Contents

About This Manual .................................................................................................................. 4
Getting Started ...................................................................................................................... 5
Overview .................................................................................................................................. 5
  Overall Structure of the STOP HIV/AIDS Collaborative .................................................... 5
Collaborative Milestones........................................................................................................ 6
Schedule .................................................................................................................................. 7
Checklist of Preparation Activities ...................................................................................... 8
The Models of the Collaborative .......................................................................................... 9
  The Expanded Chronic Care Model (CCM) ........................................................................ 9
The Model for Improvement .................................................................................................. 10
Instructions for Completing Preparation Activities ............................................................. 12
  1. Collaborative Charter ..................................................................................................... 12
  2. Forming a team ............................................................................................................... 12
Team Roster – STOP HIV/AIDS Collaborative ................................................................. 15
  3. Developing an Aim Statement ...................................................................................... 19
  4. Defining the Population of Focus (POF) ................................................................... 21
  5. Measurement ................................................................................................................ 22
    The Why, What, and How Much of Measurement ........................................................... 22
    Measurements Related to your Aim .............................................................................. 25
    Measurement Reporting ................................................................................................. 25
    Measurements: Guidelines for Getting Started ............................................................ 25
  6. Preparing a Storyboard .................................................................................................. 26
Leadership for Improvement ............................................................................................... 26
  Senior Leadership Roles .................................................................................................. 27
  Senior Leadership Responsibilities .................................................................................... 27
Glossary of Terms and Concepts ..................................................................................... 29
Resource Section .................................................................................................................. 35
  Team Dynamics ............................................................................................................... 35
Getting the Most from Your Team ..................................................................................... 36
  Strategic Planning ............................................................................................................ 37
Cooperative, Connected Network ...................................................................................... 37
Building Capacity for Improvement .................................................................................... 38
About This Manual

The purpose of this manual is to help lay the foundation for activities leading up to the first Learning Session. These activities include defining team membership, establishing data collection systems, creating a registry of patients, developing an aim, completing team-self assessments, and summarizing your team’s work progress with a storyboard for presentation at the first Learning Session. This manual will provide resources to support your team in this work.

Getting Started contains an overview of the Collaborative, a schedule and timeline of major events and periods, and a checklist of preparation activities—tasks your team should accomplish before the first Learning Session on January 26th and 27th, 2010.

The Models of the Collaborative section provides an overview of the Care and Improvement Models, utilized by all teams within the Collaborative structure.

The section on Completing Preparation will walk your team step-by-step through preparing for the first Learning Session.

The Collaborative Charter contains the mission and rationale for this Collaborative along with a description of the methods that will be used and lists of Collaborative expectations—what your team can expect from the Collaborative and what the Collaborative expects from your team.

The Measurement Strategy section describes the data that your team will collect to monitor your progress during the Collaborative.

The Change Package contains a variety of ideas for improving the process of delivering care to patients with HIV/AIDS. A high level overview of the change package will be provided to teams during the Preparation period. A more detailed version, with specific change ideas, will be provided at Learning Session 1. You will refer to it throughout the Collaborative.

The section on Leadership for Improvement describes the basic roles and responsibilities that the senior leader must embrace to help develop and to sustain a successful team.

A Glossary of Terms and Concepts will serve as a reference throughout the Collaborative.

In addition, a Resource Section has been included to provide teams with a variety of topics and tools that may be helpful throughout the Collaborative journey!
Getting Started

Welcome to the STOP HIV/AIDS Collaborative! We embrace you as leaders in managing quality improvement, pursuing excellence in practice, and in actively advancing improvements in healthcare outcomes for patients living with HIV and AIDS. Towards achieving these goals, a fundamental change from a provider-oriented to a patient/family/community-oriented system of care is required.

Over the next 18 months, your team will learn and implement the Collaborative care and improvement models as a strategy to improve health outcomes for underserved people and to eliminate health disparities. The skills learned in this evidence-based approach can be applied throughout your practice in the near future. This section provides your team with useful information to get started including an overview of the Collaborative, a schedule of activities, and a list of preparation activities and tasks for your team to accomplish before the first Learning Session.

Overview

A Structured Learning Collaborative is a systematic approach to healthcare quality improvement. In this approach, organizations and providers test and measure practice innovations and subsequently share these experiences in an effort to accelerate learning and widespread implementation of successful change concepts and ideas.

Overall Structure of the STOP HIV/AIDS Collaborative

The STOP HIV/AIDS Collaborative will involve multiple practice and organizational teams from across BC actively working together over the course of 18 months to improve HIV/AIDS care for known and newly diagnosed HIV/AIDS patients. Throughout this time, Collaborative teams will participate in the Collaborative Launch, three Learning Sessions, and a closing congress. Between face-to-face meetings, teams will maintain continual contact with each other and with Collaborative staff and faculty via email, website access, listserv discussions, monthly conference calls, webinars, and via site visits as required¹. Teams will be encouraged to take purposeful steps to sustain the improvements made during the Collaborative as well as to “spread” change ideas to other areas of their practice.

¹ Email and access to the Collaborative website and listserv will be the primary means of communication between Collaborative teams.
Collaborative Milestones

There are three basic milestones within the Structured Learning Collaborative process. More specifically, these components are Preparation activities, Learning Sessions, and Action Periods. These are described in more detail below.

Preparation

Preparation is the period between the STOP HIV/AIDS Collaborative Launch (December 2, 2010) and Learning Session 1 (January 26-27, 2011). Throughout the preparation period, your team will have a number of important tasks to accomplish to prepare for a successful Collaborative. These tasks are described in more detail in a later section - a checklist of these activities has also been included to help teams get organized.

Learning Sessions

Learning Sessions are the major integrative events of the Collaborative. Here, Collaborative team members will attend four highly interactive face-to-face Learning Sessions (including the closing session) to learn the elements of improving access and care for HIV/AIDS patients, and strategies to test and to implement these changes. Through plenary sessions, small group discussions, and team meetings, attendees will have the opportunity to:

- Learn from Faculty and colleagues
- Receive individual coaching from Faculty members and colleagues
- Gather new knowledge on the subject matter and on process improvement
- Share experiences and collaborate on improvement plans
- Problem-solve barriers to improvement

Action Periods

Periods between Learning Sessions are called Action Periods. These are the times during which Collaborative team members take what is learnt during Learning Session and work within their practices to test and to implement changes that lead to improved care for their patients with HIV/AIDS. Guided by their stated objectives (aim statement), teams may try out a number of changes within their practices while collecting data to measure the impact of changes in achieving these objectives. At the same time, participants will remain in continuous contact with Faculty, Collaborative staff, and with other teams that are enrolled in the Collaborative through the use of monthly conference calls, emails, website access, listserv discussions, webinars, and site visits as
required\textsuperscript{2}. Also, Collaborative participants will share the results of their improvement efforts through monthly reporting. It is important to note also that participation in Action Period activities is not only limited to those who have attended Learning Sessions.

