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

Social Determinants of Health Collaborative Concept Paper: Launching the CQII create+equity Collaborative

Background

Reducing HIV transmission requires keeping people with HIV (PWH) in care along the HIV care continuum, which is attributed to various factors within the medical system as well as social and structural conditions in the community and societal contexts, known as the social determinants of health, that pose barriers to sustained engagement in care and treatment success. The Department of Health and Human Services' Healthy People 2020 defines social determinants of health as "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." Addressing social determinants of health among PWH is a national priority included in the National HIV/AIDS Strategy for the United States: Updated to 2020 under Goal 1 (Reducing New HIV Infections) and Goal 3 (Reducing HIV-Related Disparities and Health Inequities).[1] Since 2017, several initiatives undertaken by federal agencies have sought to reach high-risk populations through housing assistance, behavioral health programs, and interventions to address co-morbidities due to aging, which demonstrate the precedence of ameliorating social determinants of health for PWH.

PWH struggle with social determinants of health, including housing, mental health, substance use, and aging, hampering them from receiving care and staying virally suppressed. For instance, the viral suppression rate among unstably housed clients served by Ryan White HIV/AIDS Program (RWHAP)-funded agencies was 72%, versus 88% among those who were stably housed.[2] In a recent study, homelessness or having an unknown housing status were among the social disparities significantly associated with not achieving viral suppression.[3] It is estimated that 20% of people with diagnosed HIV in the U.S. have depression.[4] Those with diagnosed depression were less likely to achieve sustained viral suppression compared to those without depression; this association was for persons with treated depression compared to no depression.[5] Drug dependence also remains a widespread problem among PWH, significantly associated with lower adherence to HIV medications and 52% of individuals who use substances are unable to reach viral suppression.[6] From 2014 to 2018, the age distribution is shifting among RWHAP clients, surmounting to an increase of 46,000 clients ages 55 years and older.[7] Among youth

[1] U.S. Department of Health and Human Services' Office of HIV/AIDS and Infectious Disease Policy. *National HIV/AIDS Strategy for the United States: Updated to 2020*; Progress Report 2017. https://www.hiv.gov/federal-response/national-hiv-aids-strategy/nhas-update.
[2] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2018. http://hab.hrsa.gov/data/data-reports. Published December 2019. Accessed January 20, 2020.
[3] Muthulingam D. Disparities in Engagement in Care and Viral Suppression Among Persons with HIV. Journal of Acquired Immune Deficiency Syndromes. 2013. 63(1).
[4] CDC. Behavioral and Clinical Characteristics of Persons with Diagnosed HIV Infection—Medical Monitoring Project, U.S., 2017 Cycle (June 2017–May 2018). HIV Surveillance Special Report 23. Published September 2019.
[5] Gokhale RH. Depression Prevalence, Antidepressant Treatment Status, and Association with Sustained HIV Viral Suppression among Adults Living with HIV in Care in the US, AIDS and Behavior. 2019. 23:3452-3459.
[6] Nolan S. HIV-Infected Individuals Who Use Alcohol and Other Drugs, and Virologic Suppression. AIDS Care. 2017. 29(9):1129-1136.
[7] Health Resources and Services Administration. *Ryan White HIV/AIDS Program Annual Client-Level Data Report 2018*. http://hab.hrsa.gov/data/data-reports. Published December 2019.

overall, retention in care (77%) was lower than the national RWHAP average (81%), and viral suppression (76%) was much lower than the national RWHAP average (87%).

A more detailed literature review and associated presentation slides will be developed in preparation for the upcoming collaborative to make a case about the importance of addressing social determinants of health to end the HIV epidemic in the United States.

Tackling these social determinants of health is crucial to reaching the goals of national public health priorities. In 2019, 86% of recipients responding to a national survey conducted by the Center for Quality Improvement & Innovation (CQII) viewed the topic of social determinants of health as relevant/very relevant, 96% were interested/very interested in creating quality improvement (QI) projects that address social determinants of health, and 94% indicated that they would participate in a social determinants of health collaborative focused on housing, mental health, and substance use.

Collaborative Framework

Building upon the success of the end+disparities ECHO Collaborative, the underlying collaborative framework for the upcoming social determinants of health collaborative uniquely bridges the Institute for Healthcare Improvement (IHI)'s Breakthrough Series model with its emphasis on learning sessions and in-between action periods to carry out local improvement activities and the ECHO model with its focus on virtual case presentations. This hybrid framework facilitates virtual access to subject matter expertise and learning exchanges among participants using videoconferencing technologies for all collaborative activities. This virtual community of practice model promotes an "all teach, all learn, all improve" paradigm[8] and increases opportunities to meet while reducing in-person meeting barriers.

