Virginia Commonwealth University
Virginia Ryan White Part B
Peer Review Program
Fiscal Year 2020 Final Report

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Executive Summary

This report outlines the Virginia Commonwealth University (VCU) Ryan White Peer Review program outcomes for 2020/2021 Virginia Department of Health Contract Year. The following sites were selected by the Virginia Department of Health (VDH) to be reviewed for Outpatient/Ambulatory Health Services (OAHS), Medical Case Management (MCM), Oral Health Services (OH), and Client Interviews**.**

1. Inova Juniper (Inova)
2. AIDS Response Effort (ARE)
3. Capital Area Health Network / Vernon J. Harris (CAHN)
4. CrossOver Healthcare Ministries (COHM)
5. Carilion Clinic Infectious Disease (Carilion)
6. Fredericksburg Area HIV/AIDS Support Services (FAHASS)
7. Mary Washington Health Center (MWHC)
8. Neighborhood Health (NH)
9. Three Rivers Health District (TRHD)
10. Daily Planet
11. Virginia Health Options

Medical Transportation Services and the Administrative reviews were removed in 2020/2021 by VDH and replaced with Substance Abuse, Mental Health Services, and Non-Medical Case Management which was piloted at selected sites in 2021.

Due to the travel restrictions associated with COVID-19 the Peer Review program was instructed by VDH to conduct all Peer Reviews virtually until the end of the contract year in March 2021. Through collaborative efforts with the Peer Review Team and the eleven Peer-Reviewed sites, the Peer Reviewers successfully completed the reviews through HIPAA compliant virtual platforms such as Zoom, Microsoft Teams, VCU FileLocker, and RedCap. Due to the limitations of file sharing at Peer-Reviewed sites, VDH stated that Performance Measure collection was not necessary for the 2020/2021contract year.

The key findings for OAHS overall were positive for most sites reviewed. However, it was observed at sites with multiple healthcare providers the notes and patient information were not consistent and the Peer Reviewers recommended a template based on the RWHAP B standards of care. The Peer Reviewers for MCM reported that when the documentation was available for review, most forms were completed and included the Individualized Service Plan (ISP), Assessments, and Acuities as needed. However, areas of improvement for some sites included timelines for goals, updated Service Plans based on Acuity Level, and documentation the client was offered a copy of their Service Plan. Oral Health services reviewed were commended for providing excellent Oral Health Care to clients as documented in their charts. Virtual Peer Reviews included 59 client interviews conducted by phone. These interviews were encouraging to the RWHAP B providers as most of the clients interviewed stated they appreciate the MCM and OAHS services they receive and ‘Agreed’ or ‘Agreed Strongly’ they are satisfied with the care they receive for OH.

VCU Peer Review Program Virginia Ryan White Part B Program 2020 Final Report

Background

In 2002, the Virginia Department of Health (VDH), Division of Disease Prevention established a statewide independent Peer Review (PR) team. Their mission is to monitor sub-recipients receiving Ryan White HIV/AIDS Program Part B (RWHAP B) funding and to measure the quality of care provided to consumers with Human Immunodeficiency Virus (HIV) eligible for RWHAP B services. In 2012, Virginia Commonwealth University (VCU) was awarded the contract by VDH to complete PR activities and collect HIV Performance Measure data for the state of Virginia (VA). The following report summarizes the VCU PR process for Grant Year 2020.

Selected Agencies and Funded Service Categories

Sub-recipients receiving RWHAP B funding are reviewed on a biennial schedule. In 2020, sites were selected by VDH for review. These sites included:

12. Inova Juniper (Inova)
13. AIDS Response Effort (ARE)
14. Capital Area Health Network / Vernon J. Harris (CAHN)
15. CrossOver Healthcare Ministries (COHM)
16. Carilion Clinic Infectious Disease (Carilion)
17. Fredericksburg Area HIV/AIDS Support Services (FAHASS)
18. Mary Washington Health Center (MWHC)
19. Neighborhood Health (NH)
20. Three Rivers Health District (TRHD)
21. Daily Planet

Technical Assistance (TA) was conducted at Virginia Health Options (VHO) because their first year of RWHAP B funding was in 2019 and their services for RWHAP B expanded. The PR site visit is the same process as the TA site visit. No corrective actions are required for a TA site visit as this is a preliminary visit to help those sites prepare for a PR visit. The total number of reviews in 2020 was ten.

Process and Methodology

In the previous contracts awarded by VDH, the PR site visit was a two-day onsite review at the selected RWHAP B agency. The processes for Peer Reviews in 2020/2021 reflect guidance from the Virginia Department of Health regarding no on-site Peer Reviews until March 2021 due to COVID-19.

Virtual Peer Review Process

Schedule Site Visits, Obtain Site Information and Pre-visit Conference Calls

The PR staff notified agencies selected for PR in 2020 by email to establish a traceable reference for communication and by phone for follow-up correspondence; their VDH HIV Services Coordinators and lead agency (if any) were also notified. Following the initial email, site review dates were scheduled and confirmed by email. After confirming the method of virtual data collection and the PR virtual review dates with the agency, at least two web conferences between the PR Program staff and the agency were scheduled. The PR staff and agency staff web-conferenced via Microsoft Teams and Zoom at least three months before and one week before the virtual PR. Confirmation emails were sent to the agency and their lead agency before the web conferences. During the web conferences, PR staff reviewed the necessary data for collection with the PR sites. The PR process and procedures were outlined in the preliminary meetings as well as in checklists submitted by email. PR staff also explained to RWHAP B staff how to prepare for the site visit, reviewed their previous PR reports and TA resources available, and answered any questions that came up during the meeting.

Each site was contacted to determine if they use an electronic health record or paper charts. The sites stated their document sharing capabilities for the Peer Review such as data and Ryan White client charts for review. Through collaborative meetings with each site, it was determined since each site has a different method of collecting and storing client charts the PR process to collect information would be amended for each site to accommodate their file-sharing capabilities. Therefore, the staff at each site determined the most practical method to conduct a Peer Review with the Peer Review Team. Additionally, all Peer Reviewers were contacted to verify their virtual review and file-sharing capabilities to conduct off-site Peer Reviews.

Multiple virtual meetings were conducted with each site before the virtual PR to determine the following:

- Primary contacts: Medical Case Managers, Quality Team, Non-Medical Case Managers, Medical Providers, Oral Health Providers, etc.
- Verification of their RW services and number of RW clients
- Determine the type of charts for Ryan White clients; paper chart or electronic health record
- The timeline for meetings to prepare for their Peer Review
- The date or month, they can be prepared and conduct a Peer Review

All TA was conducted virtually. All RWHAP B Peer Review client interviews were conducted by phone in a private and secure location. Once the chart reviews for the

RWHAP B reviewed services were complete, the Peer Reviewers met by Zoom to collaborate and developed their summary reports. The Peer Reviewers then met with the site by Zoom to report their findings and schedule follow-up TA, if necessary.

Data Collection Tools

The PR Program employs REDCap as its primary data collection tool. REDCap is a web-based application created in 2004 at Vanderbilt University to securely manage data online and build surveys and databases.

VDH Part B Standards of Care modules and the data collection tool for RWHAP B care markers were built into the online PR database in REDCap. The PR team collects the data from the site using a secure remote internet access card to ensure confidentiality & Health Insurance Portability and Accountability Act (HIPAA) compliance.

Peer-Reviewed sites with paper charts were scanned and uploaded into the VCU secured file-sharing portal, FileLocker, before the PR and securely shared with the Peer Reviewers through an encrypted link to FileLocker and reviewed on a secured Peer Review laptop assigned to the Peer Reviewer to use offsite.

Electronic Health Records were screen shared by Zoom, which is secured through VCU Health IT. The Peer Reviewers reviewed the charts with the site in real-time. The Peer Reviewed sites navigated the charts and screen shared with the Peer Reviewers to locate the necessary information. Medical providers were given secured read-only access to the electronic health records for sites with Outpatient Ambulatory Health Services.

Using VDH PR Standards and Modules, the Peer-Reviewed RWHAP B categories OAHS, MCM, Oral Health Services, and Client Interviews were conducted in close collaboration with RWHAP B agency personnel. The PR Program selected 10% of the eligible charts, with a minimum of 10 charts for each funded service category. Peer Reviewers for the funded RWHAP B categories randomly selected clinical charts from a preselected qualifying list of RWHAP B eligible clients. The Peer Reviewers entered the results directly into REDCap for data collection. After the collection of all data, the Peer Reviewers and the PR team reviewed all data and composed a summary of the information.

It was determined by VDH through TA with the PR Team that due to the limitations of file sharing and the administrative problems of working offsite for many agencies the data collection for RWHAP B Performance Measures would be suspended in 2020.

Post-Visit Activities

Final site visit reports were prepared by the PR staff and submitted to VDH Quality staff for review and final approval; reports were due to the agency within 45 days of the visit. After VDH's final approval, the reports were sent to each agency by email. The final site visit reports identified strengths and challenges. A Corrective Action Plan was required for

identified challenges requiring corrective action steps. The Corrective Action Plan was submitted by the Peer-Reviewed site within 90 days of receiving the report to the VDH Quality and Peer Review staff.

Qualified Peer Reviewers

The PR Program is comprised of a group of experts in the HIV field recruited throughout the state of VA. These individuals are professionals in Ryan White (RW) services and include medical providers, dental providers, and medical and non-medical case managers. A thoroughly vetted team of RWHAP B consumers has been selected to conduct the client interviews. To have a range of Peer Reviewers and not have a conflict for regional reviewers, PR staff sought to select reviewers from each of the five VA health regions and place them in areas where they have not practiced or received HIV care.

Peer Reviewer Training

A virtual training was conducted in August 2020 and required for all current and new Peer Reviewers. The multi-day training included a one-day review for all Reviewers about PR conduct, mission, goals, confidentiality agreement, conflicts of interest, honorarium guidelines, and travel restrictions. A second virtual training was conducted for all Peer Reviewed RWHAP B categories; OAHS, MCM, OH, Client Interviews. The training for Peer-Reviewed RWHAP B categories included current implemented standards and modules for PR and updates to the modules. The training also included data collection and reporting standards. It was concluded by the Review team the training would be an annual meeting moving forward in 2021.

Added & Removed Service Categories in 2020

In 2019, the Quality team at VDH proposed adding three new RWHAP B service categories for review, Mental Health (MH), Substance Abuse (SA), and Non-Medical Case Management (NMCM). The reviews for Medical Transportation and the Administrative Review were removed as determined by VDH. Using the skills, expertise, and resources of recruited Peer Reviewers a pilot test, or field test, was developed and implemented for MH, SA, and NMCM. Through a series of collaborative meetings, a module in REDCap was developed using the RWHAP B standards. The pilot testing was designed to test the quality of the data from the questions, as well as to test the viability of the module as a whole, and the coordination of the PR team's procedures and systems.

