create+equity ECHO Collaborative Report: Key Progress Steps in Intervention Implementation

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create+equity ECHO Collaborative
Intermediate Implementation Evaluation
Final Report
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Introduction
While many create+equity Collaborative Community Partners have made strides in their internal CQI processes and intervention implementations and worked towards improvements in their reported viral suppression rates (VSR), there was limited understanding of the progress steps participants took to achieve these outcomes, and whether there are critical steps for such achievement.

Collaborative process steps are activities performed by participating teams to work towards improving general aspects of quality management programs or local quality improvement capacities, independent of activities related to the implementation of a site-selected intervention. For example, “improving data quality” and “routinely engaging partners on the QI team” are steps separate from the predetermined evidence-informed interventions that were offered to Collaborative participants to address the needs of one of the four subpopulations (housing, mental health, substance use, and age).

The Collaborative process steps are broad and generalizable, and thus not specific to any individual Affinity Group. They strengthen the overall competency levels of staff and maturity of an HIV program and can be ideally applied to future improvement efforts. The list of Collaborative process steps was determined by Collaborative faculty and included categories, such as building capacity, consumer engagement, Affinity Group-specific screenings, and clinic operations; see attachment for the full list of Collaborative process steps.

This evaluation sought to address the gap in understanding of participants’ completion of the process steps and to identify process steps key to participants’ success by examining the relationship between participant perspectives on participation and the implementation of their intervention.

Key Findings
Joining the Collaborative and Selecting an Intervention
- A majority of participants had participated in at least one previous collaborative.
- Some participants came to the Collaborative with an intervention they had been hoping to implement for some time, while others reported newly looking at data to inform their choice.
- The most common intervention was some form of active referral, followed by UberHealth.
- Several programs chose a “user-defined intervention.”
- Many participants intended to implement their intervention with high fidelity (31%), but even more expected to use the prescribed model to create their own (35%).
  - Many reported valuing the ability to customize their implementation to the demands of their organization and their client population.

Implementing Collaborative Process steps
- The greatest extent of implementation was seen for Collaborative process steps related to QI infrastructure and performance data. Lowest implementation was seen for steps related to external partnerships, consumer engagement, and clinic operations.
- There was nearly universal implementation of the following process steps: using data analysis results for improvement activities (100%), tracking Affinity Group-specific patients over time...
There remained some Collaborative process steps that had been implemented by fewer than two-thirds of the programs by the time of the survey in May 2022: engaging people with HIV in Affinity Group-specific QI work (65%), building capacity among patients for Affinity Group work (63%), setting up peer support systems (61%); integrating screening into the EHR (51%); and setting up formal partnerships (57%).

- Most programs who had not yet implemented these steps did not have plans to do so.
- Prior to the start of the Collaborative, steps most commonly taken were those related to QI infrastructure. Performance data steps were more likely to be taken after the Collaborative was underway.

**Outcomes and Successes**

- Participants found value in the presentations made by other organizations.
- Participants noted the limitations of change in VSR as a short-term outcome and took a broader view of what success meant for their organization.
- The majority of the programs that completed the survey did experience increased VSR. Twenty-two programs showed an increase in VSR, while five showed a decrease.
  - Sixteen programs showed an increase in VSR among their Affinity Group patients; eight showed a decrease.
  - It should be noted that the programs that completed the survey only represented a subset of all the participating programs and interested parties should refer to the overall program evaluation for more comprehensive information about changes in VSR.
- Certain individual Collaborative process steps or categories of process steps were substantially associated with improvements in overall or Affinity Group-specific VSR.
  - Completion of at least six of the seven performance data steps and completion of all five of the Affinity Group-specific screening steps\(^1\) were associated with higher overall VSR.
- Other specific changes reported by respondents as a result of participation in the Collaborative included new staff, training, QI processes, and screenings/assessments.
- There were also a number of changes in the general approach to service provision, such as realizing weaknesses in processes that had previously been believed adequate or having a new awareness of how to identify and address barriers.

**Barriers to Participation and Support Needs**

- Some participants felt that the time commitment involved for meetings was onerous.
- Participants also cited challenges working with other staff at their site, particularly clinical staff.
- Some participants felt that they did not fully understand the resources available from coaches.
- Several respondents indicated that they would like to see a continuation of the services and supports that were provided to them going forward.

**Respondents overwhelmingly reported that they would recommend others to participate in the Collaborative.**

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\(^{1}\) Programs in the Age Affinity Group were excluded from this analysis, as the screening steps were not relevant to them.
Data and Methods

Multiple data collection methods were utilized to evaluate the role of specific process steps in achieving successful outcomes. These included quantitative data collected via an online survey, qualitative data collected via focus groups, as well as secondary data review. Data collection instruments were reviewed by the CQII Team prior to implementation.

An online survey, which focused on process steps, timing of these steps, the selected intervention, and model fidelity, was distributed to participants in May 2022. Although 72 surveys were begun, only 53 were completed. Some programs had multiple respondents; in these cases, data from all respondents from the same site were combined to provide the most comprehensive picture of process steps undertaken. As such, these 53 respondents represented a total of 33 programs (out of 60 surveyed) and 34 sites. (Many programs only operated one site, but some programs operated multiple participating sites.) For these programs, Partners’ overall and Affinity Group-specific Viral Suppression Rate (VSR) data were examined through March 2022.

