



**Health Resources and Services Administration (HRSA)
Ryan White HIV/AIDS Program (RWHAP)
Center for Quality Improvement & Innovation (CQII)**

**Concept Paper:
CQII Care Collaborative | Linking and Re-engaging
People with HIV Who Are Out of Care**

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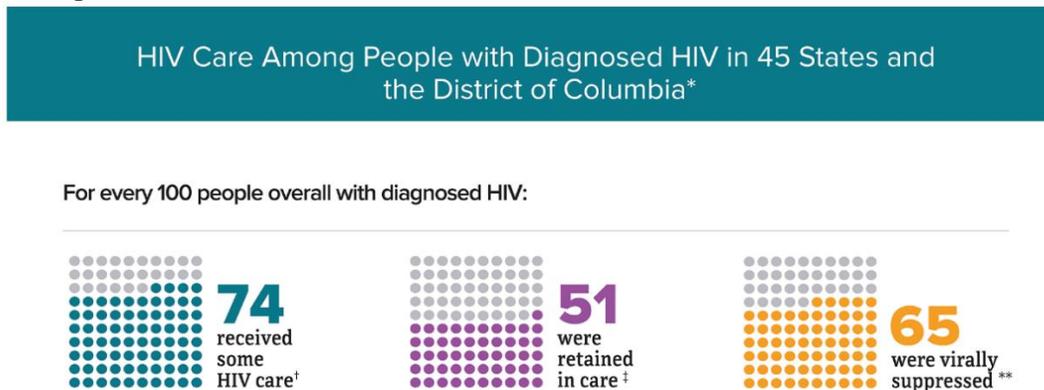
Concept Paper: CQII Care Collaborative | Linking and Re-engaging People with HIV Who Are Out of Care

Background

The Ryan White HIV/AIDS Program (RWHAP) provides critical healthcare and support services to over half a million people with HIV in the United States, accounting for more than half of the country's diagnosed HIV population.¹ Despite this extensive federal support, only 74% of all people with diagnosed HIV have received HIV care, with only one of two individuals retained in continuous care.²

Out of care individuals are a public health priority as they face higher risks of poor health outcomes, such as uncontrolled viral loads and increased susceptibility to opportunistic infections.³ For the purpose of the upcoming CQII Care Collaborative, individuals who are out of care include those who are not linked to care following their HIV diagnosis, and those who were previously, but not currently, engaged in HIV medical care. The risks associated with disengagement from care also heightens the risk of forward HIV transmissions to others. By re-engaging these individuals, HIV providers can improve health outcomes and quality of life and mitigate the impact of the epidemic.⁴ Prioritizing this is vital to advancing public health strategies and achieving the ambitious goals set forth in the National HIV/AIDS Strategy⁵ to prevent new HIV infections, improve health outcomes for people with HIV, reduce HIV-related disparities and health inequities, and create a unified and effective response to the HIV epidemic.

Figure 1: Diagnosis-based HIV Care Continuum⁶



¹ Health Resources and Services Administration. (2023). Ryan White HIV/AIDS program annual client-level data report: 2022. U.S. Department of Health and Human Services.

² Padilla, M., Carter, B., Gutierrez, M., & Fagan, J. (2022). The Boundary of HIV Care: Barriers and Facilitators to Care Engagement Among People with HIV in the United States. *AIDS patient care and STDs*, 36(8), 321–331. <https://doi.org/10.1089/apc.2022.0062>

³ Dombrowski, J. C., Galagan, S. R., Ramchandani, M., Dhanireddy, S., Harrington, R. D., Moore, A., Hara, K., Eastment, M., & Golden, M. R. (2019). HIV Care for Patients With Complex Needs: A Controlled Evaluation of a Walk-In, Incentivized Care Model. *Open forum infectious diseases*, 6(7), ofz294. <https://doi.org/10.1093/ofid/ofz294>

⁴ Bouabida, K., Chaves, B. G., & Anane, E. (2023). Challenges and barriers to HIV care engagement and care cascade: viewpoint. *Frontiers in reproductive health*, 5, 1201087. <https://doi.org/10.3389/frph.2023.1201087>

⁵ Zang, X., Jalal, H., Krebs, E., Pandya, A., Zhou, H., Enns, B., & Nosyk, B. (2020). Prioritizing Additional Data Collection to Reduce Decision Uncertainty in the HIV/AIDS Response in 6 US Cities: A Value of Information Analysis. *Value in health: the journal of the International Society for Pharmacoeconomics and Outcomes Research*, 23(12), 1534–1542. <https://doi.org/10.1016/j.jval.2020.06.013>

⁶ HIV.gov. (n.d.). HIV/AIDS care continuum. U.S. Department of Health and Human Services. <https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum>

There are multifaceted barriers to link and retain people with HIV who are out of HIV care, each contributing to the complex challenges of maintaining consistent HIV treatment.⁷ Demographic factors, such as race, ethnicity, and age can influence access to and engagement in healthcare services. Social determinants of health (SDOH), such as poverty, lack of insurance, housing instability, food insecurity, and racism can severely impact an individual's ability to maintain regular care. Co-occurring conditions, including mental health and substance use disorders, lack of access to an HIV care provider, or mistrust with providers and the healthcare system, further complicate routine access to care.^{8,9} Individuals living in rural or underserved areas face additional difficulties accessing specialized HIV care and support services.¹⁰

Addressing these multifaceted barriers requires a comprehensive and syndemic¹¹ approach that considers and integrates various factors to improve linkage and retention rates so that people with HIV receive the continuous care they need.¹² By understanding and tackling these obstacles, healthcare systems can develop focused and person-centered strategies to enhance care delivery, reduce disparities, improve patient experiences with the healthcare system and providers, and improve health outcomes for people with HIV.

