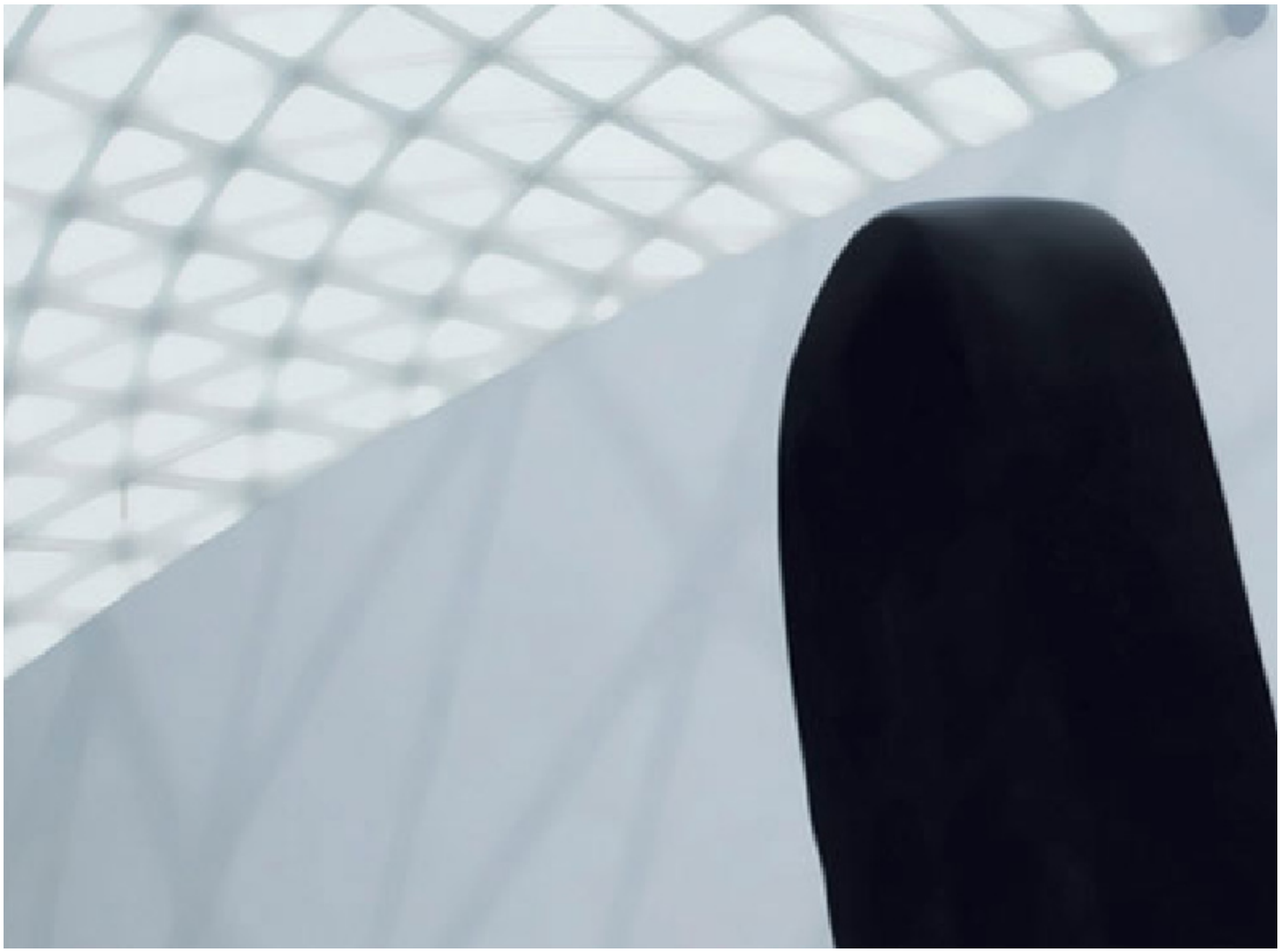
Planning and Implementing a Successful Learning Collaborative

Guide to Build Capacity for Quality Improvement in HIV Care

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



'White: Black Stella 2006' Photograph by Kermit Berg, HIV-positive artist

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Developed by the New York Department of Health AIDS Institute

For the Health Resources and Services Administration HIV/AIDS Bureau

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Introduction

In the last two decades, care for individuals with HIV/AIDS has advanced at a phenomenal pace. However, gaps in care still exist and many providers face barriers when trying to deliver high quality care to every patient every time. The 2003 Institute of Medicine report, *Measuring What Matters*, which focused on the allocation, planning, and quality assessment of Ryan White funding, highlighted the need to continue measuring and improving the quality of care provided by Ryan White Program-funded grantees. At the same time, consumer and professional media have focused increasing attention on medical errors and the need to improve the quality of care.

Since 2000, the Ryan White legislation has included specific provisions directing each grantee to establish and sustain quality management programs. Eight years after reauthorization, however, many Ryan White grantees lack the knowledge, expertise, and resources needed to deliver effective quality management programs that are linked to improved health outcomes.

Many Ryan White HIV/AIDS Program grantees face challenges in developing quality management programs, including unfamiliarity with quality improvement concepts, lack of staff resources and organizational barriers. Often, a key barrier to quality improvement work is not lack of desire but rather a lack of certainty about how to proceed. Learning collaboratives, in which teams of individuals work in parallel toward common goals, provide a tool for increasing capacity and knowledge of quality improvement, building an infrastructure supportive of quality care, learning through peer connections, and sharing of best practices.

Since 2000, the New York State Department of Health (NYSDOH) has sponsored learning collaboratives for grantees of Parts A through D—agencies that provide clinical and non-clinical services. These initiatives, which are modeled on the Institute for Healthcare Improvement's Breakthrough Series Collaboratives, provide HIV providers with valuable opportunities to learn from peers with similar funding and needs. Working with peers and expert faculty over the course of the learning collaboratives, grantees build the capacity and capabilities for quality improvement. This Guide captures the combined experience of Ryan White HIV/AIDS Program grantees and improvement experts who participated in learning collaboratives.

Use of Guide

Purpose

The purpose of this Guide is to help HIV providers to lead a learning collaborative designed to improve the quality of HIV care. The Guide explains in detail how quality leaders of health departments and HIV/AIDS health programs can successfully execute a learning collaborative for HIV providers, service providers, and support staff. Those who are considering initiating, as well as those who have successfully implemented a collaborative, regardless of the Part-specific funding, can benefit from the use of this Guide.

Design and Objectives

The Guide does not provide a single, "cookie cutter" approach to planning and implementing a learning collaborative; instead, it focuses on the lessons learned from the experience of New York State Department of Health staff, consultants, and constituents. The Guide goes beyond describing what has been done and describes a vision of what might be done. Created through in-depth interviews with facilitators, faculty, and participants of learning collaboratives, the Guide provides best practices and practical tips, and where appropriate, recommendations, for planning and implementing an HIV-focused learning collaborative.

The objectives of the Guide are to:

- Present the basic elements of a learning collaborative
- Provide step-by-step approach and recommendations for planning and implementing a learning collaborative focused on improving the quality of HIV care
- Provide tools that can be used to plan and implement a learning collaborative

Target Audience

This Guide is designed for anyone who works with a number of HIV providers and wants to build their capacity to provide better HIV care. It is designed to make the valuable lessons learned from learning collaborative participants and leaders available to a wider audience of all Parts, their staff, and subgrantees. We hope that the Guide will facilitate the successful implementation of many learning collaboratives, expanding quality improvement capacity and capabilities among Ryan White HIV/AIDS Program grantees across the country, and beyond.

Structure

The Guide begins with an introduction to the learning collaborative, including the history of its inception. It then provides step-by-step tips for planning and implementing a successful learning collaborative. Required action steps are divided into five sections:

- Plan Learning Collaborative
- Build Infrastructure for Upcoming Collaborative
- Prepare and Facilitate Face-to-Face Meetings
- Maintain Momentum Between Face-to-Face Meetings
- Mark Successes and Foster Sustainability

Each section discusses specific action items, which are described in detail and illuminated through practical tips. The Guide also includes the following components and corresponding icons:

- Case Study: An ongoing case study runs throughout the Guide, illustrating how specific steps might be implemented in a particular environment.
- Real World Tip: These practical suggestions can help you successfully implement a specific action step discussed in the main body of the text.
- Real World Example: Throughout the Guide, these short vignettes describe how a collaborative leader used a specific action or best practice to plan and execute a learning collaborative.
- Toolbox: A 'Toolbox' icon designates content that explains how to apply quality tools at appropriate time when planning and implementing a learning collaborative.
- Additional Resources: An appendix at the end of the Guide provides a number of resources relevant to planning and implementing a learning collaborative that you may want to consult for additional information.

Acknowledgement

The New York State Department of Health AIDS Institute gratefully acknowledges the help of the following individuals for their efforts in developing and shaping this Guide: Barbara Boushon, Johanna Buck, Virginia Crowe, Tracy Hatton, Anne McAfee, Donna Yutzy, Lori DeLorenzo, and Meera Vohra.

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Background

A learning collaborative is an initiative in which teams of peers come together to study and apply quality improvement methodology to a focused topic area. First conceived by the Institute for Healthcare Improvement (IHI) in 1994, learning collaboratives help organizations apply known improvement principles to current health care practices with the goal of achieving "breakthrough improvements in quality while reducing costs."[1] Since its first Breakthrough Series (BTS) focused on reducing cesarean section rates, IHI has sponsored numerous learning collaboratives and has helped participants achieve improvements in a wide range of topic areas. Learning collaboratives in the BTS generally include these features:[2]

- 12 to 40 teams
- Duration of 12 to 15 months
- Three 2-day learning sessions, led by content and improvement experts
- Action periods between learning sessions, during which teams carry out and report on tests of change
- Monthly reporting of results and improvements
- Interim conference calls with experts

For more information on the IHI Breakthrough Series, read *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement* at http://www.ihi.org/IHI/Results/WhitePapers.

Over the last 4 years, the New York State Department of Health AIDS Institute has established numerous national collaboratives using a methodology adapted from the IHI Breakthrough Series model. Most recently, the National Quality Center, funded by the HRSA HIV/AIDS Bureau and administered by the New York State Department of Health, managed two national Ryan White HIV/AIDS Program collaboratives: Part B Collaborative Demonstration Project and Low Incidence Initiative.

The Part B Collaborative Demonstration Project: Improving Care for People Living with HIV Disease, involved eight states and jurisdictions working together from April 2005 to November 2006. During this time, Collaborative participants developed and strengthened their existing quality management programs, supported by an expert faculty. Written quality management plans were developed by each participating team. Support was provided by the NQC through three Learning Sessions and by facilitating continual contact between the participants and the collaborative leadership team and faculty mem-

1. 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/. Accessed June 27, 2008.
2. Baker GR. Collaborating for Improvement: The Institute for Healthcare Improvement's Breakthrough Series. *New Med*. 1997;1:5-8.

bers through email, a dedicated website, and conference calls. Participating states and territories included: Alabama, Georgia, Florida, Michigan, Missouri, Ohio, Oregon, and Washington, DC.

The multifaceted nature of Part B environments along with limited resources and other unique challenges faced by states with lower HIV incidence often result in less than optimal coordination and collaboration among grantees in local communities. In March 2007, 17 Part B low incidence states met to kick off a 12-month collaborative initiative. The goal of the initiative was to assist these states in the development and/or refinement of an effective quality management plan and program for the state and the implementation of processes to ensure and demonstrate quality of care and services, in accordance with the Ryan White Program legislation.

Other organizations have applied the use of learning collaboratives to various clinical settings. Through the BTS and these additional arenas, learning collaboratives are thought to be helpful in accelerating improvements in the quality of care.

For administrators charged with quality oversight of HIV/AIDS programs, learning collaboratives are a way to engage constituents in the process of change, with the ultimate goal of improving the quality of care provided to individuals with HIV/AIDS. However, learning collaboratives require time, resources, and commitment—from the participants as well as those responsible for planning and implementing them. Many administrators of HIV care programs work under funding constraints that may prevent them from sending teams to large-scale, resource-intensive learning collaboratives. This Guide is designed to help these quality leaders run HIV care-focused learning collaboratives that are small in scale and less resource intensive—yet capable of achieving measurable, clinically relevant improvements in care.

Case Study: Introduction

The following case study has been created to show how one individual in charge of a statewide quality program might go about planning and executing a learning collaborative to improve the quality of HIV care. Portions of the case study appear in corresponding sections of the text that follows.

Susan Ashcroft is the Director of the Health Department of a relatively populated state in the Mid-Atlantic region. Her state serves a medium-incidence population of individuals with HIV/AIDS. Administrators of HIV/AIDS clinics and community health centers with a significant population of HIV/AIDS patients are concerned about recent Part B quality mandates regarding patient retention in services. Susan decided that a learning collaborative might be a useful way to support these care providers.

Step 1: Plan Learning Collaborative

The Big Picture

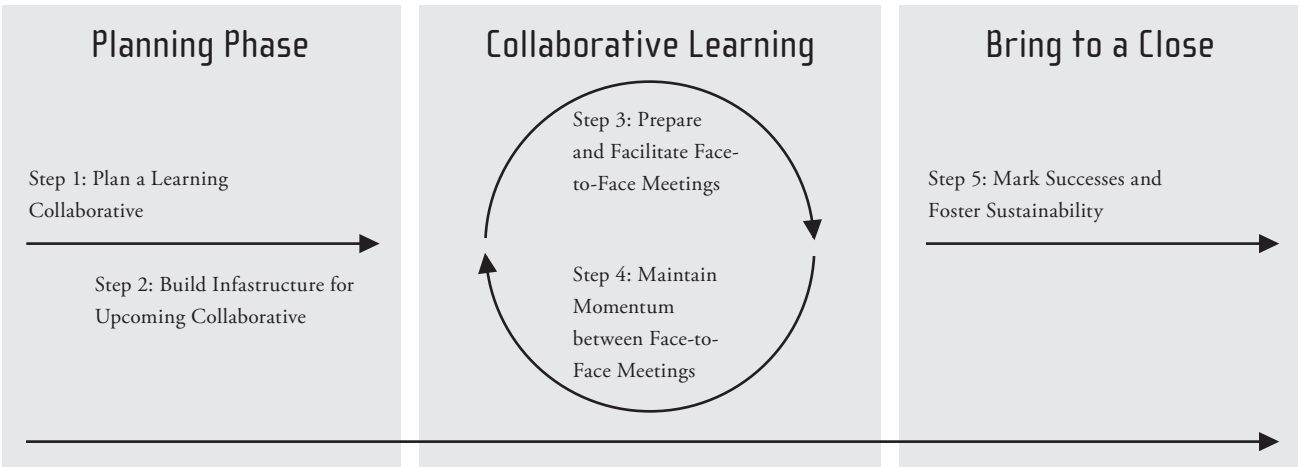
Planning and executing a learning collaborative is an exciting yet potentially daunting task. But taking that first step can eventually bring about changes that substantially improve the lives of individuals living with HIV/AIDS. It is less daunting once you know the steps. This section describes the first ones.

What To Do:

- Envision the General Purpose of the Learning Collaborative
- Set up a Planning Group
- Select Planning Group Members
- Solicit Input to Plan a Learning Collaborative
- Detail the Objectives, Goals, and Focus
- Support the Planning Group

Toolbox: Learning Collaborative Model

The following model outlines the needed steps in planning and implementing a successful learning collaborative. This Guide describes in detail each step, with descriptions of corresponding activities and real world tips.



Envision the General Purpose of the Learning Collaborative

A successful learning collaborative can be launched only after several key questions have been answered:

- What is the general purpose of the learning collaborative?
- Are the resources available to plan, implement, and sustain this activity?
- Is the necessary buy-in of key stakeholders in place?
- Who will lead the planning of the learning collaborative?

Those responsible for planning a learning collaborative, which will be referred to as "collaborative leaders" in this Guide, need to find satisfactory answers to these questions before committing valuable resources to the endeavor. Only in this way can they ensure the initiative is off to a good start.

- General Purpose. The organization or individuals responsible for planning a learning collaborative must clearly understand the general purpose of the initiative. Specifically, collaborative leaders must be able to answer the following questions: What do we hope to achieve with the learning collaborative? What are the general goals and aims of the initiative? What groups comprise the potential participants? How would the population of focus (e.g., consumers) benefit from improvements made as a result of the learning collaborative? Are there clearly defined issues or problems to be addressed? If so, is a learning collaborative the most effective means for addressing these problems?
- Availability of Resources. A learning collaborative requires an allocation of funds to cover meeting rooms, meals, salary of additional support staff, and other direct costs. In addition, many non-financial resources, such as technology, administrative staff, and access to topic and quality improvement experts, are necessary for a successful learning collaborative.
- Buy-in From Key Stakeholders. The success of a learning collaborative depends on buy-in from key stakeholders, such as organizational leaders of the sponsoring organization, opinion leaders in the HIV provider community, external funders, and consumers. Early in the planning process, collaborative leaders must identify and engage stakeholders in planning discussions.
- Leadership of Planning Process. Planning a learning collaborative requires intensive focus and the execution of a number of decisions. For this reason, it is essential to clearly identify the leaders primarily responsible and accountable for planning and implementation and the individuals who will help support these leaders. It also is essential to identify early in the planning process the resources that the leaders need to effectively complete the planning and implementation process.

Set up a Planning Group

The success of a collaborative is dependent on its Planning Group, the group of individuals brought together to provide guidance and oversee all necessary steps in planning, implementing, and maintaining a successful collaborative. This Group provides the strategic perspective for the learning collaborative and helps to maintain focus on the key underlying purpose of the initiative.

The Planning Group should meet the following responsibilities:

- Strategic Planning. The Planning Group should strategize on how to best establish and maintain a sustainable learning collaborative. The Group assumes the responsibility for developing the goals and objectives, defining detailed indicators, and setting the project timetable.
- Soliciting Input. To better understand the environment in which the learning collaborative operates, the Planning Group needs to solicit input from the relevant provider and consumer communities. The input of these groups is essential for planning an initiative that will meet the needs of the participants and be maximally effective.
- Generate Buy-in. The Planning Group should communicate with various groups about the upcoming collabora-

tive, generating the needed buy-in and ensuring that the necessary resources remain available.

- Providing Guidance and Reassurance. Learning collaboratives require a change in the status quo. During the planning process, the Planning Group needs to be responsive to participants' difficulties enacting change within their organization and provide support and encouragement at appropriate junctures. A well-functioning Planning Group will help remove any negative restraints or barriers to achieving and sustaining improvements.

Select Planning Group Members

The composition of the Planning Group depends on several factors, including the scope of the learning collaborative, complexities of improvement goals, and the existing buy-in for this peer learning opportunity. Typically a cross-functional representation of all professional and hierarchical backgrounds proves most effective for the planning and decision-making necessary for a successful learning collaborative.