Four focus groups were completed (one for each Affinity Group) in June 2022. These focused on participant experiences in the Collaborative, including their starting goals and expectations, their process of selecting an intervention and intended model fidelity, the outcomes they experienced as a result of Collaborative participation, and the facilitators of and barriers to participating in the Collaborative and implementing the chosen intervention.

There were 11 participants in the Age group; 13 participants in the Housing group; eight participants in the Mental Health group; and five participants in the Substance Use group. The focus groups were supplemented with two one-on-one interviews with participants not able to attend the scheduled focus group (one Age and one Mental Health). CHSR staff also attended some Affinity Group meetings and Learning Sessions to gain further context.

Additionally, secondary program data were reviewed, including Partner Case Presentations, Quarterly Reports, and other program documents available in Glasscubes.

Results

Starting Collaborative Work

Joining the Collaborative. A majority of participants reported having participated in one or two collaboratives prior to joining the create+equity Collaborative. Many, however, were new to the Collaborative model. One participant noted that they personally had not participated in a collaborative previously, but had previous done work with a CQII coach, and that staff from other parts of their organization had participated in a previous collaborative.

Participants had diverse expectations and goals for their participation. Several noted that they felt it was an opportunity to focus on one of their more challenging populations, or as one described, “To customize our policies to consumers.” Participants hoped to accomplish specific objectives such as addressing a lack of stable housing or strengthening the transition to behavioral health services. One
participant noted what they characterized as a “very ambitious goal” to change their case manager assessment in a move to standardized tools.

Others had more general improvement objectives:

- **We were looking to improve our practices.**
- **We were already doing some things but were looking at how to really focus in more intently and maybe try something new.**
- **Strengthening our base knowledge on how do we get to those viral load things that we need.**

One participant, a formerly unhoused person with HIV, said “I joined the Collaborative because I want to share my story and see other people get housing and get what they need.”

**Intervention.** Some participants came to the Collaborative with an intervention they had been hoping to implement for some time, while others reported newly looking at data to inform their choice. Regardless, many participants reported an evolving progression in the identification and implementation of their intervention.

For example, multiple participants realized that they were not ready to implement the chosen intervention. One participant reported that their organization had planned to do an intervention on linkage and referral but discovered that there was no unified screening tool even within agencies. Thus, they had to “take a detour” to identify and implement a unified screening tool in order to build towards their original goal. Another participant similarly described that they “thought we were going to have total fidelity but as we started doing work, new discoveries were made... had to fill in some steps in between.”

Another participant described how their selected intervention evolved based on what they learned about client needs:

- **Originally our plan was to make sure we were increasing our screenings first before we decided what our intervention would be... That ended up being our ongoing intervention because it took us that long... the plan initially was to get the info from those screenings, and when patients needed additional screenings, we needed to get patients in the office. We ended up doing a transportation-related intervention because some patients couldn’t get to the office. The transportation initiative became central. We ended up implementing an intervention before we thought we would do that, because it came up so early on.**

From the survey and Partner Case Presentation document review, the evaluation team was able to identify the interventions chosen by 42 of the 60 participating programs. Some programs indicated more than one intervention (four programs reported two interventions, and three programs reported three interventions). By far, the most common intervention was some form of active referral, which was common among all Affinity Groups, but especially Mental Health and Substance Use. The next most common was UberHealth, implemented by two programs each in the Age, Mental Health, and Substance Use Affinity Groups. Several programs chose a “user-defined intervention.” Two programs had not yet selected interventions.
Figure 1. Selected Interventions by Affinity Group (Programs Could Choose Multiple Interventions)

Many participants had initially intended to implement their intervention with high fidelity (31% of survey respondents intended to implement as closely as possible to the prescribed intervention model, and 12% planned only to make a few minor changes.). However, the majority of survey respondents indicated that they planned to make larger changes (12%), used the prescribed model to create their own (35%) or did not use a prescribed model at all (12%).
Interestingly, achieved fidelity was typically better than intended. Partners who had intended to use a prescribed model to create their own intervention most often reported ultimately making only a few minor changes to the prescribed model. Similarly, those who planned to make larger changes either did so or made a few minor changes instead. Almost all of the Partners who intended to follow a model as closely as possible ultimately did so, with a few making minor changes. As such, while flexibility was utilized, it was most often used to make only minor changes to the prescribed models.

Many participants reported valuing the ability to customize their implementation to the demands of their organization and their client population, and to be responsive to what they were seeing in their data. One described the selected intervention as “a good baseline,” noting that “every community is
Another reported following their intervention with high fidelity but still modifying it a little “only because with the motivational interviewing, personalities play a role.”

Another summarized their implementation as follows:

> We tried to implement it in the way it was written, but probably not in the same time frame. We did it as time allowed, as things came up, as other trainings were happening; we incorporated harm reduction into it. It specified training for all different groups of staff, but how we did that training was how we put our own twist to it.

