



# RYAN WHITE FUNDED AREAS IN VIRGINIA

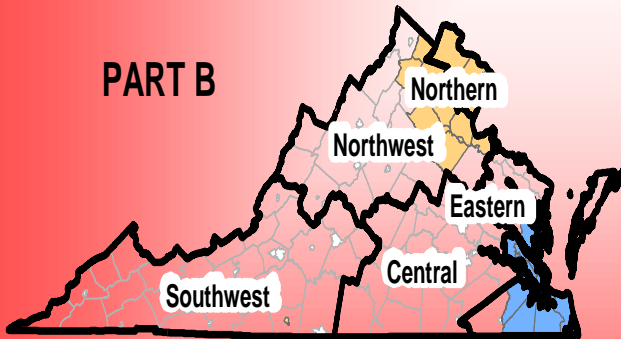
**PART A  
LOCALITIES  
IN NORFOLK  
TGA**



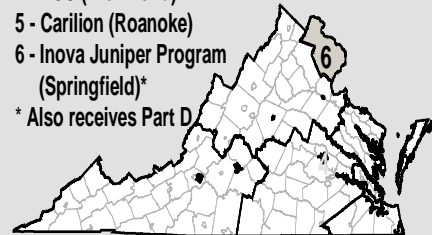
**PART A  
N. VA  
LOCALITIES  
IN DC EMA**



**PART B**



- 1 - UVA (Charlottesville)
- 2 - Mary Washington Hospital/Medicorp (Fredericksburg)
- 3 - Centra (Lynchburg)
- 4 - VCU (Richmond)\*
- 5 - Carilion (Roanoke)
- 6 - Inova Juniper Program (Springfield)\*
- \* Also receives Part D



**PARTS C & D**



# TABLE OF CONTENTS

<b>SECTION: A</b>	
<b>INTRODUCTION.....</b>	<b>1</b>
<b>SECTION: B</b>	
<b>QUALITY STATEMENT.....</b>	<b>2</b>
<b>MISSION.....</b>	<b>2</b>
<b>VISION.....</b>	<b>2</b>
<b>VALUES.....</b>	<b>2</b>
<b>GOALS.....</b>	<b>2</b>
<b>PURPOSE.....</b>	<b>3</b>
<b>AIM STATEMENT.....</b>	<b>3</b>
<b>SECTION: C</b>	
<b>DEFINITION OF QUALITY.....</b>	<b>3</b>
<b>QUALITY.....</b>	<b>4</b>
<b>QUALITY MANAGEMENT.....</b>	<b>4</b>
<b>QUALITY ASSURANCE.....</b>	<b>4</b>
<b>QUALITY IMPROVEMENT.....</b>	<b>4</b>
<b>PLAN, DO, STUDY, ACT (PDSA) CYCLES.....</b>	<b>4</b>
<b>SECTION: D</b>	
<b>SCOPE OF RYAN WHITE PART B PROGRAMS.....</b>	<b>4</b>
<b>SECTION: E</b>	
<b>QUALITY IMPROVEMENT INFRASTRUCTURE.....</b>	<b>6</b>
<b>LEADERSHIP AND ACCOUNTABILITY.....</b>	<b>6</b>
<b>QUALITY MANAGEMENT COMMITTEES.....</b>	<b>7</b>
<b>QUALITY IMPROVEMENT PROJECT TEAMS (QIPT).....</b>	<b>9</b>
<b>STATEWIDE PROVIDER PEER REVIEW.....</b>	<b>9</b>
<b>DEDICATED RESOURCES.....</b>	<b>9</b>
<b>MEETING SCHEDULE.....</b>	<b>10</b>
<b>SECTION: F</b>	
<b>QUALITY PLAN IMPLEMENTATION (WORK PLAN).....</b>	<b>10</b>
<b>QUALITY MANAGEMENT PROGRAM-THREE YEAR STRATEGIC     WORK PLAN.....</b>	<b>11</b>
<b>QUALITY MANAGEMENT PROGRAM, WORK PLAN 2011-2012.....</b>	<b>13</b>
<b>SECTION: G</b>	
<b>PERFORMANCE MEASUREMENT.....</b>	<b>22</b>
<b>DATA COLLECTION.....</b>	<b>22</b>
<b>REPORTING MECHANISMS OF DATA.....</b>	<b>23</b>
<b>SECTION: H</b>	
<b>PARTICIPATION OF STAKEHOLDERS.....</b>	<b>28</b>

<b>SECTION: I</b>	
<b>EVALUATION.....</b>	<b>31</b>
<b>SECTION: J</b>	
<b>CAPACITY BUILDING.....</b>	<b>33</b>
<b>SECTION: K</b>	
<b>PROCESS TO UPDATE THE PLAN.....</b>	<b>34</b>
<b>SECTION: L</b>	
<b>COMMUNICATION.....</b>	<b>34</b>
<b>SECTION: M</b>	
<b>COORDINATION WITH OTHER STATEWIDE QUALITY MANAGEMENT</b>	
<b>ACTIVITIES.....</b>	<b>36</b>
<b>SECTION: N</b>	
<b>LIMITATIONS &amp; CAUTIONS .....</b>	<b>37</b>
<b>APPENDIX 1 – ACRONYMS.....</b>	<b>39</b>
<b>ACKNOWLEDGEMENT.....</b>	<b>40</b>

**LIST OF TABLES**

**TABLE 1:**  
**HIV CARE SERVICES UNIT.....5**

**TABLE 2:**  
**THREE-YEAR STRATEGIC PLAN.....11**

**TABLE 3:**  
**IMPLEMENTATION/WORK PLAN FY2011-2012.....14**

**TABLE 4:**  
**PERFORMANCE MEASURES.....24**

## 1. INTRODUCTION

The Ryan White (RW) Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) Treatment Extension Act of 2009 requires Clinical Quality Management (CQM) programs as a condition of grant awards. The Virginia Department of Health (VDH) is committed to improving the quality of care and services for people living with HIV and AIDS through continuous quality monitoring and improvement in a comprehensive performance measurement program. This effort requires ongoing communication with consumers, employees, stakeholders, Quality Management Advisory Committee (QMAC), Quality Management Leadership Team (QMLT), Peer Review Team, contractors, subcontractors and all levels of management. The Quality Management (QM) expectations for RW Part B (RWPB) Program grantees include:

- Assist HIV/AIDS service contractors and subcontractors funded through the RW Program in assuring that funded services adhere to established HIV clinical practice standards and Public Health Services (PHS) Guidelines to the greatest extent possible;
- Ensure that strategies for improvements to quality medical care include achieving appropriate access to HIV care and support for treatment adherence; and
- Ensure that available demographic, client satisfaction, clinical, and health care utilization information is used to monitor the spectrum of HIV-related illnesses and trends in the local epidemic.

The QM Plan (QMP) reflects an ongoing improvement process, which also informs the delivery system of outcome results, demonstrating commitment to quality services for all individuals served within the Virginia RWPB provider network. The QMP also guides root cause analysis and corrective actions for identified problems. To ensure a useful and current QMP, the QM Committees (QMC) will review the progress of the plan on a quarterly basis and conduct an annual review of the QMP.

The 2011 QMP was developed based on the latest Statewide HIV Comprehensive Plan (SCP) and Statewide Coordinated Statement of Need (SCSN), which included input from stakeholders and consumers throughout Virginia and across RW Programs. Both can be found at:

<http://www.vdh.virginia.gov/epidemiology/DiseasePrevention>.

This QMP is effective April 1, 2011. If you have any questions concerning this plan, please contact Safere Diawara, MPH, QM Coordinator at (804) 864-8021 or by email [Safere.Diawara@vdh.virginia.gov](mailto:Safere.Diawara@vdh.virginia.gov)

This document describes the structure, guiding principles, and process that will be used to implement a QM Program, and includes a timeline for annual implementation, revision, and evaluation of the plan.

## **Structure of the HIV Quality Management Plan**

This document is organized into the following sections:

1. Introduction
2. Quality Statement
3. QM Infrastructure
4. Goal and Implementation Plan
5. Capacity Building
6. Performance Measurement
7. Participation and Communication with Stakeholders
8. QM Evaluation Plan
9. Process to Update the QMP
10. Communication
11. Cautions and Limitations

## **2. QUALITY STATEMENT**

### **A. Mission Statement**

The Virginia RWPB QM Program exists to ensure the highest quality medical care and supportive services for people living with HIV/AIDS in Virginia through statewide leadership and stakeholder collaboration.

### **B. Vision**

We envision optimal health for all people affected by HIV/AIDS, supported by a health care system that assures ready access to comprehensive, competent, quality care that transforms lives and communities.

### **C. Values**

We believe in creating HIV/AIDS services that inspire and promote:

- Mutual respect
- Safe and confidential environments
- Education to increase empowerment and self sufficiency
- Quality Improvement (QI) and accountability
- Creativity and innovation
- Diversity
- Cultural competency
- Community responsibility
- Wellness

### **D. Goals**

The overall goal of the RWPB QM Program is to monitor continuous quality improvement (CQI) activities of contractors and subcontractors providing services throughout Virginia. Other goals include:

- Assessing QM needs, educating service providers, and building capacity within RWPB funded agencies statewide;
- Providing stakeholders with valid and reliable outcomes data as well as needs assessment and client satisfaction data;
- Improving quality of care in meeting the service needs of clients statewide;
- Assisting providers in assuring adherence to PHS Guidelines; and
- Improving existing databases and data management.

#### **E. Purpose**

The QM Program is designed to:

- Provide guidance, assistance, and educational activities related to QI, Quality Assurance (QA) and QM;
- Meet or exceed the QM expectations of current federal RW legislation;
- Assess the extent to which HIV health services provided to clients under the grant are consistent with the most recent PHS Guidelines for the treatment of HIV diseases and related opportunistic infections;
- Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to care and quality of HIV health services; and
- Promote commitment to quality of care throughout the RW continuum of care.

#### **F. Aim Statement**

The aim is to establish and maintain a seamless system of comprehensive HIV services that provides a continuum of care and eliminates health disparities across jurisdictions for the quality of life of people living with HIV/AIDS in Virginia. Additionally, the QM Program aims to continuously improve the quality of care and services of the HIV/AIDS programs provided by RWPB providers and their partners and to be compliant with recognized treatment guidelines, standards of care, and best practices. This will be accomplished by:

- Developing and implementing a statewide QMP;
- Monitoring core performance measures across RWPB recipients and sub-recipients;
- Improving services through quality development modules; and
- Participating in national QM collaborative projects initiated by Health Resources and Service Administration (HRSA) and the National Quality Center (NQC) including the Patient Safety and Clinical Pharmacy Services Collaborative (PSPC), District of Columbia (DC) Eligible Metropolitan (EMA) Cross-Parts Collaborative, and the VA RW Cross-Parts Collaborative.