The Planning Group should include committed representatives from the following groups:

- Sponsoring Organization. The organization sponsoring the learning collaborative generally takes the early lead for the Group. However, to obtain the necessary buy-in, it is essential that members of the sponsoring organization consider the perspectives and values of other Planning Group members.
- HIV Provider Representatives. The Planning Group should include representatives of relevant HIV providers, such as physicians, nurses, nurse practitioners, case managers, and others. Ideally, individuals selected for the Planning Group are opinion leaders (i.e., individuals who are active in their professional realm and well respected by peers) who have previous experience with learning collaboratives.
- Content Experts. The Planning Group should include at least two types of content experts: individuals with expertise in quality improvement (e.g., a consultant who has facilitated learning collaboratives in the past) and individuals with expertise in the topic area of focus (e.g., a quality manager who has run an ADAP program in the past). In addition, it can be helpful to include experts in adult learning principles and application in the Planning Group.
- Consumers. The Planning Group should include at least one individual who is a recipient of the services to be improved. A consumer will provide insights that are unobtainable from other sources and can help the Group anticipate barriers and keep the focus on improvements that will positively affect consumers.
- Funder. If the funding organization is separate from the sponsoring organization, a representative should be included in the Planning Group. His or her participation is essential for ensuring their comfort with the Group's accountability for resources spent in relation to results obtained.

Although the number of individuals on the Planning Group may vary, the group usually includes between 3 and 6 members. A smaller group is usually more effective. If necessary, additional individuals can be included who have specialized knowledge in relevant areas, such as adult learning theory, organizational learning, finance, administration, or measurement. To identify possible members for the Planning Group, collaborative leaders should consider their interest in the content area, their role in the provider and consumer community, and their time availability. The roles and responsibilities should be clearly explained to potential Planning Group members.

The Planning Group should have several operational ground rules in place:

- Leadership Identification. One individual is responsible for directing activities, mediating and resolving conflicts, and representing the Group. This individual needs to fully understand the collaborative model, the barriers HIV providers face, and the principles of collaboratives management.

- Meeting Structure. Collaborative leaders must schedule regular Planning Group meetings, either face-to-face or via conference calls. The scheduled time should be as convenient as possible for all members. It is often best to schedule a regular time for meetings for the duration of the learning collaborative. Many groups meet weekly for the first several months.
- Documentation. Planning Group meetings should have an agenda to guide points of discussion and prevent the meetings from extending beyond the scheduled time slot. If it is not possible to develop an agenda in advance, the first few minutes of the meeting should be spent drafting one. Likewise, minutes of the meeting should be recorded to provide a summary of discussion points and remind members about assigned action items.

Detail the Objectives, Goals, and Focus

The first goal of the Planning Group is to clarify and document the objectives, goals, and focus of the learning collaborative. The group must specify in detail the overall purpose of the collaborative, possible participants, benefits to participation, and main challenges to engaging participants.

To begin planning of the learning collaborative, the Planning Group should first address the following topics:

- Detail the Learning Collaborative Purpose. Based on the general vision for the learning collaborative, the Planning Group should specify in detail the general purpose of the initiative, balancing the available resources with the needs of participants. The Group must consider the needs of the targeted audience, applying various strategies to solicit input from potential participants. The Group also must clearly identify the intended outcomes and goals of the learning collaborative.
- Collaborative Infrastructure. Ideally, learning collaboratives run for a duration of 12 to18 months, include 3 to 4 face-to-face meetings, and maintain momentum with monthly conference calls. However, the infrastructure of the learning collaborative must reflect participants' needs and available resources. For example, if funding for traveling to face-to-face meetings is extremely limited, the Planning Group may decide to use "virtual" meetings in place of one or more face-to-face meetings or combine a site visit with a face-to-face meeting.
- Specify the Target Audiences and Benefits of Participation. The Planning Group should identify criteria for participation in the learning collaborative. Will participants be clinical providers, non-clinical providers, or both? Is the focus a specific health care facility or a region? Additionally, it is critical that the Planning Group develops a list of the benefits for participation in the learning collaborative. For example, potential benefits to participation may include improved efficiency of work, reduction of paperwork, or specific targeted outcomes for improvement. The Planning Group must clearly demonstrate how participation will help teams meet their long-term goals and address their most vexing problems. If possible, the Planning Group should define the business case for engaging in the learning collaborative.
- Define the Participating Team Structure. The Planning Group should define the ideal number and structure of participating teams. Many effective learning collaboratives include 10 to 15 teams. The Group also should make recommendations or list requirements for team composition.
- Data Collection and Reporting. The Planning Group must make decisions about data reporting for the learning collaborative. How many indicators will be used? Will all indicators be required or will some be optional? Will the teams be asked to report on measures they have customized? What mechanisms will teams use to report data? In addition, how will teams report on their improvements, challenges, barriers, and any unintended consequences?

- Timetable. Once the Planning Group has made decisions about the basic infrastructure of the learning collaborative, the Group should create a preliminary timetable of key milestones. The timetable should include the dates of the initiation and end point of the initiative, as well as the dates of all face-to-face meetings, the introductory call, any focus group meetings, and deadlines for teams' applications, prework assignments, and gathering of testable ideas and package of measures.

The individual or organization responsible for the initiation of the collaborative may want to create a concept paper that outlines these details. This concept paper will assist the Planning Group in crafting consistent documentation of agreed points among Planning Group Members and, ultimately, in ensuring consistent messages with future participants.

Toolbox: NQC Cross-Part Quality Management Collaborative Concept Paper - DRAFT-

Background

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program) and its respective programs create an environment where grants are awarded under various Parts, each with its own structure and reporting requirements. Despite these differences, the overarching goal for clients remains the same: seamless access to quality HIV care and services.

The HIV/AIDS Bureau (HAB) has defined "quality" as the degree to which a health or social service meets or exceeds established professional standards and user expectations, as defined by the Institute of Medicine.[3] Legislative requirements of the Ryan White HIV/AIDS Program direct grantees of all Parts to develop, implement and monitor clinical quality management (QM) programs to ensure that providers adhere to Public Health Service guidelines and established HIV clinical standards, to include support services in QM strategies to help people receive appropriate HIV health care, and to ensure that demographic, clinical, and health care utilization information is used to monitor trends in the spectrum of HIV-related illnesses and the local epidemic. Though the exact QM requirements may differ slightly across Parts to address their unique circumstances, the overall expectations remain the same.

In response to the legislated mandates for quality management, often grantees across the Ryan White funding continuum strive to meet the quality management requirements in their own way. This lack of coordination and communication can result in potential duplication of efforts, inadequate sharing of information and less than optimal knowledge management of best practices across grantees.

This past year, HRSA HIV/AIDS Bureau has launched a series of core measures for its grantees. Grantees are encouraged to focus on the core measures as well as additional measures appropriate to the individual program. The measures present new challenges for grantees in terms of data collection and the use of the measures to drive improvement in quality of services delivered. The measures have presented an opportunity to create alignment within a state across programs and foster collaboration around data collection and use of data for improvement.

When grantees across Parts work in partnership towards this goal, they have the potential to strengthen their individual programs and speed the pace of improvement by working collectively towards common priorities to improve the overall quality of HIV care for clients in their region. Numerous opportunities exist to better align QM efforts to meet the needs of clients and reduce administrative burden on grantees.

Purpose

The HRSA HIV/AIDS Bureau has sponsored the development of the Quality Management Cross-Part Collaborative to strengthen statewide collaboration across Ryan White

3. Institute of Medicine. 1990. Medicare: A Strategy for Quality Assurance, Vol. 2. ed. Kathleen Lohr. Washington, DC: National Academy Press

HIV/AIDS Program Parts (Parts A, B, C, D and F), for improved alignment of quality management goals to jointly meet the Ryan White HIV/AIDS Program legislative mandates, and for joint quality improvement activities to better coordinate HIV services seamlessly across Parts.

The overarching purpose of the Collaborative is to advance the quality of care for people living within a state.

Methods

The NQC Cross-Part Quality Management Collaborative will involve state teams, each including representatives from the various Parts in each state, working together intensely for a period of 12 months, launching in September 2008. During this time, these state teams will take part in three to four learning sessions and maintain continual contact with each other and faculty members through conference calls, listserv discussions, and email. Over time, a community of learning will develop where teams collaborate with each other to share good ideas and best practices, as well as raise issues and lessons learned. Finally, the Collaborative will share its findings and achievements with other states, regions and stakeholders in order to facilitate wide-spread improvement efforts.

Aims

At the end of this Collaborative, the following will have been achieved:

- Strengthened partnerships across Parts as evidenced by established communication strategies for the purpose of collaboration for quality management; state-wide quality management priorities; and joint training opportunities to avoid duplication.
- A portfolio of performance measures will be in place for strategic planning and quality improvement processes and data are routinely collected based on established data collection methodologies.
- A unified statewide written Cross-Part quality management plan will be in place for each participating State; supported by a work plan for implementation.
- At least one joint quality improvement project initiated by cross-Part teams.
- Development of a cross-Part quality management assessment tool.

Participants

- Prospective state teams have been identified by HAB as: Pennsylvania, Connecticut, Virginia, New Jersey and Texas.
- Teams will consist of representatives from every Ryan White HIV/AIDS Program Part in the state. The Vanguard Meeting will help to define team composition.
- Faculty for this collaborative will include key NQC staff and consultants with cross-Part as well as collaborative learning expertise; HAB representatives, including identified Project Officers; and a grantee representative with relevant experience.

List of Activities

- Vanguard Meeting: A meeting will be held with key stakeholders including representatives from HAB, the NQC, and representatives from state teams, and other stakeholders with relevant experience to assess the needs and priorities of states and to finalize the technical assistance strategies for this Collaborative.
- Learning Sessions: Teams will meet together with the faculty three to four times during the Collaborative to learn from each other, to share experiences, to receive coaching from faculty and to develop new plans for action and tests for change. The final meeting will conclude this Collaborative and will take stock of progress made, lessons learned and best practices to share with other grantees. Meetings may be held virtually if resources do not allow for face-to-face.
- Reporting: Teams will be responsible for tracking and reporting bi-monthly on a uniform set of outcome and process measures in addition to the state -specific measures that each team wishes to track. Recommended measures and data collection frequency will be discussed at the Vanguard meeting. A standard reporting template,

provided by the NQC, will include performance data, data follow-up activities, QI projects, QM infrastructure updates and offers and requests for other teams. The faculty will meet jointly to review all reports submitted and will send individual feedback to teams as well as aggregate findings each reporting period.

- Listserv: The NQC will launch a listserv specifically developed for this Collaborative to foster communication and peer-learning among participants. Offers and requests will be promoted on the listserv.
- TA Web-Conference Calls: Virtual QM training calls will be held between learning sessions on needed topics that arise from the group and will include content experts, when appropriate.
- Final Report and Documentation: NQC will summarize progress and best practices from this Collaborative and a final report will be developed.

Solicit Input to Plan a Learning Collaborative

To get a sense of the degree of coaching assistance that will be necessary, the Planning Group should assess the level of quality improvement experience of potential participants, as well as the degree of variation among teams in quality improvement-related experience and participants' access to available improvement resources. Planning Groups often use an assessment tool to evaluate the current level of quality improvement knowledge before the first face-to-face meeting. (See the Sample Quality Improvement Skills and Knowledge Assessment in the Toolkit in Step 2.)

To plan an effective learning collaborative, leaders must clarify the potential benefits of participation, outline the necessary expectations for participation, plan various activities, and anticipate resource needs and limitations. Stakeholders (e.g., funders, care providers, opinion leaders, and consumers) and other individuals knowledgeable with the area of focus are the best source of information upon which to base these planning decisions. The Planning Group can use several methods to gather this information, including interviews, on-line or paper-based surveys, and focus groups. The Group should gather input from a range of individuals to ensure understanding of all perspectives. The input is invaluable in planning and implementing an effective learning collaborative.

REAL WORLD TIP

Use a standardized list of questions to conduct the interviews, ensuring that similar information is gathered from all interviewees and comparisons can be made between individuals or teams. Quickly test the effectiveness of the interview tool with one or two potential participants before launching its use with all participants.

REAL WORLD TIP

If the collaborative topic is relatively complex and you are concerned about the focus, scope, or feasibility of the learning collaborative, consider holding a preliminary fact-finding meeting (sometimes referred to as a "Vanguard meeting") before beginning the planning process. Convene a focus group of individuals who are candidates for participating, making sure to include representatives who understand various aspects of the process to be studied (e.g., care providers, case managers, nurse managers, schedulers). Plan on a one-day meeting and cover travel expenses if necessary. Present a preliminary description of the collaborative at the meeting and solicit feedback. Ask meeting participants to brainstorm on possible barriers. Use this information to further refine the objectives, goals, and focus of the learning collaborative.

Support the Planning Group

The Planning Group will need administrative and logistical support to handle the planning, logistics, and implementation of the learning collaborative. Leadership should identify an individual to provide logistical support, including arranging conference calls, booking conference spaces, and disseminating meeting minutes.

After completing the activities described in Step 1, the Planning Group can determine the logistical requirements of the learning collaborative, including a budget, staffing needs, technology needs, logistical requirements, travels costs, and necessary forms and materials. At this point, the preliminary planning process is complete, and leaders must decide whether or not to proceed with the collaborative.

Toolbox: Support Functions for Planning and Implementing a Learning Collaborative

The following logistical responsibilities need to be covered for a successful learning collaborative. These may be assigned to one person or a group of individuals:

Planning Group Conference Calls

- ☐ Scheduling of conference calls of the Planning Group
- ☐ Providing Planning Group Members with meeting agenda and dial-in information
- ☐ Forwarding of conference call materials
- ☐ Writing of meeting minutes and distributing minutes to all Planning Group Members

Planning Group Meetings

- ☐ Arranging face-to-face meetings of Planning Group
- ☐ Assisting in logistical matters, including reserving conference room and required equipment
- ☐ Preparation of meeting materials
- ☐ Writing of meeting minutes and distributing minutes to all Planning Group Members

Planning of Learning Collaborative

- ☐ Providing logistical support for Planning Group Members
- ☐ Developing a contact list for the Planning Group
- ☐ Responding to or forwarding requests for information to appropriate Planning Group Meeting members
- ☐ Assisting in the development of the concept paper
- ☐ Developing relevant materials, including indicator definitions, reporting requirements, and testable changes for improvement
- ☐ Collecting feedback from collaborative participants
- ☐ Setting up and maintaining listserv
- ☐ If needed, developing dedicated-website and maintaining website content

Communication with Collaborative Participants

- ☐ Gathering contact information from all participants and maintaining an up-to-date contact list
- ☐ Mailing/emailing any pertinent information to learning collaborative participants
- ☐ Sending key conference call and meeting information to teams
- ☐ Reminding teams about upcoming events, reporting deadlines, meeting dates, and conference calls
- ☐ Mailing key resource materials, such as quality improvement resources and assessment tools, to participating teams
- ☐ Tracking key milestones of the collaborative
- ☐ Maintaining key quality improvement documents, including descriptions of best practices and milestones

Case Study: Get Ready

Susan garnered the commitment of a colleague in her program, Danielle Jamison, to share planning and decision-making responsibilities and Natalie Green, an administrative assistant, to help with logistics. She scheduled weekly conference calls with this "action arm" of the Planning Group throughout the duration of the learning collaborative.

Susan and Danielle began convening a Planning Group. They asked a widely respected family practice physician, a clinic nurse, a patient with HIV, and the state epidemiologist to join the planning body. Based on feedback from the Planning Group, the implementation team decided to focus on improving patient retention in primary care clinics that receive Part B funds and to invite both care providers and service providers—and related staff—to participate. Susan and Danielle convened a focus group of providers, administrative staff, and patients to gather specific input about patient retention.

Step 2: Build Infrastructure for Upcoming Collaborative

The Big Picture

Once the Planning Group is established and the overall objectives, goals, and focus of the learning collaborative have been documented, collaborative leaders can begin to build the infrastructure necessary for carrying the initiative through until the end. Putting energy and focus into creating an effective infrastructure before the collaborative officially begins will prevent technical glitches later.

What To Do:

- Identify the Faculty for the Collaborative
- Determine Indicators for the Learning Collaborative
- Specify Requirements for Data and Improvement Reporting
- Develop Testable Change Ideas
- Decide on Team Composition
- Develop a Timetable with Key Milestones
- Develop a Learning Collaborative Charter
- Assess and Identify Technology Resources
- Develop Pre-work Assignments
- Invite Participating Teams

Identify the Faculty for the Collaborative

After planning the general framework for the collaborative, the initiative moves into its next phase: the development of the infrastructure needed to carry the learning collaborative smoothly to its conclusion. Identification of Faculty members is the first step. Collaborative leaders must select who have the skills and expertise needed to guide participants through the process of improvement. Some Planning Group members may be ideal candidates for the Collaborative Faculty. It is important to appreciate that in some cases individuals who are critical for planning a learning collaborative may not be best suited to provide ongoing support and facilitation.

When choosing the Faculty consider the following questions:

- Does he or she have relevant expertise in the content area?
- Does he or she have quality improvement background or skills?
- Does he or she have experience with previous learning collaboratives? (If not, it may be possible to pair an inexperienced Faculty with an experienced one.)
- Does he or she have the expertise to support, coach, and guide participating teams?

The Faculty should include individuals capable of filling the following roles:

- Quality Lead. One member of the Faculty, designated as the Quality Lead, is responsible for leading the Faculty. This individual must have prior experience in learning collaboratives and expertise in quality improvement.
- Content Experts. The Faculty should include two types of contact experts: individuals with expertise in the specific topic area (e.g., an expert in consumer advocacy) and individuals with expertise in quality improvement.
- Learning Collaborative Experts. For the initiative to be successful, the Faculty must include individuals who are knowledgeable about learning collaboratives and capable of supporting participating teams throughout the initiative.
- Facilitator. For optimal functioning, the Faculty should include an individual with facilitating skills who is designated to assist group meetings and phone calls.

REAL WORLD TIP

It can be extremely useful to consider the perspective of the receiver of services (e.g., client, patient, consumer) during the planning of a learning collaborative. Including a representative receiver of services in the Faculty can help identify potential barriers, resources, and participants.

The number of Faculty members required to support a learning collaborative depends on the intensity of responsibilities for the collaborative, the ability of individual Faculty members to commit time to the project, the experience level of participating teams in quality improvement, and the number of teams. Ideally, a learning collaborative is supported by 3 to 6 Faculty members.