A more detailed literature review was conducted by CQII in preparation for the upcoming *Care Collaborative*. It is titled *Literature Review: Barriers and Facilitators of People with HIV Who Are Out of HIV Care and Implications for a National Learning Collaborative* and is available upon request.

Learning Collaborative Framework

Peer learning is an opportunity to draw on the expertise of others and is a powerful mechanism for accelerating the spread of effective programming¹³ to have a ‘collective impact.’¹⁴ Learning collaboratives are an evidence-based methodology that creates learning communities designed to achieve rapid scale-up of improvement across health care facilities. The Institute for Healthcare Improvement (IHI) developed the Breakthrough Series¹⁵ in 1994 to help health care organizations make “breakthrough” improvements in quality while reducing costs.

⁷ Mgbako, O., Conard, R., Mellins, C. A., Dacus, J. D., & Remien, R. H. (2022). A Systematic Review of Factors Critical for HIV Health Literacy, ART Adherence and Retention in Care in the U.S. for Racial and Ethnic Minorities. *AIDS and behavior*, 26(11), 3480–3493. <https://doi.org/10.1007/s10461-022-03680-y>

⁸ Anderson, A. N., Higgins, C. M., Haardörfer, R., Holstad, M. M., Nguyen, M. L. T., & Waldrop-Valverde, D. (2020). Disparities in Retention in Care Among Adults Living with HIV/AIDS: A Systematic Review. *AIDS and behavior*, 24(4), 985–997. <https://doi.org/10.1007/s10461-019-02679-2>

⁹ Dasgupta, S., Weiser, J., Craw, J., Tie, Y., & Beer, L. (2020). Systematic monitoring of retention in care in U.S.-based HIV care facilities. *AIDS care*, 32(1), 113–118. <https://doi.org/10.1080/09540121.2019.1619660>

¹⁰ Centers for Disease Control and Prevention. (n.d.). HIV data & research: Facts and statistics. Centers for Disease Control and Prevention. <https://www.cdc.gov/hiv/data-research/facts-stats/index.html>

¹¹ Bhardwaj, A., & Kohrt, B. A. (2020, July). Syndemics of HIV with mental illness and other noncommunicable diseases. *Current Opinion in HIV and AIDS*. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7539237/>

¹² Brawner, B. M., Guthrie, B., Stevens, R., Taylor, L., Eberhart, M., & Schensul, J. J. (2017). Place Still Matters: Racial/Ethnic and Geographic Disparities in HIV Transmission and Disease Burden. *Journal of urban health : bulletin of the New York Academy of Medicine*, 94(5), 716–729. <https://doi.org/10.1007/s11524-017-0198-2>

¹³ Dudgeon, D., Knott, C., Chapman, C., [et al.]. (2009). Development, implementation, and process evaluation of a regional palliative care QI project. *Journal of Pain and Symptom Management*, 38, 483-495. <https://doi.org/10.1016/j.jpainsymman.2009.04.017>

¹⁴ Collective Impact Forum. (n.d.). Collective impact. Stanford Social Innovation Review. Retrieved from https://ssir.org/articles/entry/collective_impact

¹⁵ Institute for Healthcare Improvement. The Breakthrough Series: IHI’s Collaborative Model for Achieving Breakthrough Improvement. 2003. Available at <http://www.ihl.org/IHI/Results/WhitePapers>

Since 2004, CQII, formerly known as the National Quality Center (NQC), has managed nine national collaboratives (see *Table 1*) in partnership with the HRSA HIV/AIDS Bureau (HAB), using the “all teach, all learn, all improve” approach.¹⁶ The following elements were applied to all CQII collaboratives so far, consistent with the IHI model:¹⁷ ten to 200 RWHAP recipient teams of similar needs participate; collaboratives last between 12 to 24 months; one to two day learning sessions are held every three to six 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 quality improvement experts.

These unique experiences with collaboratives resulted in publications by CQII: *NQC Guide: Planning and Implementing a Successful Learning Collaborative*,¹⁸ *Cross-Part Quality Management Guide: Collaborating across Ryan White Funding Streams to Improve HIV Care*,¹⁹ and *Guide to Conducting a Virtual QI Collaborative-Lessons Learned from the end+disparities ECHO Collaborative*.²⁰

Table 1: CQII-Led Learning Collaboratives (2004-2024)

Collaborative	Timeframe	RWHAP Recipients	Reach of People with HIV
Part B Collaborative	Nov 2004-Nov 2006	8 State Departments of Health	129,000
Low Incidence Collaborative	Jun 2006-May 2008	17 State Departments of Health	20,000
TGA Initiative	Jun 2008-Oct 2009	5 City Departments of Health	19,880
Cross-Part Collaborative	Oct 2008-Apr 2010	91 Part A-F recipients from 5 States	192,018
D.C. Collaborative	Mar 2011-Jun 2012	19 recipients in 2 states and the D.C.	35,642
H4C Collaborative	Mar 2014-Jan 2016	55 Part A-F recipients from 5 States	76,990
end+disparities ECHO Collaborative	Jun 2018-Dec 2019	200 Part A, B, C, and D recipients from 31 States/Territories	138,826
create+equity Collaborative	Jan 2021-Jun 2022	83 Part A, B, C, and D recipients from 29 States/Territories	95,071
Impact Now Collaborative	Jan 2023- Jun 2024	23 Part A-D sites from 11 States	53,694