### **3. DEFINITION OF QUALITY**

QI terminology is often used interchangeably. The following definitions can be found in the QM Technical Assistance manual developed by HRSA.

#### **A. Quality**

Quality is the degree to which a health or social service meets or exceeds established professional standards and user expectations. Evaluation of the quality of care should consider: The quality of the inputs, the quality of the service delivery process, and the quality of life outcomes.

### **B. Quality Management**

QM is a larger concept, encompassing continuous QI activities and the management of systems that foster such activities: communication, education, and commitment of resources. The integration of quality throughout the organization of the agency is referred to as QM. The QM Program embraces QA and QI functions.

### **C. Quality Assurance**

QA refers to a broad spectrum of ongoing/continuous evaluation activities design to ensure compliance with minimum quality standards. An ongoing monitoring of services for compliance with the most recent PHS guidelines for the treatment of HIV disease and related opportunistic infections, and adherence to State and federal laws, rules, and regulations.

### **D. Quality Improvement**

QI is generally used to describe the ongoing monitoring, evaluation, and improvement process. It includes a client-driven philosophy and process that focuses on preventing problems and maximizing quality of care. This focus is a means for measuring improvement to access and quality of HIV services.

### **E. Plan, Do, Study, Act (PDSA) Cycles**

The Virginia QI process is based on the PDSA cycle methodology. This model for performance improvement will be used for all QI activities:

- **PLAN** – Identify and analyze what you intend to improve, looking for areas that hold opportunities for change.
- **DO** – Carry out the change or test on a small scale (if possible).
- **STUDY** – What was learned? What went wrong? Did the change lead to improvements in the way you had hoped?
- **ACT** – Adopt the change, abandon it, or run through the cycle again.

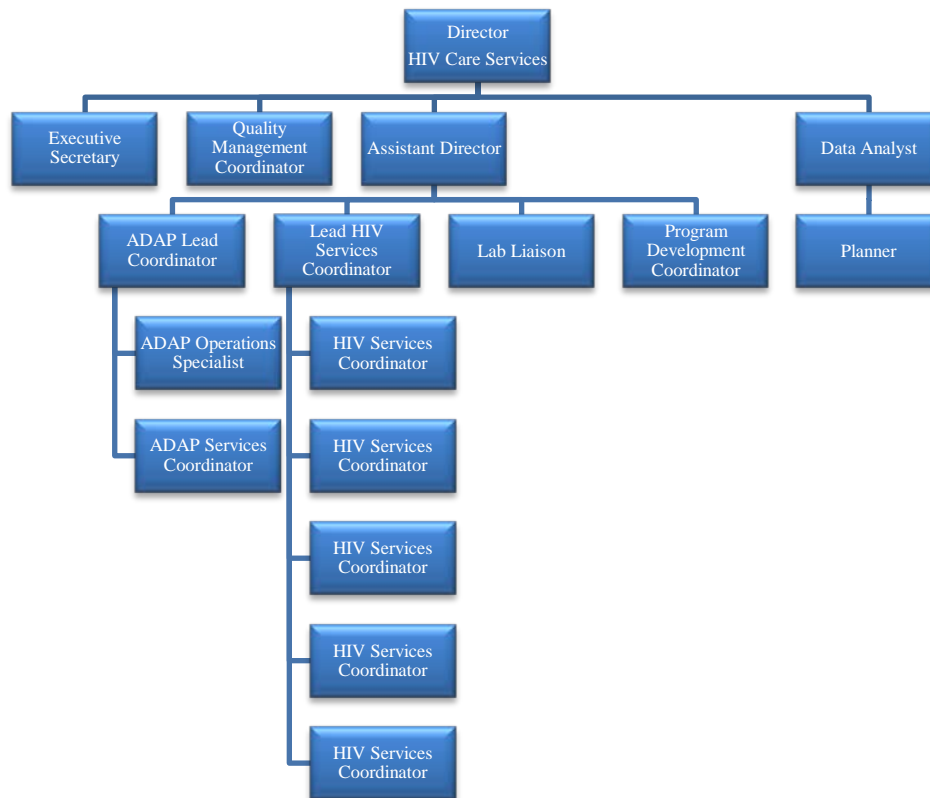
## **4. SCOPE OF RWPB PROGRAMS**

RWPB provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five U.S. Pacific Territories or Associated Jurisdictions. Part B grants include a base award, an AIDS Drug Assist Program (ADAP) award, ADAP supplemental funds, Minority AIDS Initiative (MAI) funds, and awards to states for Emerging Communities - those reporting between 500 and 999 cumulative AIDS cases over the most recent five-year period. All funding is distributed via formula and other criteria.

The Governor of Virginia has designated the Secretary of Health and Human Resources as the individual responsible for delegating responsibility for the administration of the Part B grant. The Secretary has designated the State Health Commissioner to submit the grant application and

administer these funds (designation letters available upon request). The VDH Division of Disease Prevention (DDP) carries out these functions under the Commissioner’s authority. Within DDP, the Director of HCS (HCS) reports to the Director of DDP. The Director of HCS supervises the QM Coordinator, the Data Analyst and Evaluator, the Executive Secretary, and the Assistant Director of HCS. The Assistant Director supervises staff responsible for direct coordination and oversight of Part B-funded and state-funded services, including the ADAP Coordinator, the Lead HIV Services Coordinator, a Program Development Coordinator who manages all elements of grants management, and a lab liaison to facilitate statewide access to Trofile testing and coordinate centralized lab testing and billing for services. The Lead HIV Services Coordinator supervises five HIV Services Coordinators who monitor Part B and state-funded contracts. The ADAP Coordinator supervises two ADAP Operations Specialists, medication exceptions, and daily ADAP operations support. These two positions also monitor ADAP-funded service contracts. The Data Analyst supervises the Health Planner,

Portions of positions assigned to other units are funded to provide additional support in administering Part B activities including business, fiscal and pharmacy operations.



**Table 1: HCS unit**

The RWPB attempts to meet the complex needs of eligible persons living with or affected by HIV/AIDS.

- VDH provides core medical and support services for over 4,200 HIV/AIDS clients by funding regional consortia, ADAP, and one emerging communities (EC) Program. In addition, VDH has direct service agreements to provide medical care, adherence support,

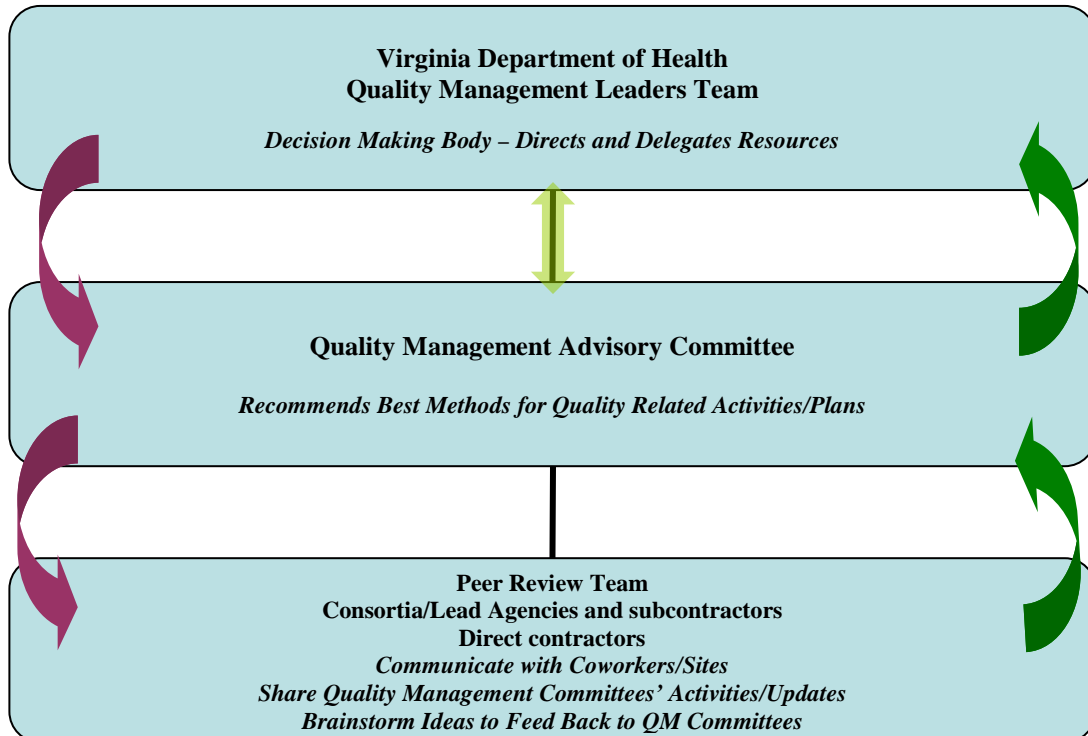
eligibility determination services, and client-level database management. ADAP provides anti-retroviral medications, drugs used for the prophylaxis and treatment of HIV-related conditions and co-morbidities, associated testing, and is implementing a statewide centralized eligibility determination system.

The RWPB QM Program ensures that clients receive comprehensive care based on mandated guidelines, professional standards and best practices.

## 5. QUALITY IMPROVEMENT INFRASTRUCTURE

### A. Leadership and Accountability

- Health Resources and Service Administration (HRSA)  
 An agency of the U.S. Department of Health and Human Services (DHHS) is the primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable. HRSA writes and delivers guidance and expectations to grantees.
- VDH through the DDP (DDP)  
 VDH DDP provides leadership and support to local health departments, medical providers, and community-based organizations (CBOs) in the prevention, surveillance, and treatment of HIV and other sexually transmitted diseases, tuberculosis, and other complications. It is also dedicated to the provision of education, information, and health care services that promote and protect the health of all Virginians. Additionally, DDP collaborates with the Central Pharmacy to ensure the provision of medications and vaccines through ADAP statewide.



