



**Virginia Commonwealth University  
Virginia Ryan White Part B  
Peer Review Program  
Grant Year 2024 Final Report**

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## **VCU Peer Review Program Final Report: Grant Year 2024**

### **Background**

In 2002, the Virginia Department of Health (VDH) Division of Disease Prevention established a statewide independent peer review (PR) team. The PR program provides quality assurance monitoring and technical assistance to VDH Ryan White HIV/AIDS Part B (RWHAP B) sub-recipients. The PR team is comprised of a group of RWHAP B peers who provide quality assurance monitoring to promote a collaborative learning process and share best practices. Virginia Commonwealth University (VCU) is contracted to conduct peer review activities. The following report summarizes the VCU PR process for grant year 2024.

### **Selected Agencies and Funded Service Categories**

RWHAP B sub-recipients are reviewed on a biennial schedule. The following sites were selected for grant year 2024:

1. AIDS Response Effort (ARE)
2. Capital Area Health Network (CAHN)
3. Carilion Medical Center
4. Community Access Network (CAN)
5. CrossOver Healthcare Ministry (COHM)
6. Daily Planet Health Services (DPHS)
7. Fredericksburg Area Health and Support Services (FAHASS)
8. LGBT Life Center (LGBTLC)
9. Mary Washington Health Care (MWHC)
10. Neighborhood Health (NH)
11. Serenity
12. Three Rivers Health District (TRHD)
13. Virginia Health Options (VHO)

### **Peer Reviewers**

The PR Program is comprised of a group of selected experts in the HIV field recruited throughout the state of Virginia. These individuals are professionals in Ryan White services and include medical providers, mental health providers, dental providers, medical case managers, and non-medical case managers. The team also consists of a group of client interviewers who are RWHAP B consumers and participate in the Virginia Consumer Advisory Committee (VACAC). All five health regions in Virginia are represented on the PR team. Reviewers receive onboarding and annual training to participate in the PR process.

### **Process and Methodology**

The peer review process involves a review of the RWHAP B standards of care for:

- Outpatient Ambulatory Health Services (OAHS)

- Oral Health (OH)
- Mental Health (MH)
- Medical Case Management (MCM)
- Non-Medical Case Management (NMCM)
- Substance Abuse – Outpatient (SAO)
- Client Interviews (CI)

Reviews were conducted in person.

A sample size of 10% of clients served for each service category was reviewed. Client interviews were also conducted at each site review.

The site review activities are outlined as follows in Figure 1.

**Figure 1:** Site Review Outline



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

RWHAP B sub-recipients and VDH HIV Services Coordinators are notified at the beginning of the grant year that they are up for review. Following the initial notification, preliminary meetings were scheduled via Zoom at least one month before the review date.

Preliminary meetings were scheduled to provide an overview of the PR process and logistics, request client lists for each funded service category, and provide information to the sites on how to prepare for the visits. Sites were provided a pre-visit checklist and the VDH Part B Standards of Care for each service category that would be reviewed. Client lists were shared by sites by secure email and/or VCU FileLocker, a secure file-sharing platform.

## **Data Collection Tools**

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

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

## **Post-Visit Activities**

The PR program drafted final site visit reports and submitted them to VDH Quality staff for review and final approval; reports were due to sites within 60 days of the visit. Final site visit reports summarized the process and the review results. Strengths and challenges for each site were identified in the reports. Certain challenges required corrective action plans. Corrective action plans from sub-recipients were due within 30 days of receiving their final report and were submitted to VDH Quality staff and the PR program.

## **Technical Assistance**

Sites with challenges were provided with technical assistance during the site visit. Following the visit, sites were also given the opportunity to request technical assistance and/or utilize technical assistance as part of their corrective action plan. Technical assistance is provided by the PR program and in collaboration with the VCU MidAtlantic AIDS Education and Training Center (MAAETC).

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

### **Outpatient Ambulatory Health Services**

#### **Key Findings**

Of the sites reviewed, ten reported providing OAHS. The data below is based on the aggregate data collected. See Attachment A for raw data. The sites presented client-level data through progress notes and documentation shared through their Electronic Health Record systems and paper charts. When present in the charts, the documentation was clear. Progress notes were present, legible, signed, and dated in the client's record (n=166/166). The challenges noted from the charts indicated the following standards were not present: ophthalmology exam or referral for clients with CD4 < 100 or history of Diabetes and/or Hypertension, and vaccines including Influenza, Pneumovax 23, Prevnar 13, Hepatitis B series, Tetanus/Diphtheria, COVID-19, and HPV.