More importantly, engagement in these collaboratives was associated with measurable improvements in health outcomes. In the *create+equity Collaborative* (Jan 2021 to Jun 2022), CQII engaged 83 recipients to focus on viral suppression rates among affected populations including those with housing, substance use, and mental health needs. Based on data from ~60,000 patients, the viral suppression rate significantly increased for these patient groups in comparison to other patients seen by the same sites.²¹ The most recent CQII *Impact Now Collaborative* (January 2023 to June 2024) focused on RWHAP recipients and subrecipients that had the potential to make the largest gains by raising the viral suppression rates of clients receiving HIV medical care in their organizations to the national mean and beyond. Data suggest

¹⁶ Health Care Management Review. (2012). April/June 2012 - Volume 37 - Issue 2, 154–164.

¹⁷ Baker, GR., Collaborating for Improvement: The IHI’s Breakthrough Series. New Med. 1997;1:5-8.

¹⁸ 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>.

¹⁹ Cross-Part Quality Management Guide: Using Collaboratives across Ryan White Funding Streams to Improve HIV Care. National Quality Center (NQC). <https://targethiv.org/library/cross-part-quality-management-guide-collaborating-across-ryan-white-funding-streams-improve>.

²⁰ 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>.

²¹ Weinberg, S. (Ed.). (2023). *Findings from the create+equity Learning Collaborative*. AIDS Institute. Report submitted to HIV/AIDS Bureau for approval, Unpublished.

measurable viral suppression rate improvements by participating sites (~53,000 patients) by 3.10 percentage points, from 84.64% at baseline (Mar 2023) to 87.74% in Jun 2024.²²

Care Collaborative

Introduction

The next national CQII learning collaborative, called the *Care Collaborative*, will address critical challenges and gaps in HIV care among people. This collaborative, commencing January 2025 and concluding October 2026, will focus on five key areas to improve health outcomes for those who are out of HIV medical care, who are either newly diagnosed with HIV (linkage to care) or out of ongoing HIV medical care (retention in care). This collaborative will focus on six key areas to improve health outcomes for those who out of HIV medical care:

1. **Linkage to Care.** The goal is to ensure patients have an HIV medical care encounter within 30 days of the HIV diagnosis.²³ Currently, 19% of people with diagnosed HIV are not linked to care within the first month of HIV diagnosis.²⁴ The 2022 RWHAP Services Report (RSR) data highlight that certain populations, such as younger clients (aged 13-24) and transgender individuals, have lower rates of timely linkage to care. Specifically, 76.2% of young clients were linked to care within 30 days, compared to 80.5% overall. Research shows the sooner an individual is linked to care the better their adherence and retention rates.²⁵
2. **Retention in Care.** The goal is to ensure that patients with a diagnosis of HIV attend at least two medical encounters, spaced at least 90 days apart, each year.²⁶ National improvement goals aim to have 95% of people with HIV retained in care. The current estimated national rate of all people with HIV in the United States suggests that only 57% of people with HIV are retained in care.²⁷ Retention in care remains a challenge, particularly among certain racial and ethnic minority groups.²⁸ According to the 2022 RSR, Black/African American clients aged 20-39 and younger clients aged 13-24 have lower retention rates, with only 71.1% of Black/African American clients and 66.7% of younger clients retained in care, compared to 74.5% overall. Retention in care can be a predictor for antiretroviral therapy (ART) adherence and viral suppression.^{29, 30}

²² Weinberg, S. (Ed.). (2024). *Findings from the Impact Now Collaborative*. AIDS Institute. Report submitted to HIV/AIDS Bureau for approval, Unpublished.

²³ U.S. Department of Health and Human Services. (2023). *Guidelines for the use of antiretroviral agents in adults and adolescents with HIV*. <https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/adult-adolescent-arv/guidelines-adult-adolescent-arv.pdf>

²⁴ The White House. (2021). *National HIV/AIDS strategy: Update to the 2020-2025*. <https://www.whitehouse.gov/wp-content/uploads/2021/11/National-HIV-AIDS-Strategy.pdf>

²⁵ Gillot, M., et al. (2022). Linkage to HIV medical care and social determinants of health among adults with diagnosed HIV infection in 41 states and the District of Columbia, 2017. *Public Health Reports*, 137(5), 888–900. <https://doi.org/10.1177/00333549221121537>

²⁶ Health Resources and Services Administration. (n.d.). *Annual Retention in Care*. Ryan White HIV/AIDS Program. <https://ryanwhite.hrsa.gov/grants/performance-measure-portfolio/core-measures/annual-retention-in-care>

²⁷ U.S. Department of Health and Human Services. (2023). *Guidelines for the use of antiretroviral agents in adults and adolescents with HIV*. <https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/adult-adolescent-arv/guidelines-adult-adolescent-arv.pdf>

²⁸ Anderson, A. N. (2020). Disparities in Retention in Care Among Adults Living with HIV/AIDS: A Systematic Review. *AIDS and behavior*, 24(4), 985–997. <https://doi.org/10.1007/s10461-019-02679-2>

²⁹ Padilla, M., Carter, B., Gutierrez, M., & Fagan, J. (2022). The Boundary of HIV Care: Barriers and Facilitators to Care Engagement Among People with HIV in the United States. *AIDS patient care and STDs*, 36(8), 321–331. <https://doi.org/10.1089/apc.2022.0062>