Mental Health

Three Peer Reviewers were recruited to collaborate with the VCU Peer Review to develop a MH module based on the RWHAP B service standards. The reviewers are licensed practicing MH professionals in the Ryan White field. These reviewers were engaged in the development of the module by participating in four virtual meetings. These meetings also created a plan to pilot the MH module at two test sites. The chosen test sites were ARE and Inova which provide on-site individualized MH services to RWHAP B clients. Twelve charts were virtually reviewed from ARE and ten charts were reviewed from Inova.

Key Findings

Strengths

The MH module was developed directly from the RWPB service standards. The reviewers were able to find initial assessments, treatment plans, documentation of contacts, and reassessments when available in the client records.

Challenges

One of the two sites reviewed provided support groups under the MH service category. RWPB service standards and the proposed module created by Peer Reviewers reflect individual (one-on-one) mental health services and are not designed for group therapy. The MH peer reviewers felt that testing/diagnosis (initial assessments and mental health screenings) was not appropriate for group work and create additional barriers to getting support group participants.

Recommendations

The MH reviewers recommended the RWPB standards and module be modified to accurately capture group therapies which consist of referrals from the MCM or MH provider with identified needs and goals for the clients. These clients could be reviewed

every 90 days and summary notes provided for every session. It was suggested the MH module be separated into two sections, one for individual clients, and one for group clients. It was also suggested that support group services be provided under Psychosocial Support as described in PCN 16-02 which lists the support group services as an appropriate service activity.

Substance Abuse Outpatient

One Peer Review was recruited to collaborate with the VCU Peer Review to develop a SA module based on the RWHAP B service standards. The reviewer holds a Ph.D. in Psychology with a specific focus on substance abuse and HIV. The reviewer engaged in the development of the module by participating in two virtual meetings. INOVA was chosen as the test site. Nine charts were reviewed as part of the test pilot.

Strengths

The SA module was developed directly from the RWPB service standards. The SA reviewers reported the REDCap module was generally straightforward to complete during the evaluation of each chart. The reviewer was able to find initial assessments, treatment plans, documentation of contacts, and reassessments when available in the client records.

Challenges

The reviewer identified three areas of the module that need further guidance from VDH regarding standards of care. The questions needing further guidance from VDH are concerning determining the areas that qualify as necessary for Substance Abuse reviews such as nicotine addiction, a history of long-term recovery, and the criteria for substance use disorder (abuse or dependence) for drug and alcohol use.

Recommendations

No recommendations at this time.

Non-Medical Case Management

Two Peer Reviewers were recruited to collaborate with the VCU Peer Review to develop a NMCM module based on the RWHAP B service standards. The reviewers are active Ryan White NMCMs professionals. These reviewers were engaged in the development of the module by participating in two virtual meetings. INOVA was chosen as the test site. Fourteen charts were reviewed as part of the test pilot.

Strengths

The NMCM module was developed directly from the RWPB service standards. The reviewer was able to find eligibility intake, supporting documentation, six-month certification, and referrals when available in the client records.

Challenges

No challenges were identified.

Recommendations

No recommendations at this time.

Standards of Care Assessment: Chart Review, Documentation Assessment & Recommendations

Outpatient/Ambulatory Health Services

Key Findings

Of the sites reviewed in Peer Review 2020/2021, four reported providing OAHS. The data below is based on the aggregate data collected. See Attachment A for raw data. The Peer Reviewed sites presented client-level data through progress notes and documentation shared through their Electronic Health Record systems. When present in the reviewed charts, the documentation was clear and available. However, it was observed at sites with multiple healthcare providers the notes and patient information were not consistent and the Peer Reviewers recommended a template based on the RWHAP B standards of care. The challenges were to ensure that documentation, regarding the assessment of all relative symptoms and risks, are present in the medical record as well as referrals and vaccine information.

Strengths

A total of 62 charts were Peer Reviewed for OAHS, 7 of the 62 charts reviewed had information regarding patients diagnosed in the previous 12 months. The charts reviewed determined that clients diagnosed in the previous 12 months were given an initial Medical History within 30 days of client contact with the provider (n=7/7), the (Initial) Physical Examination was documented within 30 days of client contact with the provider (n=7/7), the medication history which includes: drug allergies; current medications; drug/substance abuse was present in the charts (n=7/7), the initial laboratory results or orders were documented as a component of the initial assessment (n=7/7), Oral Health assessment/referral was documented (n=7/7), Psychosocial/Mental Health assessment and/or referral (n=7/7), and Substance Abuse assessment and/or referral was documented as a component of the initial assessment (n=7/7).

The sites reviewed were commended for reaching over 90% for the following measures in OAHS when ten or more charts were reviewed: RWHAP B clients were seen at least twice in the last 12 months or as needed (90% n=56/62); CD4 and CBC documentation within 12 months or as necessary (98% n=61/62); Chemistry Panel, every six months or as

needed (90% n=54/60). There was documentation the charts reviewed the initial, 6 months, or annual Liver/Hepatic Panel was collected (98% n=61/62) and the panels for Glucose (if not in Chemistry Panel); Hemoglobin A1C were collected at baseline, 6 months or as needed (98% n=61/62). The reviewed charts indicted that Hepatitis B (93% n=57/61) and C (90% n=56/62) serology at baseline and as need along with ongoing risk factor behavior was present in the charts. The Rapid Plasma Reagin (RPR) and Venereal disease research laboratory (VDRL) tests were present in the reviewed charts initially and every 12 months as applicable (92% n=57/62).

Tuberculosis (TB) testing (purified protein derivative (PPD) skin test or interferon-based testing) was present in the chart at initial presentation, repeated if baseline if the CD4+ was < 200 but has risen to > 200, and as needed based on risk factors (98% n=56/57).Documentation of all current medications; medication history which includes drug allergies and side effects was present in 100% of the reviewed charts (n=62/62). Medication adherence was present in 97% of the charts (n=60/62), and medication side effects were addressed in 90% of the reviewed charts (n=56/62).

It was noted in the charts that 100% (n=62/62) clients were offered Highly Active Antiretroviral Therapy (HAART), and 98% (n=61/62) are currently on HAART and HAART is consistent with the current U.S. Public Health Service (PHS) Guidelines (98% n=61/62). All progress notes were present, current, legible, signed, and dated in the client's record (100% n=62/62). The charts determined an appropriate out-come based medical plan of treatment developed with the client and present in the client's record for all reviewed records (100% 62/62).

Challenges

The agencies reviewed with any total standard not met at ≤ 70% with a minimum of 10 charts were deemed as challenges. Documentation of an annual Lipid panel was present in 68% (n=42/62) of the charts reviewed. When a Hepatitis A serology was negative, 67% (n=14/21) of patients were referred for immunization. Documentation was present in 66% of the reviewed charts (n=41/62) about whether the patient was asked about Sexually Transmitted Disease (STD) symptoms at each visit. Of the reviewed charts, five out of 11 (45%) indicted a record of a Pap Smear, twice in the first year and then annually thereafter.

Recommendations

It was recommended by the PR team that each site create a process for all providers to chart consistently or develop a template for medical notes that includes a checklist of needed labs, vaccines, assessments, and outpatient standards of care; this template should reflect the PR module for OAHS. A Peer Reviewer noted that medical templates make documentation easier to review and manage, and also serve as a reminder for upcoming care markers and patient follow-up at future visits.

Documentation needs to be present within each progress note stating the medical provider acquired labs for an annual Lipid panel, referrals for immunization such as Hepatitis A

serology, and Pap Smears (as necessary for selected patients). Medical providers must document they have asked about STD symptoms at each visit.

Medical Case Management - Peer-Reviewed Sites

Key Findings

Peer Reviewers analyzed 145 MCM files from all three MCM levels at eight RWHAP B sites in Virginia. See Attachment B for raw data. It was reported by Peer Reviewers, when properly documented and recorded in the client's files, the agencies had detailed case notes, indicated a high level of client contact which resulted in the setting of and progress toward goals for the clients. The Peer Reviewers for MCM reported that when the documentation was available for review, most forms were completed and included the Individualized Service Plan (ISP), Assessments, and Acuities as needed.

Strengths

The following strengths were evaluated by the MCM Peer Reviewers at over 90% for 10 or more charts reviewed.

MCM records showed that at the time of the PR, 49 newly diagnosed client charts revealed the initial assessment was completed in the first 30 days of intake for 98% (n=48/49); the initial assessment was signed and dated by MCM at 92% (n=45/49), and at least one face to face interview was conducted (100% n=49/49).

A summary of the MCM's findings was noted on the last page of the MCM Assessment in 96% (n=118/123) of the reviewed charts, and Treatment Adherence was addressed on the MCM Assessment Form in 99% (n=143/145) of the charts. An Acuity Scale was present in the Peer-Reviewed charts reflecting the client's current Acuity Level at 90% (n=130/145). Progress notes were completed within 48 hours of the client encounter overall at 99% (n=144/145). There was documentation the client participated in the development of the Service Plan as indicated by client signatures in 90% (n=92/102) of the reviewed charts.

Challenges

The MCM data for all agencies reviewed at every level showed the following standards not met at ≤ 70% with a minimum of 10 charts.

The charts reviewed indicated that 15 of the 104 eligible charts did not have a Service Plan developed in 45 days; of those 15 charts, there was not documentation as to why the Assessment was not completed (27% n=4/15).

The client Service Plan was updated within the appropriate time frame for the client's Acuity Level in 62% of the charts reviewed (n=56/91). The records reviewed by the PR team indicated that overall 63% of the charts had documentation the clients were offered a copy of their Service Plan (n=64/101).

Medical Case Management Recommendations

Five sites reviewed had recommendations to develop a system to ensure the Service Plans and Assessments were updated and scored according to the RWHAP B Case Management Standards and within the appropriate time frame for the Acuity Level. Four Peer-Reviewed sites had recommendations to document the clients had been offered a copy of their Service Plan.

MCM – TA Sites

Key Findings
One site received PR TA in 2020/2021, Virginia Health Options (VHO). Twelve MCM charts were reviewed at VHO to evaluate their new MCM services offered in 2020. The Peer Reviewer commended VHO for their compliance with the RWHAP B Case Management Standards and overall client care.

Strengths
VHO scored over 90% for all parts of the Review except for three questions that scored between 80% and 85%.

Challenges
There were no challenges found by the Peer Reviewer.

Oral Health

Key Findings
The Peer Reviewer collected information from 76 client charts at seven Peer-Reviewed sites. See Attachment C for raw data. The Peer Reviewer commended the sites for providing excellent Oral Health care for patients. None of the sites presented any significant challenges.