#### **Strengths**

A total of 166 clients were reviewed for OAHS across ten sites. 46 of the 166 charts reviewed had information regarding patients diagnosed with HIV 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=46/46) and the initial physical examination was documented within 30 days of client contact with the provider (n=46/46), the initial laboratory results or orders were documented as a component of the initial assessment (n=46/46), nutritional assessment was documented (n=44/46), and women with HIV ages 21 to 29 years received a Pap test at the time of initial HIV diagnosis (n=6/6).

The following standards were reviewed and 100% of the charts included the following: clients positive for Hepatitis C were evaluated and/or referred for treatment (n=13/13), women with HIV aged < 30 years received Pap test within 12 months of initial diagnosis (n=8/8), women with HIV aged < 30 years with three consecutive normal Pap tests received follow up Pap tests every three years after (n=1/1), all current medications were documented in client records (n=166/166), medication adherence assessment with documentation done at each visit (n=166/166), medication side effects assessed and documented (n=151/151), appropriate outcome based medical plan of treatment developed with client and present in the client's record (n=165/165), and progress notes were present, current, legible, signed and dated in client records (n=166/166).

It was noted in the charts that 100% of clients (n=139/139) were offered Highly Active Antiretroviral Therapy (HAART) when applicable, and 100% (n=164/164) are currently on HAART.

For sites with third-party OAHS payers, all associated standards of care were met at 100%. These included adequate documentation of care provision in the client's record (n=54/54), initial history, physical, and laboratory reports in the client's record (n=54/54), progress notes reflect health status, response to treatment and services provided to client (n=54/54), current laboratory reports and medication records in the client's record (n=54/54), appropriate referral and follow-up documentation in the client's record (n=54/54), and documentation in the client's record that current standards of HIV/AIDS care are practiced for the client (n=54/54).

The sites reviewed were commended for reaching  $\geq 95\%$  for the following measures in OAHS when 10 or more charts were reviewed: laboratory testing every six months (n=157/162), CD4 every 12 months (n=163/166), Viral Load (HIV/RNA) every six months (n=159/165), CBC every 12 months (n=165/166), Chemistry Panel every six months (n=159/165), Liver/Hepatic Panel (baseline; every six months; annually) (n=159/165), Hepatitis C serology (baseline; annually; ongoing risk factor) (n=157/165), and Resistance Genotyping/Phenotyping as needed (n=113/117). Sexually Transmitted Disease (STD) risk factors were evaluated at each visit (n=158/166), and clients were asked about STD symptoms at each visit (n=155/163). Clients with positive Tuberculosis (TB) testing received chest X-ray at baseline, and clients with underlying lung disease received chest X-ray as needed with dates, results, patient education, and initiation or referral for LTBI treatment if indicated (n=20/21). Other special studies were provided to clients based on individual needs, with dates and results in the record (n=79/80). Women of childbearing age received pre-conceptual discussion and counseling at baseline and routinely thereafter (n=26/27). Documentation of follow-up from referrals was present in 95% of

charts (n=91/95). HAART was consistent with current Public Health Services (PHS) guidelines in 97% of charts (n=161/165).

## **Challenges**

The standards reviewed with any standard met at  $\leq 70\%$  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 of Diabetes and/or Hypertension was present in 67% of charts (n=49/73). Documentation of current breast exam, where applicable in the client's record was present in 63% of charts reviewed (22/35). Charts reviewed indicated that Influenza (annually) vaccinations were present in 57% of charts (n=88/155). Pneumovax 23 vaccinations were present in 63% (n=95/152) of charts. Prevnar 13 vaccinations were present in 47% of charts reviewed (n=75/159). For clients with negative serology, Hepatitis B series vaccinations were present in 66% of charts (n=75/113). Tetanus/Diphtheria vaccinations (every ten years) were present in 64% of charts reviewed (n=101/159). Charts reviewed indicated that COVID-19 vaccinations based on current CDC guidelines were present in 57% of charts (n=90/158). HPV and Meningococcal vaccinations based on current CDC guidelines were present in 32% of charts (n=46/146).

## **Recommendations**

It was recommended by the PR team that sites create a process for all providers to chart consistently and/or develop a template for medical notes that includes a checklist of necessary labs, vaccinations, assessments, exams, client education, and counseling. In addition, the PR team recommended that documentation include that the client reviewed their treatment plan of care and was offered a copy of their plan.

## **Oral Health**

### **Key Findings**

Of the sites reviewed, nine reported providing OH services. A total of 95 charts were reviewed across sites. The data below is based on the aggregate data collected. See Attachment B for raw data. The sites presented client-level data through progress notes and documentation shared through their Electronic Health Record systems and paper charts.

