?
  - The Response Team Data Liaison representative joins the routine Data Affinity Group Sessions. Are additional individuals joining these Affinity Sessions?

Regional Performance Data Management Plan Sample

The following sample plan allowed Regional Groups to draft a Regional Performance Data Management Plan. Each Regional Group was encouraged to adapt parts of the plan, make changes where needed, and add their personal perspectives to the plan.

"[*Regional Group Name*]
[*date*]

[*overview*] The end+disparities ECHO Collaborative, a national quality improvement initiative with participation by Ryan White HIV/AIDS Program (RWHAP) recipients and subrecipients across all Parts, focuses on reducing disparities by increasing viral suppression rates in four disproportionately affected subpopulations of people with HIV (PLWH): MSM of Color, Black/African American and Latina Women, Transgender People, and Youth. The 18-month Collaborative, which is managed by the HRSA Ryan White HIV/AIDS Program Center for Quality Improvement & Innovation (CQII), formally known as NQC, in partnership with the HRSA HIV/AIDS Bureau, aims to decrease the number of PLWH who are not virally suppressed by 25% by engaging one in three RWHAP recipients across the nation.

[*purpose*] The purpose of this Regional Performance Data Management Plan is to outline how performance measurement data, an expectation to participate in the end+disparities ECHO Collaborative, are routinely collected from all HIV agencies providing medical care across our region, data results are tabulated and analyzed, benchmark reports are generated and shared, and the roles and responsibilities of those who oversee this process.

[*performance measure*] Performance measurement plays an important role throughout the Collaborative, evaluating the impact of changes made to improve the quality and systems of HIV care in our region. Please keep in mind that the ultimate goal of this Collaborative is improving care for people with HIV, not measurement alone. The following list of measures, consistent with HIV/AIDS Bureau measure definitions, are collected every other month, starting on July 20, 2018:

1. For all HIV patients receiving HIV outpatient ambulatory health services (entire HIV caseload): Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year (HAB Measure: HIV Viral Load Suppression)

2. For all HIV patients identified in the participant-selected disparity group who receive HIV outpatient ambulatory health services (identified HIV subpopulation): Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year (HAB Measure: HIV Viral Load Suppression)

It is the expectation that regional RWHAP recipients/subrecipients in our region that provide adult or pediatric HIV care submit their performance data. Recipients who subcontract HIV medical care are to collect performance data from their subcontracted agencies.

[*data reporting timeline and reporting database*] Each agency providing HIV medical care submits their viral suppression performance data as outlined by the Collaborative Faculty every other month starting in July 2018 (the third Friday in each reporting month).

The Data Liaison, who routinely joins the Data Liaison Affinity Group led by the Collaborative Faculty, discusses the data reporting details with and reported potential changes over time to regional providers. The Response Team or the designated Data Liaison provides notification about the upcoming data submission, at least 3 (three) weeks prior to the bi-monthly submission deadline.

Any technical assistance questions by agencies regarding the performance measures and reporting cycle are directed first to the designated Data Liaison and/or the assigned Regional Group QI Coach.

[*unduplication of local data submissions*] While our Regional Response Team is not expected to unduplicate individual patients' data, even though patients may have received services at more than one location, we unduplicate the agency data. Based on the list of all local HIV providers and their funding streams, a data reporting hierarchy is developed to ensure that each agency is counted only once throughout the region. Accordingly, each agency is informed how to report the data, either directly into the end+disparities Database or to a recipient on record for reporting the data into the database by the recipient. [*insert data reporting hierarchy, either in a table or graphic*].

[*data analysis and benchmarking*] Once all performance data are collected across the region, the Response Team computes the aggregated numbers for each Part. The Data Liaison has the appropriate access in the online end+disparities Database. The Response Team reviews the findings and discusses any follow-up step to further improve the performance score and provide technical assistance to individual sites. A benchmarking report is openly shared within two (2) weeks after each reporting cycle with all regional stakeholders.

[*technical assistance*] When individual agencies need assistance to report their performance data, the Response Team will provide the necessary support or discusses the challenges of the individual agency with the assigned Regional Group QI Coach.

[*responsibilities for data collection, analysis, review, and reporting*] The following individuals have assumed responsibilities to analyze and review the performance data, to provide guidance to Community Partners, to disseminate benchmarking reports… [*TBD*].'

