Virginia Commonwealth University
Virginia Ryan White Part B
Peer Review Program
Fiscal Year 2022/2023 Final Report

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Executive Summary

This report outlines the 2022/2023 Virginia Commonwealth University (VCU) Ryan White Peer Review program outcomes for the Virginia Department of Health. The following sites were selected by the Virginia Department of Health (VDH) for Peer Review:

1. Daily Planet
2. Neighborhood Health
3. AIDS Response Effort (ARE)
4. Virginia Health Options (VHO)
5. Fredericksburg Area Health and Support Services (FAHASS)
6. Three River Health District (TRHD)
7. Mary Washington Health Center (MWHC)
8. Inova Juniper
9. Carilion
10. Crossover Healthcare Ministries (COHM)
11. Community Access Network (CAN)
12. Capital Area Health Network / Vernon J. Harris (CAHN)
13. Serenity
14. LGBT Life Center

These sites were reviewed for Outpatient/Ambulatory Health Services (OAHS), Medical Case Management (MCM), Non-Medical Case Management Services (MH), Oral Health Services (OH), Mental Health Services (MH), and Client Interviews. Due to the travel restrictions associated with COVID, the Peer Review program was instructed by VDH to conduct all Peer Reviews virtually until the end of the contract year in March of 2023. Through collaborative efforts with the Peer Review Team and the Peer-Reviewed sites, the Peer Reviewers 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 unnecessary for the 2022/2023 contract year.

VCU Peer Review Program

Virginia Ryan White Part B Program 2022 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 a 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 2022.

Selected Agencies and Funded Service Categories

Sub-recipients receiving RWHAP B funding are reviewed on a biennial schedule. In May 2022, sites were selected by VDH for review. These RWHAP B agencies included Daily Planet, Neighborhood Health, ARE, VHO, FAHASS, TRHD, MWHC, Inova, Carilion,

CAN, and CAHN. Technical Assistance (TA) was conducted at Serenity and LGBT Life Center. 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. However, a Corrective Action Plan is recommended to address any areas needing improvement.

Process and Methodology

The processes for Peer Reviews in 2022/2023 reflect guidance from VDH regarding no on-site Peer Reviews until further notice due to travel restrictions in response to COVID. All fourteen Peer-Reviewed sites in the 2022/2023 contract year were reviewed virtually.

Virtual Peer Review Process

Schedule Site Visits, Obtain Site Information, and Pre-visit Meetings

The PR Quality Coordinator notified Ryan White Part B agencies selected for PR in 2022 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, preliminary meetings and the site review dates were scheduled and confirmed by email. Confirmation emails were sent to the agency before the web conferences as a reminder. Each site was contacted to determine if they use an electronic health record (EHR) or paper charts to assess the logistical and technical preparations. At least two web conferences between the PR Quality Coordinator and the agency staff were scheduled after confirming the best method for virtual file sharing and the virtual review dates. Web meetings between the PR Quality Coordinator and the agency staff via Microsoft Teams or Zoom were scheduled at least three months before the date of their PR and again a week before their virtual PR. The PR process and procedures were outlined in the preliminary meetings, the REDCap modules were shared with the agency, and checklists were submitted by email. The PR Quality Coordinator explained to the agency staff how to prepare for the site visit, reviewed their previous PR reports, provided TA resources, and answered any questions during the meetings.

Because each site has a different method of collecting and storing client charts and information, it was determined that the PR process to gather information would be amended to accommodate their file-sharing capabilities. The sites stated their document-sharing capabilities, such as fax, scanning, uploading charts, or screen sharing. Additionally, all Peer Reviewers were contacted to verify their virtual review and file-sharing capabilities to conduct offsite Peer Reviews. The agency submits a list of unduplicated RWHAP B clients for each service category that will be Peer Reviewed to the PR Quality Coordinator. The PR Quality Coordinator randomized the client list by service category and selected 10% of the total number of clients per service category for review. Technical Assistance is offered to the RWHAP B agency to develop their client list if necessary, and all final client lists are submitted to the agency to begin uploading documents to VCU FILELocker or to screen share with the Peer Reviewers.

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, Mental Health Providers, Oral Health Providers, etc.
- Verification of their RWHAP B services and number of Ryan White (RW) clients
- Determine the type of charts for RW clients; paper charts or electronic health record
- The timeline for meetings to prepare for their PR
- The date or month they can be prepared and conduct a Peer Review
- Client lists and how to compile the client lists

Technical Assistance

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 developed their summary reports with the assistance of the PR Quality Coordinator. The Peer Reviewers then met with the RWHAP B site via Zoom to report their findings and schedule a 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 manage data online and build surveys and databases securely. The 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 secure remote internet access to ensure confidentiality & Health Insurance Portability and Accountability Act (HIPAA) compliance.

Peer-Reviewed sites with paper charts were scanned and uploaded into FileLocker and securely shared with the Peer Reviewers through an encrypted link to FileLocker. The client charts were reviewed on a secured VCU-issued PR 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 client information. Medical providers were given secured read-only access to the electronic health records for sites with OAHS and OH.

The Peer-Reviewed RWHAP B categories OAHS, MCM, OH, NMCM, MH, and Client Interviews were conducted in close collaboration with RWHAP B agency personnel using the REDCap Modules created and updated from VDH RWHAP B Standards. The PR Program selected 10% of the eligible charts based on current RWHAP B enrollment, up-to-date signed consent to share, and whether the client received RWHAP B in the previous 12 months. If sites had less than ten eligible charts, all eligible charts were reviewed. A minimum of 10 charts for each funded service category were reviewed.

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 collecting all data, the Peer Reviewers and the PR team reviewed all data and composed a summary of the information.

Post-Visit Activities

The PR agency reports were prepared by the PR Quality Coordinator 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 site visit reports identified strengths and challenges. A Corrective Action Plan (CAP) was required for identified challenges requiring corrective action steps. The Peer-Reviewed site submitted the CAP to the VDH Quality Coordinator within 90 days of receiving their report. When requested, the PR Quality Coordinator provided TA to assist the site to develop their CAP.

Qualified Peer Reviewers

The PR Program consists of a group of selected and nominated experts in the HIV field recruited throughout the state of VA. These individuals are professionals in Ryan White Services and include medical providers, mental health 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 determine 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 September 2022 and was required for all current and new Peer Reviewers. The training included a recorded session for all Reviewers concerning 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, NMCM, MH, MCM, OH, and 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.

Standards of Care Assessments:

Chart Review, Documentation Assessment & Recommendations

Outpatient/Ambulatory Health Services

Key Findings

Of the 14 sites reviewed in Peer Review 2022/2023, eight reported providing OAHS. (See Attachment A for raw data.) The Peer Reviewed sites presented client-level data through progress notes and documentation shared through their ERH systems and paper charts. The Peer Reviewers reported that their limitation to the virtual PR process was that although the agency's medical provider may have captured the information, the reviewers could only report the information they had access to in the EHR or the scanned charts. Therefore, a limitation of their review is that not all necessary information was scanned or shared in the EHR.

Peer Reviewers stated that most of the documentation in the charts was clear and available. Progress notes were current, legible, signed, and dated in the client's record (n=71/71). However, it was observed at sites with multiple healthcare providers that the notes and patient information were inconsistent. The Peer Reviewers recommended a template based on the RWHAP B standards of care if one was not already in place. The Peer Reviewers recognized that most of the sites had implemented a template in their EHR since their last PR.

Charts reviewed for newly enrolled patients were reported to have thorough initial care. Such as, the initial physical examination was documented within 30 days of the client's contact with the provider for all charts reviewed (n=28/28), and the initial laboratory results or orders were documented as a component of the initial assessment (n=29/29). However, the oral health assessment or referral (n=19/29 66%) and nutritional assessment (n=20/29 69%) were not always present in the client charts with their initial assessment.

The challenges noted from the charts reviewed indicated that women's health remains an area of improvement for RW part B recipients. The reviewers report that none of the client charts reviewed with a new HIV diagnosis under the age of 30 years (ages 21 to 29 years) had documentation of a Pap test at the time of initial diagnosis with HIV (n=0/2 0%). Only 33% (n=3/9) of women with HIV aged 30 years or older had documentation present in the client chart of a cervical cancer screening, such as Pap testing or Pap testing and HPV co-testing as needed. Annual mammograms, with dates and results, were present in 15% (n=2/13) of the charts reviewed for women over the age of 50 years. A current breast exam was documented in 14% (n=2/14) of the charts reviewed.

An area of concern noted in the client charts reviewed is that twelve (n=12/71 17%) charts reviewed noted the client refused to receive vaccines which reflects the outcomes for:

F. 1. Influenza (annually)	48/65	74%
F. 2. Pneumovax 23	42/64	66%
F. 3. Prevnar 13	46/68	68%
F. 4. Hepatitis B series -if serology is negative -is the series completed?	36/50	72%
F. 5. Tetanus/Diphtheria (or Tdap x 1) (every/ ten years)	51/68	75%
F. 6. COVID-19 vaccinations based on current CDC guidelines?	41/66	62%

F. 7. HPV and meningococcal vaccinations based on current CDC guidelines?	23/69	33%
Monkeypox *reported in notes section of 'other vaccine.'	7/71	10%

Strengths

A total of 71 charts were Peer Reviewed for OAHS, an appropriate out-come based medical plan of treatment present in all client records (n=71/71). The following standards were reviewed, and 100% of the charts included the following:

All charts reviewed had a current CD4 resulting in the previous 12 months (n=70/70); had documentation of current medications (n=71/71); HAART had been offered to the client, when applicable (n=71/71); HAART was consistent with current PHS Guidelines (n=71/71); documentation the client was on PCP prophylaxis if CD4<200 (n=6/6); the client is on Toxoplasmosis prophylaxis if CD4<100 (3/3); and client on MAC prophylaxis if CD4<50 (n=1/1).