Strengths
Documentation of referrals was located in all of the client records and noted in the charts for all (n=76/76) sites. Documentation was in the client record of encouragement to seek routine dental care as a preventive measure for 100% of sites (n=76/76). Appropriate dental education materials were located in waiting rooms or offered to clients at 100% (n=76/76). Documentation that overseeing the RW agency has approved dental services was reported by the sites at 100% (n=76/76). Documentation at baseline, a completed medical history, chief complaint, medical alert (if appropriate), radiographs, and drug history was all present in the client charts at 100% (n=76/76). Documentation in treatment plan addressing cavities (n=75/75), missing teeth (n=41/41), for 100% of the sites reviewed. Signed and dated documentation that the treatment plan was reviewed and updated as needed and identified or at least every six months was clearly documented in 100% of the client charts reviewed (n=74/74). All PR charts were signed and dated with documentation that all services provided were recorded, prescriptions and drugs dispensed (n=18/18), post-operative instructions were given for surgical procedures (n=15/15), and pre-medications and local anesthetics were used (n=66/66). Signed and dated documentation in client's record of medical history (n=76/76), medications (n=21/30), a

treatment plan of care (n=74/74), interim progress notes (n=73/73), and referrals/follow-ups (n=32/32) was present and reviewed.

Challenges
No challenges were identified based on the aggregate data collected. The only challenge presented by the Peer Reviewer was the availability to review the documentation at two sites for Labs and Physical Examinations as they were not available to be viewed virtually due to file sharing limitations.

Client Interviews

Key Findings
Fifty-nine RWHAP B clients were interviewed during the PR review year. Clients for both Peer-Reviewed sites and TA sites were selected for interviews. Client interview questions consisted of a variety of open-ended, yes or no, and Likert scale questions developed from the New York State Department of Health AIDS Institute Patient Satisfaction Survey for HIV Ambulatory Care (https://careacttarget.org/library/patient-satisfaction-survey-hiv-ambulatory-care). See Attachment D for raw data of both Peer Reviewed and TA sites.

Of the 59 RWB clients interviewed, 36 received OAHS, 42 received Oral Health Care, and 50 received MCM.

Fifty-eight out of the 59 clients interviewed reported they understand what RWHAP B services are and/or how RWHAP provides care (98% n=58/59). Eighty percent of the clients reported that a grievance procedure has been explained to them (80% n=47/59) and 86% (n=51/59) know how to write a grievance/complaint procedure. Of the 59 clients interviewed, 58% (n=34/59) have been asked to participate in a patient/consumer advisory board and 78% percent have participated in a satisfaction survey (n=46/59).

Thirty-six RWHAP B clients were interviewed about their experiences in OAHS. When asked if clients could schedule an appointment soon enough for their needs, 25 (69% n=25/36) responded ‘All the Time’ and 8 responded ‘Most of the Time’ (22% n=8/36). Most clients interviewed agreed their providers tell them on a consistent basis how important it is to keep their appointment and responded, ‘All of the Time’ (97% n=35/36). Clients interviewed reported the medical providers made sure they understood what lab test results (such as CD4 and viral load) meant for their health ‘All of the Time’ at 94% (n=34/36). When clients were asked if they had questions they wanted to ask providers about HIV care but did not ask most clients interviewed stated ‘Never’ (89% n=32/36), followed by ‘Rarely’ (n=3/36), and ‘Sometimes’ (n=1/36). Eighty-six percent of the clients reported it was ‘Never’ difficult to understand the providers when questions were asked (n=31/36), followed by ‘All of the Time’ (n=3/36) and ‘Rarely’ (n=2/36). Ninety-seven percent of the interviewed clients found their medical providers to be accepting and non-judgmental of their life and health care choices (n=35/36). Twenty-six clients reported it was ‘Never’ hard to get HIV medication prescriptions filled when needed (72% n=26/36) followed by ‘Rarely’ (n=6/36), and ‘Sometimes’ (n=4/36). All of the clients interviewed stated the providers explained the side effects of HIV medications in a way

the client could understand answered (n=36/36). All of the clients interviewed reported they were informed by the medical provider about how to prevent the spread of HIV (100% n=36/36), and most were informed on prevention and the spread of Hepatitis C (Hep C) if they were diagnosed (97% n=35/36). All of the clients reported they feel they were never treated poorly at the clinic (100% n=36/36) and felt the staff kept their HIV status confidential (100% n=36/36)

Fifty clients were interviewed about MCM services. Of the 50 clients, 70% stated they were aware of the different levels of case management (n=35/50). Most of the clients interviewed agree they work with their case manager to determine their needs (96% n=48/50) and agreed they do not find it hard to talk to their Medical Case Manager (98% n=49/50). The clients interviewed reported they 'Agree' (48% n=24) or 'Agree Strongly' (52% n=26) their provider works with their case manager to help them. All of the respondents 'Agreed' (46% n=23/50) or 'Agreed Strongly' (54% n=27/50) they could get an appointment when they needed.

Forty clients reported they have received Oral Health Services through Ryan White Part B and were interviewed. Twenty-four reported they have received services in the past year. Eleven of the clients (28%) reported they have received oral health services in the past one to two years, two in the past three to five years (5%), and twenty-one in the past year (53%). Twenty-one of the clients 'Agreed' (58%) and 11 'Agreed Strongly' (38%) they are satisfied with the Oral Health services they receive at their agency. All clients interviewed 'Agreed' (58% n=21/36) or 'Agreed Strongly' (42% n=15/36) they receive information on how to care for their teeth and gums (4 answered they could not recall).

When asked to think about the care at their clinic or agency, clients were asked to select from a list of words. Figure 13 shows the responses with the majority of clients using positive words to describe their experiences as a RWHAP B client.

Figure 13: Client Words

When I think about my care at this clinic/agency, these words come to mind:		
WORD	**NUMBER**	**RESPONSE**
Excellent	53	90%
Caring	51	86%
Friendly	50	85%
Safe	48	81%
Understanding	45	76%
Personal	41	69%
Warm	33	56%
Adequate	28	47%
Dignified	24	41%
Busy	10	17%

OK	5	8%
Scary	0	0%
Humiliating	0	0%
Other (please write in)	0	0%
Terrible	0	0%
Poor	0	0%
Rushed	0	0%
Impersonal	0	0%
Cold	0	0%

Recommendations

Each site had positive responses to open-ended questions about the client's care at the agency. The recommendations from clients included suggestions such as more support groups; peer mentors for newly diagnosed; time spent waiting for medical care; and less staff turn-over.

Corrective Action Plans

Of the eleven sites Peer Reviewed in 2020/2021, five sites were identified with challenges that required action plans. Challenges across these sites were focused on documentation in OAHS and MCM charts. Corrective Action Plans are submitted within 90 days of receiving the final report and the PR teamwork with the sites to coordinate with MidAtlantic AIDS Education and Training Center (MAAETC) and their VDH HIV Services Coordinator when necessary.

The OAHS corrective actions included recording information in the patient's medical chart for addressing documentation of vaccines; assessment of STD symptoms; assessment of TB risk factors (prison/jail, travel, homelessness, exposure to persons with chronic cough, etc); documentation of referrals and follow-up of referrals especially in regards to ophthalmology, pap smears, and mammograms as appropriate; routine baseline labs and yearly for those on tenofovir/TDF; documentation of referrals; and note that the after-visit summary was offered to the patient, and/or declined by the patient, Prevention/Risk Reduction documented in the client's chart.

Corrective Action Plans were required for sites that did not meet MCM Standards and follow-up TA was provided for needed sites. MCM sites that required Corrective Action Plans were cited for needing to address the following:

- Correct the Acuity Level and timeline
- Updated ISPs with signature and date by MCM and the client
- If Treatment Adherence is identified as a need, it should be included on the Service Plan with a goal and action steps to address it

- Target dates/timelines should be indicated as to when a goal is expected to be completed and it should relate to the timeframes required according to the MCM Acuity Level.
- A summary of the MCM's findings must be noted on the MCM Assessment form or in the progress notes to ensure proper documentation.

Peer Review Evaluation

PR site evaluations were sent to the Peer-Reviewed sites after each site visit, the same survey was sent a second time at the end of the contract year to sites that did not respond to the survey. Ten of the eleven sites reviewed responded to the survey at a 91% response rate. The sites were sent an evaluation survey using the online data collection tool REDCap. Figure 1 shows the number of respondents that answered "Yes" and "No" to the 26-question survey.

Figure 1: Peer Review Evaluation Survey

Evaluation Survey	Yes	No
Did the VCU Peer Review staff provide you with the necessary information needed to prepare for the review?	10/10	0/10
Were the steps to prepare for the Peer Review explained in preliminary meetings?	10/10	0/10
Comments: • The Peer Review team was very professional. • Katrina did an incredible job and made the peer review smooth. • Everything was provided before the review and assistance were provided throughout the review. • The Peer Review team is very collaborative.		
Did you participate in a virtual Peer Review due to COVID restrictions?	10/10	0/10
Comments: • This was a very easy process. • This was our first peer review. Having a virtual peer review seemed less stressful for us with ample time to provide information. • Katrina made everything easy and with no stress. • The virtual peer review was very easy. • The virtual review went very smoothly.		
Did your team find it difficult to share documentation with the Peer Reviewers?		
Comments: • No • The only problem was when trying to send paper documents we had a problem with the fax machine. We were able to get things uploaded into the file locker much easier and it worked fine. • Not difficult at all • Not at all • No, the secure site was easy for uploading requested documentation.		