Benchmark Report

Each end+disparities ECHO Collaborative participant submitted their total caseload and subpopulation viral suppression data every two months during the Collaborative. A benchmark report was then generated and distributed to all participants, which included the number of sites submitting, total number of patients and their corresponding aggregate viral suppression rates, the running subpopulation viral suppression rates, as well as tables of raw data. Key findings and

indicator definitions were also included in each report and shared in the Collaborative Announcements.

Learn More | URL: database.enddisparities.org

Next Steps

- Become familiar with the reporting expectations – June 2018
- Mark the reporting deadlines in your calendar – June 2018
- Set up accounts in the end+disparities Database – June 2018
- Draft the Regional Performance Data Management Plan and identify who is reporting to whom for the first data collection cycle – July 2018
- Get ready for first data collection cycle – July 2018

Frequently Asked Questions

Can I use my account from the in+care Campaign?	Should I sign up multiple people from our agency?
Yes. In case you have used the in+care database before, we have reset all accounts and left all profile information and passwords in the database. If you have not used the database before, simply set up a new account.	No. We ask you to set up one account per agency to avoid double entry and reporting.
I am a Part A subrecipient. Should I report to the database directly or submit the data to Part A/B?	Do I need to report on all HIV subpopulations?
A Regional Performance Data Management Plan needs to be developed by the Regional Group prior to the first data collection cycle to clarify the reporting structure (who reports to whom).	No. Each agency reports every other month on the entire caseload and the agency-selected HIV subpopulation.
How do I know that my performance data were 'acceptable'?	What happens if my performance is lower than expected?
If you submit your performance data to the Response Team, check with the assigned individual(s), likely the Data Liaison on the Response Team, to clarify the accuracy of your submission. Routine feedback by the Response Team is critical to allow for corrections in the data submission process and to suggest improvements.	The aim of the Collaborative is to improve HIV care, learn from the other agencies and improve the data collection process. Lower than expected performance scores provide opportunities for learning.
Patients are seen by multiple medical providers over time. Are we expected to unduplicate these patients across agencies when reporting?	Should fee-for-service medical providers be included in the measurement process?
No. We do not expect the Response Team to un-duplicate individual patients' data across agencies even though patients may have received services at more than one location.	Each Regional Group should determine whether performance data is incorporated from all agencies, including fee-for-service or not, and develop their Regional Performance Data Management Plan accordingly.
I have additional questions. Whom should I ask?	An agency that does not currently receive RWHAP funding wants to get involved in the Collaborative?

Any technical assistance questions by agencies regarding the performance measures and reporting cycle should be directed first to the designated Data Liaison, Regional Group QI Coach, or email CQII. Office Hours are also available to individual agencies	One of the Collaborative goals is to build a local community of learners. The Regional Group will determine how to best integrate non-RWHAP funded providers in the Collaborative.

VII) Quality Improvement Intervention Submission

Individual Community Partners, including RWHAP recipients and subrecipients, and Regional Groups reported their improvement efforts to reduce HIV-related disparities on a quarterly basis. QI Intervention reports were expected from participants and Regional Groups every three months beginning in September 2018. The following table outlines the due dates the reports were submitted:

Report Due Dates
September 3, 2018
December 3, 2018
March 1, 2019
June 3, 2019
September 2, 2019

Community Partners

A QI reporting template, called Community Partner Reporting Form Template, was provided to Community Partners, as well as a completed sample, and included the following data fields:

- Agency Name
- Selected Subpopulation of Focus
- Improvement Activities
- Performance Data over time
- Major Accomplishments/Lessons Learned
- Major Challenges
- Technical Assistance Needs

The completed reporting form was submitted by participants to the designated Glasscubes folder to ensure that their Regional Response Team members, assigned Regional Group QI Coach, and Regional Group participants had appropriate access, and to promote peer sharing and networking.

The information on the Community Partner Reporting Form Template should have grown cumulatively over time and chronicled the individual improvement journeys. Each data field did not need to be completed each submission cycle period; only activities/findings related to that reporting period were reported. Ideally, the reporting template submitted by participants had life well beyond the submission cycles. The Planning Group reviewed the reports and aggregated relevant findings each submission cycle to highlight QI successes and QI champions.

Submitters were encouraged to pass the information forward for use:

- Within their organizations for staff and board meetings
- In their locality/region for use in educating the community and development purposes
- At local/regional/national QI and HIV conferences

Quality Improvement Expectations for Network Agencies

The following expectations were for network agencies, like Part A, Part B, and potentially Part D:

- Conduct meaningful and impactful QI efforts to reduce disparities in your network, regardless of whether you provide medical and/or supportive services
- Support HIV providers in your network regarding their improvement efforts
- Report your improvement efforts every quarter, following the same expectations as other Community Partners

Learn More | Community Partner Reporting Form

Regional Groups

A separate reporting form for Regional Group activities was shared with the Regional Response Team. This form was completed by the assigned Regional Group QI Coach in collaboration with the Regional Response Team. Monthly Regional Group meetings provided a routine forum to discuss the content and to jointly complete this form. The same reporting deadlines apply here as for the reporting of QI interventions by Community Partners.