Challenges

The agencies reviewed with any total standard not met at ≤ 70% with a minimum of 10 charts were deemed as challenges. Documentation of a current (in last year) ophthalmology exam or referral if CD4 < 100 or history present need was present in 65% of charts (n=8/22). Documentation for a referral regarding immunization for Hepatitis A was not present in 64% of the charts reviewed (n=9/14). TB risk factors were not recorded annually or as necessary in 65% of the reviewed charts (n=46/71). Documentation of STD symptoms discussed at each medical visit was not present in 51% of the charts (n=35/69). Whether the client reviewed the plan and/or was offered a copy of the plan was documented in 27% (n=19/71) of the charts reviewed.

Recommendations

The PR team recommended 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. The Peer Reviewers recommend a method of communication from the VDH Quality Program to ensure the medical providers of RWHAP B have received updated standards and sign-off on these standards to ensure their awareness of all RWHAP B updates.

Non-Medical Case management

Key Findings

A total of 222 charts were Peer Reviewed for NMCM from 14 agencies in 2022/2023 (see attachment B for detailed information). Eleven agencies reviewed for NMCM scored above 90% on all questions based on chart review information entered into REDCap. The Peer Reviewers commended the NMCM teams at the agencies for providing excellent care to their clients. Rapid access to Ryan White services for new clients was evident in many charts reviewed, such as documentation of a completed and dated eligibility/intake review form present in the client's chart within ten business days of the first contact (n=54/59 92%). The Peer Reviewers noted four charts had rapid intake completed for a new client on the same day.

Strengths

The Peer Reviewers noted that the charts reviewed were organized, and the client notes were thorough and well-written. Eligibility documents were clear, indicating the staff was well-trained regarding the Ryan White Part B Case Management standards. One reviewer stated both the non-medical and medical case managers followed up with RWB clients as indicated in the client chart. The agencies reviewed in 2022/2023 demonstrate client-centered care for their patients. Two agencies reviewed met all standards at 100% for NMCM.

Challenges

There were a few challenges to report overall. Two sites had difficulties addressing areas such as engaging new clients in care. If eligibility was delayed more than 30 days, documentation needed to be present in the client's chart of attempted communication.

The Peer Reviewers were challenged to review all necessary documentation for some charts as the PR was conducted virtually. One Peer Reviewer noted limitations of receiving partially scanned charts made access to all needed information difficult and extended the PR process.

Recommendations

Peer Reviewers for NMCM were impressed with the charts reviewed and the documentation of care provided to PWHA. The only recommendation for improvement was to include documentation of eligibility/intake when delayed more than 30 days; make at least three contacts on different days by phone, mail, or in-person. (n=90/118 76%)

Medical Case Management

Key Findings

Peer Reviewers evaluated 209 MCM charts from MCM levels 1, 2, & 3 at 14 RWHAP B sites in Virginia (See Attachment C for raw data). It was reported by Peer Reviewers that when properly documented and recorded, the agencies had detailed case notes, indicating 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, 51 newly diagnosed client charts revealed the initial assessment was completed in the first 30 days of intake for 98% (n=102/104); the initial assessment was signed and dated by MCM at 95% (n=103/108), and at least one face to face interview was conducted (95% n=103/108). The charts reviewed indicated an ongoing full assessment signed and dated by MCM in 95% (n=198/209) of the charts. Ninety-two percent (n=178/194) of the charts reviewed included a summary of the medical case manager's findings noted on the last page of the MCM Assessment Form. Documentation of Treatment Adherence addressed on the MCM Assessment Form was present in 96% (n=200/209) of the reviewed charts, and if Treatment Adherence was identified as a need, 91% (n=39/43) included information on the Service Plan. The documentation of minimum contact (telephone or face-to-face) within the appropriate time frame for acuity level was present in 96% (n=201/209) of charts, and progress notes were completed within 48 hours for 99% of reviewed charts (n=207/208).

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 client Service Plan was not updated within the appropriate time frame for the client's Acuity Level in 44% of the charts reviewed (n=79/141 56%). Also, there was no documentation as to why the Assessment was not completed (39% n=2/23) in charts that did not have an ISP developed within 45 calendar days.

Recommendations

Three of the 14 Peer Reviewed sites had recommendations to improve their systems to ensure the Service Plans and Assessments were updated and scored according to the RWHAP B Case Management Standards. Other than the challenges previously stated, the Peer Reviewers noted the increased employee turnover in the previous year greatly impacted the availability of the staff for their PR and impacted their knowledge of the VDH Case Management Standards. Through thoughtful discussions with staff at the Peer Reviewed agencies it was recommended when new staff has been hired to reach out to the MAAETC, Peer Review Program, and VDH HIV Services Coordinators for training to establish their knowledge of the standards.

Mental Health

Key Findings

Peer Reviewers evaluated 30 charts from three RWHAP B sites in Virginia (See Attachment F for raw data). Overall the MH services offered at the three sites were positive and the Peer Reviewers commented on the systematic order of the client records. Diagnoses were present in charts and documentation of appropriate mental health screenings. Each site reviewed received positive feedback from the Peer Reviewers.

Strengths

Six out of sixteen questions in the REDCap module were over 90%. The charts reviewed had documentation of a service plan (n=21/28 96%) in the client records, including a diagnosis (n=26/28 93%), service modality (n=26/28 93%), and initial screening (n=13/30 97%). The sites reviewed provide multiple RWHAP B services, when the services are utilized by the client the documented is present in their chart (n=12/12 100%).

Challenges

Areas of improvement for the MH services offered include adding a projected end date of services (n=5/26 19%) and a number of estimated sessions needed (n=6/21 29%). Additionally, when clients are discharged, there should be a discharge plan summary (n=4/7 57%) in the file with reasons for discharge or attempts to contact the client if unable to locate (n=0/1 0%).

Recommendations

Both PR MH Providers stated it is not typical for clinicians to project an end date or the number of sessions for their clients. Therefore, if Service Plan includes a projected end date for services (n=5/26 19%) and the number of sessions (n=6/26 23%) it is not a universal standard in MH services but only in RWHAP B. New issues arise in future sessions that would make this an invalid projection and therefore the Peer Reviewers recommend updating the standard for RWHAP B.

Oral Health

Key Findings

The Peer Reviewers collected information from 56 client charts at four sites in 2022/2023 (See Attachment D for raw data). The Peer Reviewer commended the sites for providing excellent Oral Health care for patients. Out of 32 questions based on the current oral health standards, 22 questions received above 90%. The Peer Reviewers complimented the sites reviewed for providing regular care to the clients. For example, documentation that the treatment plan was reviewed and updated as needs were identified at least every 6 months (n=49/51 96%).

Virtual chart reviews impacted the outcomes for many sites as the information was not available to reviewers. These limitations included access to Radiographs, referrals, treatment plans, and diagnosis notes, which were not accessible remotely in the ERH or scanned from the client charts. The reviewers reported the chart information present. However, there was information such as Radiographs that were not accessible due to EHR security measures.

Strengths

Treatment priority was given to clients for pain, infection, traumatic injury, or other emergency condition in 98% of the charts reviewed (n=55/56). Documentation was thorough when present, as reflected by the following information collected medical history (n=55/56 98%), physical examination (n=38/38 100%), laboratory reports (6/6 100%), medications (n=54/55 98%), treatment plan of care (n=55/56 98%), interim progress notes (n=52/53 98%), referrals and follow-ups (n=49/50 98%).

Challenges

Due to a lack of staff, inability to fax or transfer records, and limited access to electronic medical records, there was a challenge for the Peer Reviewers to review the complete client oral health chart from some agencies. Consequently, some questions were unable to be answered 'yes' in the REDCap module by the Peer Reviewers. For example, 67% (n=31/46) of the charts had a referral in the client record. After their PR, one site discovered all referrals for oral health are located in the client's MCM chart. Additionally, periodontal conditions are not always treated onsite at the Ryan White agency, and therefore the information may not have been present in the records, which affected the results of the following questions:

14. Is there documentation of a treatment plan in the client's record showing concurrence with the dentist and client to address periodontal conditions? (n=19/28 68%)

14a. Are diagnoses made for each quadrant or sextant to address periodontal conditions? (n= 9/18 50%)

14b. If periodontal disease exits, has a full mouth probing been performed every six months? (n= 9/14 64%)

14c. Has a full mouth series of radiographs been conducted to substantiate periodontal disease? (n=8/18 44%)[1]

Recommendations

The Peer Reviewers had few recommendations as two of the four reviewed sites received a perfect evaluation. However, the following recommendations were made when referring to the Virginia Ryan White Part B Quality Standards for Oral Health. Documentation of a treatment plan must be in the client's record when they receive oral health services. A referral to oral health from MCM or NMCM services needs to be present in the oral health chart. Include documentation in the client's record encouraging the client to seek routine dental care as the American Dental Association recommends. Radiographs must be

[1]The ADA encourages dentists and patients to discuss dental treatment recommendations, including the need for X-rays, to make informed decisions together. The ADA, in collaboration with the FDA, developed recommendations for dental radiographic examinations to serve as an adjunct to the dentist's professional judgment of how to best use diagnostic imaging. https://www.ada.org/resources/research/science-and-research-institute/oral-health-topics/x-rays-radiographs

included in the client's chart to appropriate their need for an accurate diagnosis and treatment of periodontal conditions. Periodontal diagnosis should be determined with comprehensive oral health evaluations. If a periodontal diagnosis exists, then include PSR and a plan of treatment in the client's chart or at minimum, make sure there's an agreement between the patient and provider as to the presence of periodontal issues and suggest that the patient seek a referral if they want to address the issue. Signed treatment consent forms must be in the client chart.