IHI Breakthrough Series Model. QI collaboratives are an evidence-based methodology that creates learning communities designed to achieve rapid scale-up of improvement across health care facilities. IHI developed the Breakthrough Series in 1994 to help health care organizations make "breakthrough" improvements in quality while reducing costs.[9] Since 2004, CQII, formerly known as the National Quality Center (NQC), has managed 7 national collaboratives in partnership with the HRSA HIV/AIDS Bureau (HAB). The following elements were applied to all CQII-sponsored collaboratives, consistent with the IHI model:[10] 10 to 200 recipient teams of similar needs participate; collaboratives last between 12 to 24 months; 2-day learning sessions are held every 3-6 months; action periods between learning sessions are used to carry out tests of change; reporting of standardized HAB-endorsed measures; and teams are supported by QI experts. These unique experiences with national collaboratives resulted in two written publications by CQII—*NQC Guide: Planning and Implementing a Successful Learning Collaborative*[11] and *Guide to Conducting a Virtual Quality Improvement Collaborative-Lessons*

[8] Nembhard IM. All teach, all learn, all improve?: The role of interorganizational learning in quality improvement collaboratives Health Care Manage Rev 2012 Apr-Jun; 37(2): 154-64.
[9] 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.
[10] Baker, GR., Collaborating for Improvement: The IHI's Breakthrough Series. New Med. 1997;1:5-8.
[11] Planning and Implementing a Successful Learning Collaborative. NYSDOH and HIV/AIDS Bureau. Sep 2008. https://targethiv.org/library/planning-and-implementing-a-successful-learning-collaborative-guide-build-capacity-quality.

Learned from the end+disparities ECHO Collaborative.[12]

Table 1: Past CQII-Led Collaboratives (2004-2019)

Collaborative	Timeframe	RWHAP Recipients	Reach
Part B Collaborative	Nov 2004-Nov 2006	8 State Departments of Health	129,000 PWH
Low Incidence Collaborative	Jun 2006-May 2008	17 State Departments of Health	20,000 PWH
TGA Initiative	Jun 2008-Oct 2009	5 City Departments of Health	19,880 PWH
Cross-Part Collaborative	Oct 2008-Apr 2010	91 Part A-F recipients from 5 States	192,018 PWH
D.C. Cross-Part Collaborative	Mar 2011-Jun 2012	19 recipients in 2 states and the D.C.	35,642 PWH
H4C Collaborative	Mar 2014-Jan 2016	55 Part A-F recipients from 5 States	76,990 PWH
end+disparities ECHO Collaborative	Jun 2018-Dec 2019	200 Part A, B, C, and D recipients from 31 States/Territories	138,826 PWH

ECHO Model. Project Extension for Community Health Outcomes (ECHO) expands the concept of quality improvement collaboratives to encompass virtual communication technologies, offering an innovative distance learning paradigm for team-based interdisciplinary professional capacity building. Project ECHO was developed originally by the University of New Mexico in 2003 to help primary care providers in rural New Mexico address hepatitis C.[13] ECHO sessions use videoconferencing to deliver medical education and care management and has been shown to be an effective and cost-saving model.[14] The ECHO model has been used to address a variety of health issues and has in fact been used previously to improve HIV care in the United States.[15] A typical ECHO session includes a brief didactic lecture, after which providers from multiple sites present their patient cases to a multidisciplinary team of mentors for discussion, feedback, collaborative problem-solving, and patient health management.

end+disparities ECHO Collaborative. The recent end+disparities ECHO Collaborative, the largest national HIV QI collaborative of its kind in the U.S., concluded its 18-month long efforts in December 2019 to reduce disparities in four disproportionately affected HIV subpopulations: MSM of Color, African American and Latina Women, Transgender People, and Youth. The collaborative was named by PRNews among the best campaigns of 2019, the only Department of Health and Human Services campaign to receive recognition in the "government" awards category.[16] This initiative reached 36% (202 out of 567) of all RWHAP recipients across 31 states/territories. An estimated 1 in 8 persons with HIV in the U.S. were impacted. Over 120 virtual sessions with over 3,400 participants were held, utilizing the ECHO virtual case-based communities of practice approach. The overall viral suppression rate increased from 83.2% (Jul 2018) to 85.2% (Nov 2019) among collaborative participants. Most importantly, the viral suppression gap between the subpopulations and other patients seen by the same provider was reduced from 5.7% to 3.8%, a 33.5% reduction, and these improvements were found across all