³⁰ U.S. Department of Health and Human Services. (2023). *Guidelines for the use of antiretroviral agents in adults and adolescents with HIV*. <https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/adult-adolescent-arv/guidelines-adult-adolescent-arv.pdf>

3. **Viral Suppression.** The goal is to increase the percentage of patients with HIV to have an HIV viral load less than 200 copies/ml.³¹ The *Care Collaborative* emphasizes the importance of increasing the percentage of individuals who are supported to achieve viral suppression, the key indicator of effective HIV treatment. Viral suppression not only improves the health of the individual but also significantly reduces the risk of onward HIV transmissions.³² While reaching viral suppression is critical, disparities continue to exist. The 2023 RSR data show that while 89.6% of overall RWHAP clients reached viral suppression, lower rates were observed among Black/African American clients (87.1%) and younger clients aged 13-24 (80.1%).
4. **Quality Improvement (QI) Capacity:** The *Care Collaborative* is committed to strengthening the organizational capacity for QI among participating sites to meet and exceed the clinical quality management expectations set by the HRSA HAB. A standardized assessment tool will be routinely used to assess QI capacity. This tool includes the following dimensions: Quality Infrastructure (Program Leadership, Quality Management Committee, Staff Engagement in QI, Engagement of People with HIV); Performance Measurement (Performance Data Findings Are Used for QI); and QI Activities (QI Project Implementation, QI Project Outcomes). By increasing the percentage of participating sites that meet the quality management expectations, the collaborative will enhance their ability to meet the collaborative goals as well as external quality management requirements as outlined by the HRSA HAB in the Policy Clarification Notice 15-02.³³
5. **Patient Engagement in QI Efforts:** Recognizing the importance of involving people with HIV as equal partners in site-specific improvement efforts, the *Care Collaborative* strives to increase the number of participating sites that routinely and meaningfully engage people with HIV in improvement efforts. CQII developed the first ever validated *Client Involvement in Quality Improvement Toolkit (CIQIT)* to assess the involvement of patients in improvement efforts, which is currently under review by HRSA. Upon approval, this tool will be used in this national collaborative.
6. **Patient Experiences:** In addition, this collaborative will assess and measurably improve the HIV care experiences of those recently diagnosed or out of care with the healthcare system to foster a more patient-centered approach. A recently developed CQII guide, called the *Patient Reported Outcomes Measures [PROMs] and Patient Reported Experience Measures [PREMs] Guide*,³⁴ will be used in this collaborative to guide the selection and implementation of patient experience measures.

Collaborative Structure

The following *Table 2* provides a general overview of the *Care Collaborative* structure, audience, number of participants to be reached, and general timeline.

Table 2: Care Collaborative Structure

Care Collaborative Overview

³¹ Health Resources and Services Administration. (n.d.). *Viral Load Suppression*. Ryan White HIV/AIDS Program.

<https://ryanwhite.hrsa.gov/grants/performance-measure-portfolio/core-measures/hiv-viral-load-suppression>

³² Zandoni, B. C., & Mayer, K. H. (2014). The adolescent and young adult HIV cascade of care in the United States: Exaggerated health disparities. *AIDS Patient Care and STDs*, 28(3), 128–135. <https://doi.org/10.1089/apc.2013.0345>

³³ Health Resources and Services Administration. (2015). PCN 15-02: Clarification on the use of clinical quality measures (CQMs) in the Ryan White HIV/AIDS Program. U.S. Department of Health and Human Services.

<https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-02-cqm.pdf>

³⁴ Center for Quality Improvement and Innovation (CQII). (2024). PROMS and PREMs Guide: Patient-reported outcomes measures (PROMs) and patient-reported experience measures (PREMs). Retrieved from <https://targethiv.org/cqii/proms-prems-patient-reported-outcomes-measures-proms-and-patient-reported-experience>

Format	18-month national QI learning collaborative (Jan 2025 to Jun 2026) with five 2-day Learning Sessions and QI Group Sessions with assigned QI coaches; pre-work phase (Feb 2025 to Apr 2025).
Audience	Enrollment of RWHAP recipients and subrecipients with high caseload of patients and linkage and retention rates below the national average, recommendations from HRSA Project Officers, and individual applications by RWHAP recipients.
# of Participants	Up to 40 RWHAP recipients and subrecipients across Part A through Part D RWHAP funding streams.
Learning Session Dates	Design Meeting (virtual - Nov 2024); Learning Session 1 (in person - Jun 2025); Learning Session 2 (virtual - Oct 2025); Learning Session 3 (in person - Feb 2026); Learning Session 4 (virtual - Jun 2026); Learning Session 5 (in person - Oct 2026)
QI Coaching Sessions	QI coaches virtually meet with assigned group of participating sites twice a month, once in QI Group Session starting May 2025 and once during an individualized coaching session, and a pre-work QI Group Sessions (Feb 2025 to Apr 2025).
Reflection Sessions	Reflection Sessions are conducted every quarter with groups of participating sites to document site-specific QI activities, successes, and challenges.
Reporting	Reporting of linkage, retention, and viral suppression data every two months via CQII’s online database; reporting of QI activities and QI capacities at learning sessions.

Collaborative Aim and Goals

The overall aim of the *Care Collaborative* is to promote the application of QI methodologies and tools to measurably increase linkage to care, retention in care, and viral suppression rates for people with HIV served by RWHAP-funded recipients and subrecipients.