Learn More | Regional Response Team Reporting Form Template and Sample
Regional Group Aim Statement and Template

Next Steps

- Mark the reporting deadlines in your calendar – June 2018
- Familiarize yourself with the reporting templates and completed samples – July 2018
- Rather than waiting till the reporting deadline, complete the form along the way

Frequently Asked Questions

I represent the Community Partner and I am a member of the Regional Group. Do we need to submit two updates?	Do I need to fill out the form every time we report?
Yes. You need to submit one for submission for your agency. Work with other Regional Group members since you will need to submit one joint regional QI update.	No. The Reporting Form Template should grow cumulatively over time. Each data field does not need to be completed each submission cycle period; only activities/findings related to that reporting period are reported.

VIII) Final Results of Collaborative Outcomes

Intermediate Implementation Evaluation

An Intermediate Implementation Evaluation was conducted by the Center for Human Services Research at the University at Albany, State University of New York. Key Findings regarding viral suppression data and affinity and regional group experiences included:

Viral Suppression Data. Most survey respondents (79%) reported having submitted viral suppression data to the Collaborative at some point over the past year. On average, viral suppression rates for both Community Partner's entire population and for their disparity subpopulation were reported to have improved about 4% over the course of the Collaborative; these numbers were highly similar to those recorded in the end+disparities Database, demonstrating reliable data. Participants reported that they had used viral suppression data to track their progress toward QI goals and determine the impact of their QI projects, identify and address HIV disparities, and benchmark their performance to that of other participants.

Affinity and Regional Group Experiences. Partners were very positive about their Affinity Group experiences, over 85% agreed that they were helpful, over 80% agreed that they were well-run, and 74% agreed that they felt comfortable participating. They also felt that Affinity Groups kept them informed about QI information that supported their projects. • Partners were similarly positive about their Regional Groups. Participants agreed that they strengthened partnerships (78%), coordinated efforts (79%), followed up on data (79%), and helped them prepared for QI work (87%). They also reported that Regional Groups effectively connected them to local resources relevant to their work. • Most respondents (81%) agreed that the Collaborative had helped strengthen their Regional Group, often by increasing regional QI capacity, providing support for activities, and strengthening peer and regional networks.

Collaborative Data Findings

The end+disparities ECHO Collaborative represents the largest quality improvement collaborative that CQII, formerly known as the National Quality Center, has managed in terms of number of participating RWHAP recipients and number of HIV patients impacted. It represents the largest quality improvement ECHO across the world, regardless of the focused disease. One in eight persons with HIV in the U.S. were reached by the Collaborative.

end+disparities ECHO Collaborative Results

Reach:

- 35% (201 out of 567) of all RWHAP Part A, Part B, Part C and Part D-funded recipients participated the end+disparities ECHO Collaborative (Part A=24, Part B=21, Part C=108, Part D=48)
- 46% of RWHAP Part A recipients (24/52) and 41% of Part B recipients (21/51) participated
- Out of the 201 RWHAP recipients participating in the Collaborative, 185 (92%) RWHAP recipients actively participated in the Collaborative
- HIV providers across 31 States or Territories were represented in the end+disparities ECHO Collaborative

- 17 Regional Groups participated with an average of 12 RWHAP recipients per Regional Group
- Collaborative reached 138,000 people with HIV or 38.4% of all Ryan White patients receiving medical care; 1 in every 2.6 RWHAP patients (RSR 2018 Data)
- 11 out of 15 States and Territories with the lowest viral suppression rates were participating, as well as 6 out of 10 EMAs/TGAs with the lowest viral suppression rates (RSR 2018)

Collaborative Activities:

- Over 1,100 individuals participated in end+disparities ECHO Collaborative activities
- Throughout the 18-month Collaborative, a total of 120 Affinity Sessions were held with over 3,400 participants; an average of 29 participants per Affinity Session
- 422 unduplicated individuals participated in Affinity Sessions; on average 7.7 Affinity Sessions per individual recipients
- 144 RWHAP recipients submitted data; on average, 6.7 out of 9 reporting cycles
- 119,766 patients were reported; an average for each reporting cycle
- Over the course of the Collaborative (June 2018-December 2019), 92% of RWHAP recipients actively used the online shared drive (Glasscubes); 80% of RWHAP recipients participated in at least one virtual Affinity Session; 72% of RWHAP recipients submitted viral suppression data at least once; 67% of RWHAP recipients attended any Learning Session; 63% of RWHAP recipients have documented quality improvement efforts; 48% of RWHAP recipients presented their Case Presentation; and 15% of RWHAP recipients participated in the virtual QI training course that was offered three times (up to 15 training participants per training)
- 173 (86%) RWHAP recipients meet any of the following five core Collaborative activities, while 99 (49%) recipients met four or more these conditions: (1) attendance of 5 or more Affinity Sessions, (2) 2 or more data submissions, (3) at least one Case Presentation, (4) attendance of at least one Learning Session, and (5) documented QI efforts

Impact:

- Overall, the viral suppression rate for entire HIV caseload increased from 83.2% (Jul 2018) to 87.2% (Nov 2019)
- The end+disparities ECHO Collaborative decreased the number of people with HIV who are not virally suppressed by 24.0%, nearly reaching the Collaborative goal of 25%
- Between July 2018 and November 2019, the subpopulation viral suppression rates increased on average 5.1%
- During that time period, the subpopulation viral suppression rates increased for Black/AA Latina Women from 81.8% to 86.8%; MSM of Color from 82.0% to 84.0%; Transgender from 77.9% to 85.3%; and Youth from 72.2% to 78.2%
- The viral suppression rates for agency-identified HIV subpopulations improved at a higher rate than the overall viral suppression rates between July 2018 and November 2019
- The average agency viral suppression rates difference between HIV subpopulations and the entire caseload were reduced by 3.9%: Black/African American and Latina Women from 0.4% to 1.0%; MSM of Color from -3.3% to -1.4%; Transgender from -13.3 to -4.2%; Youth from -11.0 to -7.1%

IX) Appendix

Index of Resources and Forms

Name of Resource (Link provided when applicable)	Description	Format
Affinity Group Faculty Training	A training that provides an overview of Affinity Groups and Sessions, how to facilitate virtual meetings through Zoom, and advanced Zoom technology.	Zoom Session
Case Presentation Template	This is a template created to help Community Partners prepare for their Case Presentation. It includes the required elements for a Case Presentation.	Slide Show
Collaborative Benchmark Reports	Benchmark reports are released after every data submission by CQII. It provides information on the progress of meeting the Collaborative aims and how the data performance results compare to the overall Collaborative goals.	Reference Document
Collaborative Toolkit	This is a document for all participants in the Collaborative that details the roles, expectations, and submissions of the Collaborative. It outlines participants how to approach each specified task in the Collaborative and the corresponding resources.	Reference Document
Community Partner Aim Statement Template and Sample	A guide that instructs participants on how to develop an Aim Statement to target their subpopulation specific goal.	Form
Community Partner Reporting Form	A reporting template for Community Partners to document their improvement journey and submit via Glasscubes every quarter. A completed form is attached.	Form
Community Partner Survey	A survey given to Community Partners that ensures that the Collaborative is meeting their needs. This form provides participants with an opportunity to suggest changes to the Collaborative or within their Regional and Affinity Groups.	Form/Survey
Consumer Affinity Sessions	An Affinity Session dedicated to consumers, consumer advocates, or consumer liaisons to ensure that the consumer voice is heard, and that	Zoom Session

	relevant feedback can be incorporated into other aspects of the Collaborative.	
Regional Group Assessment Tool	A tool designed to assess the regional alignment of improvement efforts in a Regional Group. It is used during or after the Learning Sessions.	Form
Data Liaison Affinity Sessions	An Affinity Session that is designed for Data Liaisons on the Response Teams to help support Regional Response Team members with data collections and the corresponding technologies.	Zoom Session
Detailed Calendar	A calendar of suggested agenda items for monthly Regional Group Meetings.	Document
Disparity Calculator	A tool designed to help participants find disparities within their client populations. This information can then be used to select a subpopulation of interest for the Collaborative.	Other
end+disparities ECHO Collaborative Website	The website for this Collaborative allow RWHAP recipients access to resources and tools of the Collaborative.	Website
Glasscubes	A file sharing platform used to share and submit all documents for the Collaborative aside from Viral Suppression Data submissions which are done through the database.	Website
Group Enrollment Form	The form participants must use to nominate a group for enrollment. This form is used in the first phase of enrollment before Regional Groups are created and individual RWHAP-funded recipients and subrecipients can register as Community Partners.	Form
HIVQUAL Workbook	An explanatory guide for the HIVQUAL model.	Guide
HRSA HIV/AIDS Bureau CQM Technical Assistance Referral Form	A link to the Target center which can help participants in the Collaborative sign-up to receive Technical Assistance beyond what is provided within the Collaborative.	Online Form
HRSA HIV/AIDS Bureau Invitation Letter	An introduction to the Collaborative for HIV/AIDS Bureau Leadership.	Letter
Individual Agency Registration Form	The form RWHAP recipients/subrecipients must fill after receiving their Regional Group assignment to confirm their participation in the Collaborative.	Form
Intervention Grid	A tool designed to help participants select potential interventions for their QI Interventions/Projects.	Reference Document
Key Terminologies and Definitions	A document listing and defining key terms used throughout the Collaborative.	Reference Document