The responsibilities of the Faculty include:

- Serving as a resource for participating teams and other Faculty members
- Providing guidance during the process of indicator/measures development
- Providing input about possible changes or categories of changes to be tested
- Providing guidance and suggesting adjustments during the lifespan of the collaborative
- Facilitating and coaching the work of participating teams and responding to their questions and concerns
- Assessing progress of the teams and the success of the learning collaborative

Determine Indicators for the Learning Collaborative

Quality indicators are carefully defined measures of specific aspects of patient care, services, or processes that quantify how a team provides patient care. These indicators generally are based on specific standards of care derived from the guidelines of professional societies or government agencies. To allow participating teams to measure their improvements over time and to benchmark performance with other teams, Faculty and collaborative leaders must carefully select specific quality indicators that are in alignment with the overall aim of the collaborative.

When considering potential quality indicators, the Faculty should assess quality-related funding requirements, individual performance measurement preferred by providers, availability of standards of care, and existing indicator definitions. The use of existing indicators allows teams to compare their performance with groups outside the collaborative and potentially with national dashboards. Use of existing indicators also allows teams to use measures they are already collecting, saving time and increasing team buy-in for measurement.

The process of indicator selection is facilitated by a broad representation of expertise among the Faculty and consultation with additional content experts as needed. The key to choosing truly useful performance measures is the selection of a set of measures that is simple, includes both process and outcome measures, and balances the various aspects of performance (e.g., clinical, financial, administrative, customer experience, staff experience).

Faculty and collaborative leaders should select a set of three to five core measures that are required for routine reporting by all participating teams. They also may decide to select one to three optional measures, which teams cay use to target specific areas of performance. In addition, Faculty and collaborative leaders should decide whether to ask teams to report on any measures they have customized.

The main criteria for an effective quality indicator include:

- Relevance: the indicator relates to a condition that occurs frequently or has a great impact on the population of focus.
- Measurability: the indicator can be measured efficiently within the constraints of the teams' finite resources.
- Improvability: the indicator is associated with an aspect of performance that can realistically be improved, given the limitations of the teams' services and patient population.
- Accuracy: the indicator is based on accepted guidelines or developed through formal group-decision making methods.

Only indicators that meet all four criteria are likely to be both relevant and realistically possible to measure within the limits of measurement resources. Other criteria for selecting an effective indicator include the strength of the evidence supporting its use and whether it measures aspects of care that are linked to desired patient outcomes.

REAL WORLD TIP

- Begin collecting best practices for performance and outcome measures early in the process
- Include a balancing measure that reflects a system or process that could potentially be compromised by the improvement work
- Use or adapt measures from respected resources, because the development of reliable, valid measures is often difficult and the use of indicators that the teams already measures will minimize additional work

Toolbox: Available Indicator Definitions

Collaborative Faculty should begin the process of selecting indicators by reviewing those already identified by relevant quality improvement groups. Resources that list HIV care-related indicators include:

- HAB Core Clinical Performance Measures. The HIV/AIDS Bureau has defined five performance measures that it considers critical for HIV programs to monitor. These measures, which focus on anti-retroviral therapy for pregnant women, CD4 T-cell count, use of HAART, regular medical visits, and PCP prophylaxis, can be used by all Ryan White HIV/AIDS Program grantees and can be used to assess performance at either the provider or system level. HAB encourages grantees to include these performance measures in their quality management plan. Detailed definitions of the HAB performance measures are available at http://hab.hrsa.gov/special/hab-measures.htm.
- 'Measuring Clinical Performance.' A Guide developed by the New York State Department of Health with detailed steps how to develop an indicator and how to establish performance measurement processes, including random sampling. The Guide, which can be accessed at NationalQualityCenter.org, also includes key clinical HIV indicators, detailed indicator definitions, and manual data collection tools.

- HIVQUAL Project. The National HIVQUAL Project has created a list of numerous indicator resources, including adult, adolescent, and pediatric performance measures. The Project provides various resources, including indicator definitions, manual data collection forms, and sampling methodologies, on its website at www.HIVQUAL.org.
- National Quality Center (NQC). NQC has gathered a myriad of performance measurement resources on its website at NationalQualtyCenter.org. The section of the website dedicated to the topic, titled 'Measuring Performance in HIV Care,' includes examples of indicators and data collection tools.

Toolbox: Sample Measures from Past Learning Collaboratives

Part A Collaborative:

- Percent of patients with CD4 T-cell count > 350
- Percent of patients with viral load < 10,000
- Percent of patients who enter primary care HIV positive and asymptomatic
- Percent of patients with primary care visit(s) in last 3 months
- Percent of patients whose service plan is current
- Percent of patients with self-management goal setting

Part B Collaborative:

- Percent of ADAP applicants approved or denied for ADAP enrollment within two weeks of receiving a complete application
- Percent of ADAP recertified for ADAP eligibility criteria annually
- Percent of individuals newly reported with HIV infection who also have AIDS diagnosis
- Percent of individuals newly reported with HIV infection who progress to AIDS diagnosis within 12 months of HIV diagnosis
- Ratio of individuals who die within 12 months of HIV diagnosis to the number of individuals newly reported with HIV infection
- Percent of individuals with at least two general HIV medical care visits in the last 12 months
- Percent of individuals with either a CD4 or viral load measured in the last 6 months

Specify Requirements for Data and Improvement Reporting

Once the indicators have been determined, the Faculty should identify the most appropriate methods and tools for routinely measuring the teams' performance and improvement ideas over time. In specifying these requirements, Faculty should focus on the overall aim of the collaborative but also remain cognizant of the available resources of participating teams.

The Faculty should clarify the following:

- Frequency of reporting. Monthly data and improvement reporting is ideal. Faculty should discuss the importance of frequent reporting with participants and should inform teams that their data and improvement ideas will be shared within the learning collaborative.
- Use of sample approach. Data sampling allows participating teams to make inferences about a total patient population based on observations of a smaller subset of the group, saving both time and resources during data collection. To select a valid sample population, teams first must identify clearly the larger eligible population (i.e., the measurement population or active case load).
- Design of data collection tool. Teams should create a data collection tool that uses selected performance indicators to facilitate the data collection process. It is essential that teams test the reliability and effectiveness of collection tools prior to data collection.

- Data collection process. Faculty should determine which data reporting method teams will use—either on-line reporting or emailing of completed spreadsheets.
- Improvement reporting: Faculty should create an improvement reporting form that allows teams to easily share successes and unintended consequences as they test changes related to the chosen area of focus.
- Team training on data collection. Faculty should help teams navigate the data collection process, starting with the creation of a data collection tool that will build the database queries to extract the desired data. Faculty should plan on being available to teams who require additional clarification on the data collection process.

REAL WORLD TIP

Ask a spreadsheet expert to create a workbook template that will automatically create graphs and tables from the data that team members enter into the relevant cells.

REAL WORLD TIP

Faculty should recommend that teams walk through a four-part process to obtain reliable data when developing customized indicators:

1. Identify desired measures.
2. Create definitions for the desired measures (i.e., with specified numerators and denominators). (A measures definition tool can be helpful here.)
3. Determine which database(s) contain the information required for all defined measures (i.e., all numerators and denominators).
4. Work directly with IT specialists to build queries that will extract the desired data. (Electronic worksheets can be useful here.)

Toolbox: Low Incidence Initiative Measures

There are 3 Required Measures for all States participating in the Low Incidence Initiative. Two other measures must be chosen from the Optional Measures listed below for a total of 5 measures that each State will report on bi-monthly. The 2 Optional Measures cannot be from the same category (i.e. both ADAP, CM, or Clinical).

REQUIRED #1: Percent of Ryan White funded clients who have a CD4+ test done at least every six months.
Numerator: Then number of clients with CD4+ tests measured at least twice in the past 12 months, at least 6 months apart.
Denominator: All active clients who have received a Ryan White funded service within the past 12 months from the reporting period.
Sampling Plan: At the end of the 2-month reporting period, count the total number active, living clients within the last twelve months i.e. their 12-month anniversaries appear within the 2 reporting months (D). Then from this group, count the number of clients with at least two 2 CD4+ tests, at least 6 months apart (N). Finally, divide N by D and multiply the result by 100%.

REQUIRED #2: Percent of applying state ADAP clients approved/denied for ADAP services within two weeks of ADAP receiving a complete application.
Numerator: The number of ADAP applicants that were approved or denied for ADAP enrollment within two weeks of the ADAP receiving a complete application.
Denominator: The number of complete applications that the ADAP received during the 2-month reporting period.
Sampling Plan: At the end of the 2-month reporting period, count the total number of complete applications that the state ADAP received during those 2 months. Then from this group, count the number of ADAP clients that were approved or denied for ADAP services within two weeks of the state ADAP receiving their application. Finally, divide N by D and multiply the result by 100%.

REQUIRED #3: Percent of clients with at least two general HIV medical care visits in the last 12 months who are enrolled in case management.
Numerator: The number of clients with 2 general HIV medical care visits in the last 12 months who are enrolled in case management.
Denominator: The number of clients actively enrolled in case management within the last twelve months.
Sampling Plan: At the end of the 2-month reporting period, count the total number of clients actively enrolled in case management within the last twelve months, i.e., their 12-month anniversaries appear within the 2 reporting months (D). Then from this group, count the number of clients with at least 2 general HIV medical care visits in the last 12 months (N). Finally, divide N by D and multiply the result by 100%.

OPTIONAL ADAP #1: Percent of ADAP enrollees re-certified for ADAP eligibility criteria at least every six months.
Numerator: Number of all ADAP clients who were due for re-certification and that have been re-certified.
Denominator: Total number of ADAP clients who were due for their six-month re-certification within the reporting months.
Sampling Plan: At the end of the 2-month reporting period, count the total number of ADAP enrollees who were due for their six-month re-certification within the 2 reporting months (D). Then from this group, count the number who have been re-certified (N). Finally, divide N by D and multiply the result by 100%.

OPTIONAL ADAP #2: Percent of active clients who are inappropriately enrolled in both Medicaid and ADAP.
Numerator: The number of active clients who are inappropriately enrolled in both Medicaid and ADAP.
Denominator: The number of active clients who are enrolled in both the Medicaid and ADAP databases.
Sampling Plan: At the end of the 2-month reporting period, count the total number of active clients who are enrolled in both the Medicaid and ADAP databases. Then from this group, count the clients who are inappropriately enrolled in both. Finally, divide N by D and multiply the result by 100%.

OPTIONAL ADAP #3: Percent of active adolescent and adult clients in ADAP with AIDS who are prescribed HAART.
Numerator: The number of active adolescent and adult clients in ADAP with AIDS who are prescribed HAART.
Denominator: The number of active adolescent and adult clients in ADAP with AIDS.
Sampling Plan: At the end of the 2-month reporting period, count the total number of active adolescent and adult clients in ADAP with AIDS (D). Then from this group count the number who are prescribed HAART. Finally, divide N by D and multiply the result by 100%.

OPTIONAL Case Management #1: Percentage of case managed clients with HIV infection who have a Case Management Care Plan documented and updated at least every 6 months.
Numerator: Number of active case managed clients whose Care Plan was due for a 6-month review and had documentation of a Case Management Care Plan being reviewed.
Denominator: Number of active clients in case managed whose Care Plan is due for a 6-month review.
Sampling Plan: At the end of the 2-month reporting period, count the total number of active case management clients who are due for a 6-month review of their Care Plan (D). Then from this group count the number of case management clients whose care plan was reviewed and updated. Finally, divide N by D and multiply the result by 100%.

OPTIONAL Case Management #2: The percent of active case management clients with HIV infection who have a CD4+ test done at least every 6 months.
Numerator: The number of active case management clients who had at least 2 CD4+ test done at least every 6 months.

Denominator: The number of active case management clients enrolled in the past 12 months.
Sampling Plan: At the end of the 2-month reporting period, count the total number of clients actively enrolled in case management within the last twelve months i.e. their 12-month anniversaries appear within the 2 reporting months (D). Then from this group, count the number of clients with at least 2 general CD4+ tests done in the last 12 months (N). Finally divide N by D and multiply the result by 100%.

OPTIONAL Case Management #3: The percent of case management enrollees re-certified for case management eligibility criteria at least annually.
Numerator: The total number of clients whose 12 month anniversary falls within the 2-month reporting period, who have documentation of eligibility recertification.
Denominator: The total number of clients actively enrolled in case management in the past 12 months.(i.e. if their 12-month anniversary falls in the 2 month reporting period)
Sampling Plan: At the end of the 2-month reporting period, count the total number of active case management clients whose 12 month anniversary appears during the reporting months (D). Then from this group count the number of case management clients with current eligibility documented. Finally, divide N by D and multiply the result by 100%.

OPTIONAL Clinical #1: Percentage of Ryan White funded clients who have a medical visit in an HIV care setting at least every 6 months.
Numerator: Number of clients who were seen by an MD, PA or advanced practice nurse in an HIV care setting at least twice in the past 12 months, <6 months apart.
Denominator: Number of clients with a Ryan White service who were seen within the past 12 months from the reporting period.
Sampling Plan: At the end of the 2-month reporting period, count the number of clients, with at least one Ryan White service, seen within the last twelve months i.e. their 12-month anniversaries appear within the 2 reporting months (D). Then from this group, count the number of clients who were seen by an MD, PA or advanced practice nurse in an HIV care setting at least twice in the past 12 months, <6 months apart (N). Finally, divide N by D and multiply the result by 100%.

OPTIONAL Clinical #2: Percentage of Ryan White funded clients with a CD4+ count below 200/µL who were prescribed PCP prophylaxis.
Numerator: Number of clients who were prescribed PCP prophylaxis at the time when the CD4+ count was below 200/µL.
Denominator: Number of clients who have received a Ryan White funded service in the past 12 months, and had a CD4+ count below 200/µL.
Sampling Plan: At the end of the 2-month reporting period, count the total number of active clients within the last twelve months i.e. their 12-month anniversaries appear within the 2 reporting months with a CD4+ count less than 200/µL (D). Then from this group, count the number of clients who were prescribed PCP prophylaxis at the time when the CD4+ count was below 200/µL (N). Finally, divide N by D and multiply the result by 100%.

OPTIONAL Clinical #3: Percentage of Ryan White funded adolescent and adult clients with AIDS who are prescribed HAART.
Numerator: Number of clients with AIDS who were prescribed a HAART regimen within the past 12 months.
Denominator: Number of adolescent and adult clients who have a diagnosis of AIDS (history of a CD4+ count below 200/µL or other AIDS-defining condition), and were seen within the past 12 months from the reporting period.
Sampling Plan: At the end of the 2-month reporting period, count the total number of adolescent and adult clients with a diagnosis of AIDS who were seen within the last twelve months i.e. their 12-month anniversaries appear within the 2 reporting months (D). Then from this group, count the number of clients who were prescribed a HAART regimen within the past 12 months (N). Finally, divide N by D and multiply the result by 100%.

OPTIONAL Clinical #4: Percentage of pregnant women with HIV infection who are on antiretroviral therapy.
Numerator: Number of pregnant clients with an HIV infection who were placed on an appropriate antiretroviral therapy regimen during the antepartum period.
Denominator: Number of pregnant clients with an HIV infection who were seen within the past 12 months of the reporting period.
Sampling Plan: At the end of the 2-month reporting period, count the total number of pregnant clients who were seen within the last twelve months i.e. their 12-month anniversaries appear within the 2 reporting months (D). Then from this group, count the number of pregnant clients who were placed on an appropriate antiretroviral therapy regimen during the antepartum period. (N). Finally, divide N by D and multiply the result by 100%.

OPTIONAL Clinical # 5: Percent of individuals newly reported with HIV infection who also have AIDS diagnosis.
Numerator: The number of individuals newly reported with HIV infection who also have an AIDS diagnosis.
Denominator: The number of individuals newly reported with HIV infection.
Sampling Plan: At the end of the 2-month reporting period, count the total number of individuals newly reported with HIV infection for the reporting period (D). Then from this group count the number who have an AIDS diagnosis (N). Finally, divide N by D and multiply the result by 100%.

OPTIONAL Clinical #6: Percent of individuals newly reported with HIV infection (not AIDS) who progress to AIDS diagnosis within 12 months of HIV diagnosis.
Numerator: The number of individuals who progress to AIDS diagnosis within 12 months of HIV diagnosis.
Denominator: The number of individuals newly reported with HIV infection (not AIDS).
Sampling Plan: At the end of the 2-month reporting period, count the total number of individuals newly reported with HIV infection (not AIDS) that are twelve months from diagnosis (D); then from this group count the number of individuals who progressed to AIDS diagnosis within 12 months (N). Finally, divide N by D and multiply the result by 100%.

OPTIONAL Clinical # 7: Ratio of individuals who die within 12 months of HIV diagnosis to the number of individuals newly reported with HIV infection.
Numerator: The number of individuals who die within 12 months of HIV diagnosis.
Denominator: The number of individuals newly reported with HIV infection.
Sampling Plan: At the end of the 2-month reporting period, count the total number of clients newly reported with HIV infection that are twelve months from diagnosis (D). Then count the number of clients who die within 12 months of HIV diagnosis (N). Finally, divide N by D.

OPTIONAL Clinical #8 : Percent clients with at least two general HIV medical care visits in the last 12 months with at least one visit in the first six months and at least one visit in the second six months of the 12 month period.
Numerator: The number of clients with at least one HIV medical care visit in the first six months and at least one in the second six months of the last 12 months.
Denominator: The number of clients with at least one visit within the last twelve months.
Sampling Plan: At the end of the 2-month reporting period, count the total number of clients with at least one visit within the last twelve months (D). Then from this group count the number of clients with at least two general HIV medical care visits in the last 12 months. Then from this group count the number of individuals with at least one medical care visit in the first six months and one in the second six months (N). Finally, divide N by D; multiply by100%.

OPTIONAL Clinical #9: Percent of clients with at least two lab tests (CD4 or VL)* in the last 12 month with at least one lab test in the first six months and at least one identical* lab test in the second six months of the same 12 month period.

Numerator: The number of clients with at least one lab test (CD4 or VL) in the first six months and at least one identical lab test* in the second six months of the last 12 months (*both lab tests must be alike).
Denominator: The number of clients with at least one visit within the last twelve months.
Sampling Plan: At the end of the 2-month reporting period, count the total number of clients with at least one visit within the last twelve months (D). Then from this group count the number of clients with at least two identical lab tests (either two or more CD4 or two or more VL) in the last 12 months. Then from this group count the number of individuals with at least one of the identical lab tests (CD4 or VL) in the first six months of the year and one of the same lab tests in the second six months of the year (N). Finally, divide N by D and multiply the result by 100%.