In sum, as one participant noted, “Flexibility is important—hey, we are seeing that this intervention isn’t working, let’s try something different. This flexibility was an important part of the Collaborative.”

Implementing Collaborative Process steps

**Collaborative process steps undertaken.** The participant survey focused heavily on the Collaborative process steps that programs undertook as part of their participation. By the time of the survey, which occurred near the end of the Collaborative, the 34 programs had implemented (or begun implementation of) an average of 23.7 (median = 26) of the 30 listed Collaborative process steps.

Comparatively, the greatest extent of implementation was typically seen for steps related to QI Infrastructure (with 31 programs reporting implementation of all four steps) and Performance Data (20 programs reporting implementation of all seven steps). Lowest implementation was seen for steps related to External Partnerships (six programs reporting no implementation), Consumer Engagement (two programs reporting no implementation), and Clinic Operations (seven programs reporting no implementation).

![Figure 4. Average Percent of Total Collaborative Process Steps in Each Category Implemented by Survey Participants by Time of Survey](image)

Note: Programs in the Age Affinity Group were excluded from the calculation for percent of Affinity Group-specific screening steps, as screening is not relevant to identifying age.
There was nearly universal implementation of the following individual Collaborative process steps: using data analysis results for improvement activities (100%); tracking Affinity Group-specific patients over time (97%); and identifying Affinity Group-specific definitions to focus on targeted subpopulations (97%).

**Figure 5. Collaborative Process Steps Implemented by Time of Survey**

<table>
<thead>
<tr>
<th>QI Infrastructure</th>
<th>Engaging staff and partners with the QI team</th>
<th>Engaging agency leadership in Collaborative and QI work</th>
<th>Setting up an effective QI team</th>
<th>Improving organizational infrastructure for quality mgmt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Data</td>
<td>Using data analysis results for improvement activities</td>
<td>Tracking Affinity Group-specific patients over time</td>
<td>Identifying Affinity Group-specific definitions</td>
<td>Collecting Affinity Group-specific performance data</td>
</tr>
<tr>
<td></td>
<td>Developing new performance reports stratified by patient data</td>
<td>Flagging Affinity Group-specific patients prior to clinic visit</td>
<td>Improving the EHR system to track information</td>
<td></td>
</tr>
<tr>
<td>Capacity Building</td>
<td>Building capacity among staff for Affinity Group topics</td>
<td>Building capacity among staff for QI</td>
<td>Building capacity among patients for QI</td>
<td>Building capacity among patients for Affinity Group work</td>
</tr>
<tr>
<td>Affinity Group-specific Screening</td>
<td>Identifying appropriate Affinity Group-specific screening tools</td>
<td>Educating staff and patients in the use of screening tools</td>
<td>Tracking Affinity Group-specific screening results</td>
<td>Developing a clinic flow to integrate the screening tools</td>
</tr>
<tr>
<td></td>
<td>Integrating screening into EHR systems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic Operations</td>
<td>Improving clinic/documentation flow related to Affinity Group</td>
<td>Improving aspects of the clinic not targeted by Collaborative</td>
<td>Improving staff morale</td>
<td></td>
</tr>
<tr>
<td>Consumer Engagement</td>
<td>Engaging people with HIV in QI activities</td>
<td>Gathering routine input and feedback from patients with HIV</td>
<td>Engaging people with HIV in Affinity Group-specific QI work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Setting up peer support systems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External Partnerships</td>
<td>Increasing outreach to identify external partners</td>
<td>Managing and monitoring referrals and follow-ups</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Setting up formal partnerships</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Process steps prior to beginning of the Collaborative.** The survey also investigated the timing of process steps by asking about steps begun before joining the Collaborative. Ninety-three percent of programs
had already begun to implement one or more of the Collaborative process steps prior to joining the Collaborative, and on average had implemented 9.25 of them (median = 9.5). However, it is unclear if respondents took this to mean during the “pre-work” period prior to the official start of the Collaborative, or prior to any involvement with the Collaborative.

**Figure 6. Count of Programs by Total Number of Collaborative Process Steps Implemented Prior to Start of Collaborative**

<table>
<thead>
<tr>
<th>Number of Progress Steps Implemented</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than 5</td>
<td>8</td>
</tr>
<tr>
<td>5-9</td>
<td>6</td>
</tr>
<tr>
<td>10-14</td>
<td>8</td>
</tr>
<tr>
<td>15-19</td>
<td>3</td>
</tr>
<tr>
<td>20-24</td>
<td>2</td>
</tr>
<tr>
<td>25 or more</td>
<td>1</td>
</tr>
</tbody>
</table>

**Process steps implemented prior to the Collaborative** The most common steps that programs had taken prior to the start of the Collaborative were: setting up an effective QI team (60%); engaging agency leadership in Collaborative work and overall QI work (53%); building capacity among staff for QI (50%); improving organizational infrastructure for quality management (47%); and engaging staff and partners with the QI team (47%).