- HCS Quality Management Coordinator  
Provides general oversight of the QM Program, coordinates all program evaluation and QM activities, oversees standards of care and outcomes measurement activities, analyzes outcomes data, and integrates the data into requested reports.

The QM Coordinator reports to the Director of HCS, who assumes overall responsibility for the QM Program. The QM Coordinator primary responsibilities include:

- Identifying QM team leaders and champions;
  - Ensuring development, implementation, and evaluation of the QMP;
  - Ensuring the development, implementation, and evaluation of statewide standards, modules, and other tools;
  - Delineating specific goals and responsibilities for the QM team members (e.g. development of the improvement project/PDSA test cycles, meeting facilitation, note taking, etc.);
  - Conducting coordinated QI projects at targeted program sites that are demonstrating lower performance on key indicators;
  - Developing a data collection plan for each project;
  - Identifying potential solutions for performance improvement on key indicators, including immediate and long-term solutions;
  - Providing QM technical assistance, training and support, as needed; and
  - Coordinating QMC meetings.
- The HIV/AIDS Data Team  
The Data Analyst is responsible with the data team for coordinating the Virginia Client Reporting System (VACRS), CAREWare, ADAP Eligibility Reporting system (AERS), Program Evaluation Monitoring System (PEMS), Department of Medical Assistance Services (DMAS) and other databases, generating QM-related reports, submitting required performance measurement data reports, and assisting with other data needs.

The VACRS is a real-time, client-level database that links service providers together through the Internet. Data captured within the VACRS includes client intake information and encounter and medical update information for each client including demographics, co-morbidities, lab markers, service utilization data, and outcomes survey and assessment data.

- RWPB Consortia , direct contractors, subcontractors and Other Providers  
Each individual agency/program is responsible for its own QMP and is accountable to RWPB to provide data, make improvements on areas of low performance, and to share QI Plans with the QMCs.

## **B. Quality Management Committees**

### **1. Quality Management Leadership Team (QMLT)**

The QMLT is charged with providing leadership and oversight for all QI/management activities. The QMLT works closely with the QM Advisory Committee and Statewide Peer Review Team to develop and implement the statewide RWPB QMP, ensure

adequate resources to carry out the annual QM work plan, and engage key stakeholders in the QM Program when appropriate.

Membership of the QMLT consists of:

- Director of HCS
- Assistant Director of HCS
- ADAP Coordinator
- Lead Contract Monitor
- QM Coordinator
- Data Analyst

2. Quality Management Advisory Committee (QMAC)

The membership of the QMAC reflects the diversity of disciplines involved in the Health Resources and Service Administration (HRSA) defined RWPB HIV core and clinical support services. The committee provides oversight and facilitation of the Virginia RWPB QM Program and provides a mechanism for review of objectives evaluation, and continuing improvement of HIV care and support services. The team membership will be reviewed annually and changes made accordingly.

The Committee structure consists of:

- Representatives from the five regions
- VDH- HCS QM Coordinator
- QM Coordinators from local sites
- ADAP Data Coordinator
- Consumers
- Data Managers
- Physicians
- Program Administrators
- Consortia lead agencies

The members will be responsible for:

- Developing priorities and setting QI goals;
- Using continuous improvement methodologies (Plan, Do, Study, Act);
- Providing feedback to address problems/concerns to improve the QM Program;
- Developing and coordinating implementation of the QM work plan;
- Reviewing the QMP on an annual basis and making recommended changes as needed;
- Participating in quarterly meetings to review system-wide QM issues/challenges and developing strategies to improve care;
- Planning and development of educational strategies for RWPB-funded providers; and
- Participating in annual evaluation to review peer review outcome measure reports and determine statewide quality initiatives and performance indicators and goals.

### **C. Quality Improvement Project Teams (QIPTs)**

QIPTs Teams will be ad hoc teams charged with making improvements in specific aspects of care delivery. Using accepted QI methods; the QIPTs identify and test potential care delivery strategies. Membership of the QIPTs is determined by the QMCs, which provide guidance and assistance as needed to the teams.

The QIPTs will assume the following responsibilities:

- Identifying and testing potential solutions for the QI projects identified by the Quality Committees through Plan-Do-Study-Act (PDSA) cycles;
- Sharing the results of the improvement project with the QMCs;
- Making recommendations for implementation and integration of successful improvements throughout the state; and
- Evaluating the teams' work and the process upon completion of the QI project.

The composition of the QIPTs is dependent on the area of improvement selected. Membership should include, but not be limited to, program collaborators, consumers, community members, other individuals identified with relevant expertise, and RWPB staff. Each QIPT will designate a team leader for the process. A QIPT work plan will identify the action steps to be taken, and the person(s) responsible for the identified activities. The Team will meet as often as necessary to accomplish the planned activities. Meeting minutes and work plan updates will be maintained and copies of the minutes will be disseminated to the QI and QMCs.

### **D. Professional Peer Review Team**

The team is comprised of members with experience in specific services areas and includes members who have been diagnosed with HIV. The team will have sufficient members to ensure appropriate review of all service areas for each subcontractor. The team selected for each site review will have a designated chairperson whose role will be to lead the team through the site review, and to compile and submit the reports.

The Statewide Peer Review Team annually reviews 50 percent of the agencies funded. These reviews are held in order to:

- Evaluate the quality of services by examining client charts for eligibility documentation, individual service plans, and adherence to the standards of care as required by HRSA, VDH, and the PHS requirements;
- Conduct client interviews;
- Coordinate the collection of client and program outcome data; and
- Analyze and report the findings to all relevant stakeholders.

Peer review services will be put out for bid to cover grant year 2011 review cycle.

### **E. Dedicated Resources**

- The Virginia RWPB grant provides funding and personnel resources for QM Improvement.

- HRSA, HIV/AIDS Bureau, QM Technical Assistance Manual, and other QI and outcome related documents located at <http://hab.hrsa.gov/tools/QM>.
- The National Quality Center of the New York State Department of Health will provide technical assistance, training, and QI resources as needed <http://www.NationalQualityCenter.org>.
- HIV Clinical Resource – New York State Department of Health AIDS Institute <http://www.hivqual.org>.
- The Local Performance Sites of the Pennsylvania/Mid-Atlantic AETC.
- Virginia Northern, Eastern and Central/Southwest HARCCs.
- The RWPB QMCs.
- VDH HIV/AIDS Surveillance Unit.
- Consortia and direct providers.
- Other personnel as needed.
- Epidemiology Profile for Virginia.

#### **F. Meeting Schedule**

The QMLT will meet at least weekly after the staff meeting and as needed.

The QM Leadership Team will be meeting on a quarterly basis and the QM Coordinator will prepare and distribute an agenda prior to the meeting.

The QM Advisory Committee will meet quarterly as follows:

First quarter – Review data and set objectives.

Second quarter – Agency report on QI projects.

Third quarter - Agency report on QI projects.

Fourth quarter – Continued reporting and revising plans.

## **6. WORK PLAN IMPLEMENTATION**

The work plan specifies objectives and strategies for QM goals.

Client-level health outcomes goals are based on the HAB-HIV Clinical Performance Measures.

The QMP includes a timeline that incorporates the development, implementation, and revision of the plan based on the RWPB grant year. The work plan will be revised at least quarterly by the QMCs.

### **A. Quality Management Program Three-Year Strategic Work Plan**

Goals include:

1. Develop, implement and deploy the statewide RWPB QMP;
2. Strengthen the existing HIV QM infrastructure within the RWPB Program that supports QI activities in Virginia;
3. Develop and implement the outcome and performance measures at all levels, providing necessary technical assistance and training when necessary;
4. Enhance the ability to evaluate and address the crucial questions related to QM;
5. Assure QI projects occur at state and local levels; and
6. Strengthen the evaluation of RWPB QM Program

Implementation Timeframe:  
 Year one: 2009-2010  
 Year two: 2010-2011  
 Year three: 2011-2012

**Three-year strategic plan will include:**

**TABLE 2: THREE-YEAR STRATEGIC PLAN**

<b>GOAL A: Develop, implement and deploy the statewide RWPB QMP.</b>			
<b>Area</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
<b>Develop QMP</b>	Develop, implement and evaluate QMP and Annual QM Work plan.	Review QMP; update annual QM Work Plan as needed.	Review QMP; update annual QM Work Plan as needed.
<b>GOAL B: Strengthen the existing HIV QM Infrastructure within the RWPB that supports QI activities in Virginia.</b>			
<b>Area</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
<b>Infrastructure:</b> <ul style="list-style-type: none"> <li>▪QM Leadership Team (VDH)</li> <li>▪QM Advisory Committee</li> <li>▪Peer Review Team</li> </ul>	Identify members from key agencies, invite members to serve on committees, and develop and provide orientation.	Expand membership to include other representatives.  Establish linkages and connections to HCS unit within VDH to develop partnerships.	Expand membership to include other representatives.  Maintain linkages and connections to HCS unit within VDH such as DDP Partnership.
<b>GOAL C: Develop and implement the outcome and performance measures at all levels, providing necessary technical assistance and training when necessary.</b>			
<b>Area</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
<b>Performance Measurement</b>	Develop/refine data collection methodologies.	Evaluate and update data collection plan and methodologies as needed.	Revise and update data collection plan and methodologies as needed.
	Select five indicators to monitor during the fiscal year to be tracked, analyzed and reported.	Expand indicators to be monitored.	Expand indicators to be monitored.
	Determine performance baseline data.	Determine performance benchmark data for the year.	Determine performance benchmark data for the year.
	Measure indicators.	Measure indicators.	Measure indicators.
	Improve data assurance by reducing missing data.	Reduce missing data and standardize data collection tools for accuracy and completeness.	Reduce missing data and standardize data collection tools for accuracy and completeness.
<b>GOAL D: Enhance the ability to evaluate and address the crucial questions related to QM</b>			
<b>Area</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
<b>Capacity Building</b>	Identify and address the unmet trainings and education needs for staff, QMCs, Part B	Identify and address the unmet trainings and education needs for staff, QMCs, Part B	Identify and address the unmet trainings and education needs for staff, QMCs, Part B funded service providers and consumers.

	funded service providers and consumers.	funded service providers and consumers.	
	Hold all RW Grantee meetings February 2009.	Hold all RW Grantee meetings in 2010.	Hold all RW Grantee meetings in 2011.
	Peer review site visits planning and timely reporting results.	Peer review site visits Planning and timely reporting results.  Receive feedback from peer reviewers and providers about content and process.	Peer review site visits Planning and timely reporting results.  Receive feedback from peer reviewers and providers about content and process.
	Provide ongoing QM trainings through VHARCCs, NQC, AETC, and VDH.	Provide ongoing QM trainings through VHARCCs, NQC, AETC, and VDH.	Provide ongoing QM trainings through VHARCCs, NQC, AETC, and VDH.