**Schedule**

The sequence of the STOP HIV/AIDS Collaborative Learning Sessions and Action Periods is expected to follow the schedule below:

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborative Launch</td>
<td>December 2, 2010</td>
</tr>
<tr>
<td>Preparation</td>
<td>December 2, 2010 – January 25, 2010</td>
</tr>
<tr>
<td>Learning Session 1</td>
<td>January 26 -27, 2011</td>
</tr>
<tr>
<td>Action Period 1</td>
<td>January 28, 2011 – May 24, 2011</td>
</tr>
<tr>
<td>Learning Session 2</td>
<td>May 25, 2011</td>
</tr>
<tr>
<td>Action Period 2</td>
<td>May 26, 2011 – September 27, 2011</td>
</tr>
<tr>
<td>Learning Session 3</td>
<td>September 28, 2011</td>
</tr>
<tr>
<td>Closing Congress</td>
<td>January 25, 2012</td>
</tr>
</tbody>
</table>

\textsuperscript{2} Collectively this network of communication is referred to as the Virtual Community of Practice.
Checklist of Preparation Activities

☐ Select team membership using the guiding principles contained within this manual and with the guidance of the Collaborative staff

☐ Complete the ‘team roster’ sheet and submit to the Collaborative Director

☐ Distribute this Preparation manual (or make available) to all team members

☐ Hold first team meeting and make decisions about team roles and regular meeting times

☐ Develop an aim statement, with the assistance of the Collaborative staff, and submit to the Collaborative Director for review and comment

☐ Define your Population of Focus with the assistance of Collaborative staff. Ensure all patients with HIV/AIDS are in your registry or database

☐ Plan and discuss the data collection and measurement strategy with team members (use the draft measures – provided below – to guide this discussion)

☐ Register the team for Learning Session #1, information will be sent to you through the Collaborative listserv

☐ Sign up all team members for the listserv to join the Virtual Community of Practice (i.e., website)

☐ Prepare a storyboard and bring to Learning Session 1 (a template will be provided to guide this effort)
The Models of the Collaborative

The Expanded Chronic Care Model (CCM)

The province of British Columbia uses the Expanded Chronic Care Model (CCM)\textsuperscript{3} to guide improvements in primary healthcare within the province. This model, depicted below, is evidence-based and its application has been reported to achieve better health outcomes resulting in healthier patients, more satisfied providers, and more cost-effective expenditures of health care resources. The Expanded CCM may be employed to improve care in a variety of health care settings, for a number of target populations.

\textsuperscript{3} The model is based on the “Chronic Care Model” used by a national program in the United States called Improving Chronic Illness Care (ICIC). This program is based at the McColl Institute for Healthcare Innovation at the Group Health Cooperative of Puget Sound.
The Expanded CCM identifies five action areas at the community level (i.e., build healthy public policy, create supportive environments, strengthen community action) and four areas of focus (i.e., self-management/develop personal skills, delivery system design/re-orient health services, decision support, information systems) that exist across the levels of the community and the health system. In targeting changes to these areas, Collaborative teams may work towards improving health outcomes for their patients with HIV/AIDS.

To facilitate teams in making these changes, a detailed ‘Change Package’ will be provided to teams after the Collaborative Launch. This package provides teams with evidence-based ideas for changes that teams can test out. The change ideas contained within the package have been aligned with the following areas of focus within the Expanded CCM:

- **Health system** – to create a culture, organization, and mechanisms that promote safe, high quality care
- **Self-management support** – to empower and prepare patients to manage their health and healthcare
- **Decision Support** – to promote clinical care that is consistent with scientific evidence and patient preferences
- **Delivery system design** – to assure the delivery of effective, efficient clinical care

### The Model for Improvement

In addition to the Expanded CCM, the Collaborative will employ an improvement model developed by the Associates in Process Improvement which has been tested and used in many Collaboratives. When combined with the Expanded CCM, the improvement model provides a process to improve the quality of care at an accelerated pace.

---

The improvement model is based on three fundamental questions:

**1) What are we trying to accomplish?**

The first question is meant to establish an aim for improvement that focuses the team effort. Teams should select aims that align with the overall goals of the Collaborative (refer to the Collaborative Charter). Aim statements should be SMART (specific, measureable, attributable, realistic, and time-bound). They should also be concise and mutually agreed upon by the team. An aim statement may require a few trials of testing for it to become truly focused.

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

To answer this question, data is required to understand and to assess the effect that the changes may have towards achieving the aims of the team. Furthermore, when these measures are shared among teams in the Collaborative, learning is further enhanced as common successes, challenges, and barriers may be shared among participants. In this way, superior performance and best-practices may be identified and disseminated more rapidly.

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

When aims and measures have been defined, teams may select among changes (guided by the ‘Change Package’) that they predict will help them achieve their aims. When a change has been selected, teams may subsequently act to rapidly test the change within their local context using Plan (P) – Do (D) – Study (S) – Act cycles. In this process, teams may plan a change, execute the change, compare their predictions to outcomes (monitor measures), and act to refine and test the changes again, or to adopt a change that demonstrates an improvement.
Instructions for Completing Preparation Activities

The following pages provide information to assist teams in completing Preparation activities. A worksheet to help you complete some of these activities follows.

1. Collaborative Charter

Take the time to read the Collaborative charter (provided separately). The charter defines the Collaborative goals, summarizes the evidence that will direct your work, outlines methods that your team will use to achieve the mission, and lists what teams can expect from Collaborative leadership, and what leadership can expect from each of the teams.

2. Forming a team

2.1 Organizational Leadership

Depending on the specific characteristics of the participating Collaborative team’s practice or healthcare organization, senior leadership may be a Practice Leader, Executive Director, Medical Director, Chief Operating Officer, Chief Financial Officer, and/or a member of the Board of Directors.

Regardless of title, leadership has the authority to decide whether or not the project is undertaken. The leadership is also responsible for targeting goals, supporting changes, removing obstacles, providing support/resources, chartering the team, and communicating changes and priorities to the staff and board. Leadership directs the spread of changes that result in improvement throughout the organization by integrating these changes into the entire system of care. A more detailed discussion on the role of leadership is provided within the section entitled Leadership for Improvement.

2.2 Selecting the team

Having an appropriate and effective team is critical to achieve successful improvement efforts. Team members should be carefully selected based on a number of criteria including process knowledge, enthusiasm for change, quality improvement knowledge, and ability to work effectively as part of a team, to name a few (additional criteria are outlined in section 2.4). Ideally, Collaborative teams should include three to six individuals. This team may be larger
than the core individuals that attend Learning Sessions, but must not be so large as to make it difficult to get work done.

All teams will require four leadership roles: senior leader, senior clinical champion, clinical or technical expert, and a day-to-day leader. The senior leader should plan on attending at least the first and the third Learning Sessions, while the senior clinical champion, the clinical or technical expert, and the day-to-day leader should attend all three Learning Sessions. It is important to note, that it might be the case that one or more team members fits one or more of the leadership roles, or that one individual fills more than one leadership role; nevertheless, it is important that all leadership criteria are met on a team to successfully drive improvements in care.

Each Learning Session builds on the previous Learning Session. Therefore, to maximize learning and contribution at these Sessions, a consistent group of members should plan on attending each Learning Session.

As part of the Collaborative, the team will have technical assistance and support provided by the Collaborative Director. Faculty and staff are also available for support and guidance.