• No • No • No, the VCU Peer Review team helped plan so scan documents securely to them for review. It was a smooth process.		
How would you rate the virtual Peer Review experience? Rate 1 to 10 (1 lowest and 10 highest)	Overall score 9.5	
Would you be willing to participate in a virtual Peer Review again?	10/10	0/10
Why or why not? • It went very smoothly and didn't take a lot of time from our normal business day to complete. Also, it saved travel for those having to travel to complete the audit process. • Scheduling a peer review time and sharing documentation for the peer review was easy. The flexibility of a virtual review was good as well. • This was a very easy process. • Having our MCM upload client chart documentation to the secure site over a span of a couple of weeks made it easier to fit into her schedule. Also at the time of this year's peer review, we didn't have a good space for peer reviewers to work in person. Also, there was no juggling of time seeing clients while having visitors. • I prefer the face-to-face interaction but did not mind the virtual review. • Simplicity • It was easy to scan documents securely to VCU with a list and planning ahead of time. • While it was time-consuming, the process was smooth. • The virtual-focused peer review took fewer resources.		
Please give us feedback about your virtual Peer Review experience: • Our experience with the virtual peer review was positive. Staff members who participated agreed that it went smoothly as a virtual platform. • This was our first peer review. It was definitely helpful in discovering any weakness/gap in our record-keeping and confirming for our MCM hearing the good job she is doing and hearing feedback from client interviews. • It was easy and less intimidating. • The Peer Review team is very organized and easy to communicate with. • Wonderful! It's great to have insight. • The virtual-focused peer review took fewer resources.		
Was the VCU Peer Review Team polite and professional?	10/10	0/10
Was an introductory meeting held at the beginning of the day?	10/10	0/10
Was an exit meeting provided?	10/10	0/10
Was appropriate provider staff present as selected by the provider?	10/10	0/10
Were you satisfied with the discussion of the findings?	10/10	0/10
Were you pleased with the answers to your questions?	10/10	0/10
Was the time period for the return of the final report explained to the provider?	10/10	0/10
Do you feel the reviewers were knowledgeable in their areas of review?	10/10	0/10

Please rate your overall satisfaction with the VCU Peer Review Program	10/10	0/10
Additional Comments: • This was a great experience for me and our MCM. The peer review team made it easy for us! • Bravo, Katrina, you did great. CrossOver appreciated it. • Awesome job		

Summary and Key Findings

The 2020/2021 Peer Reviewers reported consistent themes throughout the on-site reviews. These themes included the overall documentation was good when available for both MCM and OAHS which illustrated a close and well-developed relationship between the Medical Case Managers, Medical Providers, and the clients. When documented, it was evident the Medical Case Managers were committed to client care, are compliant, and working towards improving processes.

All sites reviewed had recommendations to develop a system to ensure the MCM acuities and assessment forms were updated as required and ensure all areas are filled out and scored properly. This has been recommended by Peer Reviewers as a need for additional training from their VDH HIV Services Coordinator and MAAETC for Case Management Training. Peer Reviewers recommended the MCM teams took the Case Management Refresher course when available through the MAAETC.

It was recommended by the PR OAHS team that each site develop a template for medical notes that includes a checklist of needed labs, vaccines, assessments, and outpatient standards of care. The template could also serve as a reminder for upcoming care markers and patient follow-up at future visits. Additionally, sites need to update progress notes for clients at each visit to ensure consistency in patient care and highlight when to update the client's chart regarding symptoms and risk history. The section should have areas of concern, namely risk reduction counseling, client education, and annual vaccinations. It was also recommended that sites providing OAHS consider utilizing the VDH vaccine registry to obtain historic vaccine data for newly enrolled patients as well as to document influenza vaccines administered at other locations including pharmacies.

In conclusion, Peer Reviewers stated they were impressed with all of the sites and the level of care provided to clients. Clients reported they are grateful for the care and assistance they receive and their connection with the MCM and medical providers. One Peer Reviewer stated they are impressed with the care for clients in VA when there are so many diverse places providing RWHAP B services. All of the sites were commended for the care provided to clients regardless of the size of the case load, geographic area, and access to wrap-around services. The RWHAP B sites continue to provide care and treatment services to people living with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations. The RWHAP B clients interviewed had overwhelmingly positive feedback regarding their care.

Attachment A: Peer Reviewed Site Outpatient/Ambulatory Medical Care Raw Data

OAHS: Peer Reviewed Sites	**COHM**		**CAHN**		**Carilion**		**Inova**		**TOTAL**	
(only applicable to patients newly enrolled into care within the past year)	**Raw Value**	**%**	**Raw Value**	**%**	**Raw Value**	**%**	**Raw Value**	**%**	**Raw Value**	**%**
A.1. Initial Medical History is documented within 30 days of client contact with provider?	1/1	100%	5/5	100%	1/1	100%	N/A	N/A	7/7	100%
A.2. (Initial) Physical Examination is documented within 30 days of client contact with the provider?	1/1	100%	5/5	100%	1/1	100%	N/A	N/A	7/7	100%
A.3. Medication history which includes: a. drug allergies b. current medications c. drug/substance abuse	1/1	100%	5/5	100%	1/1	100%	N/A	N/A	7/7	100%

A.4. Initial laboratory results or orders are documented as a component of the initial assessment	1/1	100%	5/5	100%	1/1	100%	N/A	N/A	7/7	100%
A.5. Oral Health assessment/referral is documented as a component of the initial assessment.	1/1	100%	5/5	100%	1/1	100%	N/A	N/A	7/7	100%
A.6. Psychosocial/Mental Health assessment and/or referral documented as a component of the initial assessment	1/1	100%	5/5	100%	1/1	100%	N/A	N/A	7/7	100%
A.7. Nutritional assessment is documented as a component of the initial assessment	1/1	100%	5/5	100%	0/1	0%	N/A	N/A	6/7	86%
A.8. Substance Abuse assessment and/or referral is documented as a component of the initial assessment	1/1	100%	5/5	100%	1/1	100%	N/A	N/A	7/7	100%
Question	**Raw Value**	**%**	**Raw Value**	**%**	**Raw Value**	**%**	**Raw Value**	**%**	**Raw Value**	**%**

B.1. History, q. 6 months, or p.r.n.	13/13	100%	12/13	92%	6/12	50%	24/24	100%	55/62	89%
B.2. Physical Exam, q. 6 months, or p.r.n.	13/13	100%	12/13	92%	6/12	50%	24/24	100%	55/62	89%
B.3. Has client been seen at least twice in the past 12 months?	11/13	85%	12/13	92%	9/12	75%	24/24	100%	56/62	90%
B.4. Laboratory Testing, q. 6 months, or p.r.n	13/13	100%	12/13	92%	6/12	50%	24/24	100%	55/62	89%
B.5. Medication history which includes new: 1. Drug allergies 2. Current medications 3. Drug/substance use 4. Treatment adherence	13/13	100%	13/13	100%	9/12	75%	24/24	100%	59/62	95%
B.6. Oral health assessment, referral, and annual/routine dental care	13/13	100%	13/13	100%	9/12	75%	24/24	100%	59/62	95%
B.7. Nutritional assessment or referral?	13/13	100%	13/13	100%	7/12	58%	24/24	100%	57/62	92%

B.8. Current (in last year) ophthalmology exam or referral if CD4 < 100 or hx of DM or HTN	1/2	50%	2/3	67%	N/A	N/A	0/1	0%	3/6	50%
B.9. Documentation of current breast exam, where applicable in the client's record? (females)	N/A	N/A	1/2	50%	N/A	N/A	4/7	57%	5/9	56%
B.10. Is there documentation of follow up from referrals in the client's record?	2/3	67%	5/7	71%	1/1	100%	7/10	70%	15/21	71%
C.1. CD4, q. 12 months, or p.r.n.	13/13	100%	13/13	100%	11/12	92%	24/24	100%	61/62	98%
C.2. Viral Load (HIV/RNA), q. 6 months, or p.r.n.	13/13	100%	12/13	92%	6/12	50%	24/24	100%	55/62	89%
C.3. CBC, q. 12 months, or p.r.n.	13/13	100%	13/13	100%	11/12	92%	24/24	100%	61/62	98%
C.4. Chemistry Panel, q. 6 months, or p.r.n.	12/12	100%	12/13	92%	7/12	58%	23/23	100%	54/60	90%
C.5. Toxoplasmosis Antibody Titer at baseline if CD4< 100.	12/12	100%	1/2	50%	2/2	100%	7/9	78%	22/25	88%

C.6. Resistance Genotyping /Phenotyping, p.r.n. a) Genotypic resistance testing (baseline; treatment failure) b) Phenotypic resistance testing (known virologic failure; known complex drug resistance pattern(s)	12/12	100%	4/7	57%	2/11	18%	20/22	91%	38/52	73%
C.7. Lipid Panel (annually)	13/13	100%	3/13	23%	2/12	17%	24/24	100%	42/62	68%
C.8. Urinalysis (baseline & annually or if on TDF-tenofovir)	13/13	100%	7/13	54%	6/12	50%	23/23	100%	49/61	80%
C.9. Liver/Hepatic Panel (baseline; q. 6 months, annually)	13/13	100%	11/13	85%	11/12	92%	24/24	100%	59/62	95%

C.10. Glucose (if not in Chem Panel; baseline & annually); Hemoglobin A1C q 6 months or p.r.n.	13/13	100%	13/13	100%	11/12	92%	24/24	100%	61/62	98%
C.11. Hepatitis A serology at baseline	13/13	100%	8/13	62%	11/12	92%	23/24	96%	55/62	89%
C.11a. If negative, patient referred for Immunization	1/3	33%	2/5	40%	4/6	67%	7/7	100%	14/21	67%
C.12. Hepatitis B serology at baseline and p.r.n. ongoing risk factor behavior	13/13	100%	10/13	77%	11/12	92%	23/23	100%	57/61	93%
C.12a If negative patient referred for Immunization	6/6	100%	3/7	43%	1/3	33%	9/11	82%	19/27	70%
C.13. Hepatitis C serology at baseline and p.r.n. ongoing risk factor behavior	13/13	100%	8/13	62%	11/12	92%	24/24	100%	56/62	90%
C.13a. If positive, patient evaluated and /or referred	1/2	50%	1/1	100%	N/A	N/A	1/2	50%	3/5	60%

C.14. STD risk assessment evaluated at each visit (e.g. Syphilis, Gonorrhea, Chlamydia)	12/13	92%	12/13	92%	9/12	75%	12/24	50%	45/62	73%
C.14a. Asked about STD symptoms at each visit	12/13	92%	9/13	69%	6/12	50%	14/24	58%	41/62	66%
C.15. VDRL/ RPR initially and q12 months with reports on the record where applicable?	13/13	100%	12/13	92%	8/12	67%	24/24	100%	57/62	92%
C.16 TB risk factors reviewed annually and p.r.n,	13/13	100%	11/13	85%	0/12	0%	24/24	100%	48/62	77%
C16a. TB testing (PPD or interferon-based testing) at initial presentation, repeated if baseline CD4+ was < 200 but has risen to > 200, and p.r.n based on risk factor review?	11/11	100%	12/13	92%	12/12	100%	21/21	100%	56/57	98%