**GOAL E: Assure QI projects occur at state and local levels**

<b>Area</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
<b>Implement QI Activities/Projects</b>	Coordinate identification and implementation of QI projects for services to be reviewed.	Coordinate identification and implementation of at least 4 QI projects for services to be reviewed.	Coordinate identification and implementation of at least 4 QI projects for services to be reviewed.
	Convene QI Project Team.	Convene QI Project Team.	Convene QI Project Team.
	Provide technical assistance across state.	Provide technical assistance across state.	Provide technical assistance across state.
	Complete providers QM self-assessment by May 2009.	Complete providers QM self-assessment by May 2010.	Complete providers QM self-assessment by May 2011.
	Participate in the Patient Safety and clinical pharmacy services Collaborative (Recruit new team).	Participate in the Patient Safety and clinical pharmacy services Collaborative (Recruit new team and continue existing teams).	Participate in the Patient Safety and clinical pharmacy services Collaborative (continue with existing teams).
	Participate in the VA RW Cross-Parts Collaborative.	Participate in the RW Cross-Parts Collaborative.	Participate in the RW Cross-Part Collaborative and DC EMA Cross-Parts Collaborative.
	Develop liaison among QM Leaders including all Cross Parts Collaborative, Patient Safety and Clinical Pharmacy Services Collaborative, QM Advisory Committee, and the QM Leadership Team.	Maintain liaison among QM Leaders including all Cross Parts Collaborative, Patient Safety and Clinical Pharmacy Services Collaborative, QM Advisory Committee, and the QM Leadership Team.	Maintain liaison among QM Leaders including all Cross Parts Collaborative, Patient Safety and Clinical Pharmacy Services Collaborative, QM Advisory Committee, the QM Leadership Team, and DC EMA Cross-Parts Collaborative.

**Goal F: Strengthen the evaluation of RWPB QM Program**

<b>Area</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
<b>Evaluation</b>	Evaluate QM efforts and identify outcomes.	Evaluate QM efforts and identify outcomes.	Evaluate QM efforts and identify outcomes.

## **B. Quality Management Program Work Plan 2011 – 2012**

### **Implementation Timeline: Year three 2011-2012**

Specific clinical and prevention indicators to be measured for the current year include:

1. Percentage of clients with HIV who had 2 or more CD4 T-cell tests within the year.
2. Percentage of clients with AIDS who are prescribed Highly Active Antiretroviral Therapy (HAART) within the year.
3. Percentage of clients with HIV who had 2 or more medical visits in HIV primary care setting within the year.
4. Percentage of clients with HIV and CD4 T-cell count < 200 prescribed Pneumocystis Pneumonia (PCP) prophylaxis.
5. Percentage of clients with HIV infection who received testing with results documented for Tuberculosis infection (TBI) since HIV diagnosis.
6. Percentage of clients with HIV infection (equal or greater than 18 years old) who had a serologic test for syphilis at least once during the measurement year.
7. Percentage of ADAP clients who are prescribed Highly Active Antiretroviral Therapy (HAART) within the year.
8. Percentage of ADAP clients who will complete at least one eligibility determination through newly implemented centralized eligibility determination system.

The work plan will include goals, areas, objectives, key actions, responsible persons and/or parties, reporting methods, timeline, and status/follow-up.

The overall goals of the Virginia RWPB Program are to increase the quality of care for eligible clients with HIV/AIDS clients and to create a system to monitor continuous improvement.

**TABLE 3: IMPLEMENTATION/WORK PLAN FY2011-2012**

<b>Goal: A. Develop and implement the 2011 RWPB QMP and work plan</b>					
<b>Areas</b>	<b>Objectives</b>	<b>Key action steps</b>	<b>Person/Agency Responsible for Collection</b>	<b>Method of Reporting/Data Sources</b>	<b>Timeline</b>
QMP	Review 2010 QM Plan And update 2011 Annual QMP as needed.	Revise 2010 QMP.	VDH QM Coordinator QMAC/ QMLT.	Read document and submit suggestions.	Submitted by March 31, 2011
		Edit 2011 QMP based on feedback from QMCs.	VDH QM Coordinator.	Write and incorporate submitted feedback.	April 2011
		Approval process of the QMP by VDH and post it on VDH website.	HCS Director.	Approval notice.	April 2011
	Implement QMP.	Provide trainings to providers on QM identified topics.	RWPB staff, QMCs and QM Coordinator.	Trainings/workshops.	Ongoing
		Require core agencies to have in place a QMP.	A written QMP must be available for review at the provider location during site visits.	Number and percent of RW Programs with QMPs.	Ongoing
			Provide technical assistance as needed on writing a QMP.	QM Coordinator.	Ongoing
			All contractors are encouraged to submit performance measures indicators update information with their monthly or quarterly reports.	Monthly or Quarterly QI activities - reports.	Along with required reports
		Monitor implementation of QMP through on-site visits, data analysis and reports documents.	All stakeholders.	Site visit reports VACRS data analysis Submitted reports.	Ongoing

	Evaluate QM Program.	Conduct RWPB Program assessment utilizing the NQC tools.	Virginia VHARCCs.	Final report.	May 2011
		Submit final report on QI activities at the Quality committees' end of year meeting.	All RWPB funded agencies QM Coordinator.	End of year final reports.	June 2011
		Develop HRSA required reports.	VDH QM Coordinator.	Grant application Semi-annual Annual.	January 2011 November 2011 June 2012
	Encourage incorporating RW B performance goals into agencies' QI activities.	Implementation of QI Projects in agencies to meet annual goals.	RWPB funded agencies and QM Coordinators.	Monthly or quarterly contractor reports Semi and annual reports.	Ongoing

<b>Goal: B.</b> Strengthen the existing HIV QM Infrastructure within the RWPB that supports QI activities in Virginia.					
<b>AREA</b>	<b>Objectives</b>	<b>Key action steps</b>	<b>Person/Agency Responsible for Collection</b>	<b>Method of Reporting/Data Sources</b>	<b>Timeline</b>
<b>Infrastructure</b> QM Leadership Team (VDH)	Provide leadership and oversight for all QI/management activities.	Work closely with the QM stakeholders to develop 2011 QMP.	HCS Staff and stakeholders.	Approved QMP.	April 2011
		Implement the 2011 RWPB QMP.	All stakeholders.	Ongoing reports.	By March 2012
	Strengthen collaboration within DDP Partnership to share Programs, policies, and best practices.	Use Established DDP Partnership infrastructure.	HCS QM Coordinator and other DDP staff.	Conjoint documents, policies and procedures.	Ongoing
QM Advisory Committee	Provide oversight and facilitation of the Virginia RWPB QM Program.	Develop priorities and set QI goals for 2011.	All team members.	Meetings Written documents Results analysis and different reports.	April 2011
		Expand membership to include other representatives.	All stakeholders.	Membership list Attendance to required activities.	By March 2012
QI Project Teams (QIPT)	Make improvements in specific aspects of care delivery.	Create ad hoc QI Project and Teams as needed.	Project Team Members QMCs.	QM project reports based on Plan-Do- Study- Act results.	As needed , March 2012

Peer Review Team	Assess 50% of RWB funded program's compliance with relevant standards of care.	Examine client's charts for adherence to the Standards/Guidelines of care as required by HRSA and others.	Selected contractor.	Site visit reports including strengths, area for improvement, deficiencies, and recommendations.	By March 2012
------------------	--	---	----------------------	--	---------------

<b>Goal: C. Ensure that primary care and health-related support services adhere to the most recent US Public Health Service guidelines, federal and state regulations</b>					
<b>Area</b>	<b>Objectives</b>	<b>Key action steps</b>	<b>Person/Agency Responsible for Collection</b>	<b>Method of Reporting/Data Sources</b>	<b>Timeline</b>
Performance measures	75 percent of RW clients with HIV will have 2 or more CD4 T-cell completed in the measurement year.	Clinical chart abstractions, site visits, client interviews, data collection, client satisfaction surveys.	VCU-SERL and all interested stakeholders.	VACRS CAREWare Database ADAP Database.	April/May 2011 Semi-annual – Nov/Dec 2011 Annual – May/June 2012
	90 percent of RW clients with AIDS will have prescribed HAART.	Clinical chart abstractions, site visits, client interviews, data collection, client satisfaction surveys.	VCU-SERL and all interested stakeholders.	VACRS CAREWare Database ADAP Database.	April/May 2011 Semi-annual – Nov/Dec 2011 Annual – May/June 2012
	95 percent of RW clients with HIV will have 2 or more medical visits in HIV setting.	Clinical chart abstractions, site visits, client interviews, data collection, client satisfaction surveys.	VCU-SERL and all interested stakeholders.	VACRS CAREWare Database ADAP Database.	April/May 2011 Semi-annual – Nov/Dec 2011 Annual – May/June 2012
	50 percent of RW clients with HIV and CD4 T-cell count <200 will have prescribed PCP prophylaxis.	Clinical chart abstractions, site visits, client interviews, data collection, client satisfaction surveys.	VCU-SERL and all interested stakeholders.	VACRS CAREWare Database ADAP Database.	April/May 2011 Semi-annual – Nov/Dec 2011 Annual – May/June 2012
	100 percent of RW Clients with HIV infection will receive testing with results documented for Tuberculosis infection (TBI) since HIV diagnosis.	Clinical chart abstractions, site visits, client interviews, data collection, client satisfaction surveys.	VCU-SERL and all interested stakeholders.	VACRS CAREWare Database ADAP Database.	April/May 2011 Semi-annual – Nov/Dec 2011 Annual – May/June 2012