### **Strengths**

The sites were commended for reaching  $\geq 95\%$  for the following measures in OH when 10 or more charts were reviewed. In 97% of charts reviewed, documentation was present of a signed and dated baseline evaluation consisting of radiographs appropriate for an accurate diagnosis and treatment (n=85/88). Signed and dated documentation that all services provided were recorded was present in 99% of charts (n=93/94). For third-party payers, signed and dated documentation of medications were present in 99% of charts (n=87/88).

The following standards were reviewed and 100% of the charts included documentation and adherence to these standards. All referrals were documented in client records and included the consent of the Ryan White overseeing agency for dental services (n=95/95). Each client was

encouraged to seek routine dental care as recommended by the American Dental Association (n=95/95). Treatment priority given to pain, infection, traumatic injuries, or other emergency conditions was documented in 100% of the charts reviewed (n=95/95). In 100% of reviewed charts, documentation was present of a signed and dated baseline evaluation consisting of a complete medical history, existing oral conditions, and patient's chief complaint (n=95/95). If appropriate, documentation was present in the client's record with a signed and dated baseline evaluation consisting of a medical alert (n=45/45). Documentation was present in the client's record with a signed and dated baseline evaluation consisting of drug history (n=74/74). In all charts reviewed, documentation of a treatment plan showing concurrence with the dentist and client to address cavities, missing teeth, and periodontal conditions (n=53/53; n=31/31; n=24/24). Diagnoses were made for each quadrant or sextant to address periodontal conditions (n=22/22). For clients with periodontal disease, a full mouth probing was performed every six months (n=20/20). A full mouth series of radiographs were conducted to substantiate periodontal disease (n=23/23). Signed and dated documentation that the treatment plan was reviewed and updated as needs were identified or at least every six months was present in all charts (n=92/92). All treatment plans were evaluated by another dental provider to address the necessity for treatment (n=95/95). All client records included signed and dated documentation of prescriptions and drugs dispensed (n=47/47). For all clients that received surgery, signed and dated documentation was present in the record that post-operative instructions were given (n=25/25). For third-party payers, signed and dated documentation of medical history, physical examination, treatment plan of care, interim progress notes, and referrals and follow-ups were present in all records (n=95/95; n=95/95; n=95/95; n=35/35; n=81/81).

## **Challenges**

The OH data for all agencies showed all standards were met at  $\geq 70\%$  when 10 or more charts were reviewed.

There were no challenges identified for OH.

## **Mental Health**

### **Key Findings**

A total of 41 charts were reviewed for MH across four RWHAP B subrecipient sites. The data below is based on the aggregate data collected. See Attachment C for raw data. The sites presented client-level data through progress notes and documentation shared through their Electronic Health Record systems and paper charts. All charts reviewed included documentation of the mental health services provided.

### **Strengths**

The following standards were reviewed and were found to be present in 100% of charts reviewed. All records included documentation of mental health services provided (n=36/36). Documentation of consultation with medical staff, mental health, pharmacy, and other support services as needed was present in all charts (n=28/28). For all discharged clients, documentation of a discharge plan summary with clear rationale, including a certified letter if applicable, was present in the record within 30 days of discharge (n=7/7). For all transferred clients,

documentation of a discharge summary and other records sent with the patient was present in the charts reviewed (n=2/2).

The sites were commended for reaching  $\geq 95\%$  for the following standards in MH when 10 or more charts were reviewed. In 95% of charts reviewed, Service Plans included a diagnosed mental illness or condition and the service modality used (n=39/41).

### **Challenges**

The standards reviewed at  $\leq 70\%$  with a minimum of 10 charts were deemed as challenges. Documentation of a screening such as PHQ-9, GAD-9, AUDIT-DAST, Rx Abuse Screener, and/or MOCA were present in 68% of the charts (n=28/41). The number of sessions were included in 63% of charts (n=17/27). Documentation of reassessment dates of client progress every 90 days was present in 37% of charts (n=7/19).

### **Recommendations:**

It was recommended by the PR team that sites create and implement a system that utilizes a screening tool for all clients receiving MH services and include the results in the chart. Charts should additionally include the number of MH sessions. Lastly, the PR team recommended that client reassessments are completed every 90 days and documented in the chart.

## **Medical Case Management**

### **Key Findings**

Peer Reviewers reviewed 190 MCM charts across 12 RWHAP B subrecipient sites. See Attachment D for raw data. The sites presented client-level data through progress notes and documentation shared through their Electronic Health Record systems and paper charts. It was noted by reviewers that MCM charts were well organized and easy to navigate. The reviewers for MCM also reported that MCM progress notes were very detailed and thorough. In the majority of charts reviewed, required forms were completed and ISPs were updated within appropriate timeframes according to Acuity level.