Toolbox: 2007 Oregon HIV Care & Treatment Quality Management Data Report

Question #1: Do new/returning CAREAssist applicants receive status notification (letter, email or phone call) within 30 days of receipt of their application?
N = Number of newly enrolled clients who have a notification activity and date documented in their data file within 30 days of "Application Received" date (by month).
D = Total number of newly enrolled clients in the previous quarter (by month).

Question #2: Are new/returning CAREAssist applications processed within two weeks of receipt?
N = Number of newly enrolled clients who have a "Status" & date noted in their data file within 14 days of "Application Received" date.
D = Total number of newly enrolled clients in the quarter.

Question #3: What percentage of CAREAssist clients successfully re-certify every 6 months?
N = Number of clients who successfully re-certified within the quarter (by month).
D = Total number of clients due for re-certification within the quarter (by month).

Question #4: How many clients report having seen a doctor on their last re-certification?
N = total number of clients who report seeing a doctor on their re-certification application in the quarter?
D = total number of clients who re-certified in CAREAssist in the quarter. (see "N" in #5 above)

Question #5: How many clients report having had a CD4 or VL within the past 6 months on their last re-certification?
N = total number of clients who report having had a CD4 or VL within the past 6 months.
D = total number of active clients in CAREAssist in the quarter.

Question #6: How many clients in CAREAssist have a case manager listed in the database?
N = total number of clients who have a case manager listed in the database.
D = total number of active clients in CAREAssist in the quarter.

Question #7: How many clients newly reported with HIV infection also have an AIDS diagnosis?
N = Number of individuals newly reported with HIV infection who also have an AIDS diagnosis within the quarter.
D = Total number of individuals who were reported in the quarter.

Question #8: How many clients newly reported with HIV infection progress to AIDS within 12 months?
N = Number of individuals newly reported with HIV infection (not AIDS) who progress to AIDS diagnosis within 12 months of HIV diagnosis.
D = Total number of individuals who were newly reported with HIV during the period (quarter) one year ago.

Question #9: How many clients newly reported with HIV infection who die?
N = Number of individuals who die within 12 months of HIV diagnosis.
D = Total number of individuals who were newly reported with HIV during the period (quarter) one year ago.

Question #10: How many HIV/AIDS clients had a CD4 or viral load test in the first six months and a CD4 or viral load in the second six months of the year? (test does not need to match in each time period)
N = HIV/AIDS cases living 12 months after the end of the quarter who had a CD4 or viral load month in the first six months after the end of the quarter and a CD4 and viral load in the subsequent six months.
D = All active individuals in the database.

Question #11: How many clients had either a CD4 in the first six months and the second six months or viral load in the first six months and the second six months? (test must match in each time period)
N = HIV/AIDS cases living 12 months after the end of the quarter who had either:
(1) a CD4 test in the first six months after the end of the quarter and a CD4 test in the subsequent six months or
(2) a viral load test in the first six months after the end of the quarter and another viral load test in the subsequent six months.
D = All active individuals in the database.

Question #12: How many clients in HARS, who had a VL test, have a VL 10,001 and above?
N = total number of clients who have a VL 10,001 and above.
D = total number of active clients in HARS who had a VL test within the 12 month period ending at the end of the current quarter.

Question #13: How many clients in HARS, who had a CD4 test, have a CD4 below 199 and below?
N = total number of clients who have a CD4 199 and below.
D = total number of active clients in HARS who had a CD4 test within the 12 month period ending at the end of the current quarter.

REAL WORLD TIP

Before the first official data collection, require teams to complete a trial run. Ask teams to submit five records to assess the process of data collection and reporting. Based on these records, the teams can troubleshoot any problems with definitions of measures, data entry forms, and timetable before true data collection begins. Use the formal and informal feedback you received to make adjustments to the proposed indicators and routine reporting requirements.

Develop Testable Change Ideas

The planning group, with assistance from Faculty, should develop a set of changes or improvements directly related to the stated aim or purpose of the learning collaborative that teams can test in their local environments. The set of changes can be gleaned from expert opinion or experience, literature review, relevant quality improvement guides, or any combination of these sources. The guiding principle in development of these testable changes is that the changes not only relate directly to the overarching aim of the learning network but also correlate with improvement that can be measured using indicators developed by the planning group and Faculty.

Decide on Team Composition

The success of each participating team is often related to its composition. Due to resource limitations often only selected team members can actively participate in activities of the learning collaborative, such as attending face-to-face meetings or joining routine conference calls. The Faculty should

clearly outline which team members should be included in the core team that will represent the entire agency or organization.

The Faculty can ask teams to use the following approach to make decisions about team composition:

- Draw a simple flowchart of the process of focus
- Ensure that a representative from each portion of the process is included on the team
- Consider the various Parts of the Ryan White continuum

REAL WORLD TIP

The most successful teams contain a leader who is articulate and can promote the project to other decision makers, an individual with excellent organizational skills who can keep the team on track with day-to-day tasks, and content experts that represent each portion of the process.

REAL WORLD TIP

Consider sharing this list with participating organizations to help participating organizations plan the composition of their teams. To ensure the success of the collaborative, the Faculty may decide to designate certain functions as required.

Toolbox: Relevant Decision Makers

PROGRAM PART	Examples of Job Titles of Required Participants for Parts A through D
PART A	Section Chief (of region where Part A program is located) Part A Program Director Supervisor/Manager/Director of the Planning Council
PART B	Clinic Director Section Chief (of region where Part B program is located) Part B Project Officer Part B Program Director ADAP Manager Epidemiologist from Surveillance Program Medicaid Administrator
PART D	Clinic Director Nursing Supervisor Medical Director Administrator Case Manager

Develop a Timetable with Key Milestones

The complexity of the topic and the quality improvement experience of participants drives the number and frequency of face-to-face meetings and conference calls with participants. The Faculty should make the final decision about the composition of the learning collaborative and develop a timetable for the entire initiative.

The timetable should include all key milestones for the learning collaborative:

- Development of Collaborative Charter
- Finalization of data collection plan
- Identification and invitation of participating teams
- Pre-work assignments
- Kick-off meeting and future meetings
- Reporting cycles for participating teams
- Routine conference calls and communications with participating teams

REAL WORLD TIP

- Engage key providers in the selection of important dates to avoid significant scheduling conflicts
- Develop a high-level agenda for each face-to-face meeting prior to the initiation of the learning collaborative
- Begin to plan the agendas for each meeting and decide which content experts to invite to attend face-to-face meetings or to join conference calls
- Once dates are set, immediately start to block off time on the calendar and begin to arrange logistics for these meetings

Toolbox: Timetable With Key Milestones

	2007												2008											
ACTIVITIES	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Monthly Faculty planning calls																								
Engage identified states																								
Vanguard meeting																								
Finalize Cross-Part Collaborative strategies																								
Finalize initial face-to-face meeting logistics, agenda and pre-work																								
Pre-work call for Sept. kick-off meeting																								
Learning Sessions (face-to-face or virtual)																								
Develop and seed Cross-Part Collaborative listserv																								
State reports due (bi-monthly reporting)																								
Share Faculty feedback on reports shared with teams																								
TA/coaching web-conference calls																								
Debrief and next steps (Final Report to be drafted by May 2010)																								

Develop a Learning Collaborative Charter

By this point in the planning process, the collaborative leaders and the Planning Group have agreed on the parameters of the learning collaborative. The Faculty is now charged with describing these parameters in writing. The document, often referred to as a Collaborative Charter, should include:

- Purpose and overall goals of the learning collaborative
- Overview of the underlying problem to be addressed and associated opportunities for improvement when successfully participating in the learning collaborative
- Learning collaborative meeting structure and framework
- Description of participating teams and its team composition
- Expectations for participation
- Responsibilities of participating teams
- Performance measurement and data collection methodologies
- Data and improvements reporting plan
- Timetable and milestones
- Faculty roles and responsibilities
- Evaluation requirements

Toolbox: HAB/NQC 2007-2008 Low Incidence Initiative Charter

Opportunity Statement

Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White Program) provides funding to cities, states, and other public and private entities to provide care and support services to individuals with HIV/AIDS who have low income, or are uninsured/ underinsured, lacking other resources to pay for care. Currently, the Ryan White Program Part B provides over 1 billion grant dollars annually to states and jurisdictions, including the District of Columbia, Puerto Rico and US territories to improve the quality, availability and delivery of health care and support services for individuals with HIV disease. The AIDS Drug Assistance Program (ADAP) is a vital component of the Part B Program that provides life-saving HIV treatments to individuals living with HIV/AIDS.

New legislative requirements of the 2000 and 2006 Ryan White Program direct grantees to develop, implement and monitor quality management (QM) programs to ensure that service providers adhere to established HIV clinical practices, to ensure that QM strategies include support services that help people receive appropriate HIV health care, and to ensure that demographic, clinical, and health care utilization information is used to monitor trends in the spectrum of HIV-related illnesses and the local epidemic. Requirements in the 2006 Ryan White Program state that Part B programs "shall provide for the establishment of a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services."

The establishment of clinical quality management programs includes:

- Development of comprehensive clinical quality management infrastructure, including routine QM meetings with cross-functional representation
- Description of the QM program in a written quality plan, with clear indication of responsibilities and responsible parties
- Inclusion and involvement of key stakeholders in the quality management program
- Designated leaders for quality improvement and accountability

The assessment of services which are consistent with the most recent Public Health Service guidelines includes:

- Development and/or adaptation of quality indicators for key clinical and service categories

- Routine performance measurement of key care aspects
- Sharing of performance data with program staff
- Use of data to improve the organization's performance on key services

The Ryan White Program focus on quality reflects two national trends - improvement and accountability. According to the Institute of Medicine (IOM) Committee report, "Measuring What Matters: Allocation, Planning and Quality Assessment of the Ryan White CARE Act," HRSA's HIV/AIDS Bureau (HAB) and Ryan White Program grantees have undertaken a variety of quality improvement initiatives. The IOM report further states that HRSA and Ryan White Program-funded clinics and programs perform an admirable job of defining, assessing, and attempting to improve the quality of care provided to HIV-infected individuals and of establishing quality management and improvement programs. States and EMAs either have or are in the process of establishing such programs. Yet, HRSA, Ryan White Program grantees, and providers could still do much more to measure and improve quality of care. With growing interest in both measuring and improving quality (IOM 2001 and 2004), federal policy and funding decisions are increasingly based on demonstrable results measured by standardized performance indicators.

A myriad of opportunities exist to improve complex systems that support HIV/AIDS care. The multifaceted nature of Part B environments along with limited resources and other unique challenges faced by states with lower HIV incidence often result in less than optimal coordination and collaboration among grantees in local communities. To better understand the needs and challenges that these states face in developing quality management programs, a meeting was convened with representatives from 16 low incidence states (LIS), HAB representatives and National Quality Center (NQC) staff on June 26-27, 2006 in Washington DC. The group held a dialogue on the major barriers faced with respect to quality management in these states, brainstormed possible solutions and made recommendations to HAB and NQC for supporting their QM efforts. A report was developed to summarize the meeting outcomes and recommendations were used to develop an appropriate response to assist low incidence states in developing and sustaining their QM programs.

By the end of this Initiative, LIS Part B programs will have:

- Developed or refined an effective quality management plan and program for the state or territory in accordance with the Ryan White Program legislation, and initiated implementation of processes to ensure and demonstrate quality of care and services.

Methods

The Low Incidence Initiative (LII) will involve teams from 18 states and territories working together for 12 months. During that time, team participants will take part in one face-to-face meeting and maintain continual contact with each other and faculty members through conference/web-conference calls, listserv discussions, and email. Over the year, a community of learning will develop where teams collaborate with each other to discuss common issues and share ideas and best practices.

Expectations

The Faculty should:

- Offer QM training and coaching to participants.
- Provide quality improvement frameworks such as the Model for Improvement, the HAB 9-Step Model, and the HIVQUAL Model.
- Provide effective ideas to test for improvements in quality of care.
- Provide communication strategies to keep participants connected to the Faculty and other LII participants.

Participants are expected to:

- Connect the goals of the Initiative work to quality management mandates.
- Perform pre-work activities to prepare for the face-to-face meeting.
- Send 1-2 representatives to the face-to-face meeting in

Spring of 2007.

- Participate in quarterly TA web-conference calls, their respective regional meeting, and a final virtual meeting in 2008.
- Participate in 'State Dates' with assigned peer states/territories for peer mentoring.
- Provide resources to support their team including time to devote to testing and implementing changes and active leadership involvement.
- Access and use appropriate resources needed and available through the Initiative and the NQC website.
- Perform tests of changes in the state or territory that lead to widespread implementation of improvements.
- Collect and report data bi-monthly on the Low Incidence Initiative listserv.
- Share information with other participants at meetings and through the LII listserv, including tools, best practices and details of changes made as well as data to support these changes.

Sponsors

This Initiative is supported by cooperative agreements from HRSA HIV/AIDS Bureau with the National Quality Center.

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Toolbox: Part A Collaborative Demonstration Project Charter: HAB/IHI Breakthrough Series Collaborative on Improving Care for People Living with HIV Disease (PLWH)

PROBLEM STATEMENT

The IOM's Committee on Quality of Heath Care in America states, "Quality problems are everywhere, affecting many patients. Between the health care we have and the care we could have lies not just a gap but a chasm. Research on the quality of care reveals a health care system that frequently falls short in its ability to translate knowledge into practice, and to apply new technology safely and appropriately. During the last decade alone, more than 70 publications in lead-

ing peer-reviewed journal have documented serious quality shortcomings." [1] More specifically, in spite of all that is known about effective care for HIV disease, recent studies have documented significant disparities in the quality of care in a substantial proportion of HIV-infected persons. [2,3] Underuse of needed medications occurs when patients have difficulty obtaining or attending appointments, or problems with obtaining prescriptions or drugs from appropriate HIV health professionals. Even when medications are provided, underutilization may occur when inadequate education and support are provided to people with HIV disease. [4] The challenges of HIV infection, coupled with the psychosocial problems of many people confronting HIV infection, make adhering to complex medication and treatment regimens difficult. [5] Marked reductions in HIV disease morbidity and mortality have been reported in recent years. In spite of these limitations [6,7] however, there are iniquities in the distribution of these gains. [2]

Assuring that the daily practice of medicine meets the latest standards of medical care is a complex process. Providers must not only be made aware of the most current science but also must become skilled in providing access and promoting adherence in very ill and vulnerable persons. HIV medicine has become increasingly complex; the latest iteration of the HHS/KFF Guidelines for the Use of Antiretroviral Therapy is 100 pages long. [8] The service delivery system must be designed so that the most effective care is also the easiest to deliver, thus closing the gap between science and practice. Models of outstanding care for people with HIV disease are available in both community and academic medical settings, and yet the approach to care that produces the best possible quality of life and health outcomes is not widely practiced in the U.S.

In addition, new and significant legislative requirements found in the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Reauthorization of 2000 [9] direct Title I programs to develop, implement, and monitor quality management programs. Quality Management programs should assure that funded services adhere, to the extent possible, to established HIV clinical practices standards and PHS guidelines. In addition, these programs must ensure improvement strategies for vital health-related supportive services and utilize demographic, clinical, and health care utilization information to monitor the spectrum of HIV-related illness and trends in the local epidemic. Gaps must be addressed in key areas such as needs assessment, earlier entry into care, linkages and agreements with point of entry providers, as well as a framework for addressing quality management from the provider and system level.

MISSION

The IOM's Committee on Quality of Heath Care in America "is confident that Americans can have a health care system of the quality they need, want, and deserve. But we are also confident that this higher level of quality cannot be achieved by further stressing current systems of care. The current care systems cannot do the job. Trying harder will not work. Changing the systems of care will." [1] The HIV/AIDS Bureau (HAB) shares this sentiment; their stated goal is "to increase access to comprehensive, quality and integrated health care and supportive services for uninsured and underinsured individuals and families infected and affected by HIV/AIDS." Therefore, the overarching mission for this Title I work is to manage the quality of care across the Title I continuum of care so that each patient that enters this system of care can be assured of the highest quality of care that is available. Although the range of services provided through Title I funds are broad, for the purposes of this demonstration project collaborative, the primary focus will be on case management and primary care.

To accomplish that mission, the Institute for Healthcare Improvement (IHI), working with Title I Ryan White grantees and partners throughout the country and HAB, will undertake a Breakthrough Series Collaborative Demonstration Project on Improving Care for People Living with HIV disease (Collaborative) to close the gap between what is known about caring for this population and current practices. We will strive to meet the Collaborative goals in twelve to fifteen

months by sharing the best available scientific knowledge on the care for people with HIV disease, and by learning and applying methods for organizational change. We will also stress methods for spreading outstanding care, and assuring the quality of that care across the entire continuum of care.

Participants in this Collaborative who care directly for patients will learn and implement an organizational approach to caring for people with HIV disease in a community or hospital-based setting. The approach is population-based and creates practical, supportive, evidenced-based interactions between an informed, activated patient and a prepared, proactive practice team. This care model also incorporates community and organizational components of care into the improvement effort.

Grantees, lead administrative agencies, and planning councils in this Collaborative who do not care directly for patients will also learn of this organizational approach to caring for people with HIV disease in a community or hospital-based setting. They will also learn and work with The Model for Improvement. They will serve as a demonstration project for application of these models to their work within the system of caring for people with HIV disease. It is anticipated these participants will work to identify and improve processes that support the primary care and case management providers' efforts to improve, coordinate, and deliver care. It is expected that change concepts and measures for this level of involvement in the system of delivery of care will emerge from this demonstration project.

COLLABORATIVE GOAL

The long-range goals of this Demonstration Project are to maximize the length and quality of life for patients with HIV disease and satisfy patient and caregiver needs and expectations. These goals will be achieved by implementing a system-wide model of care, which focuses on assuring the delivery of evidence-based clinical care within a context of culturally and linguistically competent and appropriate services, with strong support for self-management. The following actions are inherent in this long-range goals:

- Improve access to and retention in care and services for those who know their status and are in care
- Improve access to and retention in care and services for those who know their status and are not in care
- Facilitate with appropriate partners increased numbers of those who know their HIV status at an earlier stage in the disease process
- Test Collaborative Learning, The Chronic Care Model and The Improvement Model as a method to apply quality management within the Title I programs
- Test how Title I grantees, lead administrative agencies, and planning councils can facilitate improvement in their primary care and case management providers, and in their own work

IHI and the Collaborative Faculty will help each participating organization achieve these Collaborative goals and each organization's own specific aims. Examples of potential aims for participating organizations that are consistent with the Demonstration Projects' mission and goals include:

Sample Goals:

- More than 50% of HAART naive patients will have a CD4 count > 350
- More than 35% of HAART experienced patients will have a CD4 count > 350
- More than 70% of HAART naïve patients will have a Viral Load <10,000
- More than 50% of HAART experienced patients will have a Viral Load <10,000
- MOS-HIV Quality of Life assessment will improve by 25%
- More than 70% of patients will have a current service plan that is current
- More than 60% of the patients entering care will be at stage 1
- More than 70% of the patients will have a documented self-management goal setting session within the last 6 months

Each team is expected to specify four to six goals similar to these and appropriate for their population.