	80 percent of RW Clients with HIV infection and 18 years old or older will have a serologic test for syphilis performed within the measurement year.	Clinical chart abstractions, site visits, client interviews, data collection, client satisfaction surveys.	VCU-SERL and all interested stakeholders.	VACRS CAREWare Database ADAP Database.	April 2011 July 2011 October 2011 January 2012
ADAP	95 percent of ADAP clients will be prescribed a HAART regimen within the measurement year.	Clinical chart abstractions, Data entry into the VACRS.	VCU-SERL.	VACRS CAREWare Database ADAP Database.	April 2011 July 2011 October 2011 January 2012 April 2012
	95 Percent of ADAP clients will complete at least one eligibility determination through newly implemented centralized eligibility determination system.	Data entry and monitoring into ADAP Eligibility Reporting System (AERS) and VACRS.	PSI & SERL.	AERS VACRS.	April 2011 July 2011 October 2011 January 2012 April 2012
<b>Data Collection and Reporting Process</b>	Ensure completeness in statewide data.	Selected performance indicators and measures will continue to be tracked during the year	Requires all sites to report on selected measures and indicators	VACRS Previous data reports ADAP Database Peer Review reports	Ongoing and by March 2012
		Import data from CAREWare and other data systems into VACRS.	VCU-SERL collaborates with several providers.	VACRS CAREWare Database ADAP Database.	Ongoing and by March 2012
	Strengthen strong data QA activities.	Ensure error reports for each provider site to indicate whether requirements for client level data reporting and aggregate level data reporting are met.	VCU-SERL.	VACRS CAREWare Database ADAP Database.	Ongoing and by March 2012
		Monitor the client data records – Percent of HRSA required clinical indicators that met threshold for completeness in calendar year (% known must be 95% for labs and 50% for all other indicator) and provide quarterly feedback to providers	VCU-SERL.	VACRS CAREWare Database ADAP Database.	Quarterly and by December 2011

	QM data reports.	Gather, interpret and present results to the QMCs, VDH and stakeholders.	VCU-SERL and QMCs.	VACRS CAREWare Database ADAP Database Data presentations at contractor meetings.	April/May 2011 Nov/Dec 2011 May/June 2012
--	------------------	--	--------------------	---	---

**Goal: D.** Enhance the ability to evaluate and address the crucial questions related to QM

AREA	Objectives	Key action steps	Person/Agency Responsible for Collection	Method of Reporting/Data Sources	Timeline
	Provide QM trainings for Peer Review Team, QMCs, and other stakeholders.	Identify topics, dates, and locations of trainings, Develop and provide training events.	VDH QM Coordinator and other resources.	Trainings developed and conducted.	Ongoing and by March 2012
	Provide QM trainings and technical assistance to providers.	Identify training needs Develop training materials and Provide trainings.	VDH QM Coordinator and other resources.	Trainings developed and conducted.	By March 2012
	Develop and facilitate QM trainings/workshops for People Living with HIV/AIDS.	Identify training needs and contents from the QMCs and consumers Provide and evaluate trainings.	VDH QM Coordinator and other resources.	Trainings developed and conducted.	By March 2012
	Support other QM training opportunities.	Participate in NQC web conferences, meetings, conferences, and other specific trainings (Case Managers, outreach, etc.).	All stakeholders.	Number of attended events.	Ongoing
	Provide ongoing technical assistance to providers.	Provides technical assistance to providers on QM Principles and any needed specific topics .	QM Leadership Team, QM Advisory Committee and HCS staff.	Number of requested technical assistances Number of technical assistance provided.	By March 2012
	ADAP	Address the training needs of ADAP stakeholders related to Patient Assistance Programs (PAPs) or other clinical issues to improve the service delivery of ADAP.	The ADAP team will provide or coordinate on-site training and technical assistance.  Feedback from consumers, consortia, other contractors,	TA provided Site visits Monthly reports Quarterly conference calls.	Quarterly and/as needed

			planning councils, LHDs and other RW-funded providers are all modes for assessing the medication distribution system.		
ALL grantees meeting	Hold all Grantees meeting.	Identify funding, dates, and locations for 2011 meeting.	VDH and AETCs.	Meeting report.	May 2011
		Collaborate with all grantees to hold a meeting during the 2011 grant year.	AETC sites.	Meeting report.	By December 2011

<b>Goal: E. Facilitate the implementation of QI activities in provider agencies to meet annual quality goals</b>					
<b>AREA</b>	<b>Objectives</b>	<b>Key action steps</b>	<b>Person/Agency Responsible for Collection</b>	<b>Method of Reporting/Data Sources</b>	<b>Timeline</b>
QI Activities	Encourage incorporating the RWPB QM goals into agencies' QI activities.	Disseminate performance goals to all agencies.	All stakeholders VDH staff.	Written documents, face-to-face meetings, telephone, webs and emails.	May 2011
		Implementation of selected QI activities in agencies to meet annual goals.	All providers.	Submitted QI reports and site visit reports.	Ongoing by March 2012
	ADAP QM assessments of medication treatment regimens, adherence issues, and drug utilization.	Conduct 24 site visits (2 visits per month) and chart audits to assess the adherence status. Medication regimens.	HCS ADAP staff.	ADAP database Site visits ADAP Eligibility Report system (AERS).	By March 2012
Peer Review	Strengthen peer review tools and process.	Review and update Standards of care and related Modules Make changes on processes to incorporate collected suggestions.	VHARCC, VDH, consumers and providers.	Written documents, policies and procedures.	By June 2011 and as needed

	Evaluate processes and effectiveness of HIV programs.	Conduct review of selected sites including chart abstractions.	Selected contractor and HCS staff.	Site visit reports Data analysis and presentation.	Completed by March 2012
		Present annual PR report to key stakeholders.	Selected contractor and HCS staff.	End of year final report.	May 2012
QI Projects	Assure QI Projects occur at the state and local levels.	QMCs will identify needed QI projects.	QMCs.	Meeting Minutes List of identified projects and teams.	As needed.
		Communicate findings based on Plan, Do, Study, and Act (PDSA) tests of change to key stakeholders.	Develop summary report Present at contractor meetings, QMC meetings, and other events.	End of project reports.	Ongoing and by May 2012
Collaborative	The Virginia RW Cross-Part QM Collaborative.	RWB will keep working with other RW Parts to sustain Cross-Parts alignment of quality efforts in Virginia.	Services will be tracked and measured to find improved health outcomes.	All RW Cross-Parts Teams.	By March 2012
	The HRSA Patient Safety and Clinical Pharmacy Services Collaborative (PSCPS) project.	Support the EVMS PSPC Team Keep meeting on monthly basis.	Eastern Virginia Medical School (EVMS), ESHD, TRHD, PharmD and HCS staff.	Meeting minutes, submitted reports and data analysis.	By March 2012
	The local Pennsylvania/Mid-Atlantic AETC performance sites and the HARCCs.	VDH will work closely with the local Pennsylvania/Mid-Atlantic AETC performance sites and the VHARCCs.	Planning educational conferences and videoconferencing for local ADAP Coordinators, medical providers, case managers, and other professionals working with PLWHAs.	Training reports.	Ongoing
	Incorporate survey finding into QI activities.	Assist service providers to identify processes which may impact client satisfaction and develop appropriate mechanisms to address the issues identified.	HCS QM Coordinator and stakeholders.	QM reports Agency updated QMP.	March 2012

**Goal: F. Strengthen the evaluation of RWPB QM Program**

<b>AREA</b>	<b>Objectives</b>	<b>Key action steps</b>	<b>Person/Agency Responsible for Collection</b>	<b>Method of Reporting/Data Sources</b>	<b>Timeline</b>
Evaluation	Evaluate process and effectiveness of HIV programs.	Outcomes evaluation and dissemination of results to the stakeholders.	QMCs.	Review semi-annual and annual CQI reports.	Nov/Dec 2011, May/June 2012
	Revise Virginia RWPB QMP as needed.	Get more of teams involved in data collection/chart reviews.	QMCs, Peer Review Team and other stakeholders.	Updated QMP.	April 2011
	Evaluate QI projects.	Initiate evaluation of QI projects and reporting results back to QMCs.	QM Project Teams QMCs.	End of project reports.	When applicable

## 7. PERFORMANCE MEASUREMENT

Performance measurement is the central component of the QM Program. The QMCs will use performance measurement data to identify and prioritize QI Projects and to routinely monitor the quality of care provided to clients.

### A. Data Collection

Data will be collected from a variety of sources and to the extent possible, existing data sources will be utilized from several sources including the VACRS, client interviews and chart reviews. The data collection efforts should place as minimal a burden as possible on the sources and should minimize any interference with the routine operations of provided services.

Persons involved with the collection of data will be bound by program, local, state and federal regulations regarding confidentiality. Individuals involved in the collection of data should receive appropriate training regarding their role, the confidentiality and security of data, and other ethical issues.

Data collection will include:

- Data required to determine client eligibility;
- Data required by funders;
- Outcomes data developed for specific programs;
- Client Satisfaction data;
- Data to assess the needs of people living with HIV/AIDS (PLWHA) in Virginia;
- Other data as QM activities require or deem necessary.

#### 1. Strategies

The data teams, staff from funded agencies, and peer review team will assist with data collection strategies.

Data collection will be implemented utilizing appropriate sampling methodology and will include both concurrent and retrospective review. For each data collection activity scheduled in the QM annual work plan, a data collection plan will be developed that specifies:

- The purpose of the data collection activity.
- The measures and indicators to be collected.
- The instruments and methods to be used to collect the identified data.
- The analysis plan for the data.
- The methods for data security (including issues relating to confidentiality of client-specific data, and to determine how and for how long the data instruments and databases will be stored.
- How and to whom the findings will be reported.

## 2. Data sources

The Virginia QM Program is responsible for the regular collection, analysis and reporting of QM data. This data includes, but is not limited to:

- Chart abstractions from client medical records (Paper or electronic)
- Clinical databases
- Demographic databases
- Client satisfaction surveys/interviews
- Utilization patterns
- Billing records
- Focus group summary
- Statewide Coordinated Statement of Need (SCSN)
- CAREWare
- Enhanced HIV/AIDS Reporting System (eHARS)
- VACRS
- Administrative/Programmatic monitoring tools
- ADAP database
- Unmet Needs
- ADAP Eligibility Reporting System (AERS)

### **B. Reporting Mechanisms of Data**

Findings for QM activities will be reported in aggregate format, and will not include client-level data. Program-specific data reports may be directly provided to each program for the purpose of enhancing their QM Program.

RWPB QM utilizes strategies outlined in the HIV/AIDS Bureau (HAB) HIV/AIDS Core Clinical Performance Measures for Adults and Adolescents to measure selected key performance indicators for HIV health care.