Client Interviews

Key Findings

Sixty-one RWHAP B clients were interviewed during the PR review year. Client interview questions consisted of various open-ended, yes or no, and Likert scale questions developed by 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).

Of the 61 RWHAP B clients interviewed, 41 received OAHS, 18 received Oral Health Care, and 59 received MCM (See Attachment G for raw data)

Clients interviewed reported they understand RWHAP B services and/or how RWHAP provides care (90%, n=55/61).

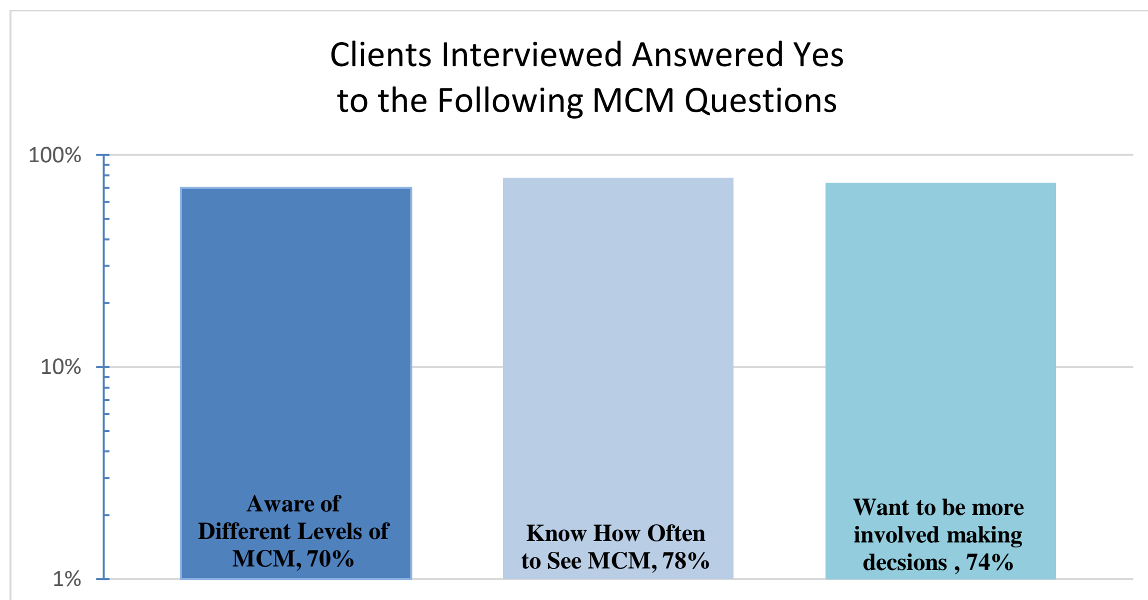
Ninety-eight percent of the clients reported they feel comfortable filing a grievance procedure (98% n=60/61), and 80% (n=49/61) recall having the grievance/complaint procedure explained to them. Forty-three (n=43/60 72%) clients remember being asked to participate in a satisfaction survey and 48% remember being asked to participate in a patient/consumer advisory board (n=29/61).

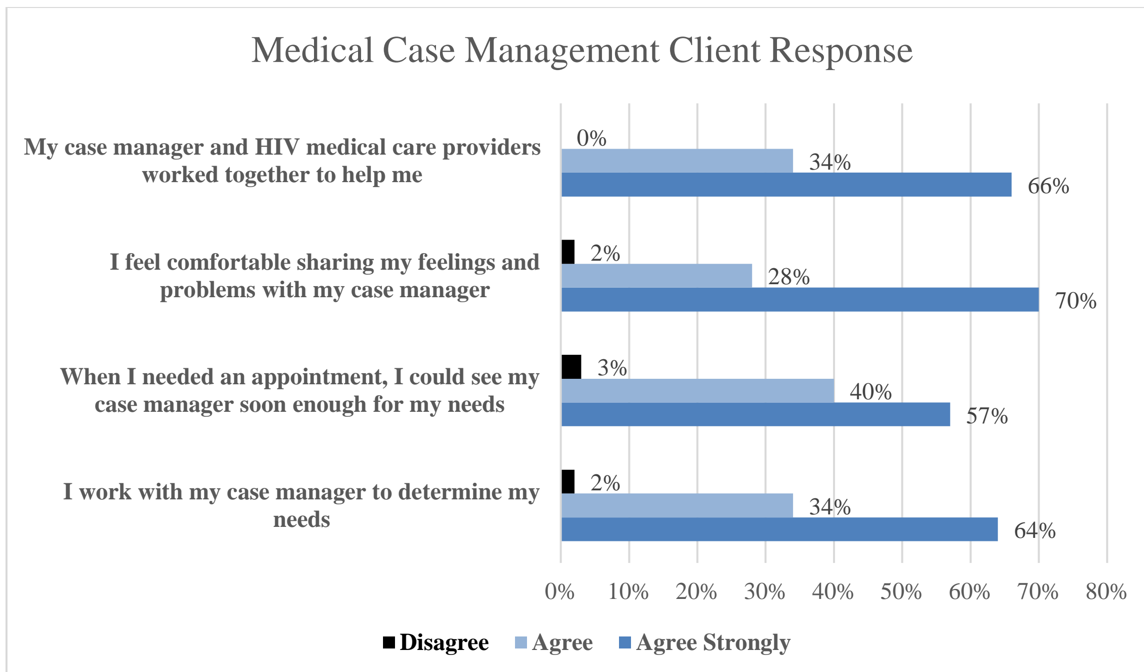
Forty-one RWHAP B clients were interviewed about their experiences in OAHS. When asked if clients could schedule an appointment soon enough for their needs, 27 (n=27/36 75%) responded 'All the Time,' eight responded 'Most Times'(n=8/36 22%), and one person responded 'Sometimes' (n=1/36 3%). All clients interviewed agreed their providers tell them consistently how important it is to keep their appointment and responded, 'All of the Time' (100%, n=41/41). 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 100% (n=41/41). 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' (n=32/40 80%), 'All of the time'(n=3/40 8%), 'Rarely' (n=3/40 8%), 'Most Times' (n=1/40 2%), and 'Sometimes' (n=1/40 2%). Clients reported it was 'Never' (n=32/41 78%) difficult to understand the providers when questions they asked questions, followed by 'All of The Time' (n=5/41 12%), 'Sometimes' (n=3/41 7%), and 'Most Times' (n=1/41 2%). Of the clients interviewed, 85% found their medical providers to be accepting and non-judgmental of their life and health care choices and reported 'All of the Time' (n=35/41 85%), 'Never' (n=4/41 10%), and 'Most Times' (n=1/41 1%). Thirty-four clients reported it was 'Never' hard to get HIV medication prescriptions filled when needed (n=34/40 85%), then; 'Most Times' (n=2/41 5%),

'Sometimes' (n=2/40 5%), Rarely (n=1/40 2%), and 'All of the Time' (n=1/40 2%). The clients interviewed reported their providers explained the side effects of their HIV medication in a way they could understand ('yes' n=39/40 98%). The clients interviewed reported they were informed by the medical provider about how to prevent the spread of HIV ('yes' n=39/40 98%), and most were informed on prevention and the spread of Hepatitis C (Hep C) if they were diagnosed (n=39/40 98%). The clients reported they are able to get the services that their provider referred them to 'All of the Time' (n=32/41 78%), 'Most Times' (n=7/41 17%), and 'Never' (n=2/41 4%). All clients reported feeling they were never treated poorly at the clinic (n=41/41 100%) and felt the staff kept their HIV status confidential (n=41/41 100%).

Sixty-one clients were interviewed about MCM services. Of the 61 clients, 70% answered they were aware of the different levels of case management (yes n=41/58 no n=17/58 29%), and most reported they know how often they need to see their case manager (yes n=47/60 78%). Clients 'Agreed' (n=20/58 34%) and 'Agreed Strongly' (n=37/58 64%) they work with their case manager to determine their needs (Disagree n=1/58 2%).