In contrast, there were some process steps that programs were unlikely to have taken prior to the start of the Collaborative: accurately and completely collecting Affinity Group-specific performance measures (13%); educating staff and patients in the use of screening tools (13%); developing new performance reports stratified by patient data (10%); and tracking Affinity Group-specific screening results (7%).
**Figure 7. Percent of Programs Which Implemented Collaborative Process Steps Prior to and During the Collaborative, versus Not Yet Implemented**

<table>
<thead>
<tr>
<th>QI Infrastructure</th>
<th>Engaging staff and partners with the QI team</th>
<th>Prior to Collaborative</th>
<th>During Collaborative</th>
<th>Not Yet Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Engaging agency leadership in Collaborative and QI work</td>
<td>47%</td>
<td>43%</td>
<td>53%</td>
</tr>
<tr>
<td></td>
<td>Setting up an effective QI team</td>
<td>60%</td>
<td>37%</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>Improving organizational infrastructure for quality management</td>
<td>47%</td>
<td>43%</td>
<td>47%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance Data</th>
<th>Using data analysis results for improvement activities</th>
<th>Prior to Collaborative</th>
<th>During Collaborative</th>
<th>Not Yet Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tracking Affinity Group-specific patients over time</td>
<td>36%</td>
<td>44%</td>
<td>64%</td>
</tr>
<tr>
<td></td>
<td>Identifying Affinity Group-specific definitions</td>
<td>33%</td>
<td>65%</td>
<td>63%</td>
</tr>
<tr>
<td></td>
<td>Collecting Affinity Group-specific performance data</td>
<td>13%</td>
<td>81%</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>Developing new performance reports stratified by patient data</td>
<td>10%</td>
<td>71%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>Flagging Affinity Group-specific patients prior to clinic visit</td>
<td>16%</td>
<td>58%</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>Improving the EHR system to track information</td>
<td>33%</td>
<td>33%</td>
<td>33%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Capacity Building</th>
<th>Building capacity among staff for Affinity Group topics</th>
<th>Prior to Collaborative</th>
<th>During Collaborative</th>
<th>Not Yet Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Building capacity among staff for QI</td>
<td>26%</td>
<td>61%</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td>Building capacity among patients for QI</td>
<td>50%</td>
<td>37%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Building capacity among patients for Affinity Group work</td>
<td>27%</td>
<td>47%</td>
<td>27%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Affinity Group-specific Screening</th>
<th>Identifying appropriate Affinity Group-specific screening tools</th>
<th>Prior to Collaborative</th>
<th>During Collaborative</th>
<th>Not Yet Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Educating staff and patients in the use of screening tools</td>
<td>29%</td>
<td>55%</td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td>Tracking Affinity Group-specific screening results</td>
<td>13%</td>
<td>63%</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>Developing a clinic flow to integrate the screening tools</td>
<td>7%</td>
<td>68%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>Integrating screening into EHR systems</td>
<td>16%</td>
<td>58%</td>
<td>16%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinic Operations</th>
<th>Improving clinic/documentation flow related to Affinity Group</th>
<th>Prior to Collaborative</th>
<th>During Collaborative</th>
<th>Not Yet Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improving aspects of the clinic not targeted by the Collaborative</td>
<td>16%</td>
<td>58%</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>Improving staff morale</td>
<td>32%</td>
<td>36%</td>
<td>32%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consumer Engagement</th>
<th>Engaging people with HIV in QI activities</th>
<th>Prior to Collaborative</th>
<th>During Collaborative</th>
<th>Not Yet Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gathering routine input and feedback from patients with HIV</td>
<td>39%</td>
<td>45%</td>
<td>39%</td>
</tr>
<tr>
<td></td>
<td>Engaging people with HIV in Affinity Group-specific QI work</td>
<td>32%</td>
<td>42%</td>
<td>32%</td>
</tr>
<tr>
<td></td>
<td>Setting up peer support systems</td>
<td>39%</td>
<td>23%</td>
<td>39%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>External Partnerships</th>
<th>Increasing outreach to identify external partners</th>
<th>Prior to Collaborative</th>
<th>During Collaborative</th>
<th>Not Yet Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Managing and monitoring referrals and follow-ups</td>
<td>42%</td>
<td>29%</td>
<td>42%</td>
</tr>
<tr>
<td></td>
<td>Setting up formal partnerships</td>
<td>40%</td>
<td>17%</td>
<td>40%</td>
</tr>
</tbody>
</table>

Legend:
- **Prior to Collaborative**
- **During Collaborative**
- **Not Yet Implemented**
Process steps implemented during the Collaborative. As expected, however, programs were more likely to implement process steps during the Collaborative. Programs implemented an average of 14.8 process steps during the Collaborative (median = 15). They were most likely to report tracking Affinity Group-specific patients over time (81%) and accurately and completely collecting Affinity Group-specific performance data (81%), followed by developing new performance reports stratified by patient data (70%) and tracking Affinity Group-specific screening results (68%).