Ultimately, the intent is to spread this work, the Models, and the improvements to all primary care and case management providers within the five demonstration project Eligible Metropolitan Areas (EMAs), and finally to every EMA in the country.

METHODS

Each Title I EMA will work with their direct care providers to improve the care of patients with HIV disease. This quality work is ideally conducted in tandem between grantees, planning bodies and service providers with the grantee focusing on provider-specific issues and planning bodies addressing system and client level needs, challenges, and changes.

Each EMA in the Collaborative Demonstration Project will develop an EMA Response Team (EMA RT) that at a minimum will include a consumer member of the planning council, a representative of the Title II grantee, an AETC representative, and either a FTE or ½ FTE quality-management staff person from the Title I grantee office. The role of this EMA RT will be to guide, support, and bring appropriate resources to primary care and case management teams, so that they can deliver improved care within the EMA. Therefore, each EMA in the Collaborative will identify at least five primary care or case management teams to bring to the Collaborative (a minimum of two of these must be Title I funded primary care sites). The case-management agencies selected may or may not have direct referral relationships with the primary care agencies selected, with anticipation of future spread of the improved system of care to the remainder of the EMA. These teams may or may not be part of a large health system.

Each primary care or case management provider is expected to identify a specific population of patients (either a subset of their patients or all of them) that can be monitored during the duration of the Collaborative. This is called a population of focus and is defined by a specific group of clinics, practitioners, or locations, but not by risk levels or patient histories. A patient database must be available during the Collaborative to document and track the results of interventions on the specified indicators.

The Clinical Encounter and Referral Form of the updated CAREWare can be used for this purpose. Participating provider care teams and their health systems must plan to change practice and systems in order to improve clinical management and practice efficiency. IHI will provide guidance to participating organizations in the testing and implementing of best practices in their population of focus. Participating organizations will capitalize on the learning and improvement from this focused project by developing a system for spreading the practice redesign to other locations/offices/clinics/centers. This spread will require active involvement and support from the senior leaders of each organization.

COLLABORATIVE EXPECTATIONS

The Institute for Healthcare Improvement, the Collaborative Chairs, and the Planning Group will:

- Provide evidence-based information on subject matter related to the delivery of care, application of that subject matter and methods for process improvement, both during and between Learning Session
- Offer coaching to organizations
- Provide communication strategies to keep organizations connected to the Planning Group, the EMA Response Team, and colleagues during the Collaborative

Participating organizations are expected to:

- Perform pre-work activities to prepare for the first Learning Session
- Connect the goals of the Collaborative work to a strategic initiative in the organization
- Provide a senior leader to serve as sponsor for the team working on the Breakthrough Series, serve as champion for spread of the changes in practice within their health

care system, and attend the Learning Sessions

- Send a team to all three learning sessions, consisting of a physician leader or case manager and the clinical and administrative staff who would be able to try changes in care in the provider organization*
- Provide resources to support their team including resources necessary for Learning Sessions, time to devote to testing and implementing changes in the practice (approximately 1 FTE for the duration of the Collaborative) and active senior leadership involvement
- Provide expert staff (Financial, Information System, Clinical Policy Development) to the team on an as needed basis
- Perform tests of changes in the organization that lead to widespread implementation of improvements in the organization and their office practices
- Collect well-defined data that relate to their aims at least monthly and plot them over time for the duration of the Collaborative. (An annotated time series will be used to assess the impact of changes.)
- Share information with the Collaborative, including details of changes made and data to support these changes, both during and between Learning Sessions and for the National Congress

A typical team traveling to the meetings might consist of a lead physician or case manager caring for people with HIV disease, advanced practice nurse or nursing staff, and a patient educator/outreach worker. The team would be supported by others in the organization, including managers, quality improvement professionals, and information systems staff.

SPONSORS

This Collaborative is supported by a cooperative agreement from the Health Resources and Services Administration (HRSA), HIVAIDS Bureau (HAB) to the Institute for Healthcare Improvement.

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The Faculty needs to decide whether to include a prescribed aim statement in the Charter or allow teams to create their own aim statements with guidance. The disadvantage of using a prescribed aim statement is that if it fails to resonate with the teams' needs, the group may lose enthusiasm for the project. However, team-crafted aim statements can introduce variation, be inconsistent with the goals of the collaborative, and be hard to interpret.

REAL WORLD TIP

Check, check, and double check that the aim, goal, and call to action of the learning collaborative are very clear. For example, "We will improve care for our HIV patients" is not sufficiently clear. A clear aim statement includes both the overarching mission and numeric goals. It should specify the population of focus, the timeframe, and measurable changes. If unclear in your aim for the learning collaborative, convene focus groups of constituents to hone the focus.

REAL WORLD TIP

Use feedback from the Planning Group and Faculty to create the start-up materials, but enlist a smaller group to do the actual writing; writing by committee can be very time-consuming.

Assess and Identify Technology Resources

Faculty can use several different technology resources to foster ongoing communication between participants and peer learning during the learning collaborative. The Planning Group and Faculty should select the most appropriate resources based on the results of team assessments.

The Planning Group and Faculty should consider the following options for technology resources:

- Conference calls. Regular conferences calls (e.g., monthly except during months in which a face-to-face meeting will be held) are an important way to build a sense of community, keep all involved individuals connected in between sessions, and encourage sharing of best practices. Planners need to consider the number of available phone lines for participants and decide whether to use a toll- or toll-free phone line number.
- Webconferencing. Faculty can use webconferencing in lieu of or in addition to conference calls or face-to-face sessions, if participants' resources support this tool. This tool allows the facilitator to control presentation slides, which participants view via the internet. The tool may also support a chat box, whiteboards, and alternative sessions. Planners need to consider the costs associated with this resource and the availability of IT staff for supporting the conference.
- Listserv. A listserv is a communication device to manage group emails, automatically sending messages to multiple email addresses on a mailing list. Once a participant subscribes to the mailing list for the collaborative listserv, the listserv software will automatically add his or her address to the list and distribute future email messages to him or her along with all the others on the list. Faculty should be actively involved in monitoring the listserv, posing questions that engage participants if use of the tool should lag. Planners need to investigate the technical and staff requirements for setting up and maintaining a listserv, assign a lead to monitor and manage the tool, and create and distribute instructions on how to subscribe to and unsubscribe from the listserv.
- Dedicated website. If participants' resources support the tools, Faculty can use dedicated websites to provide information, solicit feedback, and receive data reports. A dedicated website or extranet allows teams to post data reports, share tools, and follow trend data. Faculty can post comments and summaries of aggregate data. If routinely updated, the tool can be very helpful. However,

dedicated websites require funding to host the site, IT staffing, and Faculty time to develop and oversee posted content.

- Online surveys. On-line surveys are an inexpensive and useful tool for learning collaboratives. They can be used to collect baseline information about the quality improvement capacity of participating teams. Because teams can post information anonymously, on-line surveys also are ideal for conducting evaluations of face-to-face meetings and the entire learning collaborative. In addition, on-line survey instruments tally results quickly, providing summary data as soon as polling is closed.

REAL WORLD TIP

- Keep it simple. If you don't need to go high tech, use a simpler solution.
- If you anticipate that travel costs and time may be a barrier to attending face-to-face meetings, consider replacing one or two of the meetings with a web-based format.

The Planning Group should anticipate the technology needs of participants and Faculty throughout the duration of the learning collaborative. Often the technology requirements are easily available, but require considerable time for organization and maintenance. The Planning Group should ensure that adequate training on the use of selected resources is available to participating teams and Faculty members.

Develop Pre-work Assignments

To maximize the effectiveness of the first face-to-face meeting, participants should be familiar with basic information about quality improvement and should have gathered some baseline data on their organizations. Homework assignments, referred to as pre-work, are used to expedite this preparation.

Pre-work often includes materials that describe the learning collaborative: its purpose, goals, proposed or required measures, a timetable, information on logistics, expectations, and available resources and support. In some cases, the Collaborative Charter is included in pre-work reading materials.

In addition to reading materials describing the learning collaborative, participants may be asked to:

- Read pertinent articles on the topic of focus and quality improvement principles and theories.
- Complete on-line training in quality improvement, such as Quality Academy, an on-line training resource available at NationalQualityCenter.org.
- Collect baseline data on the core indicators. To complete this task, teams will need adequate instruction on data collection to ensure inter-rater reliability. (These data are essential for illuminating the gaps in the current process and highlighting the potential gains to be achieved through participation in the learning collaborative.)
- Develop a quality improvement project memo, which is a concise description of the project that includes a problem statement, project goals, a list of team members, and other relevant information.
- Conduct an organizational assessment using standardized evaluation tool; take advantage of already developed assessment tools.
- Complete self-assessment to evaluate their quality improvement competencies and knowledge.
- Create a focused presentation (using a presentation template) on their current quality management program to share at first face-to-face meeting with other teams.

Faculty should remind participants to bring these relevant materials to the first face-to-face meeting or—better yet—submit them prior to the meeting for review by the Faculty and sharing with other teams.

REAL WORLD TIP

Consider the time commitment for start-up materials. Provide an estimate for the number of hours participants will need to invest to complete start-up materials assignments.

REAL WORLD TIP

Insert questions into the tool to help assess whether participants have access to needed databases.

Toolbox: Improvement Project Memo

PROJECT START DATE:	October 22, 2005
COMPLETION DATE:	April 15, 2006
INDICATOR:	PCP prophylaxis
PROBLEM STATEMENT:	Currently, only 65% of patients with CD4 count less than 200 receive appropriate PCP prophylaxis, compared to the statewide average of 92%. In the last year the performance rate declined by 31%.
IMPROVEMENT GOAL:	The team will work to improve the clinic's performance on this important prevention measure. The team should focus on increasing the number of patients with CD4 count less than 200 receiving appropriate PCP prophlyaxis to 95% and above.
TEAM MEMBER:	Ann Cavanaugh, C.S.V. (team leader) Peter Brown Paul Sabo, M.D. Santiago Rodriguez Helen Kearney Cheryl March, R.N.
OTHER: (RESOURCES, AUTHORITY, FREQUENCY OF REPORTING, GROUND RULES)	Team will be given time to meet. There's money for supplies or other similar expenses, but not for additional staff. Mac Martin (MIS department) will be available to help with data analysis. Team members should give a verbal report at the next quality committee meeting, November 15. All team members should be on time and no excuses.

Toolbox: Part B Quality Management Program Assessment Tool

A) Quality Management Plan

A.1. Is a comprehensive HIV-specific, statewide quality management plan in place with clear definitions of leadership, Part B roles, resources and accountability?

SCORE 0	SCORE 1	SCORE 2	SCORE 3	SCORE 4	SCORE 5

SCORE 0	Part B program has no or minimal written quality plan in place; if any in existence, written plan does not reflect current day-to-day operations.
SCORE 1	Part B program has only loosely outlined a quality management plan; written plan reflects only in part current day-to-day operations.
SCORE 2	
SCORE 3	A written statewide quality management plan is developed describing the quality infrastructure, frequency of meetings, indication of leadership and objectives; the quality plan is shared with staff; the quality plan is reviewed and revised at least annually; some areas of detail and integration are not present.
SCORE 4	
SCORE 5	A comprehensive and detailed HIV-specific, statewide quality management plan is developed/refined, with a clear indication of responsibilities and accountability across DOH, quality committee infrastructure, outline of performance measurement strategies, and elaboration of processes for ongoing evaluation and assessment; engagement of other DOH department representatives is described; quality plan fits within the framework of other statewide QI/QA activities; staff and providers are aware of the plan and are involved in reviewing and updating the plan.
COMMENTS:	

A.2. Are appropriate performance and outcome measures selected, and methods outlined to collect and analyze statewide performance data?

SCORE 0	SCORE 1	SCORE 2	SCORE 3	SCORE 4	SCORE 5

SCORE 0	No appropriate performance or outcome measures are selected; methods to collect and analyze statewide performance data are not outlined.
SCORE 1	Only those indicators are selected that are minimally required; no process takes place to annually review and update indicators and its definitions; methods to collect data are not described.
SCORE 2	
SCORE 3	Selection of indicators is based on results of past performance data and some input of Part B representatives; indicators include appropriate clinical or support service measures; indicators reflect accepted standards of care; indicator information is shared with DOH staff; processes are outlined to measure and analyze statewide performance data.

Toolbox: Part B Quality Management Program Assessment Tool...Continued

SCORE 4	
SCORE 5	Portfolio includes clinical and support service indicators with written indicator descriptions; measures are annually reviewed, prioritized and aligned with DOH quality goals; all indicators are operationally defined, and augmented with specific targets or target ranges, including desired health outcome; DOH performance measurement activities include partnering with other data sources such as Medicaid and Epidemiology data; Program Assessment Rating Tool (PART) measures and unmet need are integrated; statewide data collection plans are clearly outlined and strategies to analyze data are detailed.
COMMENTS:	

A.3. Does the work plan specify timelines and accountabilities for the implementation of the statewide quality of care program?

SCORE 0	SCORE 1	SCORE 2	SCORE 3	SCORE 4	SCORE 5

SCORE 0	No work plan is specified for the implementation of the statewide quality of care program.
SCORE 1	A work plan is only loosely outlined; no specific timelines for the implementation of the statewide quality of care program are established; no formal process to assign timelines and responsibilities; follow-up of quality issues only as needed.
SCORE 2	
SCORE 3	A written, annual work plan which outlines the implementation is in place; timetable is shared with appropriate DOH staff; updates in the work plan are discussed in quality committee(s); quality activities are planned before execution.
SCORE 4	
SCORE 5	A process to assign timelines and responsibilities for quality activities is in place and clearly described; annual plan for resources is established; DOH staff are aware of timelines and responsibilities; quality committees are routinely updated and consulted on the implementation of the statewide quality program.
COMMENTS:	

B) Organizational Infrastructure

B.1. Does the Part B program have an organizational structure in place to oversee planning, assessment and communication about quality?

SCORE 0	SCORE 1	SCORE 2	SCORE 3	SCORE 4	SCORE 5

SCORE 0	No quality structure is in place to oversee planning, assessment and communication about quality.

Toolbox: Part B Quality Management Program Assessment Tool...Continued

SCORE 1	Only a loose quality structure is in place; a few DOH representatives are involved; knowledge of quality structure among staff is limited.
SCORE 2	
SCORE 3	Senior DOH representative heads the HIV quality program; DOH representatives from some internal departments are represented in the HIV quality structure; findings and performance data results are shared; staff for the quality program are identified; resources for the quality program are made available.
SCORE 4	
SCORE 5	Senior DOH leaders actively support the program infrastructure and planned activities; key staff are identified and supported with adequate resources to initiate and sustain quality improvement activities at the DOH program as well as the provider level; Part B staff are routinely trained on quality improvement tools and methodologies; findings and performance data results are frequently shared internally and externally.
COMMENTS:	

B.2. Is a quality management committee with appropriate membership established to solicit quality priorities and recommendations for quality activities?

SCORE 0	SCORE 1	SCORE 2	SCORE 3	SCORE 4	SCORE 5

SCORE 0	No Part B quality management committee is established to solicit quality priorities and recommendations for quality activities.
SCORE 1	Quality meetings are held with only a few DOH representatives and/or provider representatives; ad hoc meetings are only used to discuss immediate issues.
SCORE 2	
SCORE 3	Quality committee is established that engages various representatives; routine quality committee meetings are held to solicit quality priorities and recommendations for quality activities; reporting of committee updates in place.
SCORE 4	
SCORE 5	Senior DOH leader, key Part B providers and consumer representatives are actively involved in quality committee(s) to establish priorities and solicit recommendations for current and future quality activities; membership is reviewed and updated annually; HIV quality meetings include written minutes and reporting mechanisms.
COMMENTS:	

Toolbox: Part B Quality Management Program Assessment Tool...Continued

B.3. Does the Part B quality program involve providers, consumers and representatives, such as ADAP, Medicaid, Epidemiology and from other Ryan White Program Parts?

SCORE 0	SCORE 1	SCORE 2	SCORE 3	SCORE 4	SCORE 5

SCORE 0	Part B quality program does not involve providers, consumers and representatives, such as ADAP, Medicaid Epidemiology and from other Ryan White Program Parts.
SCORE 1	Part B quality program includes only internal DOH staff, with limited input from other departments; neither Part B providers nor consumers are involved.
SCORE 2	
SCORE 3	Representatives from a few DOH departments, Part B providers and at least one consumer representative are participating in quality committee meetings; other Ryan White Parts are involved.
SCORE 4	
SCORE 5	Representatives from all appropriate internal DOH offices, including ADAP, Medicaid, and Epidemiology; Part B providers and consumers are actively engaged in the statewide quality of care; representatives from other Ryan White Parts are structurally integrated in the quality program.
COMMENTS:	

B.4. Are processes established to evaluate, assess and follow up on HIV quality findings and data being used to identify gaps?

SCORE 0	SCORE 1	SCORE 2	SCORE 3	SCORE 4	SCORE 5

SCORE 0	Processes are not established to evaluate, assess and follow up on HIV quality findings.
SCORE 1	No processes are established to evaluate the HIV quality program; quality infrastructure and its activities are reviewed only if necessary; when establishing/updating the annual work plan, past performance is not considered; quality of care program does not learn from past successes and failures.
SCORE 2	
SCORE 3	Review process is in place to evaluate the Part B quality infrastructure, and assess the performance data; findings are generated for follow up and used to plan ahead; summary of findings are documented.
SCORE 4	
SCORE 5	Process to annually assess effectiveness of HIV quality program; data findings are used to identify gaps in care and service delivery; DOH staff are actively involved; assessments and follow ups are documented; HIV leadership is well aware and involved in evaluation of HIV quality program; findings and past performance scores are used to facilitate and shape Part B quality program.
COMMENTS:	

Toolbox: Part B Quality Management Program Assessment Tool...Continued

C) IMPLEMENTATION OF QUALITY PLAN AND CAPACITY PLANNING

C.1. Are appropriate performance data collected to assess the quality of HIV care and services statewide?