C.17. Pap Smear, twice in first year and then annually thereafter -Are dates and results in the record?	0/1	0%	0/1	0%	0/1	0%	5/8	63%	5/11	45%
C.18. Mammogram annually > 50 years with dates and results in the record?	0/1	0%	N/A	N/A	N/A	N/A	1/2	50%	1/3	33%
C.19. Chest x-ray at baseline for patients with positive TB testing or prn for underlying lung disease - dates and results in the record?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
C.20. Special Studies- other testing based on individual needs. Dates and results in the record (as applicable)	N/A	N/A	3/4	75%	N/A	N/A	3/3	100%	6/7	86%
C.21. Pre-Conceptual Discussion and Counseling for all women of childbearing age at	N/A	N/A	0/1	0%	N/A	N/A	4/4	100%	4/5	80%

baseline and routinely thereafter.										
D.1. Are all current medications documented in the client's record?	13/13	100%	13/13	100%	12/12	100%	24/24	100%	62/62	100%
D.2. Is medication adherence assessment with documentation done at each visit?	13/13	100%	12/13	92%	11/12	92%	24/24	100%	60/62	97%
D.3. Are medication side effects assessed and documented?	13/13	100%	12/13	92%	7/12	58%	24/24	100%	56/62	90%
D.5. Has HAART been offered to the client, when applicable?	5/13	38%	6/13	46%	1/12	8%	3/22	14%	15/60	25%
D.6. Is the client currently on HAART?	13/13	100%	13/13	100%	12/12	100%	24/24	100%	62/62	100%
D.7. Is HAART consistent with current PHS Guidelines?	13/13	100%	13/13	100%	11/12	92%	24/24	100%	61/62	98%
D.8. Is the client on PCP prophylaxis if CD4<200?	13/13	100%	13/13	100%	11/12	92%	24/24	100%	61/62	98%

D.9. Is the client on Toxoplasmosis prophylaxis if CD4<100?	2/2	100%	1/1	100%	1/1	100%	2/3	67%	6/7	86%
D. 10. Is the client on MAC prophylaxis if CD4<50?	1/1	100%	N/A	N/A	N/A	N/A	N/A	N/A	1/1	100%
E. 1. Is an appropriate out-come based medical plan of treatment developed with the client and present in the client's record?	13/13	100%	13/13	100%	12/12	100%	24/24	100%	62/62	100%
E.1.a. Is there documentation that the client reviewed the plan and/or was offered a copy of the plan?	13/13	100%	9/13	69%	11/12	92%	2/7	29%	35/45	78%
E.2. Is Client Education documented in the client's record?	13/13	100%	5/13	38%	12/12	100%	18/23	78%	48/61	79%
E.3. Are progress notes present, current, legible, signed and dated in the client's record?	13/13	100%	13/13	100%	12/12	100%	24/24	100%	62/62	100%

E.4. Is there documentation of a Prevention/Risk factor reduction/ Counseling message at each visit?	13/13	100%	9/13	69%	11/12	92%	19/23	83%	52/61	85%
F.1. Influenza (annually)	11/12	92%	5/13	38%	7/12	58%	22/24	92%	45/61	74%
F.2. Pneumovax	10/12	83%	7/12	58%	8/12	67%	20/23	87%	45/59	76%
F.3. Prevnar 13	11/13	85%	2/12	17%	8/12	67%	22/24	92%	43/61	70%
F.4. Hepatitis B series- if serology is negative- is series completed?	8/9	89%	3/8	38%	4/6	67%	12/15	80%	27/38	71%
F. 5. Tetanus/Diphtheria (or Tdap x 1) (every/ ten years)	11/13	85%	6/12	50%	8/12	67%	19/24	79%	44/61	72%
F. 6. Others	13/13	100%	2/8	25%	7/12	58%	11/20	55%	33/53	62%
G.0. Is the agency a third party payer?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
G.1. Is there adequate documentation of care provision in the client's record?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
G.2. Are there an initial history, physical, and laboratory reports in the client's record?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

G.3. Do all progress notes reflect health status, response to treatment and services provided to client?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
G.4. Are there current laboratory reports in the client's record?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
G.5. Are there current medication records, VAMAP and non-VAMAP (name of drug, dosage, time) in the client's record?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
G.6. Is appropriate referral and follow-up documented in the client's record?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
G.7. Is there documentation in the client's record that current standards of care for the HIV/AIDS client are practiced? If not, comment.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Attachment B: All Levels of Case Management Raw Data

Peer Reviewed Levels of Medical Case Management								
Question	**Level 1**		**Level 2**		**Level 3**		**Total Raw**	**Total %**
	Raw	**%**	**Raw**	**%**	**Raw**	**%**		
1. Was the initial assessment completed within 30 days of Intake?	10/11	91%	18/18	100%	20/20	100%	50/51	98%
2. Was initial assessment signed and dated by MCM?	11/11	100%	15/18	83%	19/20	95%	47/51	92%
3. Was at least one face-to-face interview completed?	11/11	100%	18/18	100%	20/20	100%	51/51	100%
1. Was the full assessment completed within the acuity time frame?	19/21	90%	38/47	81%	24/26	92%	92/106	87%
2. Was ongoing full assessment signed and dated by MCM?	20/21	95%	36/47	77%	22/26	85%	90/106	85%
3. Were the appropriate number for face-to-face interviews based on acuity level completed within the last 12 months?	51/54	94%	52/62	84%	23/29	79%	138/157	88%
4. Is a brief summary of the MCM's findings noted on the last page of the MCM Assessment Form?	51/51	100%	45/49	92%	22/23	96%	130/135	96%
5. Is there documentation of Treatment Adherence addressed on the MCM Assessment Form?	53/54	98%	61/62	98%	29/29	100%	155/157	99%
5a. If Treatment Adherence was identified as a need, is it included on the Service Plan?	3/4	75%	18/26	69%	9/10	90%	34/44	77%
6. Is a completed Acuity Scale found in the chart reflecting client's current Acuity Level?	51/54	94%	55/62	89%	24/29	83%	140/157	89%
7. Is the Acuity Scale signed and dated by MCM and the Client on the date of completion?	50/54	93%	50/62	81%	26/29	90%	138/157	88%

8. Was the Acuity Scale updated at within the appropriate time frame for acuity level?	50/54	93%	39/62	63%	18/29	62%	117/157	75%
9. After completion of MCM Assessment, was the Service Plan developed within 45 calendar days?	12/13	92%	51/62	82%	26/29	90%	99/114	87%
9a. If not, is there documentation why?	1/1	100%	2/11	18%	1/3	33%	4/15	27%
10. Is there documentation that the client participated in the development of the Service Plan (indicated by client signatures)?	13/13	100%	52/60	87%	27/29	93%	102/112	91%
11. Is there documentation that the client was offered a copy of the Service Plan?	10/13	77%	35/59	59%	19/29	66%	64/111	58%
12. Are the goals and progress on attaining goals documented in the progress notes?	18/19	95%	43/61	70%	25/29	86%	98/121	81%
13. Is the timeline for goals set within the appropriate time frame for acuity the level?	12/13	92%	39/59	66%	21/29	72%	82/111	74%
14. Is the service plan updated within the appropriate time frame for the acuity level?	13/13	100%	28/54	52%	15/24	63%	64/101	63%
15. Does the Service Plan or progress notes contain ongoing documentation of activities toward the completion of goals?	16/16	100%	43/61	70%	24/29	83%	93/116	80%
16. Is there documentation of minimum contact (telephone or face-to-face) within the appropriate time frame for acuity level?	52/54	96%	50/62	81%	24/29	83%	138/157	88%
17. Are progress notes completed within 48 hrs?	54/54	100%	61/62	98%	29/29	100%	156/157	99%
Was client discharged or has started the discharge process?	1/54	2%	2/62	3%	2/29	7%	5/157	3%

18. Was a discharge summary placed in the client's chart within 30 days of discharge date?	1/1	100%	0/1	0%	1/2	50%	2/4	50%
19. Is documentation in the progress notes of the client's chart?	1/1	100%	1/1	100%	2/2	100%	4/4	100%
20. If client has transferred to another agency, were case management services transferred within 5 business days of request?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
21. If client could not be located, were a minimum of 3 follow up attempts made over a 3 month period?	N/A	N/A	N/A	N/A	1/1	100%	1/1	100%
22. After the last failed attempt to contact the client, was a certified letter sent within 5 business days notifying the client of discharge if no contact is made within 30 days of date on letter.	N/A	N/A	N/A	N/A	1/1	100%	1/1	100%
22a. Is a copy of the certified letter in the file?	N/A	N/A	N/A	N/A	1/1	100%	1/1	100%
23. Is documentation in the progress notes of all attempts made to contact the client?	N/A	N/A	N/A	N/A	1/1	100%	1/1	100%
24. If client was administratively discharged, was a certified letter mailed to the client's last known mailing address within 5 business days of discharge noting reason for discharge and possible alternative resources.	N/A	N/A	N/A	N/A	1/1	100%	1/1	100%
25. Is a copy of the certified letter in the file?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

MCM: Peer Reviewed Sites	**ARE**		**Carilion**		**COHM**		**FAHASS**		**INOVA**		**MWHC**		**NH**		**TRHD**		**CAHN**		**TOTAL**	
	Raw	**%**	**Raw**	**%**	**Raw**	**%**	**Raw**	**%**	**Raw**	**%**	**Raw**	**%**	**Raw**	**%**	**Raw**	**%**	**Raw**	**%**	**Raw**	**%**

1. Was the initial assessment completed within 30 days of Intake?	7/8	88%	7/7	100%	1/1	100%	7/7	100%	4/4	100%	4/4	100%	5/5	100%	3/3	100%	10/10	100%	48/49	98%
2. Was initial assessment signed and dated by MCM?	8/8	100%	7/7	100%	1/1	100%	7/7	100%	4/4	100%	4/4	100%	1/5	20%	3/3	100%	10/10	100%	45/49	92%
3. Was at least one face-to-face interview completed?	8/8	100%	7/7	100%	1/1	100%	7/7	100%	4/4	100%	4/4	100%	5/5	100%	3/3	100%	10/10	100%	49/49	100%
1. Was the full assessment completed within the acuity time frame?	11/11	100%	9/10	90%	1/1	100%	7/7	100%	27/28	96%	4/4	100%	9/20	45%	3/3	100%	10/10	100%	81/94	86%
2. Was ongoing full assessment signed and dated by MCM?	11/11	100%	8/10	80%	1/1	100%	7/7	100%	28/28	100%	4/4	100%	6/20	30%	3/3	100%	10/10	100%	78/94	83%
3. Were the appropriate number for face-to-face interviews based on acuity level completed within the last 12 months?	10/11	91%	9/10	90%	13/15	87%	17/17	100%	28/28	100%	11/12	92%	10/20	50%	9/10	90%	19/22	86%	126/145	87%
4. Is a brief summary of the MCM's findings noted on the last page of the MCM Assessment Form?	10/10	100%	8/9	89%	13/13	100%	17/17	100%	28/28	100%	10/11	91%	4/7	57%	9/9	100%	19/19	100%	118/123	96%
5. Is there documentation of Treatment Adherence addressed on the MCM	11/11	100%	10/10	100%	15/15	100%	17/17	100%	28/28	100%	10/12	83%	20/20	100%	10/10	100%	22/22	100%	143/145	99%