### 2.3 Composition of the Core Team

The Core Team is minimally composed of the following:

- **Senior Leader** (generally, the practice leader, or an executive within a larger organization)
  The ideal senior leader has ultimate authority to allocate time and resources needed to achieve the team’s aims. In addition, this individual has administrative authority over all areas that may be affected by changes tested by a team. Also, this individual will champion the spread of successful changes throughout the organization. He or she is encouraged to attend all Learning Sessions and is expected to attend at least the first and third Learning Sessions.

- **Senior Clinical Champion** (principal leader at the pilot site)
  It is critical to have at least one senior clinical champion on the team. This champion should have a good working relationship with colleagues and with the day-to-day leader(s) (described below) and be interested in driving change in the system. Look for senior clinical personnel who are opinion leaders in the organization (individuals sought out for advice who are not afraid to test change). The senior clinical champion is expected to attend ALL Learning Sessions.

- **Clinical/technical expert** (subject matter knowledge and processes of care)
  A clinical/technical expert is one who knows the subject intimately and who understands the processes of care. Additional technical support may be provided by an expert on improvement methods who can help the team determine what to measure, assist in the design of simple, effective measurement tools, and provide guidance on the design of tests.
These individuals may include nursing, lab, pharmacy, front office, medical records, information systems, and/or quality personnel. The clinical/technical expert is expected to attend ALL Learning Sessions.

- **Team Leader** (Day-to-day leadership and coordination)

  The day-to-day leader will be the critical driving component of the team, assuring that tests of change are implemented and overseeing data collection. It is important that this person understand not only the details of the system, but also the various effects of making change(s) in the system. This individual also needs to be able to work effectively with the senior clinical champion(s) as well as with other staff members in the organization. The day-to-day leader will be the “key contact” within your organization. This individual should be responsible for coordinating communications within the team, between Collaborative teams, with staff, and with the practice/organizational leadership. The team leader is expected to attend ALL Learning Sessions.
Team Roster – STOP HIV/AIDS Collaborative

*Please complete this form and fax it to Christina Clarke [604.742.1773]*

Name of Practice/Organization & Mailing Address

<table>
<thead>
<tr>
<th>Team Member Name</th>
<th>Team Member Title</th>
<th>Phone</th>
<th>Fax</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Senior Leader</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Senior Clinical Champion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical/Techni cal Expert</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Day-to-day Leader/Key Contact</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.4 Characteristics of a team member

When considering potential team members, consider the following questions:

✓ Is the person respected for their judgment by a range of staff?
✓ Does he/she enjoy a reputation as a team player?
✓ What is the person’s area of skill or technical proficiency?
✓ Is she/he an excellent listener?
✓ Is this person a good verbal communicator within and in front of groups?
✓ Is this person a problem-solver?
✓ Is he/she disappointed with the current system and processes and willing to improve things?
✓ Is this person creative, innovative, and enthusiastic?
✓ Is she/he excited about change and new technology?

Your best approach in selecting team membership is to rate potential team members on each of the above attributes. While you may start with a list of ten or more candidates, the goal is to identify the three to six that best represent these characteristics and work well together. Use the tool below to help with your selection.
Rate the potential team members on each of the desired characteristics using the following scale: 1= strongly disagree (this characteristic does not represent this individual); 2= disagree; 3= neutral; 4= agree; 5= strongly agree.

<table>
<thead>
<tr>
<th>Desired Characteristics</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Candidate’s initials</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respected</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team Player</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listener</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communicator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem solver</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frustrated with current system</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creative &amp; Innovative</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open to change</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>List area of skill/proficiency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL SCORE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In selecting from the above individuals also consider: Chemistry (can team members work well together?) and balance (is there a mix of skills, styles and competencies?). It is not necessary or advisable for the team to consist of all clinical staff members.
Jointly the selected Collaborative team members should agree upon the following:

**Step 1:**
- Who will be the team leader?
- How will the Collaborative staff be involved in the team?
- Who else should be on the team?
- When, where, how often, and for how long will the team meet?
- Who is responsible for sending monthly data reports to the Collaborative Director?

**Step 2:**
- Describe the boundaries and support the team will have.
- Will the team need financial resources? Who will provide them? What limitations are there on budgets?
- What decision-making authority will the team have? What authority will the team have to call in co-workers or outside experts, request equipment or information normally inaccessible to them, and make changes in the process?
- How will team members’ normal work get done while they are involved in the project?
- Are there other resources that this team will need?

**Step 3:** Give your team a name! Be creative and have fun!

---

**2.5 Responsibilities of the Team**

**ALL Team Members:**
- Must consider their participation as a priority responsibility that is a part of their day to day work, not an intrusion on their “real jobs”
- Are responsible for contributing fully to the project, sharing knowledge and expertise
- Participate in all meetings and discussions about the project
- Carry out their assignments between the meetings and meeting deadlines
- Report back to the team at each meeting on their assignments
- Should be cross-trained (e.g., how to produce monthly registry summary reports and graphs as well as writing the senior leader narrative, documenting tests of change and changes implemented, how to lead a team meeting, etc.)

**Team Leader or Key Contact:**
- Calls and facilitates meetings
- Handles or assigns administrative details
- Orchestrates all team activities
• Oversees preparation for reports and presentations
• Meets timelines of the project
• Shares responsibilities with other team members
• Trusts the group to arrive at the best solution
• Acts as the contact point for communication between the team members and the rest of the organization, including the practice/organizational leadership
• Acts as the official keeper of team records, including correspondence; records of meetings and presentations; meeting minutes and agendas; and charts, graphs and other data related to the project
• Responsible for formally documenting the project, or assigning a team member to do so

2.6 Expectations of the Team

• All Preparation will be completed prior to Learning Session 1
• A core group of each Collaborative team (i.e., leadership roles) will attend all Learning Sessions
• The team will develop a monthly data reports using the format provided and submit it on the date specified by the Collaborative Director
• The team will have regularly scheduled team meetings and all members will attend
• At least one team member will attend all monthly Collaborative Conference calls as scheduled
• The team will learn the models used in the Collaborative and share their knowledge with the rest of the staff

3. Developing an Aim Statement

The Model for Improvement is based on the following three questions:

(1) What are we trying to accomplish? (Aim)

(2) How will we know that a change is an improvement? (Measures)

(3) What changes can we make that will result in an improvement? (Changes)

The first question is meant to establish an aim for your practice’s/organization’s improvement effort. To answer this question, you should consider the needs of your patients, your organization’s strategic plan, and what other stakeholders including employees believe is important. The aim should be as concise as possible – sometimes a team must test an aim before it becomes truly focused.
An example of an aim consistent with the goals of this Collaborative is:

**Aim:** Redesign and coordinate services provided at the health center in order to achieve quality clinical and functional outcomes, improve patients’ perceptions of their health status, and improve the overall care provided at the center. To achieve these goals, we will implement changes using the Chronic Care Model and measure the following to gauge our success:

- 30 percent increase in the percentage of patients with visit(s) within last three months
- 30 percent reduction in the percentage of patients with CD4 count < 200
- 80 percent of applicable patients on HAART
- 75 percent of patients on HAART with adherence counseling or intervention provided at the last visit

**Population of Focus:** Focus initially on the existing panel of patients with HIV/AIDS seen by two of our clinicians. After implementing changes locally, spread the changes to the rest of the clinicians in the health center.