Kick-Off Sessions Materials	A series of identical web-conferences held by CQII staff and HRSA HAB leadership that introduced the Collaborative to potential participants. It was one of the first forms of advertisement about the Collaborative. A recording of the session, as well as the slides and corresponding documents can be found through this link.	Web-conference
Learning Sessions	Learning Sessions are major meetings in the learning Collaborative. The first Learning Session is an in-person meeting, which is attended by CQII Staff, HAB, Regional Group members, and Population Experts. The follow three Learning Sessions are all conducted virtually through the Zoom platform and are open to attendance by Community Partners and not only their Regional Response Teams.	In Person Meeting/Zoom Session
Literature Review Slide Set	A PowerPoint presentation with information on the disparities within the HIV community.	Reference Document
Making a Mark: Demonstrating Health Impacts H4C Collaborative Report	The evaluation report of the H4C Collaborative that describes the impact from the last NQC/HAB Collaborative. This report was issued by an external evaluator, John Snow, Inc.	Report
Disparities Video	A video to introduce disparities within HIV and to describe the need for a national collaborative.	Online Video
Collaborative Milestones Document	A visual aid to understand the meeting structures and submission cycles of the Collaborative.	Reference Document
Mock Affinity Packet	Several Mock Affinity Sessions are held to prepare participants and Affinity Faculty members. Mock Sessions will be held by each Affinity Group Faculty Facilitator at least once before the first Learning Session. The first Learning Session will also have Mock Session to help Regional Response Team members experience the structure. This packet includes information on what the purpose and details of a Mock Session entails.	Zoom Session
NQC Cross-Part Quality Management Guide	A guide on how to development regional improvement capacity across Parts.	Guide
NQC Part B Guide	A guide which shares the best-practices from participating Part B programs in previous Collaboratives.	Guide
NQC Subcontractors Guide	A guide which shares the best-practices from participating Ryan White HIV/AIDs Program recipients that utilized subcontractors to improve HIV Care and services.	Guide
Office Hours	These are virtual meetings attended by participants in the Collaborative who have questions about an element of the Collaborative. They are	Zoom Session

	schedule ahead of time through a scheduling tool to ensure that the meeting can answer specific questions.	
One-Page Flyer	An early marketing document used to introduce the Collaborative to individuals who are assisting the Planning Group.	Reference Document
Planning and Implementing a Successful Learning Collaborative	A guide to outline the necessary steps to set up and support a quality improvement collaborative.	Guide
Prezi Presentation	A marketing tool used to advertise the Collaborative during the Kick-Off Sessions.	Other
Pre-Work Webinars	A series of three webinars that prepares agencies who have signed up to participate in the Collaborative. This link includes all documents shared during the Session as well as recordings of each session. The final of the three Pre-Work Webinars is a QI 101 Training.	Zoom Session
Regional Response Team Leaders Affinity Session	Affinity Sessions for Regional Response Team Leaders across different Regional Groups to meet and discuss challenges and best practices within their Regional Group.	Zoom Session
Regional Response Team Reporting Form Template and Sample	A document that tracks the regional quality improvement capacity of the different Regional Groups within the Collaborative.	Form
Regional Group Aim Statement and Template	This is a form designed to guide participants in developing their Regional Group Aim Statement. The template provides a completed sample.	Form
Technology Assessment	An assessment administered during the first Regional Group Meeting to understand the technological barriers or support Community Partners need moving forward in the Collaborative.	Form/Survey
Viral Suppression Database	An online database where Community Partners will submit their viral suppression data. This database will also produce the benchmarking reports.	Database