The process steps programs were least likely to report implementing during the Collaborative included steps that were already implemented by a large percentage of programs prior to the start of the Collaborative: setting up an effective QI team (37%); building capacity among staff for QI (37%); improving the EHR system to accurately and completely track information (33%); setting up formal partnerships (17%); and setting up peer support systems (23%). Also, few programs implemented improving staff morale (37%), improving aspects of the clinic not targeted by the initiative (36%), and managing and monitoring referrals and follow-up (29%).

Collaborative process steps not yet implemented. There remained some Collaborative process steps that had been implemented by fewer than two-thirds of the programs by the time of the survey: engaging people with HIV in Affinity Group-specific QI work (65%), building capacity among patients for Affinity Group work (63%), setting up peer support systems (61%); setting up formal partnerships (57%), and integrating screening into the EHR (51%). Most of the programs who had not yet implemented these steps did not have plans to do so: of all programs, fully 23% did not have plans to set up peer support systems; 29% did not have plans to integrate screening into their EHR systems; and 30% did not have plans to set up formal partnerships. Thirteen percent did not have plans to engage people with HIV in Affinity Group-specific QI work.

Predictors of Collaborative process steps. Partners in the Substance Use Affinity Group reported having implemented, or begun implementation of, the most Collaborative process steps on average (27.1), while Partners in the Age Affinity Group had implemented the fewest (18.8). Because the Age Affinity Group did not utilize screenings, further analysis was done to exclude the Affinity Group-specific screening steps. Even when excluding those steps, programs in the Age Affinity Group had still implemented fewer of the Collaborative process steps on average (16.2) than their peers in the other Affinity Groups (21.0-22.1).
There appeared to be an association between planned model fidelity and the number of Collaborative process steps that were implemented. Programs with an intention to follow a prescribed intervention model as closely as possible or with minor changes averaged 24.5 and 24.0 process steps, respectively. Programs who planned to follow a prescribed intervention with major changes averaged 22.3 process steps. Programs who planned to use a prescribed model to create their own or who did not use a prescribed model at all had the lowest levels of implementation (20.6 and 21.5, respectively). This difference could be because following a prescribed intervention more closely allows for a clearer path for implementation and next steps. This clearer path may further explain why more than half of the programs who originally planned to use the prescribed model to create their own ultimately ended up adopting the prescribed model with only minor changes (see Figure 3).

Figure 8. Average Number of Collaborative Process Steps Implemented by Affinity Group

Figure 9. Average Number of Collaborative Process Steps Implemented by Planned Level of Fidelity
However, because the Age Affinity Group had fewer relevant Collaborative process steps due to not needing to implement screenings, the average number of process steps other than Affinity Group-specific screening steps was examined. This analysis revealed less evidence of a relationship between intended model fidelity and the number of process steps implemented. The eight programs which planned to use a prescribed model to create their own model still had implemented the fewest Collaborative process steps (an average of 17.3), but there were minimal differences between other planned levels of fidelity (with averages ranging from 19.0 to 20.7).

Participation in certain Collaborative activities was associated with the number of Collaborative process steps taken. Those who participated in eight or more dedicated sessions with their QI coach (n=11) had implemented more steps than those who had participated in fewer than eight (n=18) (27.1 vs. 21.7, p=0.009). Participation in Learning Sessions or Affinity Group meetings was not associated with the number of Collaborative process steps taken.

**Figure 10. Average Number of Collaborative Process Steps Implemented by Number of QI Coaching Sessions Attended**

How Partners experienced the process of the Collaborative. The focus group interviews revealed participant perspectives on which aspects and processes of the Collaborative had been helpful to them. One participant spoke of gaining tools and templates, while another said that viewing the list of interventions had opened their eyes to possibilities they hadn’t thought of before.

More specifically, others spoke of specific processes they went through as part of their Collaborative participation, such as process mapping or value stream analysis:

*The Collaborative helped us put in perspective how to go about workflows and to process map, which helped to do a walkthrough of what the process was at this time, and how it should be.*
Looking at that PDSA cycle and how we could incorporate that as a body… let’s start this, let’s look at this, how do we go through this process. If it’s not working, how do we recircle and go back through… that was very informative for us.

I think learning the process. Just having that outline. You’re going to create your aim statement; you’re going to do a driver diagram; you’re going to do a focus group; you’re going to meet with the team. They’re all steps we know, but it’s really helpful to have that whole process laid out for you.

A few participants noted the value they found in the presentations made by other organizations, with one noting that listening to the report-backs “helped us look at success differently,” and another saying that “It was helpful learning from one another in our Affinity Group; hearing the presentations helped us get a better understanding to help support our current services and how to continue strengthening them.” Yet another noted that they were “intimidated at first, but in listening to other peoples’ projects, it gave me the confidence I need to ask the questions, to be able to put things out there for myself.”

Other aspects of the Collaborative that were specifically mentioned as helpful were the technical assistance available from the coaches: “they followed through and we received the information we wanted”, and the input of the content experts:

Content experts were encouraging, inspiring, and helpful.

The biggest takeaway from our perspective was how important it was to get content experts involved.

**Collaborative Outcomes**

Although the overarching goal of the Collaborative was to reduce the gap in VSR between the entire caseload and the selected subpopulation, most of the focus group discussion related to the more proximate changes in the way their organization functioned, which were hoped to facilitate improved VSR down the road.