**Team:**

- System/Team Leadership: Vice President of Ambulatory Services
- Technical Expertise: Family Medicine Physician
- Day-to-Day Leadership: Nurse Manager
- Additional team members: Biostatistician, Social Services Counselor, Nurse Practitioner

Source: Institute for Healthcare Improvement. Available at: http://www.ihi.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/HowToImprove/settingtheaims.htm

In setting the team’s aim, be sure to do the following:

1. **Involve senior leaders:** Leadership must align the aim with the strategic goals of the organization.
2. **Base the aim on both data and organizational needs:** Examine the data within the organization to help guide the establishment of an appropriate aim. Refer to the measurement section and focus on issues that matter to the organization.
3. **The aim should mention “redesign of the system of care based on the Expanded CCM’s components”** The Expanded CCM provides the framework for changing (redesigning) the system of care.
4. **State the aim clearly and use numerical, measurable goals:** Teams will have a clear picture of the changes that need to be made if the aim is unambiguous and clearly stated. We encourage you to list the measures you will track in your aim statement, using the goals prepared for you by the clinical faculties.
5. Include an optional Guidance Paragraph on approaches and methods to further explain your approach: Describe the practice, team, or partnerships you plan to engage. Include specific strategies that the organization intends to follow.

4. Defining the Population of Focus (POF)

Some practices in the Collaborative provide care to several hundred patients with HIV. Similarly, many have multiple sites and providers. It is not reasonable to expect that the care to all patients can be significantly redesigned over the 18 month period of the Collaborative. For practices with many patients or multiple providers, teams should consider a “focus then spread” approach. The team may focus on one or two providers and all of the HIV positive patients they care for – a patient population of focus (POF). Initially, the team will work on improving care for patients included in the POF, and subsequently share or spread that learning with other providers within the organization.

There are two criteria for selecting this sub-population (which we will refer to as the “Population of Focus” or POF).

1. **The total population size should be between 100 and 300 patients**
   - Typically, we propose that your POF have *at least 100 patients* to ensure that your team has enough patients to cause redesigns to systems of care. A POF less than this may cause your team to use short-term fixes (i.e., not system changes) to accommodate a small population of patients. Likewise, it is important that your POF have a sufficient number of patients to spread changes within and outside the practice/organization. In our experience, a POF less than 100 does not lend itself to building a convincing case for spread among providers and practice/organizational leadership. **Exceptions** are expected where the practice/organization is small, having fewer than 100 patients. In this case, the POF will include all patients.
   - To ensure the redesign task is manageable, we recommend that your POF include *no more than 300 patients*. Exceptions to this recommendation are expected where the team decides to include all patients attached to a specified provider. In this case, the POF might exceed 300.

2. **Patients are selected based on either clinic or provider, or both.**
   - For example, if are two providers at one clinic with approximately 160 patients with HIV/AIDS, your POF could be *all patients of both providers* seen at this clinic. The simplest selection basis is to work with all patients at a particular practice site. This will keep your management of tests of change and implementation for your POF relatively simple. If the one site you have in mind has more than 300 patients with the condition of your collaborative, then we recommend you take all the patients of a subset of the providers at the clinic. Depending on patient load, you might choose to work with the patients of just
one provider, who had 100 or more patients. We strongly recommend that you avoid taking only portions of one provider’s panel. For example, if you have only some of Dr. X’s patients in the POF, you add complexity in providing care—needing to constantly distinguish between those patients who should pass through the new system of care and those will continue to receive the “ordinary” system of care delivered by Dr. X and his/her provider team.

Note that POF selection should not be based on risk levels (e.g., patients with substance abuse) rather it should be selected based on provider or site. Pick the POF wisely. Pick the providers and clinics where the changes are most likely to be embraced.

Once the POF is selected, the team will concentrate improvement efforts on that group of patients. This does not mean that changes that are found to be effective with the POF cannot be spread to other clinics or providers. It only means that the initial effort and measurement will be directed toward this group. Later in the Collaborative we will focus on spread and inclusion of other providers and sites, which will likely occur during the breakthrough-learning phase. There will be an opportunity for graphing the spread sites separately from the POF. Also as the POF providers see new patients the patients should be added to the POF.

**Example of Population of Focus (POF):** During the Collaborative, we will focus on the patients of two of the four providers (Smith and Jones) at the Best Clinic site. This includes approximately 250 HIV positive patients who have been identified as active clinic patients of Dr. Smith and Jones.

### 5. Measurement

**The Why, What, and How Much of Measurement**

The STOP HIV/AIDS Collaborative is about improving the care of people with HIV/AIDS and measurement will play several important roles towards this endeavor. Measurement will assist teams in evaluating the impact of changes made to improve the delivery of care within the POF. It is chiefly important to remember that measurement should be designed to accelerate improvement, not to slow it down. Your team needs just enough measurement to be convinced that the changes you are making are leading to improvements.

Before Learning Session 1, teams will receive a document that details the STOP HIV/AIDS Collaborative measures. This document will detail the required measures within the Collaborative and the frequency with which teams will be required to report to the Collaborative. A draft version of the Collaborative measures has been provided below so that teams may begin to consider data collection.
STOP HIV/AIDS COLLABORATIVE DRAFT CORE MEASURES

*Please note that these draft measures are still under development and may be subject to change. They are provided for teams to consider future data collection expectations. A final set of measures will be provided to teams before Learning Session 1.
<table>
<thead>
<tr>
<th>#</th>
<th>MEASUREMENT</th>
<th>SUGGESTED TARGETS</th>
<th>DEFINITION</th>
<th>HOW TO COLLECT IT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Primary care visits</td>
<td>&gt;95%</td>
<td>Percentage of patients with primary care visits in the last four months.</td>
<td>Divide the number of active patients(^5) who had at least one documented primary care visit to a primary care provider(^6) during the previous four months divided by the total number of active patients registered in the database of the participating primary care team. (^7)</td>
</tr>
<tr>
<td>2</td>
<td>CD4 counts</td>
<td>&gt;95%</td>
<td>Percentage of patients with CD4 counts in the previous 4 months.</td>
<td>Number of active patients who had a CD4 test during the previous 4 months divided by the total number of active patients registered in the database of the participating primary care team.</td>
</tr>
<tr>
<td>3</td>
<td>HIV Viral load</td>
<td>&gt;95%</td>
<td>Percentage of patients with HIV viral load in the previous 4 months.</td>
<td>Number of active patients who had a viral load during the previous 4 months divided by the total number of active patients registered in the database of the participating primary care team.</td>
</tr>
<tr>
<td>4</td>
<td>ART uptake</td>
<td>&gt;75%</td>
<td>Proportion of patients who are currently prescribed ARVs</td>
<td>Number of active patients are on ARVs divided by the total number of active patients registered in the database of the participating primary care team.</td>
</tr>
<tr>
<td>5</td>
<td>ART uptake among those in most need</td>
<td>&lt;5%</td>
<td>Percentage of patients with CD4 counts of &lt;200 who are not taking ARVs</td>
<td>Number of active patients who have CD4 counts of &lt;200 cells/mm(^3) not taking ARVs divided by the total number of active patients with CD4 counts &lt;200.</td>
</tr>
<tr>
<td>6</td>
<td>Achieving maximal HIV virologic control(^8) if prescribed ART</td>
<td>&gt;95%</td>
<td>Percentage of individuals on ARVs for at least 6 months with HIV plasma viral load of &lt; 200 copies.</td>
<td>Number of active patients who are taking ARVs for at least 6 months at the time of analysis with HIV pVL &lt; 200 copies divided by the total number of active patients on ART.</td>
</tr>
<tr>
<td>7</td>
<td>Patient satisfaction</td>
<td>95%</td>
<td>Percentage of patients who report being satisfied with their visit</td>
<td>Conduct a patient satisfaction survey during the months of February and September 2010.</td>
</tr>
</tbody>
</table>

\(^5\) **Active Patients**: Patients who have at least 2 visits (60 days apart), who have not moved or died, and do not receive their HIV primary care at another clinic site.