[12] Guide to Conducting a Virtual Quality Improvement Collaborative. Center for Quality Improvement & Innovation (CQII). Jun 2020. https://targethiv.org/sites/default/files/support/CQII-BestPracticesGuide-Final%20%281%29.pdf.
[13] Struminger B, Arora S, Zalud-Cerrato S, Lowrance D, Ellerbrock T. Building virtual communities of practice for health. Lancet 2017 Aug 12; 390(10095): 632-634.
[14] Zhou C, Crawford A, Serhal E, Kurdyak P, Sockalingam S. The impact of Project ECHO on participant and patient outcomes: a systematic review. Academic Medicine. 2016; 91:1439–1461.
[15] Wood BR, Unruh K, Martinez-Paz N, Annese M, Ramers CB, Harrington RD. Impact of a telehealth program that delivers remote consultation and longitudinal mentorship to community HIV providers. Open Forum Infectious Diseases 2016 Jun 20; 3(3): ofw123. doi: 10.1093/ofid/ofw123.
[16] https://www.prnewsonline.com/prnews-to-announce-2019-agency-elite-awards-winners-in-nyc/ [1/21/2020]

subpopulations. In general, more active participation in six core collaborative activities tended to yield greater improvement in viral suppression rates and/or greater reduction in viral suppression gaps. Sites that participated in more of the Affinity Group Sessions throughout the collaborative showed greater improvement in viral suppression rates and a greater reduction in viral suppression gaps.

create+equity Collaborative

CQII proposes to conduct two national collaboratives of the course of its 4-year funding cycle: the social determinants of health-focused collaborative, called the *create-equity Collaborative* [Years 1-2] and the *High Impact Collaborative* focusing on recipients/subrecipients that score lowest on viral suppression in the most recent RSR Report [Years 3-4].

The following table outlines the overall structure of the *create-equity Collaborative* with the first Learning Session in February 2021. The overall aim of the collaborative is to promote the application of quality improvement interventions to measurably increase viral suppression rates for four disproportionately affected HIV subpopulations that face barriers due to housing, mental health, substance use, or aging, and decrease gaps in HIV disparities.

Table 2: QI Collaborative Structure and Focus Areas

	Social Determinants of Health Collaborative
Format	18-month national collaborative with four 2-day Learning Sessions; 4x Affinity Groups (twice a month, 60-minute virtual sessions); Leadership Program
Affinity Groups	4 Affinity Groups: Housing, Mental Health, Substance Use, Aging (96 Affinity Sessions across all four groups)
Target Audience	Voluntary enrollment across all RWHAP recipients/subrecipients (max enrollment of 25 recipients per Affinity Group)
# of Participants	Up to 100 RWHAP recipients/subrecipients across all RWHAP funding streams (RWHAP Part A – D)
Dates (mm yyyy)	Orientation Session (Jan 21); Learning Session 1 (Feb 2021); Learning Session 2 (Jul 2021); Learning Session 3 (Dec 2021); Learning Session 4 (May 2022)
Reporting	Reporting of viral suppression data every two months via the online CQII database; reporting of QI activities every four months
Aims	a) apply QI methodologies to address key social determinants of health; b) improve viral suppression rates for PWH with social determinants of health barriers; c) decrease the viral suppression gap between PWH with social determinants of health barriers in comparison to the other patients served by the same agency

The following structures will be in place for the *create-equity Collaborative*.

Planning Group. A Planning Group, which is comprised of CQII staff/coaches, content experts, consumers representing various community voices, HAB staff, and other stakeholders as needed, guides the planning and implementation of collaboratives. It will be formed in Aug 2020 and meet virtually on a weekly basis.

Collaborative Toolkit. A Toolkit will be developed for the collaborative and shared with all participants, modeling past examples, and include all necessary reporting forms, expectations, timelines, contact information, and other resources. Common verbiage and definitions are

provided at the onset and used across the collaborative, such as performance indicator definitions. Input from the various Affinity Faculty members and community is needed. A national survey conducted by CQII (Sep 2020) will inform the development of the collaborative and the details outlined in the Toolkit.