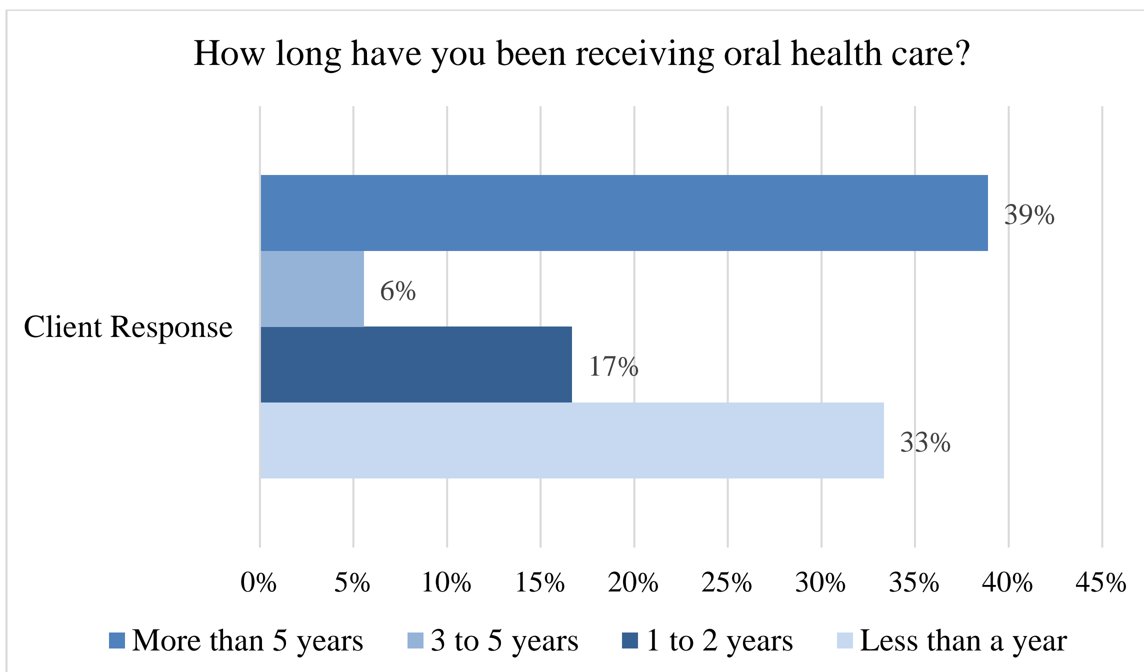
Most of the clients interviewed agree they 'Never'(n=56/58 96%) find it hard to talk to their Medical Case Manager; two clients reported 'Sometimes' (n=2/58 4%). Two clients stated " it depends on who they are talking to because of turn over and having to explain their health history over again" the other clients stated "I needed some assistance from my case manager, and she didn't seem interested in assisting me". The clients interviewed reported they 'Agree Strongly' (n=33/58 57%) or 'Agree' (n=23/58 40%) when they needed an appointment and they could see a case manager soon enough for their needs. When asked if they feel comfortable sharing their feelings and problems with a case manager, the clients stated they 'Agree Strongly' (n=41/58 70%) and 'Agreed' (n=16/58 28%). The clients also 'Agree Strongly' (n=38/58 66%) and 'Agreed' (n=20/58 34%); their medical provider works with their case manager to help them. Clients reported they would like to be more involved in making decisions about their services plans and goals (yes n=43/58 74%).

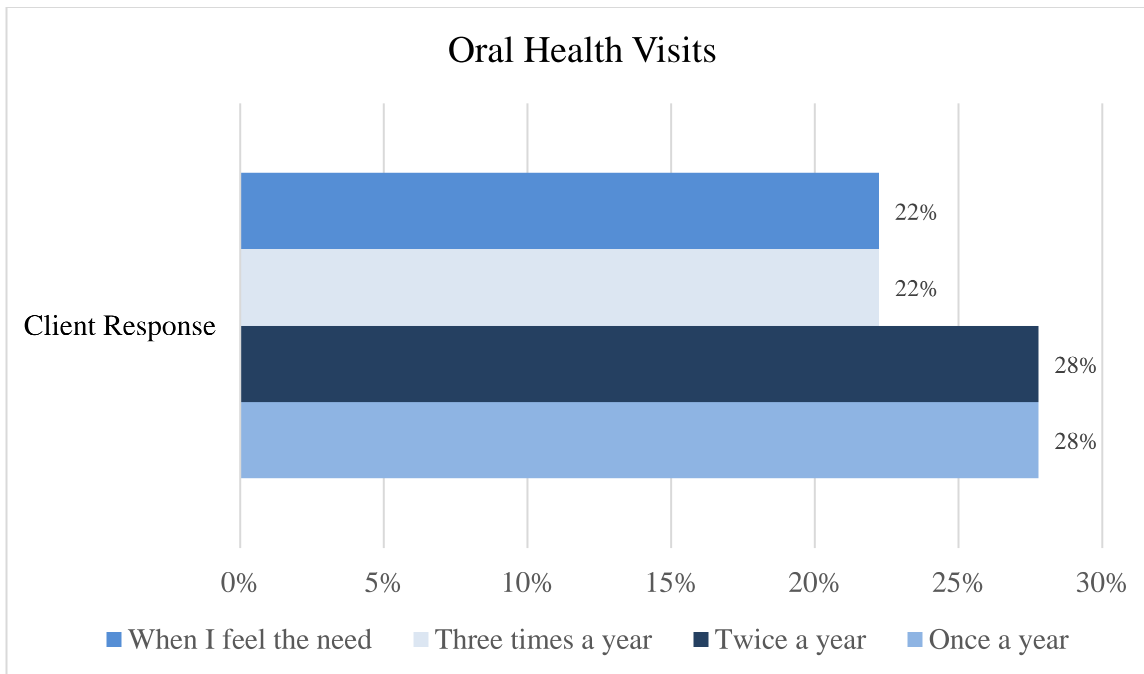




Eighteen clients reported they had received Oral Health Services through Ryan White Part B. Clients stated they began receiving OH care from their provider less than a year (n=3/18) to over five years (n=7/18). Thirteen reported they had received services in the past year (n=13/18 72%).

Eighty-five percent of the clients interviewed, ‘Agreed’ (n=3/13) or ‘Agreed Strongly’ (n=8/13) received information on caring for their teeth and gums. Most of the interviewed clients ‘Agreed’ (n=4/13) and ‘Agreed Strongly’ (n=5/13) are satisfied with the Oral Health services they receive at their agency.





When asked to think about the care at their clinic or agency, clients were asked to select from a list of words. Figure 4 shows the responses with the majority of clients using positive words to describe their experiences as RWHAP B clients.

Figure 4: Client Words

When I think about my care at this clinic/agency, these words come to mind:	
WORD	**NUMBER RESPONSE**
Caring	57
Friendly	56
Excellent	54
Safe	54
Understanding	49
Personal	46
Warm	34
Dignified	31
Adequate	23
OK	12

Busy	12
Humiliating	3
Poor	0
Cold	0
Scary	0
Rushed	0
Terrible	0
Impersonal	0

Recommendations

Each site responded positively to open-ended questions about the client's care at the agency. The recommendations from clients included suggestions such as better communication with the MCM team and access to their Medical Case Managers when needed. For example, one client stated they would like "stronger communication, and they have been a client for so long that they do not feel the case managers follow up as often as they did when they were new to care." Another client said they need more time with their case manager than their level of care reflects. Consumer communication between program staff and clients in discussing needs and barriers to care was suggested by a client.

Some of the clients interviewed recommended addressing staff turnover. One client stated there has been so much recent turnover they are unsure of who their case manager is and how to reach them. Another client recommended hiring more case managers to ensure there is always a trained case manager. An interviewer reported that a consumer interviewed doesn't clearly understand who works in the office and what their roles are with their care and would like to be notified when she is assigned to a new case manager. Additionally, a client stated that because of staff turnover, the case managers are going over client history instead of reading the chart and the client feels they are going through secondary trauma to explain their past history. The client said it's hard to connect with new case managers who do not seem to have compassion.

The clients interviewed also discussed access to services. Clients stated they would like agencies to have weekend hours or someone on call evening hours & weekends. One client requested transportation for consumers who live far from the agency. Clients asked for support for housing and better services for people experiencing homelessness. One client stated, "I would like to see more advertisements in the clinic for medication discounts, eye care, and HOPWA programs. A client suggested having someone meet with people in the waiting area or have information about additional assistance available to clients and more privacy in the waiting room with less feeling of being at an HIV clinic or ID clinic.

It was stated in an interview that "I would like to see more client activities and the clients as part of the agency planning and suggestions when it relates to consumers. Call and check on me more often and respond to Positive Links posts better. Because I posted that I was severely depressed over the holidays, and no one contacted me. It would be great to have better communication and explain the acronyms and explain details."

Corrective Action Plans

Of the sites Peer Reviewed in 2022/2023, nine areas were identified with challenges that required action plans. Corrective Action Plans are submitted within 90 days of receiving the final report. If needed, the PR team works with the sites to coordinate with MidAtlantic AIDS Education and Training Center (MAAETC) and/or their VDH HIV Services Coordinator to provide needed TA to develop their corrective actions.

The OAHS corrective actions include:

- Documentation of a nutritional assessment/ or referral need to be present in the client chart.
- Documentation of evaluation of STD risk factors evaluated at each visit need to be noted in the patient chart (e.g. Syphilis, Gonorrhea, Chlamydia), and that the patient was asked about STD symptoms each visit and noted in their chart.
- Documentation in the chart that TB testing (PPD or interferon-based testing) at initial presentation, repeated if baseline CD4+ was < 200 but has risen to > 200, and as needed based on their risk factor and symptom review. If no risk factor is present, document information in the patient chart. Documentation in the client's chart of prevention/risk factor reduction/ counseling.
- Documentation that the client reviewed or was offered a copy of the plan and indication the patient reviewed the plan, was offered a copy of the plan, and it is documented in the chart.
- HPV and meningococcal vaccinations based on current CDC guidelines need to be present in the charts.
- Refer clients not following up with OAHS for six (6) months to case management or patient navigator services for re-engagement in care.
- Engage patients and encourage consistent regular follow up for: medical visits and routine laboratory monitoring, including:
    - HIV viral load
    - Metabolic panel (at least every six months)
    - Lipids
    - Liver Panel
    - Hepatitis A, B, & C
    - Documentation of Urinalysis (baseline & annually or if on TDF-tenofovir) needs to be in the patient chart.
- Documented breast exam, mammogram, and recent Pap smear in the last year.
- Document if the client has received vaccinations such as:
    - Influenza
    - Tetanus
    - COVID
    - HPV

The MCM corrective actions include:

- Initial assessment needs to be completed within 30 days of intake for new clients.
- Service plans are updated according to RWHAP B Standards.