\(^6\) **Primary Care Provider**: A physician, nurse, pharmacist or clinical counsellor

\(^7\) **Primary care team**: An interdisciplinary primary care team with at least one prescriber (Physician or Nurse Practitioner)

\(^8\) **Maximal Virologic control**: The ultimate goal is to have a fully suppressed HIV plasma Viral Load (p-VL) below the detectable level. Due to high variability at the lowest level of detection in the assay in use in BC, and
Immediately upon receipt of the final version of the STOP HIV/AIDS Collaborative measures, teams should begin to collect data to establish a baseline. If available, teams may plot historical data using whatever frequency is at hand. By contrast, if this data is not available teams should begin plotting monthly summaries of the measures.

Ideally, some teams may come prepared to the first Learning Session with baseline data; though this will not be an expectation. Teams should however come to Learning Session 1 with a strategy to collect data that relates to the aims of the team.

**Measurements Related to your Aim**

The most important measures required during this Collaborative are measures that directly relate to your aim. The measures will provide the means to assess progress toward your aim.

**Measurement Reporting**

Once per month, your team will assess progress and report data requested by the Collaborative Director. While not all measures will be amenable to monthly reporting, a narrative report including a summary of what your team has done and your results displayed as annotated run charts, will be provided to the Collaborative staff and shared with the Collaborative Virtual Community of Practice to identify barriers and success in improvement efforts. A template for reporting measures will be provided as your team prepares for Learning Session 1.

**Measurements: Guidelines for Getting Started**

Some measurement concepts to help keep the use of data simple and effective during the Collaborative:

1. **Plot data over time.** Improvement in care of patients with HIV/AIDS will require testing and implementing throughout the Collaborative. Most of the information about performance of your system and how it has improved can be learned by observing trends and patterns in simple time series charts of key measures directly related to the aim.

2. **Focus on measures directly related to your aim.** Measures that can be used to evaluate performance of the system relative to your team’s aim should be maintained throughout the Collaborative and reported on a regular basis. Additional balancing measures (measures that track the effect that changes in one part of a system have on other parts of the system) and measures of specific components of your system may be required at different times during the Collaborative, but these do not need to be reported regularly.

3. **Integrate measures into routine processes.** Whenever possible, collect useful data as part of the normal work performance. Charts audits are not very productive ways to obtain data

limited clinical explanation, a set point of <200 copies for the HIV plasma viral load has been used by the STOP HIV/AIDS Pilot Project for monitoring and evaluation purposes.
for measures. Update your data fields after each patient visit. Develop simple data recording forms that are integrated into the patient visit.

6. Preparing a Storyboard

At each Learning Session, your team will receive a board, pushpins, and other supplies so that your team can create a storyboard to present what it has accomplished and learned so far. Storyboards help to create an environment that is conducive to sharing and learning from the experiences of others.

At the first Learning Session, your storyboard will be a way to introduce your team to the other Collaborative participants. The storyboard is an opportunity to have some fun and show the unique character of your team and your practice/organization.

The storyboard should be clear and concise. The audience for storyboards consists of other teams, the Collaborative leadership, observers, and Faculty who are not familiar with your organization, your aim, and your work. Additional information will be communicated by your Collaborative staff, with a template provided to use for the storyboard.

Leadership for Improvement

The task of the leader is to create a vision that explains to people where the team is going and how it will get there. The purpose is to convey the “big picture” and to create excitement about working together to achieve an objective. Senior leaders are the ones who best understand that picture relevant to their practice/organization. Their primary responsibility is to lead the practice/organization toward high performance goals. A team well chosen, with senior leadership assistance, can significantly improve the quality and cost of care that is delivered. As the senior leader of a Collaborative team, there are roles and responsibilities that the senior leader must embrace to help your team achieve success:

Your Storyboard

Suggested contents for your first storyboard:

- Practice/organization, team name, team members and their titles
- Brief description of the practice and population served
- Draft aim statement
- Draft description of your population of focus
- Any baseline data that you have collected so far
- Description of progress so far
- Partnerships

Bring photos, figures, colored paper, and other creative materials as desired.

HAVE FUN!
Senior Leadership Roles

Serve as sponsor for the Collaborative Team
The word sponsorship is synonymous with the words backing, support, resources, and protection. Just as any professional ball team requires these from senior management your team will require these from you. When they meet obstacles that impede their progress, they will need you to remove them.

Select a team
Using the team selection information in this preparation manual you should be able to select a high performing team.

Serve as a champion to spread of positive changes
Your team will generate positive results on a small population of patients. A major role of senior leadership is to guide the spread of these changes through the whole organization. This includes engaging the board and its support, planning for spread, and removing obstacles to change in the organization.

Attend, at a minimum, the first and third Learning Sessions
Learning Session 1 is where the foundation is laid for the years to come. You will learn about the exciting Collaborative Care and Improvement Models. You will also have an opportunity to network with other senior leaders. Learning Session 3 will provide you with insight on spread techniques for making widespread improvements within your practice or organization.

Make Improvement a Priority
Set the tone for the team and the organization that improvement is important and tie it to the strategic plan of the practice/organization. Provide the team with time to meet. Convey the message that improvement is part of each member’s regular job and not an “add on”.

Monitor the progress of the TEAM
Teams often have a difficult time coalescing and may sometimes get off track. Teams can also lose perspective in terms of being sensitive to time and progress. A key role of leadership is to monitor team progress. Check-in with the team leader regularly. Depending on the characteristics or your practice or organization, attend one or all of the Collaborative team meetings. Review monthly data reports due to the Collaborative Director.
• Communicate to staff how the Collaborative reinforces practice/organizational strategic goals
• Identify the core Collaborative team
• Select and facilitate the selection of the team leader, or assume this role where capacity exists
• Determine and acquire needed resources
• Provide feedback to the team during the Preparation Phase to:
  ✓ Prepare an aim statement (must align with the practice organizational strategic plan)
  ✓ Identify the population of focus

Responsibilities during the project:

• Meet regularly with the core Collaborative team
• Review monthly data reports expected by the Collaborative Director
• Develop and improve systems that allow team members to bring about change. This includes opening communication lines between the team and the rest of the organization
• Ensure that changes made by the team are followed up and sustained
• Implement changes that the team does not have the authority to make
Glossary of Terms and Concepts

**Action Period**
The time between Learning Sessions when teams actively work on testing changes and applying improvements in their practices/organizations. Teams are supported by Faculty, the Collaborative staff, and a Virtual Community of Practice which includes monthly conference calls, listserv discussions, website access, webinars, and site visits as required.