SCORE 0	SCORE 1	SCORE 2	SCORE 3	SCORE 4	SCORE 5

SCORE 0	No performance data are collected to assess the quality of HIV care and services statewide.
SCORE 1	Basic performance measurement systems are in place; only utilization data are collected; no process established to share data or only used for punitive purposes; data are not collected statewide.
SCORE 2	
SCORE 3	A system to measure key quality aspects among Part B providers is established; data are collected, analyzed and routinely disseminated to providers; data are collected from most providers around the state.
SCORE 4	
SCORE 5	The quality, including clinical and support services across the state, is measured by selected process and include outcome measures; organizational assessments of Part B provider quality infrastructures are conducted; results and findings are routinely shared with providers to inform and foster quality improvement activities; data are collected from the entire state.
COMMENTS:	

C. 2. Does the Part B quality program conduct quality improvement projects to improve DOH systems and/or quality of care issues?

SCORE 0	SCORE 1	SCORE 2	SCORE 3	SCORE 4	SCORE 5

SCORE 0	The Part B quality program does not conduct quality improvement projects to improve DOH systems and/or quality of care issues.
SCORE 1	Quality improvement activities focus on individual cases or incidents only; projects are primarily used for inspection; selection of quality activities is done by single person.
SCORE 2	
SCORE 3	A few DOH staff members have input in the selection of quality projects; quality improvement activities focus on issues related to structures and processes only; at least one quality project was conducted in the last 12 months to improve DOH systems and/or quality of care issues; DOH internal Part B quality improvement activities are tracked.
SCORE 4	
SCORE 5	Structured process of selection and prioritization of quality projects is in place; quality improvement projects are informed by the data and are outcome related; DOH staff across several departments is involved in quality improvement projects; findings are routinely shared with entire DOH staff, presented to the quality committee, and used to inform subsequent projects.
COMMENTS:	

Toolbox: Part B Quality Management Program Assessment Tool...Continued

C.3. Does HIV quality program offer QI training and technical assistance on quality improvement to Part B providers?

SCORE 0	SCORE 1	SCORE 2	SCORE 3	SCORE 4	SCORE 5

SCORE 0	The quality program does not offer QI training and/or technical assistance on quality improvement to Part B providers.
SCORE 1	No structured process in place to train Part B providers on quality improvement; limited technical assistance resources available for Part B providers to build capacity for quality improvement.
SCORE 2	
SCORE 3	Capacity to train Part B providers and provide technical assistance on quality improvement is available; process in place to triage TA requests from individual providers; some resources are available and mostly used in response to TA requests.
SCORE 4	
SCORE 5	A quality workshop program is established to routinely train clinical and service providers on quality improvement priorities, tools and methodologies; an annual training schedule is developed with quality topics based on needs assessment including input by providers; trainings are well attended and evaluations are routinely kept and analyzed and used to improve future training; technical assistance is provided to clinical and service providers through on-site visits by quality experts.
COMMENTS:	

Toolbox: Quality Improvement Skills and Knowledge Assessment

Caption	SCALE (1 = STRONGLY DISAGREE TO 5 = STRONGLY AGREE)				
	1 (LOW)	2	3	4	5 (HIGH)
1. I understand key quality models, methodologies and tools.					
2. I can write an effective quality management plan.					
3. I can effectively generate buy-in for quality within an organization.					
4. I can facilitate a PDSA Cycle to accelerate improvements in HIV care.					
5. I can assist organizational leadership in setting priorities to develop a sound quality program.					
6. I can assess the strengths and weaknesses of an organization's quality program.					
7. I can facilitate regular quality management committee meetings.					
8. I can assist an organization in strengthening its infrastructure.					
9. I can assist the organization to identify and prioritize quality indicators.					
10. I can facilitate groups organizing effective quality improvement activities.					
11. I can develop clinical and non-clinical quality indicators.					
12. I can link performance measurement results to efforts to improve care.					
13. I can increase staff communication around quality.					
14. I can help align the quality goals with the needs of those that are served in HIV programs.					
15. I understand the concept of learning through small, incremental changes to achieve continual improvements.					
16. I can facilitate involvement of key stakeholders, including staff and consumers around quality improvement.					
17. I can bring a process and system perspective when assessing current quality of care situations.					
18. I can solicit subject matter experts or gather available quality resources.					
19. I can explain the requirements for quality set by the HIV/AIDS Bureau.					
20. I can help others to chart processes and use them for quality improvement.					
21. I can help others to effectively sample data and randomize records for data collection.					
22. I can use data to better understand the performance of processes or systems.					
23. I can help identify and develop roles and expectations for data collection.					
24. I can assist in the analysis of data and data reporting.					

Toolbox: Slide Presentation Template for HIV Programs – First Meeting

Slide 1: Overview of Quality Management Program and Activities
Grantee Name/Organization:

Slide 2: Quality Management Program
Description of Quality Management Program Structure:
Members of the Quality Management Program:
Annual Goals of Your HIV Quality Program:

Slide 3: Performance Measures
Identify Indicators that are Routinely Measured:
Identify 3 Indicators with the Most Improvements over the Last 2 Years:

Slide 4: Quality Improvement Activities
Description of Current Quality Improvement Activities/ Projects:
What Are Your Lessons Learned?

Slide 5: Other Quality Successes
What Can you Offer to Other Programs to Learn from you?
Describe How the Results of the Performance Measures Have Been used to Improve HIV Care:
Overview of Quality Management Plan:
Describe How Consumers Have Been Engaged to Improve HIV Care:

Invite Participating Teams

Once the Planning Group and Faculty have completed the Collaborative Charter, defined indicators, secured a meeting space, and completed the other basic foundation for the learning collaborative, it is time to officially invite participating teams to the learning collaborative and its first face-to-face meeting. The Planning Group may want to use a recruitment task list to ensure completion of all necessary steps for identifying and inviting participants.

Faculty should send a written invitation via email or letter that includes the following points:

- Current contact information for participants with a request for necessary corrections.
- A request that key opinion leaders (who may not be officially titled leaders within the organization) are included on the team. It is important to obtain buy-in from these opinion leaders to facilitate the changes required for success.
- Clearly communicated expectations for team participants. (Faculty can consider requiring that participants sign a commitment statement.)
- A clearly articulated list of the individuals who should attend the face-to-face meetings.
- Pre-work assignments with clear deadlines for returning them to the Faculty.

Additional materials to be sent out to the teams with the invitation or before the first face-to-face meeting include:

- Collaborative Charter
- Checklist for upcoming learning collaborative
- List of the roles and responsibilities of team members and team composition
- Collaborative indicators and performance measurement reporting requirements
- Timetable and key collaborative milestones
- Introduction of Faculty members
- Glossary of improvement terms and concepts
- Collection of quality improvement resources (e.g., publications, relevant articles)

Toolbox: Commitment Statement: Participation in the Low Incidence Part B Quality Management Initiative

HRSA/HIV/AIDS Bureau and the National Quality Center are implementing a 12-month initiative to promote the development of quality management planning and activities in low incidence Part B States and Jurisdictions. All expenses for this Part B Quality Management Initiative, including face-to-face meetings, training, technical assistance, and web conferences will be paid for by the National Quality Center. This initiative is open to low incidence Part B grantees by invitation only. Completion of the activities listed below will assist in fulfilling the Part B Application Guidance quality management requirements.

Participants in the Low Incidence Part B Quality Management Initiative will be expected to participate in the following activities over the course of 12 months:

- Attend one full-day face-to-face meeting in Washington DC on April 12, 2007 and complete the "Pre-Work" in preparation for the meeting.
- Participate in one regional web-meeting to follow up on action plans created on April 12th, discuss challenges and learn from regional peers and faculty.
- Participate in quarterly Low Incidence Initiative (LII) technical assistance calls.
- Participate in one teleconference with another Low Incidence State in the initiative based on common interests and needs.
- Collect and report data bi-monthly on the Low Incidence Initiative listserv.
- Use the LII Initiative listserv to make offers and requests to other participating States and to share tools and best practices.
- Access and use appropriate resources available through the Initiative, the NQC website, and LII listserv.
- Attend a final virtual meeting in 2008.

At the end of this initiative, the outcomes expected from the participants include:

- Completion of a comprehensive Quality Management Plan.
- Development and/or strengthening of a Quality Management Committee within their State/Jurisdiction.
- Ability to regularly collect, trend and report quality data.
- Initiation of at least one improvement project within the 12-month period.
- Improvement in the Quality Management Program core criteria self-assessment.

YES! We are interested in improving the quality of the services we deliver with Ryan White HIV/AIDS Treatment Modernization Act of 2006 Part B funds and being part of a learning community where we can learn from peers. We want to be a part of the Low Incidence Part B Quality Management Initiative and will commit to participate in the required activities and deliver upon the expected outcomes.

Part B Jurisdiction:_____

Contact: _____

Phone: _____

Email: _____

Part B Director Signature: _____

Date: _____

Toolbox: Sample Recruiting Task List

Recruiting Activity	Resources	Time Line
Mail brochure of Collaborative intent with list of sponsors, benefits and prior successes. Make sure brochure has a response component for easy follow-up with interested systems.	• Gather mailing lists from peer review organizations, local health depts., medical professional groups, etc. • Approach health product companies for grants to defray mailing costs.	Mailing should be 6-8 months before Learning Session One start date. Allow 2 months for brochure production and list gathering.
Use sponsor leadership contacts to approach systems or practices.	• Take advantage of organizations or meetings that convene several systems.	Start at same time as brochure mailing.
Contact insurers. If they are interested, enlist them in practice team recruiting.	• Including health plans into the Collaborative provides benefits. (See "Health Plan Activities" document.).	Start at same time as brochure mailing.
Once practice or health plan expresses interest in participating, send Memo of Understanding to help solidify their commitment.	• See MOU template.	MOU needs to be completed 3 weeks before learning session.

Recruiting Tips:

1. Use informal networks of health care friends and associates.
2. Contact local medical colleges to recruit academic health centers.
3. Obtain permission to use potential participants' names as a draw for others.
4. Use email lists to save time and money.
5. Try to get local trade publications or media to publish your intent to conduct a collaborative.
6. Hire a health care communications company to assist with recruiting, if finances permit.
7. Dedicate staff time to mailings, cold calls and follow-up.

This tool was developed as part of The Improving Chronic Illness Care program, which is supported by The Robert Wood Johnson Foundation, with direction and technical assistance provided by Group Health's MacColl Institute for Healthcare Innovation.

It is essential to the success of the learning collaborative that individuals with high-level decision-making responsibility attend the various activities of the learning collaborative. Because these individuals can either facilitate or slow the changes the teams will be testing and implementing, it is important that they are fully engaged in the project and completely understand the goals of the initiative. Faculty also should encourage teams to send front-line quality improvement champions, such as individuals responsible for data collection and local project team leaders, to attend the face-to-face meetings, join scheduled conference calls, and actively participate in the performance measurement activities of the learning collaborative.

REAL WORLD TIP

Participating teams will benefit from a learning collaborative in direct measure to the energy they expend in it. Don't drag in unwilling participants. Instead, invite a smaller number of individuals who are truly engaged in the project.

The Faculty may decide to convene a conference call with participants after the introductory letter has been sent. During this call, Faculty should provide information about the planned project, outline the expected benefits of involvement, discuss the expectations of participation, describe available quality improvement resources, review the pre-work assignments, and answer participants' questions. The call facilitator should ensure that sufficient time is allocated for answering questions and addressing concerns. It is ideal if all members of the Faculty attend the call to provide teams with a greater degree of comfort and familiarity with the Faculty.

Toolbox: Agenda for Introductory Conference Call

Welcome to the Pre-Work Call for the Low Incidence Initiative

March 14, 2007

4:00- 4:05	Welcome and Introductions – Clemens
4:05- 4:15	Expectations and Commitment - Magda
4:15-4:30	Pre-Work and Deadlines - Meera
4:30-4:50	Review of Part B Quality Management Program Assessment Tool - Clemens
4:50- 5:00	April 12th Meeting Agenda and Logistics - Meera

The Planning Group and Faculty must ensure that teams have all resources needed to complete work required for the first face-to-face meeting and must allow sufficient time for completion of these tasks. Faculty members may want to convene conference calls during these preparatory months to assist teams with these assignments, especially those tasks centered on data collection and data entry into the data tool. A similar strategy can be applied prior to subsequent face-to-face meetings and before scheduled topic-specific conference calls.

REAL WORLD EXAMPLE

One organization found it effective to have an executive leader set the stage for a learning collaborative by presenting the initiative as an opportunity to take on a project that would benefit the entire organization. The executive underscored the fact that the initiative would require members of the project team to perform extra work and might require an investment of time from everyone, but would be worth

the investment in the long term. The leader listed a number of expected benefits and asked all staff to fully support the project. By creating a culture supportive of the project and articulating an expectation of complete cooperation on the part of the staff, the executive set the stage for a successful learning collaborative.

Case Study: Build Infrastructure for Upcoming Collaborative

Susan and Danielle invited five individuals to serve as Faculty: the Part B Program Director and individuals with expertise in HIV/AIDS, patient retention, quality improvement, and patient-provider communication. The quality improvement officer was designated to serve as improvement expert. The Faculty was asked to consider the topics, goals, and measures that the planning body had proposed and to begin to create a Collaborative Charter. With the input of the Faculty and Planning Group, the implementation team fleshed out and completed the document.

Susan assessed the experience level of potential participants and learned that all teams had some previous QI experience. Based on this simple assessment, Susan also knew that baseline data on retention-related measures were available from all potential participants. Because these data were available, Susan felt confident that a 12-month duration would be sufficient for the learning collaborative. If baseline data were not available, she would have chosen an 18-month timeframe.

Susan and Danielle began to plan the high-level agenda and the timetable. The Planning Group decided to hold 4 face-to-face meetings over the course of the learning collaborate. Their decision was based on the complexity of the topic and the short travel distances between teams. If the topic had been less complex or the travel distances longer, they might have scheduled just two face-to-face meetings with a virtual meeting or two in between. They also decided to use prescribed aim statements and measures.

The implementation team, with the help of the Planning Group, assessed the technology resources available for the learning collaborative. They decided that sufficient resources and staff were available to support conference calls, web-conferencing, and a listserv, but not a dedicated website. With significant input from the Faculty and Planning Group, the team decided on a set of balanced measures. They determined that there would be a core set of 3 required measures and 2 optional measures. Teams would be required to report bimonthly for the prior two-months' worth of data.

The Faculty used the collaborative charter to create start-up materials. Susan and Danielle invited 17 organizations to participate; fifteen accepted. Susan ensured that the teams understood the expectations of participation by holding an introductory conference call and requiring that team leaders sign a commitment statement. She queried team leaders about the make up of their teams to ensure that key decision-makers were included. As required pre-work, Susan decided to use the NQC Quality Management Organizational Assessment Tool, which she downloaded from the NQC website at NationalQualityCenter.org.

Susan and Danielle worked with the administrative assistant to plan the communication channels the participants would use. They investigated the benefits and challenges of web-conferencing, which neither had used previously.

Step 3: Prepare and Facilitate Face-to-Face Meetings

The Big Picture

The first face-to-face meeting of a learning collaborative is critical in setting the tone for the initiative and in preparing participants for upcoming work. This meeting serves several important purposes: to help participants better understand the topic of focus, raise enthusiasm, and create a safe environment for sharing experiences and effective peer learning. Subsequent face-to-face meetings are opportunities to share additional content, maintain the momentum of the project, provide opportunities for peer learning and exchange of best practices, and build relationships between participating teams. The Faculty should invest the time necessary to plan carefully the face-to-face meetings.

What To Do:

- Assess Participating Teams
- Plan Meeting Logistics
- Develop the Meeting Agenda
- Encourage Peer Learning
- Set Follow-up Goals for Participating Teams
- Provide Access to Quality Improvement Resources and Tools
- Obtain Feedback

Assess Participating Teams

To better understand the learning collaborative participants and meet their needs, the Faculty should conduct an assessment of participants before the first face-to-face meeting. This assessment may be a written, verbal, or on-line survey. Alternatively, the assessment may involve the use of more formalized assessment tools. Whichever format is used, the assessment should gather the following information to help in planning the initial face-to-face meeting:

- Current status of the team's quality management infrastructure (e.g., existence and viability of a quality management committee and/or written quality management plan)
- Detailed information about the participating organization (e.g., number of patients served, type of health care facility, type of services provided, information about their HIV community)
- Current level of quality improvement knowledge and capacity of individuals in the organization (e.g., results of quality improvement knowledge assessment, number of relevant quality improvement workshops attended, number of quality improvement projects completed over the last year)

The Faculty needs to make sure it receives responses to assessments with sufficient time to address gaps in responses

and answer related questions. After these data are collected, the Faculty should apply it to planning the first face-to-face meeting and to provide teams' with data compiled in aggregate form.

REAL WORLD EXAMPLE

When working on a learning collaborative of Part B grantees, the implementation team found it challenging to keep track of team members over the course of the project because many individuals changed job titles or positions. The team developed a form to help collect and organize the necessary contact information at each face-to-face meeting, see Toolbox).

REAL WORLD EXAMPLE

Using standardized assessment forms to survey the individual or organizational capacity for quality improvement has been proven critical for the success of learning collaboratives. Access the Part-specific Organizational Quality Management Assessment Form to learn more about the agency-wide quality infrastructure. To assess the individual quality competency, use the NQC TOT Application Form with its detailed quality assessment questions. Samples of these tools are in the appendix on this document.

Toolbox: Sample Team Contact Information Form:

Participants Contact Information

First Name: _____

Last Name: _____

Your Agency/Program: _____

_____

Address + ZIP: _____

_____

_____

Your Title: _____

Phone: _____

Email: _____

Fax: _____

(Please return at end of meeting)

Plan Meeting Logistics

In planning the agenda and logistics of face-to-face meetings, it is essential that the individual roles are clearly defined and communicated. Faculty members are primarily responsible for the content of the face-to-face sessions. They should be made aware of specific due dates, such as the date by which meeting organizers need to receive their presentation materials. The facilitators are responsible for the flow and process of the learning session and ensuring that the

meeting is interactive, comfortable, and effective. Facilitators should announce sessions, give directions, and keep all running smoothly and on time. They must clearly understand the learning objectives of the meeting. Lastly, the administrative support staff should ensure that all logistics and materials are in place before the start of the meeting. The NQC meeting checklist is a helpful guide for meeting planners; see the Toolkit for the checklist.