RWPB contractors and subcontractors will be required to report data on these selected key performance indicators. Compiled findings will be shared with HIV providers, Consortia, VDH leadership, and others. The QM Coordinator will be responsible for oversight and ensuring implementation of the established process.

The following table provides currently available data that are being tracked and reported for all RWPB services in Virginia. The Core Clinical Data have been selected from the recommendations of the HIV/AIDS Bureau.

**TABLE 4: PERFORMANCE MEASURES**

<b>CORE CLINICAL MEASURES</b>					
<b>Measurement Outcome</b>	<b>Indicator to be Measured</b>	<b>Data Elements used to Measure Indicator</b>	<b>Data Source &amp; Methods</b>	<b>Analyzing &amp; Reviewing Data</b>	<b>Data Usage</b>
Percent of RW clients with HIV who had 2 or more CD4 T-cell tests and Viral Load counts performed in the measurement year.	Change in the number of RW clients with HIV who had 2 or more CD4 T-cell and Viral Load counts performed in the measurement year.	<p><b>Numerator:</b> # of HIV-infected clients who had 2 or more CD4 T-cell counts performed at least 3 months apart during the measurement year.</p> <p><b>Denominator:</b> Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.</p>	VACRS CAREWare Database ADAP Database Other Sources.	RW data Coordinators and Virginia Commonwealth University Survey Evaluation and Research Laboratory are responsible for reviewing data and presenting to the QMCs.	Provide data to the QMCs to determine: 1) Was the goal met? 2) Should we continue track this measurement?
Percent of RW clients with AIDS who are prescribed HAART.	Change in the number of RW clients with AIDS who are prescribed HAART.	<p><b>Numerator:</b> Number of clients with AIDS who were prescribed a HAART regimen within the measurement year.</p> <p><b>Denominator:</b> Number of clients who have a diagnosis of AIDS, and had at least one medical visit with a provider with prescribing privileges in the measurement year.</p>	VACRS CAREWare Database ADAP Database Other Sources.	RW data Coordinators and Virginia Commonwealth University Survey Evaluation and Research Laboratory are responsible for reviewing data and presenting to the QMCs.	Provide data to the QMCs to determine: 1) Was the goal met? 2) Should we continue track this measurement?
Percent of RW clients with HIV who had 2 or	Change in the number of RW clients with HIV who	<b>Numerator:</b> Number of HIV-infected	VACRS CAREWare	RW data Coordinators and	Provide data to the QMCs to determine:

more medical visits in HIV setting.	had 2 or more medical visits in HIV setting.	clients who had a medical visit with a provider with prescribing privileges, in an HIV care setting two or more times at least 3 months apart during the measurement year.  <b>Denominator:</b> Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.	Database ADAP Database Other Sources.	Virginia Commonwealth University Survey Evaluation and Research Laboratory are responsible for reviewing data and presenting to the QMCs.	1) Was the goal met? 2) Should we continue track this measurement?
Percent of RW clients with HIV and CD4 T-cell <200 who are prescribed PCP prophylaxis.	Change in the number of RW clients with HIV and CD4 T-cell <200 who will have prescribed PCP prophylaxis.	<b>Numerator:</b> Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm3 who were prescribed PCP prophylaxis.  <b>Denominator:</b> Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year, and had a CD4 T-cell count below 200 cells/mm3.	VACRS CAREWare Database ADAP Database Other Sources.	RW data Coordinators and Virginia Commonwealth University Survey Evaluation and Research Laboratory are responsible for reviewing data and presenting to the QMCs.	Provide data to the QMCs to determine: 1) Was the goal met? 2) Should we continue track this measurement?
Percent of RW Clients with HIV infection who received testing with results documented for latent Tuberculosis infection (LTBI) since HIV diagnosis.	Change in the number of RW Clients with HIV infection who received testing with results documented for latent Tuberculosis infection (LTBI) since HIV diagnosis.	<b>Numerator:</b> Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release	VACRS CAREWare Database ADAP Database Other Sources.	RW data Coordinators and Virginia Commonwealth University Survey Evaluation and Research	Provide data to the QMCs to determine: 1) Was the goal met? 2) Should we continue track this measurement?

		<p>assay [IGRA]) since HIV diagnosis.</p> <p><b>Denominator:</b>  Number of HIV-infected clients who:</p> <ul style="list-style-type: none"> <li>▪ do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and</li> <li>▪ had a medical visit with a provider prescribing privileges at least once in the measurement year.</li> </ul>		Laboratory are responsible for reviewing data and presenting to the QMCs.	
Percent of RW Clients with HIV infection (18 years or older) who had a serologic test for syphilis performed at least once during the measurement year.	Change in the number of RW Clients with HIV infection (18 years or older) who had a serologic test for syphilis performed at least once during the measurement year.	<p><b>Numerator:</b>  Number of HIV-infected clients (18 years or older) who had a serologic test for syphilis performed at least once during the measurement year.</p> <p><b>Denominator:</b>  Number of HIV-infected clients</p> <ul style="list-style-type: none"> <li>▪ 18 years or older or</li> <li>▪ had a history of sexual activity &lt;18 years and</li> <li>▪ had a medical visit with a provider with prescribing privileges at least once in the measurement year.</li> </ul>	VACRS CAREWare Database ADAP Database Other Sources.	RW data Coordinators and Virginia Commonwealth University Survey Evaluation and Research Laboratory are responsible for reviewing data and presenting to the QMCs.	Provide data to the QMCs to determine: 1) Was the goal met? 2) Should we continue track this measurement?
ADAP	Percentage of ADAP clients with AIDS who were prescribed a HAART regimen within the	<p><b>Numerator:</b>  Number of ADAP clients with AIDS who were prescribed a HAART</p>	ADAP Database Other Sources	HCS and Virginia, PSI and SERL are responsible for reviewing data	Provide data to the QMCs to determine: 1) Was the goal met? 2) Should we continue

	measurement year.	regimen within the measurement year.  <b>Denominator:</b> Number of ADAP clients with a provider with prescribing privileges in the measurement year.		and presenting to the QMCs.	track this measurement? 30 Make needed changes
	Percentage of ADAP clients who complete at least one eligibility determination through newly implemented centralized eligibility determination system.	<b>Numerator:</b> Number of ADAP clients with at least one eligibility determination with PSI.  <b>Denominator:</b> Number of ADAP clients seen in the measurement year.	ADAP Database AERS.	HCS and Virginia, PSI and SERL are responsible for reviewing data and presenting to the QMCs.	Provide data to the QMCs to determine: 1) Was the goal met? 2) Should we continue track this measurement? 30 Make needed changes

## 8. PARTICIPATION OF STAKEHOLDERS

In addition to HRSA and the VDH- DDP HCS Unit, the following groups are stakeholders currently involved in Virginia RWPB HIV care activities.

1. QM LT
2. QMAC
3. RW service providers through Consortia or via direct VDH contracts
4. Regional Consortia lead agents
5. VDH including Prevention Unit, Office of Minority Health, or any other units.
6. SERL (data team)
7. VA RW Cross-Parts Teams
8. ADAP Advisory Committee
9. Peer Review Team
10. QIP Teams (when constituted)
11. Local health districts (LHDs)
12. VDH Central pharmacy
13. PSI
14. Consumer individuals or groups
15. Treatment community (practitioners providing health care to RW clients):
  - Dentists
  - Mental health and substance abuse practitioners
  - Private physicians
  - Pharmacists
16. Laboratory centers

As appropriate, stakeholders will be invited to QMC meetings and invited to participate on QI Project Teams. It is a goal of Virginia's Part B QMP to "Strengthen the existing HIV QM infrastructure to support QI activities in Virginia".

Other goals for Infrastructure/Stakeholders are:

1. QM will become a part of RW care provision and will be employed in everyday work.
2. Buy-in from stakeholders will be developed and advanced by clarifying their roles.
3. Infrastructures and QM models that work in a specific geographic area and under certain conditions will be replicated elsewhere in the state where similar conditions exist.
4. Virginia Part B QM system will develop relationships and technical capacity to extract data.

### **Consortia**

Regional planning entities have been established to plan and administer some RWPB services. A Consortium is generally an association of public and nonprofit private health care providers, support service providers, community-based organizations, community members, and individuals infected and affected by HIV/AIDS. The Consortium analyzes gaps in medical and support services in its area and develops a comprehensive plan to address these gaps. They are responsible for:

- Ensuring QM components of the grant agreements are met.
- Participating in the statewide RWPB QM Program.
- Monitoring performance measures as determined by the QMCs.
- Providing information related to the local QM Program as requested by VDH.
- Ensuring all RWPB providers use the statewide standards and modules.

### **Consortia Lead Agencies**

There are four regional lead agencies in Virginia responsible for contract administration. A lead agency may be a public agency, service provider or a non-profit organization.

The lead agency conducts or updates an assessment of HIV/AIDS service needs for their geographical area, establishes a service delivery plan based upon prioritized services, coordinates and integrates the delivery of HIV-related services, assures the provision of comprehensive outpatient health and support services, evaluates the consortium's success in responding to service needs, and evaluates the cost-effectiveness of mechanisms used to deliver comprehensive quality of care.

### **Service Providers**

Service providers are the agencies that provide direct services to clients and their families. These service providers may be directly funded by a contract or Memorandum of Agreement (MOA) with VDH or through sub-contracts with consortia lead agencies. Laboratory providers provide rapid, cost-efficient diagnostic laboratory testing services to support client care activities in many programs.

### **Third Party Providers**

Third party service providers are paid on a fee for service (FFS) basis and provide client level information. Provision of services to PLWHA often requires the services of third parties ("business associates") to conduct operations. A business associate is a person or entity that creates, receives, maintains or transmits protected health information (PHI) on behalf of the agency.

### **Clients**

Eligible clients are individuals and families who are infected and/or affected by HIV disease and meet program income eligibility requirements. Proof of HIV diagnosis is required. Appropriate documentation of proof is defined in the "Policy on Diagnosis Documentation" developed by HCS. This policy may be obtained through HIV Services coordinators if needed. Income eligibility requirements are updated annually and may be accessed through the VDH DDP website.

The benefits of involving people infected or affected with HIV in their own care are well documented. Active participation in treatment decisions encourages health-promoting behaviors and reduces behaviors that have serious health consequences for PLWHA and their partners. PLWHA provide valuable information for helping us to meet the challenges of planning and service delivery.