**Aim or Aim statement**
A written, measurable, and time specific statement of the accomplishments a team expects to make from its improvement efforts. The aim statement contains a general description of the work, the population of focus, and the numerical goals.

**Annotated Run Chart**
A line chart showing results of improvement efforts plotted over time. The changes made are also noted on the line chart at the time they occur. This allows the viewer to connect changes made with specific results.

**Assessment Scale**
A numerical scale used to assess the progress of participating teams toward reaching their aim. 1 = forming, and 5 = outstanding, sustainable improvement. In each Collaborative, Collaborative staff assess teams and ask them to evaluate their own progress using this scale. The expected level of attainment by the end of the Collaborative is a 4.0 (significant progress).

**Chair**
The leader (or leaders) of the Collaborative, usually an expert in the topic.

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

**Change Concept**
A general idea for changing a process, usually developed by an expert panel based on literature and practical application of evidence. Change concepts are usually at a high level of abstraction, but evoke multiple specific ideas for how to change processes. “Simplify,” “reduce handoffs,” “consider all parties as part of the same system,” are all examples of change concepts.
Change Idea
An actionable, specific idea for changing a process. Change ideas can be tested to determine whether they result in improvements in the local environment (e.g., simplify the process for data entry by having front desk staff enter visit information daily from a duplicate copy while the original is filed in the chart).

Change Package
An evidence-based collection of change concepts and key changes.

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

Collaborative Leadership and Faculty
The group of experts on the topic who assist the chairmen in developing the Collaborative and in teaching and coaching participating teams.

Collaborative Team
All individuals from the participating organizations that drive and participate in the improvement process. A core team of three to four individuals attends the learning sessions, but a larger team, often from various disciplines, participates in the improvement process in the organization.

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

Core Collaborative Team Members
The members are those individuals who attend the Learning Sessions and are accountable to the senior leadership for the work of the collaborative.

Cycle
See “PDSA cycle”

Data Collection Plan
A specific description of the data to be collected, the interval of data collection, and the subjects from whom the data will be collected. The plan is included in all senior leader reports.

Day-to-Day Leader or Key Contact
This person manages the team, arranges meetings, assures tests are being completed, and data are collected. The day-to-day leader will be the critical driving component of the team, assuring that tests of
change are implemented and overseeing data collection. It is important that this person understand not only the details of the system, but also the various effects of making change(s) in the system. This individual also needs to be able to work effectively with the physician champion(s). The day-to-day leader will be the “key contact” at your organization. This individual should be responsible for coordinating communications between the team, the Sponsorship Team and staff. Usually requires 0.25 FTEs or more to complete this role.

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

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

**Electronic mailing list, or e-mail list**
A communication system that allows teams to stay connected with the leadership team and each other during the action periods. Sharing information, getting questions answered and solving problems are all part of e-mail list activity.

**Expanded Chronic Care Model**
A model that represents the ideal system of healthcare for people with chronic disease and an approach to re-designing healthcare to mirror that ideal system. Developed by Improving Chronic Illness Care, the model has six components: community resources and policies, healthcare organization, self-management support, decision support, delivery system design, and clinical information systems.

**Implementation**
Taking a change and making it a permanent part of the system. A change may be tested first and then implemented throughout the organization.

**Information Systems (IS)**
Refers to the information system of an organization, usually the computerized information system.

**Key Changes**
The list of essential process changes that will help lead to breakthrough improvement. Key changes are more focused and detailed than change concepts, but they are not specific to the local environment like change ideas. An example of a key change is, “Enter data into registry regularly.”
**Key Contact**  
The individual on the organization team who takes responsibility for communication between the team and the Collaborative staff, including reporting monthly and disseminating information to team members.

**Learning Session**  
A three day meeting during which participating organization teams meet with Faculty and collaborate to learn key changes in the topic area, including how to implement them, an approach for accelerating improvement, and a method for overcoming obstacles to change. Teams leave these meetings with new knowledge, skills, and materials that prepare them to make immediate changes.

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

**Measure**  
A focused, reportable unit that will help a team monitor its progress toward achieving its aim. The Collaborative has a list of required key measures for each condition, as well as a list of additional key measures that have been found to be helpful to the team in achieving excellent results.

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

**PDSA Cycle**  
Another name for a cycle (structured trial) of a change, which includes four phases: Plan, Do, Study, and Act. The PDSA cycle will naturally lead to the “plan” component of a subsequent cycle.

**Pilot Site**  
The clinic location for focused changes. After implementation and refinement, the process will be spread to additional locations.

**Population of Focus (POF)**  
A designated set of patients who will be tracked to determine whether changes have resulted in improvements. The ideal size for the STOP HIV/AIDS Collaborative is between 100-300 patients, with exceptions expected where a panel of patients is fewer than 100 or where the single panel for a single provider exceeds 300. It is this sub-population that will then be the focus of the change in practice for the duration of the Collaborative.
**Preparation**
The time before the first Learning Session when teams prepare for their work in the Collaborative. Preparation activities include attending Collaborative conference calls, forming a team, registering for the first Learning Session, scheduling initial meetings, preparing an aim statement, defining a Population of Focus, and collecting baseline measures.

**Run Chart**
See “annotated run chart.”

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

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

**Storyboard**
The board that displays information about a team and its progress and that is displayed at Learning Sessions to help create an environment conducive to sharing and learning from the experiences of others. For more information, see the “Completing Preparation” section.

**System Leader**
The core team member who has direct authority to allocate the time and resources to achieve the team’s aim, has direct authority over the particular systems affected by the change, and will champion the spread of successful changes throughout the department or service area. The system leader attends all three learning sessions.

**Team**
The group of individuals, usually from multiple disciplines that drive and participate in the improvement process. A core team of at least three individuals attends the Learning Sessions, but a larger team of people participates in the improvement process in the organization.

**Technical Expert**
The team member in the organization who has a strong understanding of the process to be improved and changes to be made. A technical expert may also provide expertise in process improvement, data collection and analysis, and team function.
Test
A small-scale trial of a new approach or a new process. A test is designed to learn if the change results in improvement, and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA cycles.

Website
A communication system that allows teams to stay connected with the Virtual Community of Practice during Action Periods. Sharing information, posing questions, and solving problems are all part of website activity.
Resource Section

The resource section includes the following items:

- Team Dynamics
- Getting the most from your team
- Organizing the Team
- Organizational Team Documentation
  - Team meeting documentation
  - Project notebook
  - Senior leader reports
  - PDSA worksheet

Team Dynamics

All teams, as part of their development, go through different stages as they develop into a high performing team. It is helpful to recognize these stages to ensure they do not interfere with the work of the Collaborative.