Participants noted the limitations of change in VSR as a short-term outcome, particularly given the rolling data reporting methodology (e.g., overlapping timeframes) and timing as related to the pandemic (the baseline was still pandemic-influenced). A participant from a program that only engages patients for eight weeks remarked that because VSR was difficult to influence in that time “… we started looking at our services and how we can better implement those things that can take barriers away that would help individuals go to their primary care providers.” The housing group also noted how VSR is hard to focus on when housing is being prioritized; patients are focused on shelter and survival to the exclusion of other concerns.

As a result, participants took broader views of what success meant for their organizations. One noted that participating in the Collaborative “opened up alternative measures beyond VSR – engagement in care, retention in care.” Another said, “For patients who were not virally suppressed… once we’ve implemented better screening and interventions, it gave us more insight as to what might be happening in their lives, even if the rates didn’t improve.” Another similarly concluded that they “had to take a step back and measure success as what are we implementing in the system to make the system work better for clients.”
**Change in VSR.** As part of the work on process steps and implementation, VSR data was examined in relation to survey data focusing on processes. It should be noted that the programs that completed the survey only represented a subset of all the participating programs and – because they self-selected by completing the survey – were probably not representative of all programs. Interested parties should refer to the overall program evaluation for more comprehensive information about changes in VSR.

While focus group participants were clear that VSR was not their only metric of success, it appears that at least those programs which completed the survey did experience increased VSR. Among the 34 programs that fully completed the survey\(^2\), 27 had overall VSR data for both baseline (March 2021) and March 2022. Twenty-two programs showed an increase in VSR, while 5 showed a decrease, a statistically significant increase in overall VSR using a related-samples Wilcoxon signed-ranks test (p=0.002). The median size of the change was +1.7% while the mean change was +3.0%.

**Figure 11. Changes in Overall VSR Score, March 2021-March 2022**

![Figure shows changes in overall VSR score from the beginning to end of the reporting period; x-axis variation is random jitter, included to allow each individual data point to be seen.]

Similarly, there was a nearly significant increase in VSR among Affinity Group patients (p=0.012, n=25). Sixteen programs showed an increase in VSR for Affinity Group patients, while eight showed a decrease. The median change was +1.5% while the mean size of the change was +8.0%.

\(^2\) Three programs opened the survey and answered the first few questions without completing questions regarding the progress steps.

\(^3\) The mean change was skewed upwards by one program that reported 0% VSR among their Affinity Group clients in March 2021, but 47% VSR by the time of the survey.
Collaborative Process Steps and VSR outcomes. The total number of Collaborative process steps taken by the time of the survey was not significantly correlated with improvement in either overall or Affinity Group VSR, regardless of timing (before or after the start of the Collaborative). This held true even when Affinity Group-specific screening steps were excluded to account for the age Affinity Group not utilizing screenings. However, some individual Collaborative process steps or categories of process steps were significantly or substantially\(^4\) associated with improvements in overall VSR:

- Programs that had implemented at least six of the seven Performance Data steps \((n=18)\) by the time of the survey had average increases of 3.3% in their overall VSRs, compared to average increases of 1% among those who implemented five or fewer of these steps \((n=7)\).
- Programs that had implemented all five of the Affinity Group-specific screening steps\(^5\) \((n=13)\) had an average increase of 3.0% in their overall VSRs, compared to an average decrease of 0.1% among those who implemented four or fewer steps \((n=6)\).
- Programs that had improved their EHR system to accurately and completely track information \((n=17)\) had an average increase of 2.8% in their VSR, compared to 2.4% among those who had not implemented this step \((n=8)\).
- Programs that had implemented steps to improve staff morale \((n=16)\) had an average increase of 2.9%, compared to 2.2% among those who had not \((n=9)\).
- Programs who had implemented peer support systems \((n=16)\) had an average increase of 3.2% in their VSR, compared to 1.7% for those who had not \((n=9)\).
- Programs that had integrated screenings into their EHR \((n=15)\) had an average increase of 3% in their VSR, compared to 2.2% among those that had not \((n=10)\).

Notably, due to the small sample size, the impact of Collaborative process steps that had been implemented by more than two-thirds of the programs could not be examined, as the one-third or fewer programs that had not implemented the steps would then be a very small group (fewer than seven programs) and a poor basis for comparison. These steps may still have had substantial impact on program VSR, but individual impact could not be separated.

\(^4\) Due to the small sample size, statistical significance is difficult to obtain for all but the very largest effect sizes. Large, but not statistically significant, effects are still worth noting.

\(^5\) Programs in the Age Affinity Group were excluded because the screening steps were not relevant to them.
Affinity Group-specific VSR was substantially or significantly associated with certain Collaborative or categories of process steps.\(^6\)

Programs that implemented all four **Capacity-Building** steps (n=13) had a median increase of 5.0% in their Affinity Group-specific VSR, compared to 2.6% among programs that implemented fewer (n=8).

Programs that implemented all four **Consumer Engagement** steps (n=7) had a median increase of 7.5% in their Affinity Group-specific VSR, compared to 0.7% among programs that implemented fewer (n=15).