- 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.
- Correct the Acuity Level and the timeline for the updated Acuity Scale
- Charts should have an updated reassessment within the acuity timeframe, and a brief summary of MCM findings noted on the last page of the assessment or in progress notes.
- The Acuity Scale needs to be signed and dated by the Medical Case Manager and the Client on the completion date.
- The appropriate number of clients encounters annually based on the acuity level.
- The Individual's Service Plan has to be developed within 45 calendar days for new clients.

The NMCM corrective actions include:

- Initial contact with the client needs to occur within three business days.
- Documentation of expedited eligibility/intake for newly diagnosed, pregnant, or recently released from incarceration should be present in the client chart.
- Documentation of communication with the client regarding the date and time of the client's intake appointment and the required documentation needed to be brought to the appointment need to be documented.
- Documentation of a completed and dated eligibility/intake review form within ten business days of first contact with the client should be present in charts.

The Mental Health corrective actions include:

- The service plan should include a diagnosed mental illness and service modality.
- The service plan should include treatment goals and start dates for mental health services.
- The service plan should include documentation of consultation with other staff and support services.
- There should be documentation of any consultation and/or referrals with documentation of outcomes as needed.
- Service plans should include projected end dates of service, an estimated number of sessions, and reassessments of client progress every 90 days.
- When clients are discharged, there should be a discharge plan summary in the file with reasons for discharge or attempts to contact the client if unable to locate them.
- Documentation of referral for Mental Health Services needs to be in the client chart.

The Oral Health corrective actions include:

- Documentation of a treatment plan needs to be present in the client's record.
- Include documentation in the client's record encouraging the client to seek routine dental care as recommended by the American Dental Association.
- When appropriate, radiographs need to be included in the chart for an accurate diagnosis and treatment of periodontal conditions.

- A referral to from RWB services needs to be present in the chart.
- The periodontal status/disease of all patients needs to be documented.

Peer Review Evaluation

Evaluations were sent to sites after each Peer Review. The same survey was resent at the end of the contract year to sites that did not respond to the survey. Eleven Peer-Reviewed sites responded to the survey at a 79% response rate. The sites were sent an evaluation survey using the REDCap. Figure 2 shows the number of respondents that answered "Yes" and "No" to the 26-question survey.

Figure 2: Peer Review Evaluation Survey

<table>
<tr><th>Evaluation Survey</th><th>Yes</th><th>No</th></tr>
<tr><td>Did the VCU Peer Review staff provide you with the necessary information needed to prepare for the review?</td><td>11/11</td><td>0</td></tr>
<tr><td>Were the steps to prepare for the Peer Review explained in preliminary meetings?</td><td>11/11</td><td>0</td></tr>
<tr><td colspan="3">Comments:
• This was the first peer review I experienced since I started with MWHC in 2018. It was a smooth and organized review.
• Smooth process; staff was quick to get back to us when we had questions.
• Katrina was very thorough and helpful
• It would have been helpful to have a complete list of the documentation requirements before the peer review, so we could begin to change practice accordingly. Having the rubric or qualifications for what is explicitly being looked for would have been very helpful.</td></tr>
<tr><td>Did you participate in a virtual Peer Review due to COVID restrictions?</td><td>11/11</td><td>0</td></tr>
<tr><td colspan="3">Did your team find it difficult to share documentation with the Peer Reviewers?</td></tr>
<tr><td colspan="3">Comments:
• Somewhat - it is unclear if the reviewer fully grasped the EMR or how to view the available information best. Some of this could have been ameliorated if the review had been in person.
• No challenges in sharing documentation
• No
• No
• Yes, getting items uploaded and submitted in an organized way was a challenge.
• Not difficult at all. We were able to share our screen to show the documents.
• The process was easy and went quickly due to our having eCW. I would love for all audits to go this way.
• It could have been done in person, but we weren't able to provide access to our charts, so we had to be creative. The team was very accommodating in making it work.</td></tr>
<tr><td>How would you rate the virtual Peer Review experience?
Rate 1 to 10 (1 lowest and 10 highest)</td><td colspan="2">Overall Average
7</td></tr>
<tr><td>Would you be willing to participate in a virtual Peer Review again?
*two responses would prefer in person PRs</td><td>9/11</td><td>2/11</td></tr>
</table>

<table>
<tr><td colspan="2">Would you prefer an in-person PR onsite?</td><td>8/11</td><td>3/11</td></tr>
<tr><td colspan="4">Why or why not?
• It's just easier and more efficient to do it virtually.
• Only needed for OAHS happy to make everything else virtual.
• I am comfortable with virtual or an onsite reviews. I prefer virtual reviews.
• Better problem-solving of the EMR.
• Like the in-person interaction</td></tr>
<tr><td colspan="4">Please give us feedback about your virtual Peer Review experience:
• I would prefer to do it in person, but I understand the advantages of it being virtual
• Very easy process; everyone was ready when they said they would be.
• The biggest challenge is OAHS...we cannot provide access to someone, so we either need to coordinate to share or pull the chart and submit it...which was cumbersome.</td></tr>
<tr><td colspan="2">Was the VCU Peer Review Team polite and professional?</td><td>11/11</td><td>0</td></tr>
<tr><td colspan="2">Was an introductory meeting held at the beginning of the day?
*virtual meeting with PR Team held before remote PR for one site</td><td>10/11</td><td>1/11</td></tr>
<tr><td colspan="2">Was an exit meeting provided?</td><td>11/11</td><td>0</td></tr>
<tr><td colspan="2">Was appropriate provider staff present as selected by the provider?</td><td>10/10</td><td>0</td></tr>
<tr><td colspan="2">Were you satisfied with the discussion of the findings?</td><td>9/10</td><td>1/10</td></tr>
<tr><td colspan="4">• Seemed somewhat knit picky on topics we did not know we would be graded on. I think there were many things that were not seen, because the reviewer was not as comfortable with the EMR, which resulted in superfluous and unbeneficial discussion.</td></tr>
<tr><td colspan="2">Were you pleased with the answers to your questions?</td><td>10/10</td><td>0</td></tr>
<tr><td colspan="2">Do you feel the reviewers were knowledgeable in their areas of review?</td><td>10/10</td><td>0</td></tr>
<tr><td>Please rate your overall satisfaction with the VCU Peer Review Program</td><td>Very Satisfied
8/11</td><td>Somewhat Satisfied
2/11</td><td>Neither

1/11</td></tr>
<tr><td colspan="4">Additional Comments:
• The peer Review went really well.
• The Peer Review team is greatly appreciated. They give us another set of eyes to look at our paperwork, case notes, and chart set up, which is very valuable. It allows us to learn where we are falling a bit short and to have our strengths acknowledged.
• My first PR, and it was a good experience - I learned a lot.
• Again...Katrina bent over backward to accommodate our needs and situation. The only improvement would be to have OAHS in person or able to schedule to view screens during regular business hours.
• The peer review went well. It was very organized, and we could complete the session within the scheduled time.</td></tr>
</table>

Summary and Key Findings

The 2022/2023 Peer Reviewers reported consistent themes throughout the on-site reviews. These themes included the comprehensive 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.

Non-Medical Case Management had the best reviews throughout the 2022/2023 PR services. The attention to detail in the charts reviewed and the high level of client communication indicated the NMCM teams are well-trained and have an exceptional understanding of the Case Management Standards.

All sites reviewed had recommendations to develop a system to ensure that the MCM acuities and assessment forms were updated as required and that all areas were filled out and scored correctly. Peer Reviewers have recommended this area as a need for additional training from their VDH HIV Services Coordinator and MAAETC for Case Management Training and Non-medical Case Management. Peer Reviewers recommended that the MCM teams take the Case Management Refresher course when available through the MAAETC.

In conclusion, Peer Reviewers stated they were impressed with all of the sites and the level of care provided to clients. Clients reported at each series of interviews that they are grateful for the care and assistance they receive and their connection with the MCM and medical providers.