Toolbox: Meeting Logistics Checklist

A) ABOUT TRAINER:

Name of Trainer: _____

Organization: _____

Reporting Date: _____

E-mail Address: _____

Work Phone: _____

Completion Date of NQC TOT Program:

_____

B) TRAINING:

Date of Training: _____

Location of Training: _____

State: _____

Lengh of Training (in hours): _____

Type of Training:

- ☐ Face-to-Face Workshop
- ☐ Audio Conference Call
- ☐ Virtual Webinar
- ☐ Other: _____

# of Participants: _____

Participants' Ryan White Funding: (check all that apply)

- ☐ Part A
- ☐ Part B
- ☐ Part C
- ☐ Part D
- ☐ AETC
- ☐ Other: _____

Training Topic(s): _____

_____

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Challenges Faced: _____

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NATIONAL QUALITY CENTER

New York State Department of Health, AIDS Institute
90 Church Street, 13th floor
New York, New York 10007-2919

Meeting Worksheet

LEGEND: X = Task Items Pending/Still Needed √ = Task Items Completed

PROGRAM INFORMATION

Meeting Title:	
Day(s)/Date(s):	
Location/Room:	Program Type: (check all that apply) ☐ Scheduled Training ☐ Special Request Program ☐ In-Service ☐ Conference ☐ Meeting/Event ☐ Workshop ☐ Faculty Development ☐ Satellite Broadcast
Address/Directions:	
Meeting Organizer(s): National Quality Center	
Key Staff:	

	Name/Program	Involvement	E-mail	Phone #	Fax #
Additional Key People:					
Co-Sponser:					
Co-Sponser Address:					

MEETING PLAN CHECK LIST

Action Item	Agent Responsible	Specifications/Comments	Start Date	End Date	Status
Agenda development					☐
Pre-conference Calls					☐
Meeting Site/Rooms Confirmed					☐
Room Set-up					☐
Registration					☐
A/V Equipment					☐
Materials					☐
Catering					☐
Guest Speakers					☐
Language Services/Interpreters					☐

Depending on the size of the collaborative and the sponsoring group, one or two people may fulfill many of these roles at different times. For example the Faculty might create the agenda with input from some participant representatives, and a smaller number of Faculty members might be responsible for the logistics.

REAL WORLD TIP

Consider covering lodging or travel costs, depending on available funds and distance traveled to facilitate participation or increase the number of team members present at each meeting. Holding face-to-face meetings in conjunction with site visits can help reduce travel costs.

The collaborative leaders, with the support of administrative staff, must remember to plan for and reserve the venue, meals, and necessary audiovisual and computer equipment. Providing meals for participants encourages relationship-building and prevents late starts after meal breaks. In addition, meeting planners should request a room set-up that allows for easy interaction between team members, between teams, and between teams and Faculty. Round tables at which participants sit half way around is more conducive to interaction than traditional classroom-style seating.

REAL WORLD TIP

Remember to ask participants about dietary needs and preferences when planning face-to-face meetings.

Develop the Meeting Agenda

The length of face-to-face meetings ranges from one to two full days. All participating teams are expected to attend these meetings. In some instances, longer face-to-face meetings may be necessary. For example, the Faculty may consider longer meetings if participants are new to quality improvement, the content focus of the learning collaborative is especially complex, or participants include cross-functional representatives who do not usually work together.

Face-to-face meetings require an investment of time and money on the part of both organizers and participants. For this reason, it is important to save face-to-face time for activities that cannot be accomplished well through other communication channels. When planning face-to-face meetings, the Planning Group should strive for a balance between didactic time, interactive time, and team-action time and should keep in mind the primary goal of face-to-face meetings: providing participants with opportunities to learn from and strategize with Faculty members and each other during formal sessions and informal interactions.

REAL WORLD TIP

Structure your face-to-face meetings based on adult learning principles. Remember that adults learn best when offered multiple ways to learn, when instruction is applied to real-world situations, and when sessions are interactive.

REAL WORLD TIP

To reinforce key or confusing topics, make sure to build in a degree of repetition from one meeting to the next.

Face-to-face meetings provide participants with valuable opportunities to:

- Understand and appreciate through testimonials the impact of the improvement successes of patients and staff
- Increase their capacity for quality improvement (e.g., definitions of key terms, training use of PDSA (Plan-Do-Study-Act) Cycles, application of quality improvement theories, and use of quality improvement tools)
- Try quality improvement activities in a supportive environment (e.g., develop an aim or plan a first test of change using data collected during pre-work activities)
- Exchange best practice information with other teams
- Describe their activities or challenges and obtain feedback from Faculty and other teams
- Identify and detail possible tests of change to try in their own environment

REAL WORLD EXAMPLE

In one learning collaborative, facilitators asked volunteers to share a personal experience with the health care system. Based on these stories, teams were asked to rate the care currently provided by their organizations. Facilitators then led a debriefing discussion that underscored possible areas for improvement.

REAL WORLD TIP

Encourage Faculty to use examples relevant to your audience when explaining quality improvement methodologies. For example, when teaching food service providers how to use a PDSA Cycle for rapid testing of a change, describe an intervention relevant to a food program, such as changing a hospital menu from high fat/high calorie to low fat/low calorie, rather than a clinical one, such as increasing patient retention.

Unless the needs assessment shows otherwise, the Faculty should select activities for the meetings with the assumption that participants have little knowledge of quality improvement. Participants should receive basic quality improvement information in pre-work materials, which Faculty members should reinforce at the initial face-to-face meeting. The first meeting also should include a detailed discussion of the measures, categories of change ideas, change ideas themselves, and how to test changes. Successive face-to-face meetings should provide more in-depth training on change ideas. Each face-to-face meeting should include small group sessions during which participants can describe the ideas they are testing and receive feedback from Faculty and other participants.

REAL WORLD TIP

Don't overload participants with tools and a variety of quality improvement training topics at the first face-to-face meeting or expect them to master the concepts immediately. It may take repeat exposure at subsequent meetings for participants to absorb the information.

REAL WORLD TIP

Plan to have one or more (or possibly all) teams provide a formal presentation to the group at each face-to-face meeting, with the goal of having every team present by the end of the learning collaborative. Faculty should ask teams to present specific practices they have used, as well as challenges, solutions, and results.

REAL WORLD EXAMPLE

During a recent Part B collaborative, participating teams created detailed quality management plans, which were reviewed by the learning collaborative Faculty. The HIV/AIDS Bureau Faculty members then reviewed the plans with the HAB Project Officer for each of the 17 participating teams. It provided the Project Officers with new insight into the quality improvement initiatives underway in their states.

Faculty should consider the following content areas when creating agendas for face-to-face meetings:

Content Areas	1st Meeting	2nd Meeting	3rd Meeting	4th Meeting
Introduction to Learning Collaborative	x			
Quality Improvement Training	x	x		
Content Expert Lecture on Topic of Focus	x	x	x	x
Instruction and Reinforcement on Testable Changes	x	x	x	x
Instruction on Measures	x	x	x	x
Peer Networking	x	x	x	x
Peer Learning Opportunities	x	x	x	x
Sustainability		x		x
Celebrating Results				x

Toolbox: Agenda for a First Face-to-Face Meeting

HAB/NQC Low Incidence Initiative Meeting, April 12th 2007
Agenda

7:30-8:00am	Breakfast and Registration
8:00-8:30am	Welcome, Intros and Opening Remarks - Clemens, Meera
8:30-9:15am	Setting the Stage: Lessons from the Part B Collaborative, Low Incidence Initiative Expectations, and Summary of Pre-work - Clemens, Magda, Donna
9:15- 10:00am	Individual State Presentations: Iowa, Kansas, Nebraska, Montana, North Dakota, South Dakota, Idaho, Wyoming - Donna
10:00-10:15am	Morning Break

10:15-11:00am	Individual State Presentations: Alaska, Hawaii, New Mexico, Utah, West Virginia, Rhode Island, Maine, New Hampshire, Vermont - Donna
11:00- 12:00pm	Presentation and Group Exercise: Quality Management Principles, Model for Improvement/PDSA Cycle, and QM Infrastructure - Clemens
12:00-1:00pm	Networking Lunch: Discussions on QM Committee Development
1:00- 1:45pm	Presentation and Group Exercise: Using Data for Quality Improvement – Clemens, Donna
1:45- 3:00pm	Group Breakouts with Faculty: QM Assessments - Donna
3:00- 3:15pm	Groups to Report Back- Opportunities for Collaboration - Donna
3:15- 3:30pm	Afternoon Break
3:30 -4:00pm	State Team Breakouts with Faculty: State Action Plans - Donna
4:00-4:30 pm	Report Back: 2 Next Steps for Each State - Donna
4:30 -5:00pm	Wrap Up and Next Steps – Clemens, Meera

HAB/NQC Low Incidence Initiative Meeting, May 16th, 2007
Agenda

8:30- 9:00am	Breakfast and Registration
9:00-9:30am	Welcome, Intros and Opening Remarks – Meera, Tracy
9:30-11:00am	Individual State Presentations on QM Program Achievements
11:00-11:30am	Presentation: A Year Later-Aggregate Data from LII Reports – Donna
11:30-12:00noon	Presentation and Discussion: LII Quality Management Plans – Donna
12:00-1:00pm	Working Lunch with Remarks from Doug
1:00- 1:30pm	Presentation: Sustaining and Spreading Quality Improvement - Meera
1:30- 3:00pm	Individual State Presentations on Plans for Growth and Sustainability
3:00- 3:15pm	Afternoon Break
3:15- 3:45pm	Group Breakouts and Report Back: Key Lessons Learned-What We Would Share with Others
3:45-4:30pm	State Breakouts with Faculty and Report Back: Action Plans for Next Steps
4:30 -5:00pm	Wrap-Up and Next Steps

Encourage Peer Learning

Face-to-face meetings provide valuable peer learning opportunities: to gather relevant information from colleagues, share with peers who have experienced the same challenges, and exchange best practices with other teams. Meeting planners must ensure that sufficient time is provided for both formal and informal interaction to foster these face-to-face exchanges.

Meeting planners can use of number of activities to support peer learning, including: team presentations of best practices, posting of tools developed by participating teams, and open sharing of successful improvement ideas. Faculty can ask participating teams to develop posters that visually illustrate the demographic profiles of the patient population served, recent quality improvement activities, baseline measurement data, and information about the organization's quality management program.

In the early stages of a learning collaborative, Faculty and meeting facilitators may need to structure and proactively encourage peer learning. Group exercises are one way to encourage participants to learn from each other. Faculty can prepare topic-specific exercises to facilitate group interaction.

In the later stages of a collaborative, participants may enthusiastically seek out peer learning and networking opportunities. Actively facilitate the development of relationships between participating teams. Look for opportunities to encourage peer-to-peer learning at the face-to-face meetings, between meetings, and after conclusion of the learning collaborative.

REAL WORLD TIP

The more frequent the opportunities for informal conversation, the faster the group hits the tipping point and experiences open sharing of ideas. Consider planning longer-than-usual breaks (up to 30 minutes) and designating these periods "break and networking time." Protect the time scheduled for peer learning networking. Don't let the time be compromised by formal sessions that run late.

Set Follow-up Goals for Participating Teams

At the end of each face-to-face meeting, Faculty should ensure that participating teams have a clear understanding of what they need to accomplish prior to the next meeting and a tangible action plan. It is often effective to dedicate time during the last day of the meeting to team planning activities. During these periods, teams can synthesize information presented during previous sessions and create action plans. Action plans should cover the time period until the next face-to-face meeting and should include a list of possible ideas to test, identify individuals responsible for testing, and specify the timeframe for each testing-related activity. These activities can be supported with planning forms (see Toolbox) and Faculty coaching and input. At the close of every face-to-face meeting throughout the learning collaborative, the Faculty should ensure that participants understand assigned tasks and should follow-up with teams accordingly.

Toolbox: Quality Management Program Action Plan

Directions: *Pick 3 priorities for next steps to sustain your QM efforts and further develop your QM Program.*

Priority #1: _____

STRATEGY #	ACTIVITY/PROCESS	START DATE	START DATE	TASK OWNER(S)	COMMENTS
1					
2					
3					
4					
5					

Priority #2: _____

STRATEGY #	ACTIVITY/PROCESS	START DATE	START DATE	TASK OWNER(S)	COMMENTS
1					
2					
3					
4					
5					

Priority #3: _____

STRATEGY #	ACTIVITY/PROCESS	START DATE	START DATE	TASK OWNER(S)	COMMENTS
1					
2					
3					
4					
5					

Provide Access to Quality Improvement Resources and Tools

It is important to provide all the information and tools that participating teams need to complete assigned tasks. Faculty can use elements of the Collaborative Charter to create informational packets about the collaborative for the teams. Faculty members should collect and provide (or list electronic links to) tools that may be useful to teams. It is essential that participants have all the tools they need to complete the activities listed on their action planning form, including data collection tools, links to pertinent web resources related to topic of focus, materials for conducting quality improvement training for staff within their organization, tools for creating agendas for team meetings, and others.

Toolbox: Quality Improvement Training Resources

Reference Publications and Books

HIVQUAL Workbook: Guide for Quality Improvement in HIV Care; New York State Department of Health AIDS Institute

Quality Management: Technical Assistance Manual; developed by Health Resources and Services Administration (HRSA) HIV/AIDS Bureau; available through the National Quality Center; www.nationalqualitycenter.org/index.cfm/5857/12591

The Improvement Guide: A Practical Approach to Enhancing Organizational Performance; Gerald J. Langley, Kevin M. Nolan, Clifford L. Norman, and Lloyd P. Provost.

Curing Health Care: New Strategies for Quality Improvement; Donald M. Berwick, A. Blanton Godfrey, and Jane Roessner.

An Introduction to Quality Improvement in Health Care; The Joint Commission

Websites

Institute for Healthcare Improvement: www.ihi.org
National Quality Center: NationalQualityCenter.org
Improving Chronic Illness Care: www.improvingchroniccare.org

On-line Training

National Quality Center: Quality Academy - NationalQualityCenter.org/QualityAcademy

Slide Presentation

Improving HIV Care: A Modular Quality Improvement Curriculum; developed by the Institute of Healthcare Improvement; available through the National Quality Center; www.nationalqualitycenter.org/index.cfm/5857/13732

Obtain Feedback

The Planning Group needs to obtain two types of feedback from participants: feedback at the end of each meeting and feedback at the conclusion of the learning collaborative. Feedback on a face-to-face meeting is used to identify gaps in understanding that Faculty can address prior to the next meeting and to help plan activities for the next meeting. Feedback on the learning collaborative is used to assess its effectiveness and plan for future initiatives.

It is important to obtain both formal and informal feedback from participants.

- To gather formal feedback, ask participants to complete a written form that provides both subjective and objective data. For example, to assess a particular face-to-face meeting use a 1 to 5 scale to elicit feedback on the environment, particular sessions, and overall impressions. Use open-ended questions to obtain more subjective

data. Ask: When were you most engaged? When were you least engaged? What was the most important idea you learned? Does anything puzzle you?

- To elicit informal feedback, ask participants to respond verbally at the end of the face-to-face meeting to two questions: What about the session went well and what would you recommend be changed? Record the responses on a flip-chart and be sure to consider the recommendations for the next session.

The Planning Group should conduct debriefing meetings after each meeting to discuss the feedback on the successes, challenges, and lessons learned from the collaborative. The Planning Group members also should discuss identified problems and assign individuals to follow up on these issues.

Case Study: Prepare and Facilitate Face-to-Face Meetings

Susan used a second informal survey to assess the QI skills and knowledge, team composition, and QI infrastructure of teams. She used this information, plus input from the Faculty, to develop a detailed agenda. She enlisted Faculty to lead lectures and small group discussions and to facilitate poster presentations.

Natalie, the administrative assistant, distributed the start-up materials well in advance (6 to 8 weeks) of the first face-to-face meeting. Susan and Danielle contacted the teams several times prior to the first meeting to assess teams' progress on the pre-meeting activities. Danielle worked with the administrative assistant to address all logistical issues.

Natalie reserved a large conference room at a local hospital for the planned face-to-face meetings, and spoke with the cafeteria staff there about menu planning. She found out that the hospital would be willing to sponsor the event, and could arrange the ideal room set-up, with half-round tables and not the usual classroom set-up. The hospital liaison even agreed to provide free parking. The liaison also offered to provide the necessary electronics and projecting system, but Natalie soon realized it would be better to bring in the necessary laptop and projector.

Susan had appointed a member of the Faculty to facilitate the meeting and ensure that events kept to schedule and participants were guided through the various agenda items. However, she and the rest of the Faculty were on hand throughout the face-to-face meetings to ensure activities ran smoothly, help with logistical snags, and keep participants engaged. The team also made sure to protect time for informal conversations, ensuring that participants had opportunities for peer learning.

At the end of each face-to-face meeting, Danielle checked that teams had their "marching orders"—that they were aware of the assigned tasks they were to complete before the next face-to-face meeting. She also ensured that they had the information and tools they needed to complete the tasks. At the end of each meeting Susan distributed a short evaluation. One of the administrative assistants tallied the results of each evaluation. The Planning Group discussed the feedback at their next weekly meeting and used the information to plan future activities.

Step 4: Maintain Momentum between Face-to-Face Meetings

The Big Picture

Face-to-face meetings can generate tremendous excitement and will to change. Whether that enthusiasm builds or wanes during the work periods between meetings depends on the strength of ongoing communication channels, the quality and quantity of Faculty and peer coaching, and the attention paid to assessing participants' progress.

What To Do:

- Foster Ongoing Communication and Peer Learning
- Routine Reporting of Performance Data by Participating Teams
- Assess Progress
- Coach for Progress and Success

Foster Ongoing Communication and Peer Learning

Ensuring that participants remain engaged and enthusiastic about the improvement work is critical to the success of a learning collaborative. The culture underlying the collaborative has a significant impact on teams' engagement and enthusiasm. Collaborative leaders and Faculty must foster a culture in which mutual support is the norm. The facilitator can establish this culture with every meeting or conference call by emphasizing sharing and support. If a competitive or judgmental environment develops, the facilitator should immediately address the situation.

REAL WORLD TIP

Hold the facilitator and Faculty members accountable for their role in ensuring that a "group think" perspective is maintained throughout the learning collaborative.

REAL WORLD TIP

If teams initially are hesitant to share tools, best ideas, or lessons learned, remind participants that the purpose of sharing them is to avoid "remaking the wheel" and that perfection is not required.

REAL WORLD TIP

If you ensure that the collaborative provides valuable learning experiences and access to tools that can be applied immediately to solve a problem, the participants' enthusiasm will build and the initiative will take off.

The Planning Group can maintain motivation with structured activities and coaching. Facilitation of regular phone calls and listserv interaction also fosters ongoing com-

munication and peer learning. Specific techniques to foster engagement include:

- Asking participants to sign a commitment statement
- Holding frequent meetings (e.g., every 3 to 4 months)
- Requiring that tested changes and data are reported every one to two months and available to be viewed by all participants
- Providing in-depth feedback from Faculty on reports
- Offering regularly scheduled conference calls
- Seeding the listserv with engaging or controversial topics

During the calls, the Faculty facilitator should actively encourage participants to share questions, concerns, challenges, successes, and the status of testing. The facilitator also should invite a team to share their work on a particular topic and structure an interactive discussion around that team's successes, issues, and suggestions. For example, if a "No" team experienced a success or failure when implementing a change, the facilitator should ask the team to describe the experience in detail. The facilitator can bring other call participants into the conversation by asking them for comments or advice, or to share their own experiences. The facilitator should try to ensure that all participants have the opportunity to share or ask questions. The facilitator should work with the team on the presentation before the call to ensure a polished presentation.