Promotion. A HAB invitational letter will be issued to all RWAHP recipients to encourage them to join this collaborative, as well as CQII announcements. Several kick-off webinars will be held with participation by HAB senior leaders to further increase awareness. A 3-min animated video will be developed and widely shared to highlight the impact of social determinants of health as barriers to reach viral suppression.

Registration. Individual agencies will be encouraged to register using the online registration form to assess whether the agency has the time, staffing, technical abilities, and data system capabilities to meet the collaborative goals. This collaborative will be capped to 100 RWHAP-funded recipients to ensure that CQII provides adequate support for each team. In concert with HAB, CQII will ensure the appropriate mix of participants: diverse QI proficiencies (beginner and advanced), participation in past CQII collaboratives (with an emphasis on those that have not participated before), geographic location, Part funding, HIV prevalence, low viral suppression performance (RSR data). HAB Project Officers are encouraged to suggest individual agencies, regional/state teams to participate.

Agency Quality Improvement Team. The local quality improvement team composition is critical to address the social determinants of health. Each agency is strongly encouraged to set up a team at the onset of the collaborative that includes: a) staff at the HIV site with multi-disciplinary and cross-functional representation, including those staff members who provide services, screening, or referrals related to the focus area of choice (housing, mental health, substance use, or aging); b) HIV clients who receive medical care at the site and represent voices of the site-chosen population of focus; and c) external representatives who provide related services for HIV clients served by the HIV site.

Pre-Work Phase. In advance of the first Learning Sessions, each recipient completes pre-work tasks to prepare them to meet all collaborative goals, including participation in orientation webinars, drafting of aim statements, identification of the most appropriate Affinity Group to join, testing of communication tools, etc. Additional pre-work will occur for those recipients that have not previously participated in a CQII collaborative to better understand their contextual barriers, seek the commitments by senior agency leaders, and remove any barriers that might prohibit their full participation. Those who are QI beginners will be enrolled in the most relevant upcoming Learning Lab sessions.

Technologies. All virtual communication technologies, i.e., Zoom, Glasscubes, are field-tested in advance, and trainings are provided to participants.

Online Reporting. The previously used online database is being re-programmed to allow for routine reporting of viral suppression data and reporting of QI activities. The collaborative participant enters their aggregated agency data (no individual patient data) based on pre-defined measures every 2 months, which allow them to compare their progress to that of their peers, and

enter their QI interventions every 4 months to share and inspire other participants to improve their quality of care.

Intervention Grid and Manuals. An extensive list of evidence-informed interventions and emerging practices related to each focus area (housing, mental health, substance use, and aging) has been gathered by IHI by scanning existing work, reviewing the literature, and conducting interviews with key stakeholders. In addition, IHI will develop a set of intervention manuals relevant to this collaborative that could not be found in the literature. Collaborative participants will be asked to select those interventions and manuals for replication during the collaborative that are most relevant to meet the goals of their aim statement.

Driver Diagrams. To facilitate the initiation of improvement efforts by participants, IHI and CQII have developed Driver Diagrams for each of the Affinity Groups. These will help the conceptualization of change ideas that allow collaborative participants to end disparities in viral suppression outcomes for affected HIV subpopulations due to barriers for each of the collaborative focus areas.

Aim Statement. Given the complexity of the addressing social determinants of health, it is critical that each participating agency, which includes HIV ambulatory clinics as well as city/state health departments, selects one of the four targeted collaborative focus area (housing, mental health, substance use, aging) and identifies their population of focus within these focus areas based on local priorities; for instance for substance use (one agency selects a population of focus that includes all patients with opioid use disorders versus an agency selects all patients with any substance use disorders) or aging (one agency selects the young adult age group (25-39) versus an agency selects older adults (65 and older)). During the initial months of the collaborative, each participating agency will develop an individualized aim statement that outlines the population of focus and measurables goals to reach by June 2022. Aim statement templates, samples will be provided and discussed during the initial Affinity Group didactics. Additional support is also provided by the assigned QI Coach.

Learning Sessions. Learning Sessions allow for routine meeting points for participants to share progress made and promote peer learning and exchange. The initial Learning Session is planned to be face-to-face in February 2021 followed by virtual Learning Sessions every 5 months.

Action Periods. In between Learning Sessions, each team is charged to routinely submit their performance data based on HAB-approved performance measures, implement their QI activities as outlined in their aim statement, engage their local QI teams, and participate in all collaborative activities. CQII will establish several key milestones that each agency is expected to meet within the first 4-6 months after the kick-off of the collaborative. These milestones include: establishing a multi-disciplinary team, writing an aim statement, reporting subpopulation-specific data reports (housing, mental health, substance use, or aging), conducting a root cause analysis, and selecting relevant interventions. QI coaches are available to assist participating agencies s to meet them.