All sites were commended for the care provided to clients regardless of the caseload size, geographic area, and access to support services. The RWHAP B sites continue to provide excellent care and treatment services for people 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	**TOTAL**	
Section A (*only applicable to patients newly enrolled into care within the previous 12 months*)	**Raw Value**	**Percentage**
A.1. A.2. Initial Physical Examination is documented within 30 days of client contact with the provider?	27/28	96%
A.2. (Initial) Physical Examination is documented within 30 days of client contact with the provider?	28/28	100%
A.3. Medication history which includes: a. drug allergies b. current medications c. drug/substance abuse	28/29	97%
A.4. Initial laboratory results or orders are documented as a component of the initial assessment ?	29/29	100%
A.5. Oral Health assessment/referral is documented as a component of the initial assessment?	19/29	66%
A.6. Psychosocial/Mental Health assessment and/or referral documented as a component of the initial assessment?	25/29	86%
A.7. Nutritional assessment is documented as a component of the initial assessment	20/29	69%
A.8. Substance Abuse assessment and/or referral is documented as a component of the initial assessment	27/29	93%
A.9. TB Risk Assessment and TB Test with performance of or referral for additional evaluation as indicated (i.e., chest x-ray if positive test for TB infection or if active TB symptoms are identified).	50/59	85%
A.10. If the TB test is positive, refer for chest x-rays or other necessary follow up tests.	N/A	N/A
A.11. Document referral to the Local Health Department for individuals with presumptive active TB	N/A	N/A
A.12. Include any TB-related treatment and follow-up in treatment plan.	N/A	N/A
A. 13. Women with HIV Infection Aged < 30 years: WWH ages 21 to 29 years should have a Pap test at the time of initial diagnosis with HIV. ***new question in 2022/2023**	0/2	0%
Questions Regarding Current Clients	**Raw Value**	**Percentage**
B.1. History, q. 6 months, or p.r.n.	63/70	90%
B.2. Physical Exam, q. 6 months, or p.r.n.	62/70	89%
B.3. Has client been seen at least twice in the past 12 months?	64/69	93%
B.4. Refer clients not following up with Outpatient Ambulatory Health Services for six (6) months to case management or patient navigator services for re-engagement in care. ***new question in 2022/2023**	20/21	95%
B.5. Laboratory Testing, q. 6 months, or p.r.n	66/70	94%

B.6. Medication history which includes new: 1. Drug allergies 2. Current medications 3. Drug/substance use 4. Treatment adherence	68/69	99%
B.7. Oral health assessment, referral, and annual/routine dental care?	56/71	79%
B.8. Nutritional assessment or referral?	50/70	71%
B.9. Current (in last year) ophthalmology exam or referral if CD4 < 100 or hx of DM or HTN	8/22	36%
B.10. Documentation of current breast exam, where applicable in the client's record? (females)	2/14	14%
B.11. Is there documentation of follow up from referrals in the client's record?	25/30	83%
C.1. CD4, q. 12 months, or p.r.n.	70/70	100%
C.2. Viral Load (HIV/RNA), q. 6 months, or p.r.n.	67/69	97%
C.3. CBC, q. 12 months, or p.r.n.	68/70	97%
C.4. Chemistry Panel, q. 6 months, or p.r.n.	65/69	94%
C.5. Toxoplasmosis Antibody Titer at baseline if CD4< 100.	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)	36/40	90%
C.7. Lipid Panel (annually)	52/65	80%
C.8. Urinalysis (baseline & annually or if on TDF- tenofovir)	39/57	68%
C.9. Liver/Hepatic Panel (baseline; q. 6 months, annually)	61/69	88%
C.10. Glucose (if not in Chem Panel; baseline & annually); Hemoglobin A1C q 6 months or p.r.n.	68/70	97%
C.11. Hepatitis A serology at baseline	59/65	91%
C.11a. If negative, patient referred for Immunization	9/14	64%
C.12. Hepatitis B serology at baseline and p.r.n. ongoing risk factor behavior	61/67	91%
C.12a If negative patient referred for Immunization	22/27	81%
C.13. Hepatitis C serology at baseline and p.r.n. ongoing risk factor behavior	58/70	83%
C.13a. If positive, patient evaluated and /or referred	4/5	80%
C.14. STD risk assessment evaluated at each visit (e.g. Syphilis, Gonorrhea, Chlamydia)	66/71	93%

C.14a. Asked about STD symptoms at each visit	35/69	51%
C.15. VDRL/ RPR initially and q12 months with reports on the record where applicable?	62/70	89%
C.16 TB risk factors reviewed annually and p.r.n,	46/71	65%
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?	46/60	77%
C.17. Women with HIV Infection Aged < 30 years: Pap test should occur within 12 months (BII) of initial dx. *new question in 2022/2023	0/2	0%
C. 17 a. Women with HIV Infection Aged < 30 years: If the results of three consecutive Pap tests are normal, were follow-up Pap tests conducted every 3 years (BII)? *new question in 2022/2023	N/A	N/A
17 b. Women with HIV Aged ≥30 years: Has a cervical cancer screening in WWH; Pap testing only, or Pap testing and HPV co-testing prn? *new question in 2022/2023	3/9	33%
C.18. Mammogram annually > 50 years with dates and results in the record?	2/13	15%
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, patient education and initiation or referral for LTBI treatment if indicated?	0/1	0%
C.20. Documentation of LTBI treatment regimen, initiation date and completion date?	2/2	100%
C.21. Special Studies-other testing based on individual needs. Dates and results in the record (as applicable)	27/29	93%
C.22. Pre-Conceptual Discussion and Counseling for all women of childbearing age at baseline and routinely thereafter.	3/4	75%
D.1. Are all current medications documented in the client's record?	71/71	100%
D.2. Is medication adherence assessment with documentation done at each visit?	67/68	99%
D.3. Are medication side effects assessed and documented?	63/68	93%
D.5. Has HAART been offered to the client, when applicable?	71/71	100%
D.6. Is the client currently on HAART?	70/71	99%
D.7. Is HAART consistent with current PHS Guidelines?	71/71	100%
D.8. Is the client on PCP prophylaxis if CD4<200?	6/6	100%

D.9. Is the client on Toxoplasmosis prophylaxis if CD4<100?	3/3	100%
D. 10. Is the client on MAC prophylaxis if CD4<50?	1/1	100%
D. 11. If the pt. is not receiving ART or remain viremic on ART and have no current options for a fully suppressive ART regimen, do they receive chemoprophylaxis against disseminated Mycobacterium Avium Complex (MAC) disease if they have CD4 counts < 50cells/mm3(AI)? *Primary prophylaxis against disseminated MAC disease is not recommended for adults and adolescents with HIV who immediately initiate ART (AII).	N/A	N/A
E. 1. Is an appropriate out-come based medical plan of treatment developed with the client and present in the client's record?	71/71	100%
E.1.a. Is there documentation that the client reviewed the plan and/or was offered a copy of the plan?	19/71	27%
E.2. Is Client Education documented in the client's record?	60/70	86%
E.3. Are progress notes present, current, legible, signed and dated in the client's record?	71/71	100%
E.4. Is there documentation of a Prevention/Risk factor reduction/ Counseling message at each visit?	53/71	75%
F.1. Influenza (annually)	48/65	74%
F.2. Pneumovax	42/64	66%
F.3. Prevnar 13	46/68	68%
F.4. Hepatitis B series- if serology is negative- is series completed?	36/50	72%
F. 5. Tetanus/Diphtheria (or Tdap x 1) (every/ ten years)	51/68	75%
F. 6. COVID-19 vaccinations based on current CDC guidelines? *new question in 2022/2023	41/66	62%
F.7. HPV and meningococcal vaccinations based on current CDC guidelines? *new question in 2022/2023	23/69	33%
F. 8. Others	23/49	47%
G.0. Is the agency a third party payer?	N/A	N/A
G.1. Is there adequate documentation of care provision in the client's record?	N/A	N/A
G.2. Are there an initial history, physical, and laboratory reports in the client's record?	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
G.4. Are there current laboratory reports in the client's record?	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
G.6. Is appropriate referral and follow-up documented in the client's record?	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

Attachment B: Peer Reviewed Site Non-Medical Case Management Raw Data

	TOTAL	
Clients Enrolled in the Previous 12 months	**Raw Value**	**Percentage**
1. Is there documentation of initial contact with the client within three business days?	52/61	85%
2. Is there dated documentation of communication with the client regarding the date and time of the client's intake appointment and the required documentation needed to be brought to the appointment?	49/60	82%
3. Is there documentation of a completed and dated eligibility/intake review form within 10 business days of the first contact with client contact?	54/59	92%
4. Is there documentation of expedited eligibility/intake for newly diagnosed, pregnant, or recently released from incarceration?	42/51	82%
Questions Regarding Current Clients		
5. Is there documentation of completed and dated eligibility and recertification every six months?	210/215	98%
6. Is there documentation of eligibility/intake that includes a signed and dated Informed Consent?	218/222	98%
7. Is there documentation of eligibility/intake that includes a copy of the agency's Grievance Procedures?	209/222	94%
8. Is there documentation of eligibility/intake that includes a copy of the agency's Confidentiality Statement?	215/222	97%
9. Is there documentation of eligibility/intake that includes a signed and dated Release of Information (ROI) form?	216/222	97%
10. Is there documentation that the client received a copy of the Client Rights and Responsibilities?	216/222	97%
11. If eligibility/intake is delayed more than 30 days is there documentation of at least three contacts on different days (by phone, mail, or in-person) ?	90/118	76%
12. If the client answered 'yes' to any questions in the MCM referral section of the Eligibility/Intake Review Form is there documentation of a referral to MCM?	131/135	97%
13. Is there documentation of referral to MCM was completed in two working days?	187/194	96%
14. Is there documentation of referrals for support services as needed?	184/196	94%
15. Is there documentation of follow-up from referrals?	182/189	96%