### **Affected Individuals**

The HIV/AIDS pandemic has affected the lives of individuals, families, and communities around the globe. This infectious disease with its many complications has disproportionately affected individuals and communities with limited resources. Individuals who are HIV-affected are not

HIV-positive themselves, but are heavily impacted due to the HIV-infection of a family member, friend, or loved one.

### **Local Health Districts and Field Services**

LHDs and Field Services staff provides many services including medical, outbreak investigation, support services, health screening services, report investigations, immunizations, and HIV testing and counseling services. These providers report client-level data to VDH on an ongoing basis.

### **Virginia Commonwealth University Survey Evaluation and Research Laboratory (SERL)**

Through its Part B funded MOA with VDH, the VCU SERL, provides data management support including all ADAP and Part B services data. It is responsible for ensuring accuracy of data collection methods and reporting to the HRSA as well. The team is responsible for maintaining the VACRS, importing data from CAREWare and other databases, generating QM-related reports, submitting required performance measures data reports, and assisting with other data needs.

### **Regional HIV/AIDS Resource and Consultation Centers (HARCCs)**

The two VHARCCs collaborate with the PAMAAETC to expand quality care for persons living with HIV/AIDS and to focus on care and prevention through multidisciplinary educational programming for healthcare providers in Virginia.

### **The Tuberculosis Control (TB) and Prevention Program**

The purpose of the Tuberculosis Control and Prevention Program is to control, prevent, and eventually eliminate TB from the Commonwealth of Virginia. The program utilizes variety of strategies designed to detect every case of TB that occurs in Virginia, and assures that every case is adequately and completely treated, and prevents additional transmission of the disease in communities. The TB Control and Prevention Program provides services to LHDs, health professionals in the private sector, laboratories and individuals impacted by TB.

### **Housing Opportunities for Persons with AIDS (HOPWA) Program**

HOPWA addresses housing needs for low-income persons who are living with HIV/AIDS and their families.

### **Prevention Providers**

Sexually transmitted disease (STD) and HIV prevention program providers develop comprehensive strategies to prevent the spread of STDs in Virginia. Some programs operate an outreach testing program that provides testing for gonorrhea, Chlamydia, syphilis and HIV in areas of high morbidity throughout Virginia. They report data to the VDH. Outcomes of their activities are reported monthly, including the percentage of people who test positive among the testing population.

### **Patient Services Incorporated (PSI)**

For nearly two decades, PSI has helped people who live with certain chronic illnesses or conditions locate suitable health insurance coverage and access ways to meet expensive co-payments. PSI provides assistance with the cost of health insurance premiums, HIPAA conversion policies; and prescriptions co-payments associated with private insurance and Medicare Parts B and D. VDH contracts with PSI to manage the centralized ADAP eligibility determination program.

## 9. EVALUATION

Accomplishing the activities within the comprehensive QM program will require coordinated teamwork throughout the state, which will be facilitated by the QM Leadership Team and the QM Advisory Committee.

The information gathered from quality measurement activities is used to evaluate what quality indicators are in need of improvement. QI activities examine and modify existing process to address quality challenges. The specific quality indicators will be reviewed for appropriateness and continued relevance. Upon completion of the annual review, a new set of quality indicators will be identified, goals for the upcoming year established, and specific quality initiatives will be identified in the updated QMP.

Comparison/benchmark data will be collected. Data will be compared internally with established standards and identified best practice organizations and guidelines. Types of data that will be compared include: medical outcome, prevention, client satisfaction, and process improvement information.

Performances measures and indicators will be selected and utilized at statewide and local levels and will be integrated into annual Peer Review Modules. Data from these sources will be used by the statewide QM teams to plan, design, measure, assess and improve services and processes.

All stakeholders will be responsible for monitoring and evaluating progress on the work plans. The review will be planned and scheduled every quarter, with a report of the progress given to interested stakeholders. Monitoring will be conducted on a regular basis on the following items: QM Comprehensive Plan, Standards, Modules, Outcomes, achievements of goals and objectives, and clients' satisfaction and dissatisfaction.

### Site Visits

Peer Review Site Visits (including chart reviews and client interviews) are performed on an every other year basis for each selected health-related services delivery agency. Findings from those reviews will be used to assist in the development of agency specific QMPs and corrective action plans. Agencies review the results from their site visit reports and identify areas in need of improvement.

- Selected charts are reviewed to ensure that all supporting documents indicated in the modules are in place, are current, and meet funding source requirements for each service in the review sample. Additionally, other issues discovered in the process of reviewing the identified services may expand the scope of the review.
- All programs that have deficiencies will be required to complete a corrective action plan. This plan will specify how the provider will correct deficiencies. The plan is due to the QM Coordinator within 30 working days from the date that the site received the report. Technical assistance may be requested to assist with the development of the corrective action plan.

## **Client Interviews**

Client interviews will provide additional information regarding how well organizations are meeting consumers' expectations and information pertinent to the organization's QI efforts.

Each RWPB funded provider is contractually required to measure client satisfaction. A standardized methodology for measuring client satisfaction is used to ensure comparability of results. This methodology employs the use of a Peer-Administered Survey tool with questions that address the service, the provider and the Part B system as whole.

Performance is measured by indicators utilizing the following components:

- Efficacy: The degree to which the care for the consumer results in the desired outcomes.
- Appropriateness: The degree to which the care provided is relevant to the consumers' needs.
- Effectiveness: The degree to which the care is provided, in the correct manner, utilizing best practices and producing the desired outcome for the consumer.
- Continuity: The degree to which care is coordinated among practitioners, among organizations and over time.
- Safety: The degree to which an intervention reduces risk to consumers and others.
- Efficiency: The relationship between outcomes and the resources used to deliver consumer care.
- Respect: The degree to which consumers and their families (when appropriate) are involved in care decisions with sensitivity and respect for the consumers' abilities needs, expectations, preferences and cultural differences.
- Satisfaction: The services are provided in response to consumer strengths, needs, abilities and preferences.

## **VDH**

Findings and revised QMPs will be submitted to VDH leadership for approval on an annual basis.

## **Provider Self-Assessment**

Assessment activities will be incorporated as part of QM to assess organization and consortia processes. Evaluation will be conducted to acquire a more in-depth review of a specific process or program.

- VDH and VHARCCs will complete the HAB/NQC RWPB QM Assessment Tool.
- The QMCs will evaluate the QM Program including rating the effectiveness of improvement strategies on an annual basis.

## **Quality Assurance**

QA is the retrospective review of specific standards and requirements for a specific program or services. QA activities will include the review of contracts, database information, and medical records.

## **Quality Improvement**

Plan, Do, Study, and Act cycle is a way of continuously checking progress in each step of the focus process. This process will assist teams in focusing on specific improvement activities.

A comprehensive evaluation of all activities of the QM Program will be conducted every quarter and improvement activities and performance data will be reported to stakeholders. Also, VDH will report improvement activities and performance data to HRSA through RWPB Progress required reports and grant applications.

Virginia's criteria for organization performance excellence will be based on the following criteria:

- Leadership
- Strategic Planning
- Client Satisfaction
- Knowledge of QM, including information and analysis
- QM Process Management
- Outcomes
- Compliance with HRSA's guidelines for QM and with state and Essential Public Health Service Guidelines.

Overall, the evaluation will strengthen organizational performance through process and outcome measurement, and link organizations to operational decision-making within the state system.

## **10. CAPACITY BUILDING**

In partnership with various stakeholders, RWPB Grant Administration will develop and conduct comprehensive trainings for providers, consumers and advocacy committees regarding each element of the QM Program. RWB in collaboration with other partners will also provide multiple QM technical assistance (TA) workshops during the grant year in addition to ad hoc TAs that may be requested by individual agencies. The QM staffs will participate in the National Quality Center (NQC) and other RW QM trainings offered for grantees as needed. VDH will have several consultative meetings with providers and QMCs on process and systems issues identified from chart abstraction and/or database and offer recommendations and technical assistance for performance improvement.

Once opportunities for improvement have been identified, a multidisciplinary team will be convened (QI Project Team) to analyze the process and develop improvement plans. These teams will include staff members who are closely associated with the process under study. Every attempt will be made to include individuals from other programs, including local and consumer representation, which may be impacted by changes made by the team and to help promote collaboration between groups.

All stakeholders including employees, consumers, QM Advisory Committees, volunteers and others within the RWPB Program will be encouraged to attend at least one yearly training

opportunity related to QM, process management, leadership development, problem solving, or team building.

VDH will have a role in:

- Setting direction and performance goals through strategic planning.
- Reviewing the QM overall performance in relation to established expectations.
- Ensuring resources necessary to continuously improve services will be identified for each issue and made available for issue resolution.
- Ensuring staff will receive the necessary training to remain current in the field healthcare services and provide quality services to the consumer population.

## **11. PROCESS TO UPDATE THE PLAN**

To ensure a useful and current QMP, it will be updated systematically and consistently. The changing HIV epidemic may require a change in methods or processes to ensure the needs of the clients are being met.

The QMCs will review the progress of the plan on a quarterly basis. Annual review of the QMP will focus on the following areas: Mission, Vision, Values, Strategic Plan, Client Needs, Community Needs, Agency Needs, Performance and Outcomes.

At the beginning of each grant year, the QMCs will:

- Collaborate to establish a timeline for collecting, reporting and analyzing QM data.
- Complete the providers' QM Assessment Tool.
- Complete the checklist to help review and identify opportunities for improvement to the QMP.
- Bring proposed QI projects and performance measurements to the attention of RWPB stakeholders.
- Utilize available data/information to update the 2011 QMP.

All revised plans are to be completed and submitted through the QM Advisory Committee and QM Leadership Team for approval before implementation.

## **12. COMMUNICATION**

Statewide communication of QM activities is critical to ensure the success of excellent performance. Effective communication of goals, activities and progress fosters enthusiasm and motivation for all stakeholders to become more involved. Communication is essential to enhance the understanding of providing quality service among staff, clients, and other stakeholders.

To facilitate effective communication, several technological capabilities will be used including web sites, webinars, emails, and conference calls and/or meetings.

- The QMAC will meet at least quarterly.
- Conference calls and electronic communication - ongoing.

- The QMCs will communicate findings and solicit feedback from internal and external key stakeholders on an ongoing basis.
- Stakeholders will have the opportunity to provide feedback to reports and to assist with prioritizing quality activities.