Source: The One-Minute Manager Builds High Performance Teams

Stage 1 Orientation

- Eager with high expectations
- Anxiety about fit and expectations
- Testing situation and central figures
- Depending on authority and hierarchy
- Needing to find a place and establish oneself

Stage 2 Dissatisfaction

- Discrepancy between hopes and reality
- Dissatisfied with dependency on authority
- Angry about goals, tasks and action plans
- Feeling incompetent and confused
- Negative towards leaders and teams
- Competing for power and/or attention
- Experiencing dependence/counter-dependence

Stage 3 Resolution
• Decreasing dissatisfaction
• Resolving discrepancies between expectations and reality
• Resolving animosities and polarities
• Developing harmony, trust, support and respect
• Developing self-esteem and confidence
• Being more open and giving more feedback
• Sharing responsibility and control
• Using team language

Stage 4 Production

• Excited about participation
• Work collaboratively and inter-dependently
• Feeling team strength
• Showing high confidence in accomplishing tasks
• Sharing leadership
• Feeling positive about task successes
• Performing at high levels

Teams are not static

• Teams can get stuck
• Teams can regress
• Teams can skip stages
• Large teams = more complex relationships and communications – more subgroups
• Team members must move from individual rewards/behavior to team behavior/rewards

Getting the Most from Your Team

Leaders have a lot to consider in developing the appropriate environment for improvement. In addition to setting up an environment for improvement, leaders also must build an infrastructure to drive and to support improvement in an organization. The infrastructure should drive, manage and support organizational improvement. A model for such an infrastructure would contain the following key activities:

• Strategic Planning – establish and communicate the purpose of the organization, conduct planning for improvement and integrate it into the business plan
• Develop a cooperative, connected network- view the organization or practice as a system
• Build capacity for improvement – design and manage a system for gathering information for improvement and sustaining the changes
• Executive Sponsorship – charter and coach individual and team improvement activities
• Technical support-advice from the experts outside the team
• Knowledge Management- developing a system to synthesize, integrated and spread knowledge so everyone in the organization is on the same page

Strategic Planning

Change requires direction. The leader is responsible for helping to align the work of the team with the key business of the practice/organization. If the work of the team is not linked to the overall strategy, then the work may become a time-limited endeavor. Constancy of purpose requires that every individual in the organization understands the purpose of the organization and how their role helps accomplish that purpose. Knowing and communicating the purpose of the organization provides the organization with this constancy of purpose. Linking the work of the team to the strategic vision will help your organization maintain a long term focus on improving clinical quality. Organizational leadership can support constancy of purpose by doing the following:

- Communicating the purpose (mission or vision statement) throughout the organization and how the team’s work helps accomplish the purpose
- Incorporating improvement activities into the strategic plan and business plan - plan for improvement
- Using the mission or vision statement to guide the aim of every improvement effort – the aim of the team should be linked to both the overall aim of the Collaborative and aligned with the overall vision and mission of the practice/organization
- Allocating resources for the team to accomplish the improvements, such as time to meet on a regular basis, a computer with internet access in the clinical area, equipment, or technical assistance from other members of the organization
- Balancing short-term needs with long-term improvements – the business plan must include improvement work or the work will never get done
- Providing opportunities for everyone in the organization to become involved with the improvement – as the team tests and defines the system of care, get everyone involved in the spread of improvement
- If the improvement work of the team is not related to the organization’s vision, strategic plan, business plan and performance improvement plan it cannot be sustained

Cooperative, Connected Network

Whatever it is called in your organization – QA, QI, CQI, PI, TQM – improvement efforts must be continuous, coordinated and focused on the organization’s purpose. The work of the team will be to raise important issues within the organization and to develop and to implement changes related to these issues. For lasting change to occur, the organization must view itself as a system and operate as a system. The interdependent group of departments (lab, pharmacy, front office, medical records, and nursing to name a few) composes the practice/organization. Viewing the practice/organization as a
system or a connected network requires relating each of these groups back to the common purpose and how the team relates to that purpose. Changes in one area may have impact on another and as the team tests the changes they will need cooperation and objective feedback from individuals in these other departments. The team will have a set of measures, related to HIV/AIDS care, that provide indicators of present performance and predictors of how the system will perform in the future. These measures, as well as tests of change are to be documented and forwarded to the Collaborative Director. Integrating this information into the system’s ongoing improvement activities provides the opportunity for everyone to understand the team’s work and to provide assistance as needed. This also increases the view that improvement is everyone’s responsibility – not just that of the Collaborative team. The leader role is to make this happen.

Building Capacity for Improvement

Sustained improvement can only be accomplished by purposeful planning and testing, and by deliberate actions to fully integrate these changes into systems. Initial investments in resources to support teams in applying changes leading to improvements using the Collaborative model and the Model for Improvement increase the probability that improvements are sustainable and can be duplicated in other domains of care. This has been demonstrated as practices/organizations that have learned and practiced improvement skills, tools, and models have made significant improvements in the outcomes of a number of diseases beyond those which they initially commenced their improvement efforts (e.g., asthma, diabetes, depression). In short, this improvement methodology must be translated into an improvement culture that permeates the entire organization. Practice/organizational leaders can take action to build capacity for improvement by:

- Publicizing the work of the team – there are many ways to accomplish this, some posted their storyboard in an area trafficked by staff, some posted improvement results in the staff break room or bathrooms
- Involving and training other staff – the core team has a responsibility to train others in the skills and the tools of the Collaborative
- Supporting the team – if senior leaders clearly acknowledges the importance of the work of the team it becomes an organizational priority
- Integrating the models into the performance improvement plan – the models must become a way of life in the practice/organization, collaborative work cannot stand alone if it is to be sustained
- Reporting the team’s progress to the Board, external stakeholders, and the community
- Planning for spreading improvement work throughout the practice/organization
Executive Sponsor

When obstacles impede the progress of the team, they will need senior leadership to remove them. Micro-management of the team is not an expectation – you have selected individuals you trust to get the work done. Oversight involvement is important, knowing what obstacles the team faces and removing them is a responsibility of the executive sponsor. Some attend team meetings, some meet with the team leader for updates. This depends on the leadership style of the executive sponsor. However it is accomplished, the team must have easy planned access to the executive sponsor.

Technical support

The team will need ad hoc members to provide technical expertise that is needed to test improvements. They will also need assistance around computer and software use.

Knowledge Management

Improvement efforts generate a large body of knowledge and insight including lessons learned, failed tests, and successful tests. Testing on a small scale creates a low risk environment for learning. This knowledge will be shared with the Virtual Community of Practice and is important for the organization. Important processes to be developed as part of knowledge management:

- Communicate and publicize the team’s effort to all staff in the practice/organization – reports provided to the Collaborative Director or storyboards are effective ways to accomplish this task
- Develop a Collaborative Notebook that includes the reports, tests and work plans of the team – this historical data will be invaluable to current and future teams, as well as a means of presenting the improvement work to external reviewers
- Create a process for training other staff in improvement methodologies
- Integrate the models into new staff/provider orientation training and packages
- As improvement are made, make sure the “old” way of doing things do not remain an alternative

Organizing the Team

The First Team Meeting

Establish the ground rules. These are the rules that a team makes to govern itself and to define the behavior that is expected of all team members. **THIS IS AN IMPORTANT STEP – DON’T SKIP IT!**
Basic Ground Rules to Be Addressed

- **Attendance**: a high priority is set on attendance. Discuss what are the legitimate reasons for missing a meeting and establish a procedure for informing the team leader of the member’s absence.