REAL WORLD TIP

Call facilitators can avoid "dead air" on conference calls by choosing topics of special interest to the group. It can be helpful to provide information on call topics ahead of time.

REAL WORLD TIP

The facilitator and Faculty should speak as little as possible during conference calls. When a participant poses a direct question, the facilitator should redirect it, by asking "Does anyone have advice?" If not, invite a Faculty member to provide insight or direction.

REAL WORLD TIP

The facilitator should take attendance at the beginning of the call, and then make sure that all participants have an opportunity to speak. The facilitator may need to draw out a silent team by inviting them to weigh in on an issue or idea.

REAL WORLD EXAMPLE

During the Low Initiative, project leaders were under the impression that teams had implemented a relatively small number of changes—until a conference call held mid-way through the learning collaborative. During the course of the check in call, teams described a significant scope of quality improvement work that they had not reported. The teams simply did not consider that work to be improvement related, and therefore had not mentioned the activities in their written reports. "We didn't know you wanted to know about that," explained the team members. Without the conference calls, leaders may never have learned of the true extent of the teams' quality improvement work.

The Faculty may decide to develop a listserv to facilitate sharing and peer learning. There are two major barriers to open use of a listserv: lack of perceived value of the listserv and participants' lack of confidence in their own tools, resources, program, and quality improvement knowledge. Facilitators should encourage sharing and re-emphasize that tools and resources need not be perfect to be helpful to another group. Faculty should take steps to ensure that the listserv provides value to participants. As one collaborative leader said, "Just creating a listserv doesn't mean it will be used."

The best way to foster an active listserv is for Faculty to post compelling questions. Faculty should actively encourage peer exchange on the listserv, especially in its early stages, by seeding questions to the group. If a participant asks the Faculty a question, he or she should post the question on the

listserv, rather than directly answering the participant. After several months, participants may begin querying each other instead of Faculty.

REAL WORLD TIP

Link up teams to provide peer mentoring and learning opportunities. Create netlinks and teleconferences for each regional group, in addition to those scheduled for the entire learning collaborative. Once teams become comfortable communicating with each other through listservs, conference calls, and face-to-face meetings, they will begin to contact each other "off line."

Routine Reporting of Performance Data by Participating Teams

Between face-to-face meetings, each participating team must routinely report performance data and changes tested to the Faculty. It is critical that team members have a clear understanding of their reporting responsibilities, including the required and optional indicators, detailed definitions of indicators (i.e., numerators and denominators), frequency of reporting, use of sampling approach, timetable for reporting, and use of manual data collection forms, if required. Faculty may choose to dedicate time during routine conference calls early in the learning collaborative to discussion of the data collection processes and potential pitfalls. Later calls can be dedicated to findings reported by teams. Faculty members should be available as needed to provide clarification and individualized technical assistance to avoid reporting delays.

If additional data, such as organizational assessments, are to be routinely reported, the Faculty should guide the teams in the data collection process.

REAL WORLD TIP

The collaborative leaders, with the help of administrative assistants, play an instrumental role in ensuring that data are reported on time. They can:

- Send out frequent reminders about the upcoming submission deadlines
- Encourage teams to report their data and narrative report on listserv (if available) so other participants can see which peers have already submitted reports
- Post a list designating teams that have reported and teams that have not to encourage 'healthy' competition
- Reward teams that submit their reports on time by acknowledging their achievement during conference calls and meetings

REAL WORLD TIP

Since preparing data and reports requires an investment of time for team members, it is important for Faculty to acknowledge receiving the reports and to review each report carefully. When participants receive individualized feedback on their data and reports, they begin to appreciate the value of reporting in enhancing their quality management programs. Faculty members may consider devoting one conference call each month to the review of data and reports.

REAL WORLD TIP

Provide teams with a simple reporting form to ensure that teams provide all necessary data elements and that the Faculty can efficiently review each team improvement report. On the reporting form, ask for lessons learned and challenges that can be openly shared with all teams. See toolkit on page X for a sample reporting form.

Assess Progress

It is critically important that teams continue to regularly document their work by reporting data and narrative

descriptions about changes enacted based on the data. Faculty must assess the progress of participating teams by reviewing data and narrative reports and ensuring that teams assess both outcomes and process data. Teams should use a continuously updated status report, which can also be provided to stakeholders. The Faculty may decide to provide a report template to ensure consistency and completeness of reporting.

Toolbox: Low Incidence Initiative - Bi-Monthly Reporting Template

Directions: Please complete for a 2-month period. Submit to the LII by the 15th of the month, with the first due August 15th for the months of May and June.

State: _____

Reporting Period : (e.g., June 1-July 31, 2007) _____

Name of Reporter: _____

A. Required Indicators:

1) % of Ryan White funded clients who have a CD4+ test done at least every six months. %

Data Sources: _____

2) % of applying state ADAP clients approved/denied for ADAP services within two weeks of ADAP receiving a complete application. %

Data Sources: _____

3) % of clients with at least two general HIV medical care visitsin the last 12 months who are enrolled in case management. %

Data Sources: _____

B. Optional Indicators:

1. _____ %

Data Sources: _____

2. _____

Data Sources: _____ %

Toolbox: Low Incidence Initiative - Bi-Monthly Reporting Template (cont.)

C. QI Activities/Updates:

How did you use your data? What did you try? What worked/didn't work? What will you try next?
Any developments with your QM Committee or QM Plan?

- _____
- _____
- _____

D. Lessons Learned:

- _____
- _____
- _____

E. Offers: What can you share with other LII States? Please attach any new QM tools created with this form.

- _____
- _____
- _____

F. Requests: What QM tools or advice do you need from other LII States?

- _____
- _____
- _____

Evaluating process and outcome data can demonstrate whether teams are meeting their own aims and those of the collaborative. Assessing these data also demonstrates whether teams are making progress in developing an infrastructure conducive to quality improvement. To streamline data collection and reporting and maintain consistency, the Faculty may decide to distribute a template spreadsheet. Use of a standardized spreadsheet also facilitates the aggregation and analysis of data at the end of the learning collaborative.

REAL WORLD TIP

Help participants with their database queries. Enlist an IT specialist to craft a document that specifies the language for all the required measures, including the exact wording for numerators and denominators. Ask participants to give the document to their data collection specialists.

REAL WORLD TIP

Remember to clarify and synchronize different calendars for data collection (e.g., calendar year, state fiscal year, grant year).

The learning collaborative leaders should encourage (or require) teams to use a self-assessment tool frequently (e.g., every 3 months). It is important for Faculty members

to understand that teams may grade themselves with an inaccurately high baseline score, because they do not fully understand quality improvement terminology when they complete the initial assessment. If self-assessment tools tool are used infrequently (i.e., only at the onset and close of the learning collaborative), teams may see no change in outcomes because of the erroneous reporting at baseline. Once they begin to understand terms, teams may actually report lower self-assessment scores. When teams begin to achieve true improvement, self-assessment scores may return to baseline. If the tool is used on a frequent basis, the team will be able to observe this reporting effect. (See the sample Self-Assessment Tool included in the Toolbox in Step 2.)

Participants may complain about the data collection and reporting requirements of the learning collaborative, especially at the beginning. Faculty should expect this resistance, and be ready to assist. They should also expect that the first several reports will include data that require "clean up." Often, the data collection will take less and less time with each subsequent reporting cycle. In fact, it may be wise to encourage teams to use the first 6 months of recorded data to identify gaps in the data, learn about the data collection process at their organization, and learn to query to obtain desired data.

REAL WORLD TIP

Do not let resistance or less than ideal data change your commitment to frequent reporting. Be firm with your data collection and reporting requirements, even if participants complain. Within 6 months, participants should begin to see improvements reflected in the data, experience less time invested in reporting, and resistance should fade. However, listen carefully to ascertain whether data collection and reporting is more burdensome than expected and be prepared to make a mid-course correction if necessary.

REAL WORLD TIP

Teams often become more engaged and excited about the work once they begin testing changes.

Faculty must read and provide individualized feedback on the teams' reports. Although time-consuming, this feedback sends the critical message to participants that their work is important. Faculty members may decide to divide the work of reviewing team reports; if so, the division of labor should be clear, and the administrative assistant should ensure that every team submitting a report receives Faculty feedback.

Toolbox: Low Incidence States' Bi-Monthly Report--Faculty Review

1	STATE:		REPORTING PERIOD:		
2	REVIEWERS		DATE REVIEWED:		
A. REQUIRED INDICATORS			YES	NO	COMMENTS/QUESTIONS
3	CD4+ test done at least every six months - Indicator (Are data reported?)				
4	Data Source Identified and % defined – CD4 Indicator • Are data from an identifiable source? • Is numerator and denominator identified? • % of RW Clients? • Are client self-reported data identified? • Any problems with the data noted?				
5	Improvement activities listed – CD4 Indicator				
6	ADAP clients approved/denied for ADAP services within two weeks of ADAP receiving a complete application – Indicator (Are data reported?)				
7	Data Source Identified and % defined – ADAP Indicator • Are data from an identifiable source? • Is numerator and denominator identified? • % of RW Clients? • Are client self-reported data identified? • Any problems with the data noted?				
8	Improvement activities listed- ADAP Indicator				
9	Two general HIV medical care visits in the last 12 months who are enrolled in case management - Indicator (Are data reported?)				

Toolbox: Low Incidence States' Bi-Monthly Report--Faculty Review (cont.)

A. REQUIRED INDICATORS (CONT.)		YES	NO	COMMENTS/QUESTIONS
10	Data Source Identified and % defined • Are data from an identifiable source? • Is numerator and denominator identified? • % of RW Clients? • Are client self-reported data identified? • Any problems with the data noted?			
11	Improvement activities listed- Medical Visits			
B. OPTIONAL INDICATORS		**YES**	**NO**	**COMMENTS/QUESTIONS**
12	Two optional indicators identified			
13	Data Sources Identified and % defined • Are data form identifiable sources? • Is numerator and denominator identified? • % of RW Clients? • Are client self-reported data identified? • Any problems with the data noted?			
14	Improvement activities listed			
C. QI ACTIVITIES / UPDATES		**YES**	**NO**	**COMMENTS/QUESTIONS**
15	QM Plan (Discussion about QM Plan development?)			
16	QM Committee (Discussion about QM Committee development?)			
17	QI Activities			
GENERAL RECOMMENDATIONS				
16	Overall Impressions: Specific recommendation(s):			

When reading a team's report, Faculty members should try to identify any challenges the team may be experiencing but not reporting. If by reading between the lines, the Faculty member senses an issue is brewing, he or she should contact the team and solicit information, give support, provide suggestions, and propose alternative ideas. Stating, "Do what you can, keep trying, or perhaps try it this way" may rescue a team that might otherwise flounder.

REAL WORLD TIP

Encourage teams to submit an offer and a request on their monthly reports. An offer is a description of a best practice or tool; a request is a plea for help or advice. An administrative assistant can gather all offers and requests on one document and distribute them to the listserv on a monthly basis to foster targeted interaction and sharing.

Coach for Progress and Success

To help teams achieve their aims and the aims of the collaborative, Faculty should use every possible opportunity to coach teams both individually and collectively. Faculty can use any of the activities that occur between learning sessions—conference calls, listserv, and report feedback—as opportunities for coaching. For example, during a telephone call, Faculty can highlight a particularly successful idea or voice their concerns about an action that seems counterproductive or risky. When reading reports, Faculty can either write detailed feedback or schedule phone meetings to provide feedback. Faculty can use the listserv to share timely information and provide constructive feedback to questions raised by teams.

Case Study: Maintain Momentum between Face-to-Face Meetings

Susan and Danielle fostered ongoing communication and peer learning through regular conference calls—held monthly except in the months when face-to-face meetings were scheduled. They engaged a Faculty member to speak on a particular topic during the first half of each call (with topics chosen based on participant needs). During the second half of each call, they asked teams to check in on their progress. As time went on, teams that had tested a best practice were sometimes asked to present instead of the Faculty.

Danielle monitored the listserv and seeded probing questions to keep the group actively engaged. When a team leader emailed her to report a problem (e.g., difficulty getting buy-in from staff to shift to a scheduling system that is more convenient for patients), Danielle posted the question to the group and asked for advice. A number of teams made suggestions. After Danielle went through several rounds of seeding questions, the teams began proactively seeking each other's advice. At that point, Danielle continued to monitor the postings but remained in the background.

Susan was responsible for assessing progress of the teams. With the help of the administrative assistant, she checked that each team submitted a report every other month, with data from the proceeding two months. She ensured that Faculty provided each team with a detailed review of each bimonthly report. She encouraged Faculty to check in and offer support to any team whose progress appeared to stall. When teams complained about the frequency of data reporting, Susan was sympathetic but unwavering about the reporting requirements. After four months, the complaints lessened. At six months, teams began to see changes and report specific improvements. The atmosphere of the group lightened as teams began sharing their success stories.

Step 5: Mark Successes and Foster Sustainability

The Big Picture

Holding a meeting is essential when wrapping up a collaborative initiative. The purpose of this final meeting is to sum up the work completed, to celebrate successes, and to provide closure for participating teams and Faculty.

What To Do:

- Recall, Reflect, and Collect
- Celebrate Successes
- Highlight Future Directions

Recall, Reflect, and Collect

Faculty should help teams acknowledge and reflect on the effect of participation on the lives of participants, other staff in their organizations, and patients/consumers.

REAL WORLD TIP

Consider creating a video that showcases completed work via interviews with patients and staff or gather testimonials to record the successes of team representatives in their own words. Presentations and videos created for the last meeting also serve to document learning collaborative successes for later viewers.

The learning collaborative leaders should ask participants to complete a performance and organizational assessment and compare these data sets with baseline findings. Once these data are available, the learning collaborative leaders should prepare a presentation that highlights the overall accomplishments of the group. It's important that the presentation provides aggregate data on the progress of the group toward common goals to highlight the overall accomplishments of the group. Any limitations to the data sets should be noted and discussed with the larger group, as needed.

Prior to the final meeting, the learning collaborative leaders should create a list of best practices and tools developed by the participants during the course of the learning collaborative. Faculty should devote a session in the last meeting to the discussion and sharing of these tools. To promote maximum learning and interaction, learning collaborative leaders should make sure that specific details of best practices and actual tools are available for sharing during and after the last meeting. Posting these collaborative resources and tools on-line will ensure that other HIV providers can learn from their experiences.

As the learning collaborative draws to a close, collaborative leaders should gather input that will help in planning future initiatives. Learning collaborative leaders should ask

participants to fill out on-line or paper-based evaluations, ideally completing them prior to leaving the final face-to-face meeting.

Please let us know what parts of the meeting you thought were most useful:

_____

_____

_____

_____

Please let us know what we could have done better:

_____

_____

_____

_____

Thank you.

Celebrate Successes

Learning collaborative leaders should encourage (or require) teams to give individual presentations about their lessons learned throughout the life cycle of the collaborative, focusing not only on intended and unintended successes but also on methods used to overcome challenges. To ensure short, simple presentations, learning collaborative leaders may want to provide a presentation template. When working with teams on their presentations, learning collaborative leaders should ask them to describe a specific area in which they achieved success, display supporting data, list challenges and barriers, and discuss their plans for sustaining the gains they achieved.

Toolbox: Slide Presentation Template for HIV Programs –Last Meeting

Slide 1: Quality Management Program Plans for Growth and Sustainability
Grantee Name/Organization:

Slide 2: Quality Management Program
What Adjustments Have you Made to Foster your Quality Management Program?
Description of Next Steps for Sustaining and Further Strengthening of your Quality Management Infrastructure:

Slide 3: Performance Measures
What Collaborative Indicators Will you Continue to Measure?
What Performance Goals Have you Set for Your Indicators?

Slide 4: Quality Improvement Activities
What Are your Next Quality Improvement Activities?
How Will Staff be Involved?
How Will Staff be Trained on Quality Improvement?

Slide 5: Other Quality Successes
What Have Been the Most Critical Successes throughout the Learning Collaborative?
How will you Sustain the Momentum for Quality Improvement in your Program?
What are the Next Milestones for Your Quality Management Program?

To support a collegial learning environment, learning collaborative leaders should encourage teams to be inclusive in defining success. For example, at the final meetings of cross-Part initiatives or learning collaboratives that involve the efforts of several agencies, teams should be asked to report on team and system successes.

REAL WORLD EXAMPLE

In a learning collaborative focused on increasing patient retention, both health care providers and service agencies were involved in interventions that directly or indirectly improved retention. Learning collaborative leaders were careful to present measures that reflected shared goals and assessed the effect of improvements on the system as a whole. If the learning collaborative leaders had presented only data on provider-initiated changes, the efforts the service agency staff might have been overlooked.

Highlight Future Directions

Providing closure is an essential function of the final meeting of a learning collaborative. The group endeavor is clearly at an end. However, another critical function of the meeting is encouraging participants to look toward the future. The final meeting should include a clear call to action. What are the teams' next steps? How can participants formalize plans now for future sustainability? Learning collaborative leaders should remind teams that the end of this learning collaborative is merely a milestone on the improvement journey. If a learning collaborative has been successful, participating teams will have acquired sufficient capacity by its completion to continue the quality improvement work without the support of Faculty members. Participants will be comfortable with quality improvement concepts, will have seen first hand the benefits of effective improvement endeavors, and will feel competent initiating quality improvement projects on their own. At the final meeting, Faculty should provide relevant guidance and encourage teams to plan the methods they will use to sustain the gains achieved during the initiative.

REAL WORLD EXAMPLE

In one learning collaborative, facilitators asked participating teams to contemplate their goals for the next year. Teams then created mock headlines that proclaimed these goals. The activity proved a light-hearted way to encourage teams to think about sustaining their achievements and to create a written commitment to a long-term goal.

REAL WORLD TIP

One learning collaborative invited all participating teams to continue reporting their performance data and posts the findings on the listserv. Many of the teams continue reporting, allowing others to learn from their experiences.

Case Study: Mark Successes and Foster Sustainability

At the final face-to-face meeting of the learning collaborative, Susan and Danielle presented a comparison of baseline and current data for the group as a whole. Each team provided a short presentation on a specific improvement intervention and associated results. Faculty directed break out sessions during which teams brainstormed on techniques for building sustainability into their improvement activities. The meeting concluded with music and a lighthearted meal of regional dishes. The entire tone of the meeting was one of celebration of the results achieved with an action plan to sustain the momentum.