Mission of the Care Collaborative

“By October 2026, the Care Collaborative aims to equitably and meaningfully link and re-connect those people with HIV who are out of care to HIV medical care in order to measurably improve their HIV care outcomes and experiences with the healthcare system through the application of QI methodologies and tools.”

Goals of the Care Collaborative

- Clinical Improvements**
- *Increase the number of newly diagnosed individuals who are seen by a medical provider within 30 days of diagnosis (linkage) at participating sites to the national mean of 82% or 5% from baseline, whichever is higher.*
 - *Increase the number of HIV patients who had at least two HIV medical care encounters at least 90 days apart within the measurement year (annual retention) at participating sites to the national mean of 78% or 5% from baseline, whichever is higher.*
 - *Increase the number of patients with an HIV viral load less than 200 copies/ml at the last HIV viral load test during the measurement year (viral suppression) at participating sites to the national mean of 90% or 5% from baseline, whichever is higher.*

Process Improvements

- 90% of participating sites have implemented and documented testing changes across all primary drivers in the Care Collaborative driver diagram.
- 90% of participating sites have a person with lived experience actively on their local improvement team during the Care Collaborative.
- 90% of teams improve the involvement of people with HIV in QI activities as measured using a standardized assessment tool.
- 90% of teams have implemented a recommended patient experience measure to improve the experiences of those patients who are newly linked to and returning into HIV medical care with the healthcare system and providers.

To maximize the national impact among the portfolio of RWHAP providers, the *Care Collaborative* wishes to enroll up to 40 RWHAP recipients and subrecipients based on 2022 RSR data, recommendations from HRSA Project Officer, and site applications received. This number of sites will ensure that CQII has the resources needed to provide adequate support for each participating site to achieve a meaningful increase in linkage, retention, viral suppression, and engagement of people with HIV.

Those RWHAP recipients and subrecipients that are identified using the 2022 RSR data have the highest potential national gains if they raise linkage and retention rates to the national means and beyond. To determine these RWHAP recipients and subrecipients, the HIV caseloads and retention rates of RWHAP-funded recipients and subrecipients across the RWHAP funding streams will be analyzed using available, de-identified 2022 RSR data in advance of the collaborative. In addition, HRSA Project Officers will be consulted to suggest additional RWHAP recipients and subrecipients that would benefit from participation in this national QI collaborative. Individual applications by RWHAP recipients and subrecipients will also be considered to ensure the maximum number of 40 participating sites is reached.

Individual site-specific numeric improvement goals will be established by CQII in collaboration with each participating site at the start of the *Care Collaborative* (April 2025) to be reached by its end in October 2026: a) number of patients who are additionally linked to care within 30 days of HIV diagnosis; b) number of patients who are additionally retained in HIV care; and c) number of patients who are additionally virally suppressed. These individualized goals will be calculated by aiming to raise the participating site's linkage/retention/viral suppression rates to the national mean or 5% from baseline rates, whichever is higher.

Definitions

For the purposes of this collaborative, the following definitions are considered based on the HRSA HAB Performance Measure Portfolio:³⁵

- **Linkage to Care** refers to a patient, regardless of age, who has an HIV medical care encounter within 30 days of HIV diagnosis within a 12-month measurement year. [see Note 1]
 - **Patient Exclusions:** None.
 - **Note:** [1] An HIV medical care encounter is a medical visit with a provider with prescribing privileges or an HIV viral load or CD4 test.

³⁵ HRSA HIV/AIDS Bureau Performance Measurement Portfolio; <https://ryanwhite.hrsa.gov/grants/performance-measure-portfolio>

- **Standard of Care:** Administering antiretroviral therapy as soon as possible, ideally on same day, is the standard of care.³⁶
- **Retention in Care** refers to a patient, regardless of age, with a diagnosis of HIV attending at least two [see Note 2] medical encounters [see Note 3], spaced at least 90 days apart, within a 12-month measurement year. If a patient does not meet these criteria, they are considered ‘out of care.’
 - **Patient Exclusions:** Patients who expired during the measurement year; patients who became incarcerated during the measurement year; patients who relocated or transferred their HIV care with documentation in the medical record [4].
 - **Notes:** [2] At least one of the two HIV medical care encounters needs to be a medical visit with a provider with prescribing privileges. [3] An HIV medical care encounter is a medical visit with a provider with prescribing privileges or an HIV viral load test. [4] The following exclusions are not included in the current HRSA retention indicator definition: patients who became incarcerated during the measurement year.
- **Viral Suppression** rate refers to the percentage of patients, regardless of age, with a diagnosis of HIV with an HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year.
 - **Patient Exclusions:** Patients who expired during the measurement year; patients who became incarcerated during the measurement year; patients who relocated or transferred their HIV care with documentation in the medical record.

Key Collaborative Elements

Planning Group. To develop the conceptual outline for this upcoming collaborative, CQII has convened a Planning Group since August 2024, which is comprised of QI coaches with previous learning collaborative expertise, people with lived experience, and CQII staff. This group meets weekly and will continue to do so through April 2025, to discuss various key aspects and approaches crucial for the successful development and implementation of the *Care Collaborative*. The exchanges have vitally informed the development of this concept paper and the overall planning of the *Care Collaborative*. Upon the launch of the collaborative, the Planning Group membership will be revisited to ensure the inclusion of various perspectives, including CQII staff, QI coaches, content experts, people with HIV representing various community voices, HAB representatives, and other stakeholders, as needed. This group will guide the further planning and implementation of the *Care Collaborative* and will continue to meet virtually on a weekly basis.