- **Promptness**: meetings start and end on time. Expect that everyone be on time for meetings. Make it clear that the meeting will not wait for anyone to respect the time of each member.

- **Meeting time and place**: specify a regular meeting time and place, establish a procedure for notifying members of the meetings.

- **Participation**: the contribution of every team member is important. Establish the importance of speaking freely and listening attentively.

- **Basic conversational courtesies**: listen attentively and respectfully to others. Do not interrupt. Team Leaders holds the right to halt members who do not adhere to the rules.

- **Assignments**: since much of the team’s work is done between meetings, members must be accountable for completing their assignments on time and reporting back to the teams.

- **Interruptions**: Apply the ‘100 mile rule’: interruptions are not accepted and members should not be called out of meetings unless the matter is so urgent that the same would have occurred had the member travelled 100 miles to attend the meeting.

- **Rotation of chores**: determine a rotation of routine housekeeping chores for all team members, so no one feels overwhelmed or stuck.

- **Agendas, minutes, & records**: although the Team Leader is ultimately responsible for these activities—others may be assigned the tasks, decide how these will be handled in your team.

- **Other ground rules**: add any others that the team may feel are appropriate.

Note: Team members who show a pattern of breaking the rules of the group may need to be replaced. The intensity, amount of work and timeframe of the Collaborative require **ALL** members to carry their weight AND be committed to the work of the team.

Set the Meeting Schedule

In order to accomplish the work of the Collaborative, the team will need a time and place **set aside to meet on a regularly SCHEDULED basis**. It is vital that a regular meeting schedule be developed. Haphazard meeting times or hallway meetings will not produce a highly effective team. Initially, the team will need to meet more frequently, but as the work progresses the meetings will be less frequent.

General Meeting Rules

Consider these as you set your ground rules:

- Use and stick to agendas
- Start and end on time
- Have a facilitator (team leader’s role) to keep things on track
- Take minutes
- Draft next agenda at the end of meeting
Evaluate the meeting —obtain feedback at the meeting, were objectives met. Did the meeting move you closer to your aims? Did you plan or study a test cycle? Did you utilize the EPIC model?

Adhere to the 100-MILE RULE—no one should be called from the meeting unless the interruption is so important that it would still occur if the meetings were 100 miles away.

Effective Discussion Skills for Team Members

- Ask for clarification—keep it simple and clear
- Act as gatekeepers—no one dominates the discussion, expect equal participation among members
- Listen—actively explore other’s ideas rather than debating or defending each idea
- Summarize—compile what has been said, restate it to the group with a question to check for agreement
- Contain digression—disallow over long examples or irrelevant discussions
- Manage time—stay on time with the agenda, if items go over recognize that others will be cut short
- End the discussion—learn to tell when nothing further can be gained and end it
- Test for consensus—state decisions made and check that team agrees
- Constantly evaluate the meeting process—ask yourselves:
  1. Are we getting what we want from the discussion? If not, what can we do differently in the remaining time?
  2. Are we on track?
  3. Are we being effective?

Organizational Team Documentation

Documentation of the team’s work is an important part of the Collaborative process. The team needs the documentation to track their progress and what has been tested. The practice/organization needs the documentation to see the work of the team, to promote the improvements and gain staff buy-in, and to integrate the Collaborative as part of the organization’s Performance Improvement (PI) Program. Many teams have successfully used this documentation as part of their accreditation process. Anticipated documentation includes:

- Agendas and minutes for team meetings;
- Project Notebook;
- Storyboard; and
- Data reports to the Collaborative Director
Team Meeting Documentation

- AGENDAS: Purpose is to structure meeting, provide timeline for meeting and document topics of discussion at meeting

### Agenda Example

<table>
<thead>
<tr>
<th>Collaborative Team Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date of Meeting:</strong></td>
</tr>
<tr>
<td><strong>Time of Meeting:</strong></td>
</tr>
<tr>
<td><strong>Conference Call</strong></td>
</tr>
<tr>
<td><strong>Location of Call In Number</strong></td>
</tr>
</tbody>
</table>

**Expected Attendees**

**Facilitator:**

<table>
<thead>
<tr>
<th>----- Agenda Topics -----</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Roll Call</td>
</tr>
<tr>
<td>II. Introductions</td>
</tr>
<tr>
<td>III. Overview of Project</td>
</tr>
<tr>
<td>IV. Team Development</td>
</tr>
<tr>
<td>V. Project Notebook</td>
</tr>
<tr>
<td>VI. Q&amp;A</td>
</tr>
<tr>
<td>VII. Adjourn</td>
</tr>
</tbody>
</table>

**Other Information**

- MINUTES: Purpose is to document discussion, actions, findings and decisions of team, as well as future actions required.
  1. Provide historical information for future teams looking at a similar process.
  2. Best format is one that allows for documentation of:
     - Topic discussed;
     - Discussion;
Conclusions/findings;
Actions required;
Responsible person; and
State expected for completion of actions.

## Minutes Example

<table>
<thead>
<tr>
<th>PARTICIPANTS</th>
<th>AGENDA ITEM</th>
<th>DISCUSSION</th>
<th>DECISION/ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>Agenda Item</td>
<td>Any key items of discussion or how something is to be done</td>
<td>What is to be done By whom Date expected to be done</td>
</tr>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEAM MEMBER NAME</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEAM MEMBER NAME</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEAM MEMBER NAME</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEAM MEMBER NAME</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEAM MEMBER NAME</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEAM MEMBER NAME</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEAM MEMBER NAME</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEAM MEMBER NAME</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Agenda Item
3. Agenda Item
4. Agenda Item
5. Agenda Item
6. Agenda Item
7. Agenda Item
8. Agenda Item
9. Next Meeting/Call
Project Notebook

This is **not** a requirement of the Collaborative, but it will assist you if you plan to present this as a clinical improvement project for an accreditation body.

Set up a notebook with these tabs:

- **Team meetings**: agenda for each meeting concurrently dated and signed minutes for each meeting.
- **Project Aim**
- **Situation Analysis**: demographics about the impact of specific chronic disease in your patient population.
- **Data Collection & Analysis**: File a copy of your monthly reports behind this tab. Include narrative, registry summary reports, and graphs.
- **Project Plans and Action plans**: For each action period you will be expected to develop plans for that action period and will revise it over the course of the action period file these here.

*Note: All information must be integrated into your QI Program if you are seeking accreditation.*

Collaborative Team Data Reports

This report communicates and summarizes the activities, work of the team, and progress in meeting the stated aims. It is also the method the Collaborative Directors use to assess progress, define future Learning Session focus, and identify the support needs of teams. A third important use of these reports is to aggregate data as part of the evaluation of the entire Collaborative.

Each team must submit a monthly Team Data Report to be considered active in the Collaborative and to be eligible to attend the Learning Sessions. The specific format of the report and the date for submission will be communicated to teams during the preparation phase of the Collaborative.