Attachment C: 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?	40/42	95%	32/32	100%	30/30	100%	102/104	98%
2. Was initial assessment signed and dated by MCM?	41/45	91%	32/32	100%	30/31	97%	103/108	95%
3. Was at least one face-to-face interview completed?	41/45	91%	32/32	100%	30/31	97%	103/108	95%
1. Was the full assessment completed within the acuity time frame?	82/91	90%	66/75	88%	32/43	74%	180/209	86%
2. Was ongoing full assessment signed and dated by MCM?	83/91	91%	74/75	99%	41/43	95%	198/209	95%
3. Were the appropriate number for face-to-face interviews based on acuity level completed within the last 12 months?	85/91	93%	71/75	95%	38/43	88%	194/209	93%
4. Is a brief summary of the MCM's findings noted on the last page of the MCM Assessment Form?	80/85	94%	66/71	93%	32/38	84%	178/194	92%
5. Is there documentation of Treatment Adherence addressed on the MCM Assessment Form?	85/91	93%	74/75	99%	41/43	95%	200/209	96%
5a. If Treatment Adherence was identified as a need, is it included on the Service Plan?	3/3	100%	15/17	88%	21/22	95%	39/42	93%
6. Is a completed Acuity Scale found in the chart reflecting client's current Acuity Level?	84/91	92%	64/75	85%	31/43	72%	179/209	86%
7. Is the Acuity Scale signed and dated by MCM and the Client on the date of completion?	84/91	92%	66/75	88%	39/43	91%	189/209	90%
8. Was the Acuity Scale updated at within the appropriate time frame for acuity level?	81/91	89%	54/75	72%	18/43	42%	153/209	73%

9. After completion of MCM Assessment, was the Service Plan developed within 45 calendar days?	24/25	96%	66/75	88%	37/43	86%	127/143	89%
9a. If not, is there documentation why?	N/A	N/A	7/11	64%	2/6	33%	9/17	53%
10. Is there documentation that the client participated in the development of the Service Plan (indicated by client signatures)?	24/24	100%	66/70	94%	35/42	83%	125/136	92%
11. Is there documentation that the client was offered a copy of the Service Plan?	19/24	79%	56/70	80%	32/42	76%	107/136	79%
12. Are the goals and progress on attaining goals documented in the progress notes?	29/29	100%	63/70	90%	33/42	79%	125/141	89%
13. Is the timeline for goals set within the appropriate time frame for acuity the level?	31/31	100%	60/70	86%	30/42	71%	121/143	85%
14. Is the service plan updated within the appropriate time frame for the acuity level?	27/27	100%	43/68	63%	9/40	23%	79/135	59%
15. Does the Service Plan or progress notes contain ongoing documentation of activities toward the completion of goals?	27/28	96%	65/71	92%	31/42	74%	123/141	87%
16. Is there documentation of minimum contact (telephone or face-to-face) within the appropriate time frame for acuity level?	89/91	98%	73/75	97%	39/43	91%	201/209	96%
17. Are progress notes completed within 48 hrs.?	90/91	99%	75/75	100%	42/42	100%	207/208	100%
Discharge								
18. Was a discharge summary placed in the client's chart within 30 days of discharge date?	N/A	N/A	3/5	60%	2/2	100%	5/7	71%
19. Is documentation in the progress notes of the client's chart?	N/A	N/A	5/6	83%	2/2	100%	7/8	88%
20. If client has transferred to another agency, were case management services transferred within 5 business days of request?	N/A	N/A	1/1	100%	N/A	N/A	1/1	100%
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	1/3	33%	0/1	0%	1/4	25%
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	N/A	N/A	1/3	33%	1/2	50%	2/5	40%

letter.								
22a. Is a copy of the certified letter in the file?	N/A	N/A	1/1	100%	1/1	100%	2/2	100%
23. Is documentation in the progress notes of all attempts made to contact the client?	N/A	N/A	4/4	100%	2/2	100%	6/6	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	1/2	50%	1/2	50%	2/4	50%
25. Is a copy of the certified letter in the file?	N/A	N/A	1/1	60%	1/1	100%	2/2	100%

Medical Case Management	**TOTAL**	
	Raw	**%**
1. Was the initial assessment completed within 30 days of Intake?	102/106	96%
2. Was initial assessment signed and dated by MCM?	103/110	94%
3. Was at least one face-to-face interview completed?	103/110	94%
1. Was the full assessment completed within the acuity time frame?	181/217	83%
2. Was ongoing full assessment signed and dated by MCM?	200/217	92%
3. Were the appropriate number for face-to-face interviews based on acuity level completed within the last 12 months?	194/217	89%
4. Is a brief summary of the MCM's findings noted on the last page of the MCM Assessment Form?	178/194	92%
5. Is there documentation of Treatment Adherence addressed on the MCM Assessment Form?	201/217	93%
5a. If Treatment Adherence was identified as a need, is it included on the Service Plan?	39/43	91%
6. Is a completed Acuity Scale found in the chart reflecting client's current Acuity Level?	179/217	82%
7. Is the Acuity Scale signed and dated by MCM and the Client on the date of completion?	189/217	87%
8. Was the Acuity Scale updated at within the appropriate time frame for acuity level?	153/217	71%
9. After completion of MCM Assessment, was the Service Plan developed within 45 calendar days?	129/151	85%
9a. If not, is there documentation why?	9/23	39%

10. Is there documentation that the client participated in the development of the Service Plan (indicated by client signatures)?	127/144	88%
11. Is there documentation that the client was offered a copy of the Service Plan?	108/144	75%
12. Are the goals and progress on attaining goals documented in the progress notes?	127/149	85%
13. Is the timeline for goals set within the appropriate time frame for acuity the level?	121/149	81%
14. Is the service plan updated within the appropriate time frame for the acuity level?	79/141	56%
15. Does the Service Plan or progress notes contain ongoing documentation of activities toward the completion of goals?	125/149	84%
16. Is there documentation of minimum contact (telephone or face-to-face) within the appropriate time frame for acuity level?	202/217	93%
17. Are progress notes completed within 48 hrs.?	215/216	100%
18. Was a discharge summary placed in the client's chart within 30 days of discharge date?	5/7	71%
19. Is documentation in the progress notes of the client's chart?	7/8	88%
20. If client has transferred to another agency, were case management services transferred within 5 business days of request?	1/1	100%
21. If client could not be located, were a minimum of 3 follow up attempts made over a 3-month period?	1/4	25%
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.	2/5	40%
22a. Is a copy of the certified letter in the file?	2/2	100%
23. Is documentation in the progress notes of all attempts made to contact the client?	6/6	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.	2/4	50%
25. Is a copy of the certified letter in the file?	2/2	100%

Attachment D: Oral Health Raw Data

	Total	
Question	**Raw Value**	**Percentage**
1. Is there referral in the client record?	31/46	67%
2. Is there documentation in the client's record encouraging the client to seek routine dental care as recommended by the American Dental Association?	45/55	82%

3. Is there appropriate dental education material apparent in the waiting room or noted in the client's record that materials were offered?	35/35	100%
4. Is there documentation that the RW overseeing agency has given consent for the dental services?	43/56	77%
5. Is treatment priority given to pain, infection, traumatic injuries, or other emergency conditions documented in the client's record signed and dated for each appropriate visit?	55/56	98%
6. A completed medical history	55/56	98%
7. Existing oral conditions	55/56	98%
8. Patient's chief complaint	55/56	98%
9. Medical alert, if appropriate	55/56	98%
10. Radiographs appropriate for an accurate diagnosis and treatment	48/55	87%
11. Drug history	53/54	98%
12. Cavities	42/44	95%
13. Missing teeth	27/29	93%
14. Is there documentation of a treatment plan in the client's record showing concurrence with the dentist and client to address periodontal conditions?	19/28	68%
14a. Are diagnoses made for each quadrant or sextant to address periodontal conditions?	9/18	50%
14 b. If periodontal disease exists, has a full mouth probing been performed every six months?	9/14	64%
14c. Has a full mouth series of radiographs been conducted to substantiate periodontal disease?	8/18	44%
15. Did the client have extractions in the previous 12 months?	9/41	22%
15a. Is there a need for replacement teeth?	3/7	43%
15b. Has a removable prosthesis for tooth replacement been considered?	2/2	100%
15c. Has a fixed prosthesis for tooth replacement been considered?	N/A	N/A
15d. If implants are needed, has a cone beam analysis performed?	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?	49/51	96%
17. Has the treatment plan been evaluated by another dental provider to address the necessity for treatment?	54/56	96%
18. Is there documentation signed and dated that all services provided recorded?	55/56	98%

19. Is there signed and dated documentation in the client's record of prescriptions and drugs dispensed?	37/39	95%
20. Is there signed and dated documentation in the client's record that post-operative instructions were given for surgical procedures?	32/32	100%
21. Is there documentation signed and dated in the client's record of all pre-medications and local anesthetic used?	47/47	100%
22. Is this provider a third-party payer?	54/56	96%
Does the reviewed chart include the following information?		
Medical history	55/56	98%
Physical examination	38/38	100%
Laboratory reports	6/6	100%
Medications	54/55	98%
Treatment plan of care	55/56	98%
Interim progress notes	52/53	98%
Referrals and follow-ups	49/50	98%