QI Coaching Model. QI coaches will play a principal role throughout the *Care Collaborative* to provide ongoing support and technical assistance. They will be assigned to participating sites and provide direct coaching to meet the objectives as outlined in each site’s individualized aim statement. Each QI coach will be assigned approximately five participating sites (forming a QI Coaching Group) and will have assigned CQII staff for support. In total, approximately eight nationally recognized QI experts will be contracted by CQII as QI coaches based on extensive expertise in QI and experience with coaching sites participating in learning collaboratives. Offering a unique blend of personal insight, cultural competence, and expertise, QI coaches with lived experience will be assigned to each QI Coaching Group to provide content expertise to advance care improvements and ensure patient-centered care approach.

³⁶ <https://ryanwhite.hrsa.gov/grants/performance-measure-portfolio>

The goal of this coaching model is to strategically focus on guiding participants through each step of the QI project, ensuring that the sites address the underlying root causes that negatively impact the linkage and retention rates, supporting sites in reaching each site’s and the collective collaborative milestones, supporting the advancement of the site-specific quality management infrastructure, utilizing the patient experience measurement results to promote a patient-centered care delivery system, and engaging patients in QI activities.

QI coaches are expected to meet with their assigned group of participating sites virtually twice a month: a) once for a minimum of one hour during QI Group Sessions with other assigned sites; and b) once for an individual session to address local QI challenges. These touchpoints are complementary to the Learning Sessions (see below: Collaborative Phase) to further encourage peer learning/sharing, address common barriers, and guide activities.

Patient Engagement Model. The involvement of people with HIV is a critical component of improving HIV care and QI. They play a vital role in local, regional, and national improvement efforts. Consistent with past CQII successes, people with lived experiences will assume key roles in the planning and implementation of the *Care Collaborative*, as members of the Planning Group and QI Coaching Groups.

It is the expressed goal of this *Care Collaborative* to have at least one person with HIV actively on each participating site’s local improvement team to improve the involvement of people with HIV in local QI activities and to implement a recommended patient experience measure with the expressed goal to improve patient experiences with the healthcare system.

To reach these goals, the *Care Collaborative* will expect each participating site to have at least one patient on their QI project team, who will be identified and recruited, if needed, during the *Care Collaborative* Engagement Phase. Opportunities for building QI capacity will be provided throughout the collaborative, including available CQII resources, such as the Learning Lab and Quality Academy.

Standardized measurement tools to assess the involvement of patients in local QI efforts will be provided, using the *Client Involvement in Quality Improvement Toolkit (CIQIT)*. Each site will be asked to complete this tool during the first Learning Session (May 2025) and last Learning Session (Oct 2026) to measure any progress over time.

Using a recently developed CQII guide, called the *Patient Reported Outcomes Measures [PROMs] and Patient Reported Experience Measures [PREMs] Guide*, each site will be asked to select one PREM to assess healthcare experience based on individual feedback from patients. Each site is asked to incorporate the findings into ongoing QI efforts to better the patient experiences of those who are out of care and deliver a more patient-centered care delivery system.

Implementation Timeline

The following *Table 3* outlines the milestones to plan and implement the upcoming *Care Collaborative* in Year 1. Further descriptions for each collaborative phase are provided and detailed below.

Table 3: Year 1 Care Collaborative Milestones

Care Collaborative Timeline	
Month/Year	Activity

Aug 2024	Initiation of Planning Group and Routine Meetings
Sept 2024	Concept Paper Submission to HAB for Approval
Aug - Oct 2024	Setup Phase to Plan the Implementation
Oct 2024	Development of Collaborative Tools: Toolkit, Forms and Templates, Registration Site, Assessment Forms, Case Presentation Templates
Nov 2024	Expert Design Meeting
Jan 2025-Mar 2025	Recruitment Phase
Apr 2025	Finalization of Sites to Participate in <i>Care Collaborative</i>
May 2025	Learning Session 1
May 2025 – Dec 2026	Collaborative Phase
May 2026 – Dec 2026	Sustainability Phase
Oct 2026	Learning Session 5
Nov 2026	Transitioning of Collaborative
Apr 2027	Final Collaborative Report

Setup Phase: August 2024-Feb 2025

Expert Design Meeting. CQII is planning to hold a virtual 1-day Expert Design Meeting in Nov 2024 to generate momentum and excitement for the upcoming collaborative and review the expectations and time commitments to ensure feasibility. RWHAP recipients and subrecipients who have successfully participated in previous collaboratives will present their improvement stories and collaborative experiences, sharing reflections and feedback to refine implementation of the *Care Collaborative*.

QI Coach and Faculty Recruitment and Assignments. CQII will select the QI coaches who will support the participating sites through all aspects of the collaborative. QI coaches will include people with HIV. All individuals will be familiarized with the learning collaborative framework and routine opportunities will be provided to allow for sharing across all coaches and faculty.

Driver Diagrams. The Driver Diagram presents a graphic framework on the drivers (factors) that have been identified by the experts and stakeholders to have major impacts on achieving the preferred outcome (aim). *Primary Drivers* are the major factors driving the aim. The *Secondary Drivers* are the detailed activities and structures that make up the Primary Drivers. The Driver Diagram that has been drafted by CQII staff and coaches for the *Care Collaborative* will be introduced to participants, which will help the conceptualization of change ideas.