Assessment Form?																			
5a. If Treatment Adherence was identified as a need, is it included on the Service Plan?	0/2	0%	N/A	N/A	1/3	33%	10/10	100%	3/4	75%	6/7	86%	6/9	67%	2/2	100%	2/3	67%	30/40	75%
6. Is a completed Acuity Scale found in the chart reflecting client's current Acuity Level?	11/11	100%	8/10	80%	14/15	93%	17/17	100%	28/28	100%	11/12	92%	9/20	45%	10/10	100%	22/22	100%	130/145	90%
7. Is the Acuity Scale signed and dated by MCM and the Client on the date of completion?	11/11	100%	10/10	100%	14/15	93%	17/17	100%	28/28	100%	11/12	92%	4/20	20%	10/10	100%	21/22	95%	126/145	87%
8. Was the Acuity Scale updated at within the appropriate time frame for acuity level?	10/11	91%	7/10	70%	11/15	73%	16/17	94%	23/28	82%	9/12	75%	5/20	25%	9/10	90%	17/22	77%	107/145	74%
9. After completion of MCM Assessment, was the Service Plan developed within 45 calendar days?	9/11	82%	9/10	90%	7/7	100%	15/15	100%	15/17	88%	8/8	100%	12/18	67%	7/7	100%	7/11	64%	89/104	86%
9a. If not, is there documentation why?	1/2	50%	1/1	100%	N/A	N/A	N/A	N/A	2/2	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4/5	80%
10. Is there documentation that the client participated in the development of the Service	10/10	100%	10/10	100%	7/7	100%	15/15	100%	15/16	94%	8/8	100%	13/18	72%	7/7	100%	7/11	64%	92/102	90%

Plan (indicated by client signatures)?																			
11. Is there documentation that the client was offered a copy of the Service Plan?	8/10	80%	7/10	70%	1/7	14%	13/15	87%	13/16	81%	0/7	0%	7/17	41%	7/7	100%	8/12	67%	64/101	63%
12. Are the goals and progress on attaining goals documented in the progress notes?	11/11	100%	10/10	100%	9/9	100%	16/16	100%	16/16	100%	8/8	100%	4/18	22%	7/7	100%	5/14	36%	86/109	79%
13. Is the timeline for goals set within the appropriate time frame for acuity the level?	11/11	100%	10/10	100%	2/7	29%	14/15	93%	15/15	100%	7/8	88%	4/17	24%	7/7	100%	2/11	18%	72/101	71%
14. Is the service plan updated within the appropriate time frame for the acuity level?	11/11	100%	7/9	78%	1/5	20%	14/15	93%	10/15	67%	4/7	57%	3/16	19%	3/3	100%	3/10	30%	56/91	62%
15. Does the Service Plan or progress notes contain ongoing documentation of activities toward the completion of goals?	11/11	100%	10/10	100%	9/9	100%	16/16	100%	16/16	100%	8/8	100%	4/18	22%	7/7	100%	2/11	18%	83/106	78%
16. Is there documentation of minimum contact (telephone or face-to-face) within the appropriate time frame for acuity level?	10/11	91%	10/10	100%	14/15	93%	17/17	100%	28/28	100%	12/12	100%	8/20	40%	10/10	100%	17/22	77%	126/145	87%

17. Are progress notes completed within 48 hrs?	11/11	100%	10/10	100%	15/15	100%	17/17	100%	28/28	100%	12/12	100%	19/20	95%	10/10	100%	22/22	100%	144/145	99%
Was client discharged or has started the discharge process?	N/A	N/A	N/A	N/A	1/15	7%	N/A	N/A	1/28	4%	1/12	8%	2/20	10%	3/3	100%	N/A	N/A	5/145	3%
18. Was a discharge summary placed in the client's chart within 30 days of discharge date?	N/A	N/A	N/A	N/A	0/1	0%	N/A	N/A	1/1	100%	1/1	100%	0/1	0%	N/A	N/A	N/A	N/A	2/4	50%
19. Is documentation in the progress notes of the client's chart?	N/A	N/A	N/A	N/A	1/1	100%	N/A	N/A	1/1	100%	1/1	100%	1/1	100%	N/A	N/A	N/A	N/A	4/4	100%
20. If client has transferred to another agency, were case management services transferred within 5 business days of request?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
21. If client could not be located, were a minimum of 3 follow up attempts made over a 3 month period?	N/A	N/A	N/A	N/A	1/1	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	100%
22. After the last failed attempt to contact the client, was a certified letter sent within 5 business days notifying the client of	N/A	N/A	N/A	N/A	1/1	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	100%

discharge if no contact is made within 30 days of date on letter.																			
22a. Is a copy of the certified letter in the file?	N/A	N/A	N/A	N/A	1/1	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	100%
23. Is documentation in the progress notes of all attempts made to contact the client?	N/A	N/A	N/A	N/A	1/1	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	100%
24. If client was administratively discharged, was a certified letter mailed to the client's last known mailing address within 5 business days of discharge noting reason for discharge and possible alternative resources.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
25. Is a copy of the certified letter in the file?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Case Management TA Sites

Virginia Health Options	**Raw**	**%**
1. Was the initial assessment completed within 30 days of Intake?	2/2	100%

2. Was initial assessment signed and dated by MCM?	2/2	100%
3. Was at least one face-to-face interview completed?	2/2	100%
1. Was the full assessment completed within the acuity time frame?	11/12	92%
2. Was ongoing full assessment signed and dated by MCM?	12/12	100%
3. Were the appropriate number for face-to-face interviews based on acuity level completed within the last 12 months?	12/12	100%
4. Is a brief summary of the MCM's findings noted on the last page of the MCM Assessment Form?	12/12	100%
5. Is there documentation of Treatment Adherence addressed on the MCM Assessment Form?	12/12	100%
5a. If Treatment Adherence was identified as a need, is it included on the Service Plan?	4/4	100%
6. Is a completed Acuity Scale found in the chart reflecting client's current Acuity Level?	10/12	83%
7. Is the Acuity Scale signed and dated by MCM and the Client on the date of completion?	12/12	100%
8. Was the Acuity Scale updated at within the appropriate time frame for acuity level?	10/12	83%
9. After completion of MCM Assessment, was the Service Plan developed within 45 calendar days?	10/10	100%
9a. If not, is there documentation why?	N/A	N/A
10. Is there documentation that the client participated in the development of the Service Plan (indicated by client signatures)?	10/10	100%
11. Is there documentation that the client was offered a copy of the Service Plan?	0/10	0%
12. Are the goals and progress on attaining goals documented in the progress notes?	12/12	100%
13. Is the timeline for goals set within the appropriate time frame for acuity the level?	10/10	100%
14. Is the service plan updated within the appropriate time frame for the acuity level?	8/10	80%

15. Does the Service Plan or progress notes contain ongoing documentation of activities toward the completion of goals?	10/10	100%
16. Is there documentation of minimum contact (telephone or face-to-face) within the appropriate time frame for acuity level?	12/12	100%
17. Are progress notes completed within 48 hrs?	12/12	100%
Was client discharged or has started the discharge process?	0/12	0%
18. Was a discharge summary placed in the client's chart within 30 days of discharge date?	N/A	N/A
19. Is documentation in the progress notes of the client's chart?	N/A	N/A
20. If client has transferred to another agency, were case management services transferred within 5 business days of request?	N/A	N/A
21. If client could not be located, were a minimum of 3 follow up attempts made over a 3 month period?	N/A	N/A
22. After the last failed attempt to contact the client, was a certified letter sent within 5 business days notifying the client of discharge if no contact is made within 30 days of date on letter.	N/A	N/A
22a. Is a copy of the certified letter in the file?	N/A	N/A
23. Is documentation in the progress notes of all attempts made to contact the client?	N/A	N/A
24. If client was administratively discharged, was a certified letter mailed to the client's last known mailing address within 5 business days of discharge noting reason for discharge and possible alternative resources.	N/A	N/A
25. Is a copy of the certified letter in the file?	N/A	N/A

Attachment C: Oral Health Raw Data

Oral Health Care: PR	**Daily Planet**	**COHM**	**CAHN**	**FAHASS**	**ARE**	**Carilion**	**Inova**	**Total**

Question	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%
1. Is there referral in the client record?	13/13	100%	12/12	100%	10/10	100%	9/9	100%	11/11	100%	10/10	100%	11/11	100%	76/76	100%
2. Is there documentation in the client's record encouraging the client to seek routine dental care as recommended by the American Dental Association?	13/13	100%	12/12	100%	10/10	100%	9/9	100%	11/11	100%	10/10	100%	11/11	100%	76/76	100%
3. Is there appropriate dental education material apparent in the waiting room or noted in the client's record that materials were offered?	13/13	100%	12/12	100%	10/10	100%	9/9	100%	11/11	100%	10/10	100%	11/11	100%	76/76	100%
4. Is there documentation that the RW overseeing agency has given consent for the dental services?	13/13	100%	12/12	100%	10/10	100%	9/9	100%	11/11	100%	10/10	100%	11/11	100%	76/76	100%
5. Is treatment priority given to pain, infection, traumatic injuries, or other emergency	13/13	100%	12/12	100%	10/10	100%	9/9	100%	9/9	100%	9/9	100%	11/11	100%	73/73	100%

conditions documented in the client's record signed and dated for each appropriate visit?																
Is there documentation in the client's record signed and dated of a baseline evaluation that consists of:																
6. A completed medical history	13/13	100%	12/12	100%	10/10	100%	9/9	100%	11/11	100%	10/10	100%	11/11	100%	76/76	100%
7. Existing oral conditions	13/13	100%	12/12	100%	10/10	100%	9/9	100%	11/11	100%	10/10	100%	11/11	100%	76/76	100%
8. Patient's chief complaint	13/13	100%	12/12	100%	10/10	100%	9/9	100%	11/11	100%	10/10	100%	11/11	100%	76/76	100%
9. Medical alert, if appropriate	13/13	100%	12/12	100%	10/10	100%	9/9	100%	11/11	100%	10/10	100%	11/11	100%	76/76	100%
10. Radiographs appropriate for an accurate diagnosis and treatment	13/13	100%	12/12	100%	10/10	100%	9/9	100%	11/11	100%	3/3	100%	9/9	100%	67/67	100%
11. Drug history	13/13	100%	3/3	100%	10/10	100%	8/8	100%	11/11	100%	10/10	100%	11/11	100%	66/66	100%
Is there documentation of a treatment plan in the client's record showing concurrence with the dentist and client and addressing:																
12. Cavities	12/12	100%	12/12	100%	10/10	100%	8/8	100%	11/11	100%	10/10	100%	11/11	100%	75/75	100%
13. Missing teeth	N/A	N/A	3/3	100%	8/8	100%	4/4	100%	N/A	N/A	3/3	100%	11/11	100%	41/41	100%
14. Is there documentation of a treatment plan in the client's record showing concurrence with the dentist and client to address	N/A	N/A	N/A	N/A	1/1	100%	1/1	100%	N/A	N/A	N/A	N/A	N/A	N/A	2/2	100%

periodontal conditions?																
14a. Are diagnoses made for each quadrant or sextant to address periodontal conditions?	N/A	N/A	N/A	N/A	1/1	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	100%
14 b. If periodontal disease exists, has a full mouth probing been performed every six months?	N/A	N/A	N/A	N/A	1/1	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	100%
14c. Has a full mouth series of radiographs been conducted to substantiate periodontal disease?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**	**N/A**
15. Extractions	5/13	38%	2/7	29%	7/9	78%	1/9	11%	0/10	0%	0/6	0%	0/10	0%	15/64	23%
15a. Need for replacement teeth	N/A	N/A	0/2	0%	2/2	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2/4	50%
15b. Has a removable prosthesis for tooth replacement been considered?	N/A	N/A	N/A	N/A	2/2	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2/2	100%