Programs that implemented at least six of the seven **Performance Data** steps (n=14) had a median increase of 4.7% in their Affinity Group-specific VSR, compared to 1.8% among programs that implemented fewer (n=8).

Programs that implemented all five of the **Affinity Group-specific Screening** steps (n=11) had a median increase of 5.5% in their Affinity Group-specific VSR, compared to 1.3% among programs that implemented fewer (n=11).

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\(^6\) Medians are shown here because of the extreme skew introduced to the average by one program that reported an increase of 47 percentage points in their VSR between baseline and March 2022.
Further, when individual Collaborative process steps were examined:

Programs that engaged people with HIV in Affinity Group-specific QI work (n=14) had a median increase of 5.3% in their Affinity Group-specific VSR, compared to a decrease of 0.2% among programs that did not (n=8).

Programs that improved their EHR system to accurately and completely track information (n=13) had a median increase of 5.5% in their Affinity Group-specific VSR, compared to 1.3% among programs that did not (n=9).

Programs that took measures to build capacity of patients for Affinity Group-topic (n=14) had a median increase of 4.5% in their Affinity Group-specific VSR, compared to 1.3% among programs that did not (n=4).

Programs that set up peer support systems (n=13) had a median increase of 5.0% in their Affinity Group-specific VSR, compared to 1.3% among programs that did not (n=9).

Programs that integrated the screenings into their EHR system (n=12) had a median increase of 4.7% in their Affinity Group-specific VSR, compared to 2.6% among programs that did not (n=10).
Figure 14. Change in Affinity Group VSR by Collaborative Process Steps Implemented

Outcomes beyond VSR. Aside from improvements in VSR, focus group participants offered a wide variety of responses regarding the most important outcomes of their participation. These could broadly be categorized as specific changes that were implemented, specific processes that were undertaken, or general changes in orientation, approach, or perspective.

Specific changes. Specific changes cited by respondents commonly related to new staff, training, QI processes, and screenings/assessments. Several participants mentioned the addition of new staff as a result of the Collaborative. One organization created a position for Peer Navigator, while another had a behavioral health consultant, a case manager, and a peer recovery specialist join the team. One participant noted that they had recruited a person from the community for their data team.

Specific changes included additional training related to the work of the Collaborative, with varied topics and audiences:

We definitely included additional training for our Ryan White funded case managers, so we had them do some training on motivational interviewing, on SBIRT; our behavioral health consultants were trained on HIV diseases... Both teams and our nurses had additional training about substance use disorder.

We did several trainings around harm reduction and motivational interviewing and some other harm reduction related topics.

Many of the specific processes that were implemented as a result of the Collaborative were focused on quality improvement. One program had implemented qualitative interviews with providers to better understand their perspectives, while another started doing patient surveys. A participant noted that “before that, our quality team was one to three people. Now we have the entire staff involved in the process. We host weekly meetings in regard to this program.”
Several participants also mentioned the creation or adoption of an assessment form as a significant step. As a result, screenings and referrals increased:

*Clients are being screened regularly now and we’re following up with screening results and referrals.*

*Have since increased referrals tremendously.*

*Our focus was to increase screening as a program. We started with a baseline which was about 56% and as of last month it was 88%; although the goal was to get to 95%, I felt that was a good success.*

**General approach.** Perhaps the most frequently cited outcomes of participation in the Collaborative were changes in the general approach to service provision taken by participants and their organizations, and specifically the approach to quality improvement. One noted that it helped service providers learn more about QI, while another felt that participation had improved the quality of data and facilitated “working with data-minded people.” One noted the importance of the Collaborative in allowing the training of a “massive amount of people to learn a concept at the same time” (or as someone else put it, “The benefit for me is that everybody is learning QI and I don’t have to be in charge of it”).

Some reported realizing that the processes they had believed were adequate had weaknesses that could be addressed:

*We figured out our blind spots on data; we thought we were okay, and we realized we were not.*

*We thought our mental health programs and assessments were fine because we were getting data we were hoping to get, but after talking to patients we found we were asking a lot and it was daunting to them... [we were] able to pare that down a little bit more.*

Others spoke of a new awareness of and ability to identify barriers, and the ability to figure out strategies to address those barriers. In particular, they felt that the process of going through the Collaborative steps had given them tools to identify and strategize about barriers. One said it “helped us be a little bit more systematic about taking the time to go through all the steps and help us focus.”

Arguably, the most important change in approach was a change in the overall culture of the organization in regard to quality improvement:

*I was able to see the process at a different level, and then you help other coworkers to get insight as well. It makes the culture of the office different, and I thought that was a benefit of the program.*

*It was our first experience with being involved in that QI level of care; usually our QI department do all of that, and our peers also participated in the CQII for the peers, so all of us were able to play our role and take responsibility, ensuring screening and referral language to learn how it affects our numbers. So, for us being able to talk about our data as I was entering it, and work through it vs. us just being told what the data was important for us. It helped us take ownership as a department.*

*I think certainly the Collaborative reinforces the whole team dynamic.*

*It enhanced our services and it helped us restructure how we do the whole process.*
One participant explained that they have plans in place to identify those patients who might need screening on their next visit or need follow-up and added that “our structure became more formalized and a more multidisciplinary team approach.” Other participants reported their general approach as a result of the Collaborative included greater attention to collaboration and sustainability, an increased focus on capacity-building, and an improvement in how they engage meaningful involvement of their community members from the start (for example, one participant described how they had involved “lived experience experts” – as they now referred to their patients – in the decision-making of which screening tool to use).