Collaborative Toolkit. A *Care Collaborative Toolkit* will be developed and shared with all participants, similar to toolkits from previous CQII national learning collaboratives. The *Care Collaborative Toolkit* will include all necessary reporting documentation, expectations, timelines, contact information, etc. This resource outlines to participants and faculty how to approach each specified task in the collaborative and the corresponding resources. It will also provide common verbiage and definitions, such as performance indicator definitions.

Technologies. All virtual communication technologies (i.e., Zoom, Glasscubes), will be field-tested in advance, and trainings will be provided to participants and coaches, as needed.

Collaborative Design. A collaborative logo and branding will be designed to provide a consistent look and feel and will be integrated in all aspects of this collaborative (e.g., slide templates, etc.). Artwork created by an HIV artist, if possible, will be selected for the cover of the *Collaborative Toolkit* with the necessary signed release forms.

Recruitment Phase: January 2025-March 2025

Selection: In partnership with HAB, sites will be identified using the 2022 RSR data and invited to participate. In addition, prospective site recommendations from HRSA Project Officers will be considered as well as individual applications by RWHAP recipients to ensure that the maximum number of 40 participating sites is reached. In concert with HAB, CQII will ensure the appropriate mix of participating sites using the following criteria: a) diverse QI proficiencies (beginner and advanced), b) participation in past CQII collaboratives (with an emphasis on those that have not participated before), c) geographic location, d) RWHAP funding by Part, e) HIV prevalence, and f) ending the HIV epidemic (EHE) funding. Selected sites will receive letters from HAB and encouragements by respective HRSA Project Officers to join the collaborative. CQII will reach out to the prospective sites' points of contact (e.g., senior leadership, etc.) via email to ascertain the necessary commitment and support for this collaborative and to ask them to complete a memorandum of understanding to formalize participation.

Registration: Individual prospective sites will be asked to register using an online registration form to assess whether the site has the time, staffing, technical abilities, and data system capabilities to meet the collaborative goals.

Pre-Work Phase: In the months preceding the first Learning Session (May 2025), each participating site will complete pre-work tasks to prepare to meet collaborative goals, including participation in planning sessions with the assigned QI coach and completion of organizational infrastructural (e.g., caseload, staffing, HIV services, etc.), QI capacity (e.g., staff QI knowledge, recent QI activities, etc.), and patient involvement assessments. The pre-work phase will allow participants to align themselves with the goals and expectations of the collaborative to prepare and sustain engagement. During the pre-work phase, it will be critical to establish trusting relationships between CQII staff/coaches and participating sites that are built on open communication and joint commitment to improve HIV care.

Collaborative Phase: May 2025-Dec 2026

Site QI Teams. Each participating site is asked to set up a local QI team to meet the challenges and aims of this collaborative. The team composition includes a) staff at the HIV care site with multi-disciplinary and cross-functional representation, including site leadership; b) people with HIV who receive HIV medical care at the site and represent patient voices served by the site; and c) external representatives who provide related services for HIV clients (e.g., referral sites, etc.).

Learning Sessions. Learning Sessions allow for routine meeting points for all participants to share progress made as well as challenges and to promote peer learning and exchange. The initial Learning Session will be in-person (May 2025). The four subsequent learning sessions will be held every four months. Participating sites will be asked to present during each meeting using a provided PowerPoint slide template and utilize the feedback provided by faculty and peers in response to the presentation moving forward. During the last Learning Session, each site will present their QI Storyboard, reflecting on the improvement journey and successes. HAB Project Officers are strongly encouraged

to join each Learning Session and routinely support their sites throughout the entire *Care Collaborative*.

Action Periods. Action periods between Learning Sessions are used by participating sites to plan for improvement, carry out tests of change, report standardized collaborative measures, and engage with assigned QI coaches. CQII will establish several key milestones that each site is expected to meet. These milestones include establishing a multi-disciplinary QI team with organizational sponsorship; establishing an improvement charter with improvement rationale, aims, and a data collection plan; attending coaching sessions and Learning Sessions; testing changes across all primary drivers in the driver diagram; and submitting all data, survey, and measurement reports. A detailed listing of milestones to be reached by each team and a corresponding activity calendar will be shared with participating sites to be implemented during the action periods.

QI Group Sessions. QI coaches are nationally recognized experts with extensive expertise in QI and the collaborative model. Each will be assigned up to approximately five sites (QI Coaching Group) and support them throughout the collaborative. The QI coaches will meet virtually with their assigned group of participating sites once a month for a minimum of one hour (QI Group Sessions) and also for an individual session to address local QI challenges. These Zoom sessions are complementary to the Learning Sessions to guide activities, remind them of upcoming milestones, and provide opportunities for capacity building. A list of monthly coaching milestones will be established, and individual coaches will be tasked with developing the content to share with other coaches. QI coaches will be available to meet with their teams individually for additional 1:1 support as needed. A standardized coaching calendar will be developed to outline key milestones to be met by participating sites.

Online Data Reporting. The previously used online database at <http://aidev/CareCollaborative> will be re-programmed to allow for routine self-reporting of linkage, retention, and viral suppression data. The participating sites will enter aggregated site data (which is de-identified - no individual patient data, only aggregated facility data will be uploaded), based on pre-defined measures, every other month to allow for early identification of issues and subsequent course correction. The online database will allow participating sites to compare their progress to that of peers.