15c. Has a fixed prosthesis for tooth replacement been considered?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
15d. If implants are needed, has a cone beam analysis performed?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
16. Is there signed and dated documentation that the treatment plan was reviewed and updated as needs are identified or at least every 6 months?	13/13	100%	12/12	100%	10/10	100%	8/8	100%	11/11	100%	9/9	100%	11/11	100%	74/74	100%
18. Is there documentation signed and dated that all services provided recorded?	13/13	100%	1/12	8%	0/10	0%	1/9	11%	2/11	18%	0/10	0%	1/11	9%	5/76	7%
19. Is there signed and dated documentation in the client's record of prescriptions and drugs dispensed?	7/7	100%	12/12	100%	10/10	100%	9/9	100%	11/11	100%	10/10	100%	11/11	100%	76/76	100%
20. Is there signed and dated documentation in the client's record	5/5	100%	N/A	N/A	8/8	100%	1/1	100%	1/1	100%	1/1	100%	N/A	N/A	18/18	100%

that post-operative instructions were given for surgical procedures?																
21. Is there documentation signed and dated in the client's record of all pre-medications and local anesthetic used?	13/13	100%	2/2	100%	7/7	100%	1/1	100%	N/A	N/A	N/A	N/A	N/A	N/A	15/15	100%
22. Is this provider a third-party payer?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Is there documentation signed and dated on the client's record of:																
Medical history	13/13	100%	12/12	100%	10/10	100%	9/9	100%	11/11	100%	10/10	100%	11/11	100%	76/76	100%
Physical examination	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Laboratory reports	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medications	12/12	100%	N/A	N/A	9/9	100%	N/A	N/A	0/9	0%	N/A	N/A	N/A	N/A	21/30	70%
Treatment plan of care	13/13	100%	12/12	100%	10/10	100%	9/9	100%	11/11	100%	8/8	100%	11/11	100%	74/74	100%
Interim progress notes	13/13	100%	12/12	100%	10/10	100%	9/9	100%	11/11	100%	7/7	100%	11/11	100%	73/73	100%
Referrals and follow-ups	2/2	100%	N/A	N/A	10/10	100%	9/9	100%	11/11	100%	N/A	N/A	N/A	N/A	32/32	100%

Attachment D: Client Interview Raw Data

Section B: Overall Experiences and Satisfaction	Raw Value	Percentage
B1. The RW Grievance/Complaint Procedure has been explained to me (yes)	47/59	80%
B2. I know when and why I can write a grievance/complaint procedure	51/59	86%

B3. I have been asked to participate in a patient satisfaction survey at this agency	46/59	78%
B4. I have been asked to participate in a Patient/Consumer Advisory Board	34/59	58%

Section C: Primary Medical Care	**All the Time**	**Most of the Time**	**Sometimes**	**Rarely**	**Never**
C1. When I needed an appointment, I could schedule one soon enough for my needs	25/36 (70%)	8/36 (22%)	3/36 (8%)	0/36 (0%)	0/36 (0%)
C2. My providers told me how important it was to keep my appointments	35/36 (97%)	1/36 (3%)	0/36 (0%)	0/36 (0%)	0/36 (0%)
C3. My providers made sure I understood what my lab test results (such as CD4 and viral load) meant for my health	35/36 (97%)	1/36 (3%)	0/36 (0%)	0/36 (0%)	0/36 (0%)
C4. I had questions that I wanted to ask my providers about my HIV care but did not ask	0/36 (0%)	0/36 (13%)	1/36 (6%)	3/36 (3%)	32/36 (68%)
C5. When I asked my providers questions about my HIV care, it was hard to understand their answers	2/36 (10%)	0/36 (0%)	0/36 (0%)	2/36 (6%)	31/36 (86%)
C6. I found my providers to be accepting and non-judgmental of my life and health care choices	35/36 (97%)	0/36 (0%)	0/36 (0%)	0/36 (0%)	1/36 (3%)
C7. It was hard for me to get my HIV medication prescriptions filled when I needed them	0/36 (0%)	0/36 (0%)	4/36 (11%)	6/36 (17%)	26/36 (72%)
C11. I was able to the get the services that my provider referred me to	27/36 (75%)	8/36 (22%)	0/36 (0%)	0/36 (0%)	1/36 (3%)
C13. The staff and my providers kept my HIV status confidential	28/36 (78%)	2/36 (10%)	1/36 (3%)	0/36 (0%)	0/36 (0%)
	Agree/Yes		**Disagree/No**		**Not Sure**

C8. My providers explained the side effects of my HIV medications in a way I could understand	36/36 (100%)	0/36 (0%)	0/36 (0%)
C9. My providers talked to me about how to avoid passing HIV to other people	36/36 (100%)	0/36 (0%)	0/36 (0%)
C10. My providers talked to me about how to protect myself from getting Hep C or how to avoid passing it on to other if I already had it	35/36 (97%)	1/36 (3%)	0/36 (3%)
C12. At any point, did you feel you were treated poorly at your clinic?	1/36 (3%)	35/36 (97%)	0/36 (0%)

Section D. Oral Health	**Less than 1 year**	**1 to 2 years**	**3 to 5 years**	**more than 5 years**
D1. I have received care here for oral health for…	20/50 (40%)	16/50 (32%)	7/50 (14%)	7/50 (14%)
D2. My last visit for oral health was…	30/50 (60%)	17/50 (34%)	1/50 (2%)	1/50 (2%)
	Disagree Strongly	**Disagree**	**Agree**	**Agree Strongly**
D3. I am satisfied with the oral health services I receive at this agency	0/50 (0%)	1/50 (2%)	25/50 (50%)	24/50 (48%)
D5. At every dentist visit I receive information on how to care for my mouth, teeth, gums and what to look for in my mouth	0/50 (0%)	0/50 (0%)	29/50 (58%)	21/50 (42%)
	1 time a year	**2 times a year**	**3+ times a year**	**when I feel the need**
D4. I see the dentist	13/50 (26%)	18/50 (36%)	7/50 (14%)	12/50 (24%)
E. Case Management	**Disagree Strongly**	**Disagree**	**Agree**	**Agree Strongly**

E1. I am aware of the different levels of case management	0/50 (0%)	15/50 (30%)	35/50 (70%)	0/50 (0%)
E2. Do you know how often you need to see your Case Manager?	0/50 (0%)	4/50 (8%)	46/50 (92%)	0/50 (0%)
E3. I work with my case manager to determine my needs	0/50 (0%)	2/50 (4%)	16/50 (32%)	32/50 (64%)
E4. I find it hard to talk to my case manager	0/50 (0%)	49/50 (98%)	1/50 (2%)	0/50 (0%)
E5. When I needed an appointment, I could see my case manager soon enough for my needs	0/50 (0%)	0/50 (0%)	23/50 (46%)	27/50 (54%)
E6. I feel comfortable sharing my feelings and problems with my case manager	0/50 (0%)	1/50 (2%)	24/50 (48%)	25/50 (50%)
E7. My case manager and HIV medical care providers worked together to help me	0/50 (0%)	1/50 (2%)	24/50 (48%)	25/50 (54%)
E8. I want to be more involved in making decisions about my service plans and goals	0/50 (0%)	20/50 (40%)	30/50 (60%)	0/50 (0%)

Report Acronyms

Acquired Immunodeficiency Syndrome	AIDS
AIDS Resource Effort	ARE
Antiretroviral Therapy	ART
Capital Area Health Network / Vernon J. Harris	CAHN
Community Access Network	CAN
CD4 (cluster of differentiation 4) is a glycoprotein found on the surface of immune cells such as T helper cells, monocytes, macrophages, and dendritic cells	CD4
CrossOver Healthcare Ministries	COHM
Eastern Shore Health District	ESHD
Eastern Virginia Medical	EVMS
Fredericksburg Area HIV/AIDS Support Services	FAHASS
Highly Active Antiretroviral Therapy	HAART
Harrisonburg Community Health Center	HCHC
Hepatitis C	Hep C
Health Insurance Portability and Accountability Act	HIPAA
Human Immunodeficiency Virus	HIV
Individualized Service Plan	ISP
MidAtlantic AIDS Education Training Center	MAAETC
Mycobacterium avium complex (MAC); bacteria related to tuberculosis	MAC
Medical Case Management	MCM
Mary Washington Health Center	MWHC
Neighborhood Health	NH
Outpatient Ambulatory Health Services	OAHS
Public Health Service	PHS
Performance Measure	PM
Peer Review	PR
"When Necessary" (from the Latin "pro re nata")	PRN
Quality Management	QM
Ribonucleic Acid	RNA
Rapid plasma reagin, a blood test for syphilis	RPR
Ryan White	RW
Ryan White HIV/AIDS Program Part B	RWHAP B
Sexually Transmitted Disease	STD

Technical Assistance	TA
Tuberculosis	TB
Three Rivers Health District	TRHD
University of Virginia	UVA
Virginia	VA
Virginia Medical Assistance Program	VAMAP
Virginia Commonwealth	VCU
Virginia Department of Health	VDH
Blood test for syphilis (VDRL stands for Venereal Disease Research Laboratory)	VDRL
Virginia Health Options	VHO
Substance Abuse	SA

Peer Reviewers

Alycia T. Dickens is a recognized leader in the field of HIV/AIDS and Hepatitis C with more than 20 years of experience.
She worked as a Family Nurse Practitioner in the Infectious Disease division at Eastern Virginia Medical School (EVMS) for more than 17 years. She also worked as the Infectious Disease Nurse Practitioner and the Liver Transplant Coordinator at the Hampton Veterans Affairs Medical Center. Dr. Dickens earned a Doctor of Nursing Practice (DNP) from Duke University and completed her Bachelor and Master of Science degrees from Hampton University.