QI Coaching Model. QI Coaches are assigned to participating teams that are part of the same Affinity Group and provide direct support to meet the objectives as outlined in their individualized aim statements. The goal of this coaching model is to be able to focus on guiding

participants through each step of their QI project to address the impact of social determinants of health and on supporting participating agencies to reach all milestones as outlined in the Toolkit. QI Coaches are expected to virtually meet with their assigned group of participating agencies on a monthly basis (for a minimum of one hour each month) and to assign time to meet with individual teams for additional support as needed (office hours for one or two additional hours per month). In contrast to the end+disparities ECHO Collaborative, Regional Groups are not part of the create+equity Collaborative and are not supported by the QI Coaches.

Consumer Engagement. The involvement of PWH is a critical component of quality improvement. They play a vital role in local, regional, and national improvement efforts. Individuals with lived experiences assume key roles in the planning and implementation of the collaborative, as members of the planning group and Affinity Faculty members. In addition, the collaborative will expect each participating agency to have at least one consumer on their local quality improvement project. Opportunities for building capacity among PWH and recipients to promote consumer involvement in quality improvement activities will be provided, monthly Affinity Group Sessions open to all consumers will be hosted by CQII, and consumers will be engaged in the Leadership Program.

Leadership Program. Mirroring the success of the previous collaborative, a Leadership Program will be launched to prepare a small group of participants and consumers to assume greater leadership roles in facilitating virtual communities of learning going forward. Participants receive individual coaching from CQII staff/faculty and are engaged in monthly peer exchange opportunities with other Leadership Program participants.

Affinity Sessions. Virtual Affinity Sessions, using the Zoom platform, are held twice a month for each Affinity Group: housing, mental health, substance use, and aging. These 60-min sessions enable teams to create a community of learning while eliminating barriers to meeting in-person. Each participating agency is expected to present at least one case presentation using a provided template and a follow-up presentation 6-month afterward.

Each Affinity Group is supported by a dedicated Affinity Group Faculty, which includes content experts, including individuals with lived experiences, to provide ongoing expertise and support throughout the sessions. The following faculty members have recruited: Housing (Clanon, Conner, Keyes, Shank), Substance Use (Stanley, Clear, Drotter, Ugoji), Mental Health (Delorenzo, Keuroghlian, Parkinson, Lunda), Aging (Thompson, Dowdell, Moody, Chatterjee). Additional faculty members will be determined, including past Leadership Program participants and other individuals with lived experiences.

Learning Lab. CQII is currently expanding its training modalities by launching a new virtual QI training program, called QI Learning Lab. Each Lab will be offered every four months on a pre-determined annual schedule. Each Lab will last 3-months and consist of six 90min virtual sessions every two weeks. Participants in the collaborative in need of a quality improvement training will be offered the opportunity to participate in the most relevant Labs.

Evaluation. To evaluate the impact of the collaborative, the CQII evaluator (UCSF) will draft an appropriate evaluation plan focusing on increased viral suppression rates of the targeted

subpopulations, reductions in the gap between the overall caseload and subpopulation viral suppression rates, effectiveness of regional groups, effectiveness of quality improvement efforts as evidenced by the successful implementation of their QI project, and active participation in collaborative activities. Detailed spreadsheets will be kept for each collaborative activity and routinely shared with collaborative stakeholders.

The following table outlines the working definitions for each of the collaborative focus areas.