Collaborative Facilitators and Challenges

Factors that facilitated participation and success. When asked which factors contributed to a successful experience, most of the elements cited by focus group participants were internal to the Collaborative [see pg. 15], but there were a couple of external factors mentioned by participants. One noted that they had what they termed a “provider champion” who publicized the work to other providers. Another felt that “having another person from the same organization to collaborate with and do it together makes a big difference.” Participation in previous collaboratives also facilitated a successful experience; as one participant explained, “I think everyone will [be enthusiastic] once they go through a collaborative once; having done it, people have better expectations and enthusiasm.”

Barriers. Generally, respondents were enthusiastic about what they had gained from Collaborative participation. However, some felt that the time commitment involved in the meetings was onerous:

The number of meetings sometimes was a lot... have to get mind wrapped around what you’re committing to timewise... knowing what you’re going to need from a data perspective to get VSR every month takes a while to get a good routine down.

Just throwing it out there, maybe having meetings on a quarterly basis, but having the same meetings multiple time to give options of when to attend.

Learning Sessions were hard to attend because it was a large block of time and conflicted with a lot of already standing meetings.

Another felt that they had stepped up only to end up carrying the full burden for their organization:

I think I was the only team member who was enthusiastic about participating in this Collaborative. What I learned from this was that if everyone’s not enthusiastic, don’t do it, because a lot of the time it was me. In hindsight, if I don’t have everybody’s enthusiasm, I have to learn how to say no.

Participants also cited challenges working with other staff. Not only was high staff turnover a difficulty (especially when different staff were taking over the role of CQI), but several reported challenges working with patient-facing staff:

A barrier for us was case manager discomfort in having conversations with our patients about substance use, or who should be doing it... We thought it would be easy, but we realized that case managers weren’t ready for it.
When we would take this back to our team doing clinical work it was like pulling teeth sometimes to get them to understand this work.

Hard to convince people it can be worth their while.

Sometimes it felt like I was just giving more work to clinical people, so maybe they needed more patient-facing people on the project.

Support needs. When asked what the Collaborative could do to support them further, several participants noted that they did not take full advantage of the assistance of the coaches because they did not fully understand their role. One said, “I would recommend that Coaches make themselves absolutely known from the very beginning and what assistance they’re capable of providing.” Another participant further explained that “they introduced themselves and made themselves available, but we just learned that we could’ve asked very specific questions, but it never crossed our mind.” Others agreed, with one saying that “having that direct interaction of coaching wasn’t there most of the first time” and then we certainly took full advantage of it during the second time and it made the world of difference,” and another saying, “If I were to do it again, I would’ve reached out to coach more to have her walk me through the steps.”

The other need for support mentioned by participants was simply “a continuation of the service and support” that they had already received from the Collaborative, with specific suggestions including another training for quality leaders and monthly webinars for teaching new learning tools.

Overall, however, participants reported relatively few unmet support needs. One said there was “nothing they should have done better,” while another concluded, “At this point, I don’t think we have any need, just more resources…. I really think that we got everything that we needed.”

Would you recommend that others participate in this Collaborative? In sum, the participants generally showed high enthusiasm for the Collaborative, and overwhelmingly reported that they would recommend others to participate:

What’s not to like about collaboration?

Those who participate will learn a lot of strategies and helpful information.

Anybody would benefit from this even if they’re a beginner in QI... get the benefit of the knowledge of your peers across the country... I can get an opportunity to get answers from different perspectives... I get feedback from people who do the same thing I do across the country, not just in this state.

Absolutely... with this collaborative it shows us perspectives of other organizations trying to do same work... seeing how other people are also struggling... nice to have support and ask reference questions and to gain new skills.

Yes, [the Collaborative] was very knowledgeable and being able to network with other organizations... able to see other organizations and bounce ideas off of each other.

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7 It was unclear if “the first time” referred to experience with a previous collaborative or a prior timepoint with the create+equity Collaborative.
Now that we have gotten to the end, we have met our goals and we know what our successes and shortcomings were, so I feel like we were supported very well and still have tools to go forward with it.

Some particularly noted that the assistance and support they had received had been at no cost to their organization:

Where else would we get access to such knowledgeable professionals... really felt like we had a community in this group. CQII coaches are excellent and willing to help, and it didn’t cost a dime.

Gives you motivated to do something that’s a process and long-term, and we’re learning at the same time. They always made it interesting and lively and not too much of a burden... support you get, it’s free.

As one participant summarized: “I think overall this Collaborative is incredible because it causes people to come together and everybody is of importance. You matter out here.”