Jeffrey Donowitz, MD is an Assistant Professor of Infectious Disease at Virginia Commonwealth University. Dr. Donowitz is member of the American Academy of Pediatrics, Infectious Diseases Society of America, and the American Society of Tropical Medicine and Hygiene. He is a member of the Gold Humanism Honor Society. Dr. Donowitz is active clinically and is a researcher. His research focuses on enteric infection, inflammation, growth, and neurodevelopment. Dr. Donowitz attended Medical School at St. George's School of Medicine, Grenada, West Indies and his residency was at the Children's Hospital of Richmond at VCU.

Karen Ingersoll, PhD, is a native of New Orleans, LA. She graduated from Louisiana State University at the age of 20, majoring in psychology. She earned her master's degree in clinical and counseling psychology from Southern Methodist University, followed by her Ph.D. in clinical psychology from the University of Virginia. She spent the early part of her career completing a postdoctoral fellowship in health psychology and addiction medicine at the Medical College of Virginia. She then spent over a decade as a faculty member at Virginia Commonwealth University. Dr. Ingersoll joined UVA's Department of Psychiatry and Neurobehavioral Sciences in 2006. She specializes in clinical health psychology, using her skills for patient care in the Ryan White Clinic and the Behavioral

Medicine Center. She is an internationally recognized expert on motivational interviewing and conducts summer research on this counseling style in Limpopo, South Africa. She is the training director for the Center for Behavioral Health and Technology, which uses technologies like the Internet and mobile phones to deliver health interventions for patients. In addition, she develops psychological interventions to help people with HIV live longer and healthier and to help women reduce the risks of alcohol-exposed pregnancy.

Sarah K. West, MD is the medical provider at Community Access Network in Lynchburg, Virginia. Dr. Sarah West served in the Divisions of Infectious Diseases and General Internal Medicine in the Department of Medicine at Oregon Health and Science University. She received her Fellowship training in Infectious Diseases at OHSU following her Residency in Internal Medicine at Vanderbilt University Medical Center. Dr. West earned her medical degree from the University of Virginia and completed her undergraduate studies at Rice University.

Julie Turner Newsome, M.S.Ed., LPC started working in the field of HIV in 1991 answering hotline phones and offering crisis management to newly HIV+ people. She has a BS and MS in Counseling from ODU. She worked at various AIDS Service Organizations as a Case Manager and then at EVMS for 8 years as a Case Manager & Supervisor in a busy clinic of over 2,000 HIV+ people and 13 doctors and nurse practitioners. She started private practice counseling with her LPC in 2007 with a group in Norfolk and 75% of her clients were HIV+ or members of the LGBTQ+ community. In 2015, she started her own solo practice and continues to specialize in counseling these same populations serving all of Hampton Roads with 85% of her clients being HIV+ and/or members of the LGBTQ+ community. Additionally, she has been a Peer Reviewer in VA for 12 years for Ryan White Parts A and B.

Andrea Reynolds began working in the HIV field in 2004 in Brunswick GA. In 2007 she relocated to VA and began working for West Piedmont AIDS Task Force (WPATF) utilizing RWPB funds and HOPWA funds to assist Ryan White patients. Ms. Reynolds worked for WPATF for five years starting as CM/Housing Coordinator and was promoted to Executive Director. In 2012, Ms. Reynolds began working with Carilion Infectious Disease Clinic as a Patient Navigator, and has since been promoted to Medical Case Manager then Lead Medical Case Manager. In 2020 she graduated from Radford University with my Masters in Social Work.

Sylvester Askins is the CEO of Moving Forward Consulting. MFC provides individuals living with HIV knowledge and resources to make informed decisions about their economic futures through employment. He created the Pathway to Endependence program, designed to assist PLWH successfully navigate issues surrounding returning to work—currently offered at the University of Virginia School of Medicine ID clinic. He also works as Program Coordinator for Ryan White Programs at the Urban League of Hampton Roads. Before founding MFC, Sylvester worked at the Endependence Center, a Center for Independent Living (CIL) in Norfolk, VA. He was the Coordinator for the agency's Ticket to Work Program funded by the Social Security Administration. In this role, he assisted individuals with disabilities across all degrees of the disability spectrum,

prepare for, and obtain meaningful work. He is trained as a Community Work Incentive Coordinator (Benefits Counselor). He has focused his practice on work incentive policies that assist people living with HIV to make well-informed financial decisions about work. He has many years of experience developing and providing capacity building and leadership development. He is a seasoned facilitator and nationally certified trainer. Sylvester has many years of experience as an Advocate and Activist, including working for several major labor unions as a Labor Organizer.

Pierre Diaz is currently a Benefits Specialists at Hampton Roads Community Health Center and was a Patient Navigator at Eastern Virginia Medical School Norfolk, Virginia for 3 years. Mr. Diaz was Chair of the City of Norfolk Ryan White Part A Planning Council as well as a member of the VDH planning Group and is currently a Client Interviewer of VCU Peer Review Team.

Marjorie Barna interest in the HIV/AIDS community goes back to 1990, when she started working with AIDS patients as a hospice volunteer in San Francisco. That interest has lasted for 30 years and she has satisfied it in various capacities. She moved to Virginia in 2010, and worked as a medical case manager under Ryan White Part B programming. After seven years, Jorie was promoted to program administration. While at Thrive Healthcare (formerly AIDS Services Group) in Charlottesville, Jorie supervised all aspects of the HOPWA (Housing Opportunities for People Living with AIDS), the CHARLI (Comprehensive HIV/AIDS Resources and Linkages for inmates) and the Community HIV Testing programs. When Community Access Network in Lynchburg was awarded Ryan White Part B funds, she was recruited to spearhead and build a new and comprehensive Ryan White Part B program. Jorie has served on the Peer Review team for the past five years and works as a contracted AETC Health Educator through the HIV services program housed at Virginia Commonwealth University. Currently, she is the programs manager for a peer recovery organization in Charlottesville.

Chris Widener was a Ryan White clinical case manager for 11 years. Mr. Widner has worked in healthcare for over 16 years. From hyperbaric technician to practice and administration. Mr. Widner has always focused on patient centered care and life as a case manager in southwest Virginia posed challenges that he was able to overcome and help makes changes with services in Ryan White Care services. Aa an advocate for his patients he has a connection because of his experience and this the 20th year he has lived with HIV.

Michelle Sullivan has a Bachelors of Science in Human Services. She has been a part of the FAHASS team for the last 4 years, occupying the Culpeper office. Michelle is the point of contact for rural communities in the Culpeper area, which includes Fauquier, Culpeper, Orange, Madison, and Rapidan. She not only assists with case management services, but also with prevention, education, testing, housing and outreach in these rural communities. Michelle came to FAHASS after being employed at RRCSB in their residential drug treatment program serving the same rural populations. Michelle has over 17 years' experience assisting underserved populations in other rural Virginia communities, utilizing her background in child development and community activism.

Irene Bethel recently joined the Virginia Department of Health as a Public Health Case Investigator and is excited to be a part of the Central Shenandoah Health District. Prior to VDH, she has a background in infectious disease through the Ryan White Program. Ms. Bethel was a Medical Case Manager and Community Health Worker with the University of Virginia. During her tenure at the University of Virginia, she helped the team service hundreds of patients during the COVID-19 Pandemic. Meeting basic needs from medication access, housing and improving food insecurities to patients living in rural areas. Her work in the field began at the "Drop-In Center," which is a small non-profit agency that provided access to prevention and supportive care of HIV/STDs & Hepatitis. She is currently enrolled as an undergraduate student at the University of Virginia and resides in the Charlottesville area. When she is not keeping busy with her studies and work obligations you can find her cooking up a delicious healthy meal, dancing in Zumba classes, listening to Caribbean or other soulful music, taking a long walk or spending time with family.

Trina Welpott, LCSW received her graduate degree in 2000 in California, and has since been practicing in Virginia. Her career has allowed her to work with diverse populations across a variety of settings, and with children through older adults. She has provided service for clients with developmental disabilities, Native Americans in foster care, home and clinic-based family counseling, dually-diagnosed veterans, domestic violence survivors, active duty military (both domestic and abroad), and most recently those affected by HIV and other chronic illnesses. She has worked in healthcare, private practice, and nonprofit settings, and provides direct service as well as clinical supervision and program management. Her focus is on integrative mind-body health, and also serves as a Wellness Practitioner- she holds certifications in various methods of healing relaxation and mindfulness techniques.

Andre Christian is graduate of Social Work from Norfolk State University and has experience in the effective delivery of social services. Mr. Christian is a former Chair of the Ryan White Part A Regional Planning Council. His Ryan White experience includes outreach development, HIV/AIDS education, program evaluation, conflict resolution, advocacy/policy research, strategic planning, financial literacy, and economic empowerment.

Livingston Rush was hired at the beginning of the Peer Review Program in 2012. Mr. Rush founded the first HIV Peer Advocacy group in Virginia. (PACOV) which partnered with the VCU HIV/AIDS Center and received grant funding for programs. Mr. Rush also worked to place an HIV advocate in the ID Clinic at Hayes-Willis and Vernon J. Harris. In 2002, he started his own HIV agency, L.I.F.E. Management, Inc, to assist those who were HIV positive, to reinvent themselves to live a more positive life. L.I.F.E was an acronym for Living Independently for Empowerment. This agency facilitated substance abuse groups for HIV positive individuals in recovery at Rubicon. L.I.F.E. had contracts with VCU, the DOC, Williamsburg Aids Network, Bristol, Myers Squib as a Consumer Consultant, and Health Care Solutions in Petersburg. For DOC L.I.F.E. facilitated classes for the DOC's Re-entry program for inmates transitioning into the community at Riverside Regional Jail. The classes were "Healthy Sexuality" and "Healthy Living", VCU, HIV testing and counseling. Williamsburg Aids Network, Conducted HIV testing and referring

positives into care upon release and presentations on STD's and HIV, Health Care Solutions, HIV testing and counseling and STD/HIV presentations. Mr. Rush has traveled throughout the US doing presentations on HIV and Your Heart.

Vincent A. Sawicki, M.S., D.D.S., Ph.D. is an Associate Professor of Dentistry at Virginia Commonwealth University. He received his M.S., Virginia Commonwealth University, 1975; D.D.S., Virginia Commonwealth University, 1979; Ph.D., Virginia Commonwealth University, 1980. Dr. Sawicki is an Assistant Professor in the VCU Department of General Practice Dentistry and his areas of expertise include teaching and practicing all phases of operative and fixed prosthetic dentistry. Dr. Sawicki conducts lecture and seminar series for senior students and mentoring students at all levels. Working in conjunction with the Oral Pathology Department. Dr. Sawicki also assists with and mentors the AD Williams Scholarship recipients and Kaugars' Award recipients in Oral Pathology. He serves as a thesis advisor and assists students to acquire PGY-1 positions.