The QMCs will establish linkages with key stakeholders to ensure that they have access to QM technical assistance. They will provide continuous skill-oriented interactive training programs for all staff regarding current guidelines, and incorporate consumers into planning and decision support.

Methods for distribution of the approved QMP include:

- Public Documents
- Websites
- Newsletters
- Trainings through VDH/VHARCCs

**The QMAC Communication Sub-committee:** This subcommittee's primarily responsibility is to determine the content, format, frequency, and distribution method of information. . The subcommittee will:

- Report and disseminate QM activity results and findings.
- Coordinate internal and external communication needs; Identify, feature, and disseminate best practices resources.
- Develop and maintain membership guidelines.
- Promote scheduled trainings.
- Use multiple modes of communication.
- Make sure that new members of the QMCs will be oriented.

**The form(s) of communication depend upon the group with which we communicate.**

- Contract and Subcontract Service Providers, and Consumers
  - Introduction to QI activities
  - Routine meetings to develop buy-in to provide data for quality measurements
  - Requests for information and data gathering
  - Response to results of PDSA cycles and implementation of other quality processes
  - Introduction to the work of the QMCs
  - Press-release style updates as projects progress
  - Reports related to output and outcomes
  - Quarterly consortia conference calls (held with VDH team)
  - Quarterly ADAP Advisory Committee meetings
  - Quarterly HCS Unit contractors meetings
- National Quality Center, HAB staff
  - Updates on QI activities
  - Requests for trainings and technical assistance
- VDH and HRSA Project Officers
  - Introduction to QM activities
  - Reports related to significant output or outcomes

- Requests for feedback through phone calls, emails or written documents.

**The timing of communications depends upon the group with which we wish to communicate.**

- Subcontract service providers:
  - Routine, monthly, or bi-monthly interaction; more frequently during PDSA testing cycles.
- RW Consortia, advocacy groups, local health districts, community at-large:
  - Release E-Bulletin when there are interesting outputs or outcomes to Report.
  - Deliver of “news” at local meetings including rewards, significant VDH updates etc.
- National Quality Center and HAB staff:
  - Routine, monthly interaction describing process, outcomes, successes, challenges, and technical assistance needs
  - Outcomes, when available
- VDH and HRSA Project Officers:
  - Routine monthly calls, or as needed

### **13. COORDINATION WITH OTHER STATEWIDE QM ACTIVITIES**

#### **Coordination across RW Programs**

- The RWPB QMP will focus on collaboration of quality activities for all RW Programs in Virginia.
- The RWPB QMP includes participation of members from RW Part A, B, C, and D.
- The RWB QMCs will share results and best practices with the Virginia RW Cross-Parts Collaborative and with Virginia Patient Safety and Clinical Services Collaborative projects.

#### **Coordination within VDH**

- HCS QM Coordinator will encourage and support the VDH Partnership.
- The HCS QM Coordinator will encourage the expansion of QI/QA efforts to include an interdisciplinary approach.
- The HCS QM Coordinator will collaborate with other units of the VDH/DDP on performance measures and shared quality findings.

#### **Coordination with ADAP**


- The ADAP Data Coordinator is a member of the QMAC and QMLT.
- The RWPB QMP includes input from ADAP providers and consumers.

## **14. LIMITATIONS & CAUTIONS**

A major challenge for the QMP is that stakeholders vary in levels of understanding in applying the methods of QI principles. To avoid any delays in the implementation, the QM Coordinator and the QMAC are prepared to assist those stakeholders with training and targeted technical assistance.

**APPROVAL OF 2011 QUALITY MANAGEMENT PLAN**

This plan has been reviewed and approved by the RW Part B grantee as listed below. The annual QM Work plan must be reviewed and updated by April 30<sup>th</sup> each year. This plan will expire March 31, 2012.



\_\_\_\_\_  
Ryan White Part B – Virginia Department of Health (VDH)  
Diana Jordan

Adopted: 5/9/11 (date)

Review Annually on: April 2011 (date)  
(date)

## ACRONYMS

<b>ADAP</b>	AIDS Drug Assistance Program
<b>AETC</b>	AIDS Education and Training Center
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ART</b>	Antiretroviral Therapy/Treatment
<b>CARE Act</b>	Comprehensive AIDS Resources Emergency Act
<b>CQI</b>	Continuous Quality Improvement
<b>DDP</b>	Division of Disease Prevention
<b>DHHS</b>	Department of Health and Human Services
<b>eHARS</b>	Enhanced HIV/AIDS Reporting System
<b>HAART</b>	Highly Active Antiretroviral Therapy
<b>HAB</b>	HIV/AIDS Bureau
<b>HCS</b>	HIV Care Services
<b>HERR</b>	Health Education/Risk Reduction
<b>HIV</b>	Human Immunodeficiency Virus
<b>HOPWA</b>	Housing Opportunities for People With AIDS
<b>HRSA</b>	Health Resources and Services Administration
<b>LPS of the PA/MA ETC</b>	Local Performance Site of the Pennsylvania/MidAtlantic AIDS Education & Training Center
<b>NASTAD</b>	National Alliance of State and Territorial AIDS Directors
<b>NQC</b>	National Quality Center
<b>PDSA</b>	Plan, Do, Study and Act
<b>PCP</b>	Pneumocystis Pneumonia (either <i>P. carinii</i> / <i>P.jiroveci</i> )
<b>PLWHA</b>	Person Living with HIV/AIDS
<b>PSI</b>	Patient Services Incorporated
<b>PSPC</b>	Patient Safety and Clinical Pharmacy Services Collaborative
<b>PHS</b>	Public Health Services
<b>QA</b>	Quality Assurance – A broad spectrum of evaluation activities aimed at ensuring compliance with minimum quality standards
<b>QI</b>	Quality Improvement – Activities aimed at improving performance
<b>QM</b>	Quality Management
<b>RW</b>	Ryan White -
<b>RWTMA</b>	Ryan White HIV/AIDS Treatment and Modernization Act
<b>SERL</b>	Survey Evaluation and Research Laboratory
<b>TA</b>	Technical Assistance
<b>VACRS</b>	Virginia Client Reporting System
<b>VDH</b>	Virginia Department of Health
<b>VHARCC</b>	Virginia HIV/AIDS Resource and Consultation Center

## ACKNOWLEDGEMENT

Thank you to the many people who contributed to this document. We acknowledge the RWPB QM Advisory Committee (QMAC) members who initiated the development of this document. Thank you to the VDH - HCS QM Leadership Team members who consistently supported these efforts. We offer special acknowledgement to the work of Safere Diawara, HCSQM Coordinator, who contributed content and coordinated the compilation of this QMP.

The following individuals provided extensive time, effort and dedication to the development of this document:

**Steven Bailey**

Assistant Director  
HIV Care Services  
Division of Disease Prevention  
Virginia Department of Health  
Phone: (804) 864-8065  
Email: Steve.Bailey@vdh.virginia.gov

**Parrish F. Crosby**

Peer Educator  
Eastern Region  
Phone: (757) 254-5466  
Email: Parrishfc@att.net

**Safere Diawara, MPH**

Quality Management Coordinator  
HIV Care Services  
Division of Disease Prevention  
Virginia Department of Health  
Phone: (540) 864-8021  
Email: SafereDiawara@vdh.virginia.gov

**Cathy Fisher**

Grant Monitor  
Southwest/Piedmont HIV Care Consortium  
Council of Community Services  
Phone: (540) 985-0131, Ext. 453  
Email: cathyf@councilofcommunityservices.org

**Fuwei Goo**

Quality/Data System Management Coordinator  
Virginia Commonwealth University Part C Program  
Phone: (804) 828-2417  
Email: fgoo@vcu.edu

**Diana L. Jordan, RN, MS, ACRN**

Director, HIV Care Services  
Division of Disease Prevention  
Virginia Department of Health  
Phone: (804) 864-7958  
Email: [Diana.Jordan@vdh.virginia.gov](mailto:Diana.Jordan@vdh.virginia.gov)

**Tanya Kearney, MPA**

Director AIDS Resources and Consultation Center  
Eastern Virginia Medical School  
Phone: (757) 434-8399  
Email: [KearneTK@EVMS.EDU](mailto:KearneTK@EVMS.EDU)

**Robert Morrow**

Director of Care Services  
Southwest/Piedmont HIV Care Consortium  
Council of Community Services  
Phone: (540) 985-0131 Ext 401  
Email: [Robertm@councilofcommunityservices.org](mailto:Robertm@councilofcommunityservices.org)

**Gary Race**

Grants Administrator  
James Madison University Phone: (540) 568-8166  
Email: [Racegs@jmu.edu](mailto:Racegs@jmu.edu)

**Rachel Rees, MPA**

AIDS Drug Assistance Program Coordinator  
HIV Care Services  
Division of Disease Prevention  
Virginia Department of Health  
Phone: (804) 864-7919  
Email: [Rachel.rees@vdh.virginia.gov](mailto:Rachel.rees@vdh.virginia.gov)

**Miranda Smith, MSW**

Senior Research Specialist, Data Application Unit  
Survey and Evaluation Research Laboratory  
Virginia Commonwealth University  
Phone: (804) 827-3862  
Email: [mlsmith@vcu.edu](mailto:mlsmith@vcu.edu)

**Adam T. Thompson**

Intervention Specialist  
Phone: (864)-354-8468  
Email: [adamtthompson@gmail.com](mailto:adamtthompson@gmail.com)

**Amelia Khalil, MA**

Senior Contract Officer/Quality Manager  
Northern Virginia Regional Commission  
Phone: (703) 642-4643  
Email: akhalil@novaregion.org

**Lenore Drewry**

HIV Care Services  
Division of Disease Prevention  
Virginia Department of Health  
Phone: (804) 864-8022  
Email: Lenore.Drewry@vdh.virginia.gov

**Anne Rhodes**

HIV Care Services  
Division of Disease Prevention  
Virginia Department of Health  
Phone: (804) 864-8013  
Email: [Anne.Rhodes@vdh.virginia.gov](mailto:Anne.Rhodes@vdh.virginia.gov)

**Thomas Salyer**

Case Manager  
Southwest Region  
Phone: (276) 806-1751  
Email: Thomassalyer@gmail.com

**Zachary Hatcher**

Executive Director  
Fredericksburg Area HIV/AIDS Support Services  
Phone: (540) 371-7532 x. 11  
Email: director@fahass.org