Table 3: Affinity Group Working Definitions

Substance Use		
Targeted Populations of Focus	*Improvement Focus*	*Notes*
- Clients who are in HIV care and identified as active and recent substance users by the HIV site (site-selected population of focus) [primary focus] - Clients who are in HIV care with no documentation in the medical record of their current substance use status (all patients) [secondary focus]	- Viral Suppression: Increases in viral suppression rates of HIV clients who are identified in the medical record as active and recent substance users (site-selected population of focus) [primary focus] - Screening: Increases in routine substance use screening rates across all HIV patients served by the agency resulting in improved documentation rates in the medical record [secondary focus] - Referrals: Increases in referral rates of individuals who are identified as active substance users to appropriate (internal or external) substance use services [secondary focus]	- While the long-term goal is certainly for the individual clients to be in recovery, engaged in drug treatment programs, or use a harm reduction approach, the primary focus of the collaborative is to retain them in ongoing HIV care and reach viral suppression. - The collaborative will provide a list of substances as its focus (opioids, methamphetamine, stimulants, and alcohol); however each participating agency can determine their own focus. - When reporting on viral suppression scores, sites will not report on their entire caseload and their subpopulation of focus. - A decision needs to be made to what extent linkage is a focus of the collaborative.
Mental Health		
Targeted Populations of Focus	*Improvement Focus*	*Notes*
- Clients who are in HIV care and identified with a mental health diagnosis or diagnoses as determined by the HIV site (site-selected population of focus) [primary focus] - Clients who are in HIV care with no documentation in the medical record of their current mental health status (all patients) [secondary focus]	- Viral Suppression: Increases in viral suppression rates of HIV clients who are identified in the medical record with a mental health diagnosis or diagnoses (site-selected population of focus) [primary focus] - Screening: Increases in routine mental health screening rates across all HIV patients served by the agency resulting in improved documentation rates in	- While the long-term goal is certainly for the individual clients to successfully treat their mental health disorders, the primary focus of the collaborative is to retain them in ongoing HIV care and reach viral suppression. - The collaborative will provide a list of mental health disorders as its focus (depression, anxiety, psychotic disorders, and post-traumatic stress disorder);

	the medical record [secondary focus] - Referral: Increases in referral rates of individuals who are identified with a mental health diagnosis to appropriate and ongoing (internal or external) mental health services [secondary focus]	however each participating agency can determine their own focus. - A decision needs to be made to what extent referral is a focus of the collaborative.
Housing		
Targeted Populations of Focus	*Improvement Focus*	*Notes*
- Clients who are in HIV care and are temporarily or unstably housed (site-selected population of focus) [primary focus] - Clients who are in HIV care with no documentation in the medical record of their current housing status (all patients) [secondary focus]	- Viral Suppression: Increases in viral suppression rates of HIV clients who are identified in the medical record with temporary or unstable housing (site-selected population of focus) [primary focus] - Screening: Increases in routine screening rates of the current housing status across all HIV patients served by the agency resulting in improved documentation rates in the medical record [secondary focus] - Referral: Increases in referral rates of individuals who are identified as temporarily or unstably housed to appropriate and ongoing (internal or external) housing services [secondary focus]	- While the long-term goal is certainly for the individual client to find stable housing, the primary focus of the collaborative is to retain them in ongoing HIV care and reach viral suppression. - Definitions are temporary and unstable housing are based on the 2019 RSR - A decision needs to be made to what extent linkage is a focus of the collaborative.
Aging		
Targeted Populations of Focus	*Improvement Focus*	*Notes*
- Clients who are in HIV care and within a specific age group identified by the HIV site (site-selected population of focus) [primary focus]	- Viral Suppression: Increases in viral suppression rates of HIV clients within a specific age group (site-selected population of focus) [primary focus]	- Aging applies across all age groups, including youth, adolescents, older adults - the following age groups are used for this Collaborative: children/youth (24 and younger); young adults (25-39); adults (40-64); older adults (65 and older) - Each participating agency is asked to select one age group based on their own preference (subpopulation of focus) - Each age group will face specific barriers to care (e.g.,

		linkage to care for youth, co-morbidities for older adults) - When reporting on viral suppression scores, sites will report on their entire caseload and their subpopulation of focus

The following table outlines the milestones to plan and implement the upcoming collaborative in Year 1.

Table 4: Year 1 crate+equity Collaborative Milestones

Month/Year	*Activity*
Jul 2020	Initial Collaborative Planning Meeting
Aug 2020	Initiation of Planning Group Meeting
Aug 2020	Establishment of Affinity Faculty Membership
Aug 2020	Development of Intervention Manuals
Aug 2020	Development of Recruitment Video
Sep 2020	Development of Collaborative Tools: Toolkit, Forms and Templates, Registration Site, Assessment Forms, Case Presentation Templates
Sep 2020	Setting up Technologies: Glasscubes, Zoom
Oct 2020	Establishment of Evaluation Plan and Tracking Tools
Oct 2020	Initiation of Recruitment and Enrollment Process
Nov – Dec 2020	Kick-off Webinars to Increase Awareness of Upcoming Collaborative
Jan 2021	Pre-Work and Finalization of Affinity Group Didactics and Curriculum
Feb 2021	First Learning Session
Mar 2021	First Affinity Sessions and Performance Data Reporting
June 2022	End of *create+equity Collaborative*

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