To organize the reporting of improvement activities, the *Care Collaborative* will use the drivers of the Driver Diagrams. By the end of the collaborative, each site will have a populated Driver Diagram that delineates specific improvement actions taken during the collaborative and will be consolidated at the end of the collaborative to represent a change package that can be broadly shared.

Reflection Sessions. To document the site-specific QI activities, successes, and challenges, the *Care Collaborative* will conduct quarterly virtual Reflection Sessions. Assigned CQII staff facilitate these group calls to interview site participants using a prepared set of questions. Multiple call options will be made available to allow for greater scheduling flexibility and increased participation. A centralized and standardized process and forms are used to document the individual improvement journeys. CQII has successfully introduced this model in the last collaborative (i.e., Impact Now Collaborative). These Reflection Sessions allow sites to verbalize their journey (rather than submit a written report), provide responses to pre-determined questions, and provide feedback on what is/isn't working in the collaborative for them. CQII will document those discussions, archive them on Glasscubes, and make them widely available to the sites, QI Coaches, and HRSA HAB.

Leadership Calls and Project Officers Calls. The routine involvement of site senior leaders and HRSA HAB Project Officers is an important component of the *Care Collaborative*. Based on previous successes, quarterly Leadership Calls as well as Project Officer Calls will be held by CQII to inform them on the progress made by participants and engage them in a dialogue to further support the participant improvement journeys. Senior leaders and Project Officers will be invited to join the Learning Sessions.

Patient Affinity Group. The Patient Affinity Group is to prepare people with HIV who are equal members of the local quality improvement teams to meaningfully participate in Learning Sessions and Action Period activities with local improvement teams. The Patient Affinity Group will meet prior to Learning Sessions to discuss the upcoming agenda items and clarify expectations of participation (e.g., introductions, activities, breakout groups, action planning, etc.) and is intended to provide additional context to engage with learning session content and activities. The group will also meet shortly after each Learning Session (1-2 days following) to discuss the session, clarify any content or remaining questions, and review key activities expected of teams during the Action Period, including how they might support or be involved in them. The QI coaches leading the Patient Affinity Group will convene technical assistance webinars and/or capacity building sessions to address gaps identified through pre- and post-Learning Session Affinity Group meetings.

Community Liaison Affinity Group. The Community Liaison Affinity Group engages those individuals who are responsible for engagement of people with HIV in local QI activities (e.g., causal analysis, ideation, prioritization, process mapping, etc.) or providing feedback for the QI project (e.g., informal, and formal key informant interviews, focus groups, etc.). These individuals do not have to be a person with HIV. The Community Liaison Affinity Group will meet during Action Periods (e.g., constructing a patient journey map, etc.). The QI coaches leading the Community Liaison Affinity Group Leads will convene technical assistance webinars and/or capacity building sessions to address gaps identified during Learning Sessions and/or during Affinity Group meetings.

Leadership Program. The Leadership Program will enhance the QI leadership skill for selected participants of the *Care Collaborative* who show the potential for taking on a regional or national QI leadership role and co-facilitating *Care Collaborative* activities with QI coaches. Up to 12 participating site representatives will be selected to receive mentorship from CQII coaches, based on the following eligibility and selection requirements: a) active participation in the collaborative, b) informal leadership skills, c) facilitation, and d) QI skills. An online nomination process will be set up and CQII will determine the selection of the representatives with the collaborative planning group. The Leadership Program will begin within six months of the *Care Collaborative* launching and conclude at the end of the collaborative. Leadership Program participants will co-facilitate collaborative activities, sustain their organization's QI efforts, and may become future CQII faculty or coaches. Participants will join monthly sessions led by CQII staff, learn sustainability frameworks, and share experiences.

Sustainability Phase: May 2026 - Dec 2026

It is the goal of this *Care Collaborative* that the progress made throughout is sustained over time and that the improvement work continues beyond the duration of the collaborative, independent of CQII's involvement or coaching. Frameworks for sustainability will be introduced during Learning Sessions and actively supported by coaches. Sites will identify stakeholders to promote improvement sustainability and development of a sustainability plan.

Evaluation

To evaluate the impact of the *Care Collaborative*, CQII staff (Stephen Weinberg, PhD and Marlene Eisenberg, PhD), in collaboration with CQII external evaluator at University of California, San Francisco (Wayne Steward, PhD) will draft an appropriate evaluation plan focusing on increased linkage/retention/viral suppression rates at participating sites, reductions in the gap between the participating sites' rates and the national average, effectiveness of QI efforts as evidenced by the successful implementation of QI projects, active participation in collaborative activities, and meaningful inclusion of people with lived experience.

The data sources include the following:

- linkage/retention/viral suppression performance data submitted by participating sites via the online database,
- qualitative interviews with participants and coaches about their experiences with the *Care Collaborative*,
- input gained from quarterly Reflection Calls regarding progress,
- tracking participant attendance and teams in key collaborative activities (maintained in detailed spreadsheets by CQII staff),
- process steps completed by participating teams to ensure that each team achieves agreed collaborative milestones,
- QI organizational capacity assessed over time via a standardized assessment tool during Learning Sessions,
- tracking of changes ideas and interventions implemented by participating teams to meet the goals of individualized aim statements, and
- meaningful inclusion of people with lived experience, measured through a validated survey tool.

An evaluation plan will be presented to HRSA HAB at the initiation of the *Care Collaborative* for review and approval. A final evaluation report will be presented to HRSA within ~six months from the conclusion of the collaborative (Apr 2027).

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