Attachment E: Mental Health

	TOTAL	
	Raw Data	**Percentage**
1. Is there documentation of referral for Mental Health Services documented prior to initiation of service?	26/30	87%
2. Is there documentation of screening (PHQ-9, GAD-9, AUDIT-DAST, Rx Abuse Screener, MOCA) in client's record?	29/30	97%
3. Is there documentation of the Service Plan in the client's record signed and dated by the service provider?	27/28	96%
4. Does the Service Plan include a diagnosed mental illness or condition?	26/28	93%
5. Does the Service Plan include Service modality (individual, group, or both)?	26/28	93%
6. Does the Service Plan include treatment goals?	20/28	71%
7. Does the Service Plan include start dates for mental health services?	25/28	89%
8. Does the Service Plan include a projected end date for services?	5/26	19%
9. Does the Service Plan include a number of sessions?	6/26	23%
10. Does the Service Plan include reassessment dates of client progress every 90 days?	6/21	29%
11. Is there documentation of a complete psychosocial assessment and the result used to complete the	22/25	88%

service plan?		
12. Is there documentation of mental health services provided in the client's record?	26/26	100%
13. Is there documentation of consultation with medical staff, mental health, pharmacy, and other support services as needed?	12/12	100%
14. Is there documentation of referrals made and status of outcome in the client's record?	11/13	85%
15. Is there documentation of discharge plan summary and summary in the client's record with clear rationale within 30 days of discharge, including a certified letter, if applicable?	4/7	57%
16. If unable to locate the client, is there documentation of attempts made?	0/1	0%
17. If the client was transferred, is there documentation of discharge summary and other records sent with the patient?	0/1	0%

Attachment F: 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/no)?	49/61	80%
B2. Do you feel safe/comfortable filing a complaint/grievance (yes/no)?	69/61	98%
B3. I have been asked to participate in a patient satisfaction survey at this agency (yes/no).	43/60	72%
B4. I have been asked to participate in a Patient/Consumer Advisory Board (yes/no).	29/61	48%

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.	32/41(78%)	9/41(22%)	0/41(0%)	0/41(0%)	0/41(0%)
C2. My providers told me how important it was to keep my appointments.	41/41(100%)	0/41(0%)	0/41(0%)	0/41(0%)	0/41(0%)
C3. My providers made sure I understood what my lab test results (such as CD4 and viral load) meant for my health.	41/41(100%)	0/41(0%)	0/41(0%)	0/41(0%)	0/41(0%)
C4. I had questions that I wanted to ask my providers about my HIV care but did not ask.	3/41(7%)	1/41(3%)	1/41(3%)	3/41(7%)	33/41(80%)
C5. When I asked my providers questions about my HIV care, it was hard to understand their	5/41(12%)	1/41(2%)	3/41(7%)	3/41(7%)	29/41(72%)

answers.					
C6. I found my providers to be accepting and non-judgmental of my life and health care choices.	36/41(87%)	1/41(3%)	0/41(0%)	0/41(0%)	4/41(10%)
C7. It was hard for me to get my HIV medication prescriptions filled when I needed them.	1/41(3%)	2/41(5%)	2/41(5%)	1/41(3%)	35/41(84%)
C11. I was able to the get the services that my provider referred me to.	32/41(78%)	7/41(18%)	0/41(0%)	0/41(0%)	2/41(4%)
C13. The staff and my providers kept my HIV status confidential.	40/41(98%)	0/41(0%)	1/41(2%)	0/41(0%)	0/41(0%)

	Agree/Yes	**Disagree/No**	**Not Sure**
C8. My providers explained the side effects of my HIV medications in a way I could understand.	40/41(98%)	1/41(2%)	0/41(0%)
C9. My providers talked to me about how to avoid passing HIV to other people.	40/41(98%)	1/41(2%)	0/41(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.	40/41(98%)	1/41(2%)	0/41(0%)
C12. At any point, did you feel you were treated poorly at your clinic?	0/41(0%)	41/41(100%)	0/41(0%)

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…	6/18(33%)	4/18(22%)	1/18(6%)	7/18(39%)
D2. My last visit for oral health was…	13/18(72%)	3/18(17%)	2/18(12%)	0/18(0%)
	Disagree Strongly	**Disagree**	**Agree**	**Agree Strongly**

D3. I am satisfied with the oral health services I receive at this agency.	1/18(6%)	2/18(12%)	3/18(17%)	12/18(67%)
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.	0/18(0%)	1/18(6%)	5/18(28%)	12/18(67%)
	1 time a year	**2 times a year**	**3+ times a year**	**when I feel the need**
D4. I see the dentist …	5/18(28%)	5/18(28%)	4/18(22%)	4/18(22%)
Case Management	**Disagree Strongly**	**Disagree**	**Agree**	**Agree Strongly**
E1. I am aware of the different levels of case management (yes/no)?	0	17/58(29%)	41/58(71%)	0
E2. Do you know how often you need to see your Case Manager (yes/no)?	0	12/60(20%)	47/60(78%)	0
E3. I work with my case manager to determine my needs.	0/58(0%)	1/58(2%)	20/58(34%)	37/58(64%)
	Never	**Sometimes**	**Often**	**Always**
E4. I find it hard to talk to my case manager.	56/58(97%)	2/58(4%)	0/58(0%)	0/58(0%)
	Disagree Strongly	**Disagree**	**Agree**	**Agree Strongly**
E5. When I needed an appointment, I could see my case manager soon enough for my needs.	0/57(0%)	1/57(2%)	23/57(40%)	33/57(58%)
E6. I feel comfortable sharing my feelings and problems with my case manager.	0/58(0%)	1/58(2%)	16/58(28%)	41/58(71%)
E7. My case manager and HIV medical care providers worked together to help me.	0/58(0%)	0/58(0%)	20/58(34%)	38/58(66%)
E8. I want to be more involved in making decisions about my service plans and goals (yes/no).	0/58(0%)	15/58(26%)	43/58(74%)	0/58(0%)

Report Acronyms

Acquired Immunodeficiency Syndrome	AIDS
AIDS Response Effort	ARE
Antiretroviral Therapy	ART
Capital Area Health Network	CAHN
Community Access Network	CAN
Corrective Action Plan	CAP
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
Fredericksburg Area Health and Support Services	FAHASS
Highly Active Antiretroviral Therapy	HAART
Hepatitis C	Hep C
Health Insurance Portability and Accountability Act	HIPAA
Human Immunodeficiency Virus	HIV
Individualized Service Plan	ISP
LGBT Life Center	LGBT LC
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 regains, a blood test for syphilis	RPR
Ryan White	RW
Ryan White HIV/AIDS Program Part B	RWHAP B

Substance Abuse	SA
Sexually Transmitted Disease	STD
Technical Assistance	TA
Tuberculosis	TB
Three River Health District	TRHD
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

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's and Master of Science degrees from Hampton University.

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 new 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 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.

Erica Peak, MD, is currently completing her fellowship in combined Adult and Pediatric Infectious Diseases at VCU. She graduated from the University of Richmond in 2013 with a degree in Biology. She then remained in Richmond to attend medical school at VCU and earned her medical degree in 2017. She completed residency training in combined Internal Medicine and Pediatrics at VCU and served as Chief Resident for the program in her final year. She is board-certified in both Internal Medicine and General Pediatrics. Her main clinical interest is HIV Medicine, and she enjoys providing care for both pediatric and adult patients living with HIV in the City of Richmond. In her spare time, she enjoys spending time with her husband and toddler son, visiting restaurants, cooking for friends, and traveling."

Jeffrey S. Shirley D.D.S., is currently retired from practicing dentistry and is excited about the opportunity to help out with the Ryan White peer review process. I graduated from Wakefield High School in Arlington, Virginia in 1971, from the University of Virginia in 1975, and from the VCU School of Dentistry in 1979. I served 3 years in the Army from 1979 - 1982 and then had a private practice in Fairfax, Virginia from 1983-2000. I moved back to Richmond in 2000 and had been working part-time with a private practice until recently retiring.

Andrea Reynolds MSW, LCSW 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 before being promoted to Medical Case Manager then Lead Medical Case Manager. In 2020 she graduated from Radford University with a Masters in Social Work. In 2021 she began her private practice for mental health services.

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.

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.

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, LIFE Management, Inc, to assist those who were HIV positive, to reinvent themselves to live a more positive life. LIFE was an acronym for Living Independently for Empowerment. This agency facilitated substance abuse groups for HIV positive individuals in recovery at Rubicon. LIFE had contracts with VCU, the DOC, Williamsburg Aids Network, Bristol, Myers Squib as a Consumer Consultant, and Health Care Solutions in Petersburg. For DOC LIFE 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.

Dr. Jernice Giles is a practicing General dentist with over 15 years of clinical experience. She served as Dental Director in a community health center for many years and managed its Ryan White program. The Ryan White program has since grown to include additional HIV services. Dr. Giles now serves as District Dental Director for a dental service organization across the state of Virginia. She continues to support public health dentistry in her new role.

Thomas Salyer has been an HIV and LGBTQIA+ Advocate in rural southwest Virginia for 17 years. He was a Ryan White Medical Case Manager from 2005 – 2011. He is currently a Peer Interviewer with the VCU AETC Program and is the Virginia Consumer Advisory Committee Co-Chair. Thomas credits the consumer pieces of training through the Virginia Department of Health with his current leadership roles in the community, including SOVAH Health Hospital Martinsville’s Diversity Inclusion Equity Initiative and the Board of Directors South Side Resource Center. Thomas enjoys running and is training to run in his first Marathon.

Brittney Jones MSW, is the Assistant Director of ARE (AIDS Response Effort, Inc.) in Winchester, Virginia. Brittney has been with ARE for ten years, starting as a Medical Case Manager, then taking on the role of Quality Program Manager, and in the last three years serving as the Assistant Director. Brittney graduated from West Virginia University in 2018 with her Master’s in Social Work. Brittney started as a Peer Reviewer in 2022.