### **Strengths**

The following standards were reviewed and found to be present in 100% of charts reviewed. All initial MCM Assessments were completed within 30 days of (NMCM) intakes (n=92/92). If clients were transferred to another RWHAP B MCM subrecipient, MCM services were transferred to the new subrecipient within five business days of the request (n=3/3). For clients that were unable to be located, documentation was present that a certified letter was mailed to the client's last known mailing address within five business days after the last phone attempt notifying the client of pending inactivation (n=1/1).

Sites were commended for reaching  $\geq 95\%$  for the following standards in MCM when 10 or more charts were reviewed. In 96% of charts reviewed, at least one face-to-face MCM Assessment was completed (n=180/188). MCM Assessments included an assessment of treatment adherence in 96% of reviewed charts (n=172/179). 98% of MCM clients reviewed had

an Acuity Scale completed and documented reflecting their current Acuity level (n=186/190). In 96% of charts, documentation of a completed and dated MCM Service Plan (except for Acuity scores of 15 or less) within 45 calendar days of MCM Assessment (n=168/175). 96% of charts included documentation that reflects that the client was included in the development in the MCM Service Plan (n=171/179).

Of the charts reviewed, 32 MCM clients were discharged. In 97% of charts reviewed, a discharge summary was present with all the reason(s) for discharge in the client file, and the discharge summary was placed in the client's file within 30 days of discharge from MCM and/or the subrecipient agency (n=31/32).

### **Challenges**

The MCM data for all agencies reviewed showed all standards were met at  $\geq 70\%$  when 10 or more charts were reviewed.

There were no challenges identified for MCM.

## **Non-Medical Case Management**

### **Key Findings**

A total of 285 charts were reviewed for NMCM at 12 sites. See Attachment E for raw data. The sites presented client-level data through progress notes and documentation shared through their Electronic Health Record systems and paper charts. The PR team found that NMCM charts were organized and contained documentation of detailed case notes. Priority was given to newly diagnosed, pregnant, and/or recently released from incarceration clients for expedited eligibility/intake.

### **Strengths**

The following NMCM standards were present in 100% of reviewed charts. Documentation of expedited eligibility/intake for clients that were newly diagnosed, pregnant, and/or recently released from incarceration was present in all applicable charts (n=6/6). In cases of delayed intake completion due to missing documents during the 30-day calendar period, documentation that the Non-Medical Case Manager/Eligibility/Intake Specialist notified the client at least three times, on different days, about what documents were missing (n=1/1).

### **Challenges**

Standards reviewed at  $\leq 70\%$  with a minimum of 10 charts were deemed as challenges. Dated documentation of communication with client regarding the date and time of the client's intake appointment and the required documentation needed for the appointment was found in 62% of charts reviewed (n=16/26). For 62% of clients that were not already enrolled in MCM, documentation that the NMCM referred the client within two working days to MCM if the client answered 'yes' to questions 8-20 in the NMCM Service Plan/MCM Referral section of the Eligibility Assessment Determination Form was present in their charts (n=63/102).

Documentation that the NMCM Service Plan/MCM Referral was completed every six months was present in 54% of charts reviewed (n=111/205).

### **Recommendations**

It was recommended by the PR team that sites work to include documentation of communications with clients prior to their intake appointment, including the date of the appointment and required documentation. The PR team advised sites with NMCM services to ensure they are referring clients who answer 'yes' to questions 8-20 in the NMCM Service Plan/MCM Referral section to MCM within two working days of doing so. Lastly, the PR team recommended that sites develop a mechanism/reminder system to ensure that the NMCM Service Plan/MCM Referral form is being completed every six months for NMCM clients.

## **Substance Abuse – Outpatient**

### **Key Findings**

A total of 11 charts were reviewed for Substance Abuse – Outpatient across one RWHAP B subrecipient site. See Attachment F for raw data. The site presented client-level data through progress notes shared through their Electronic Health Record system.

### **Strengths**

The following SAO standards were present in 100% of reviewed charts. A referral for SAO services was documented in 100% of newly enrolled client records (n=7/7). All client records included documentation of an assessment (n=7/7). For newly enrolled clients, all assessments included documentation of substance abuse history and current status, medical history and current status, availability of food, shelter, transportation, and financial resources, client's support system, legal issues and/or custody status, and mental health status and co-existing conditions (n=7/7). All service plans for newly enrolled clients included documentation of medical history and current health status (n=7/7).

For ongoing clients, documentation of mental health services provided were found in all charts reviewed (n=11/11). Documentation of a signed and dated treatment plan was present in all client records (n=11/11). 100% of charts included documentation of a complete psychosocial assessment and the results used to develop the service plan (n=11/11). In each service plan, documentation was present verifying that the client participated in the development of the service plan (n=11/11). Documentation of consultation with medical staff, mental health, pharmacy, and other support services as needed was present in 100% of charts (n=11/11). All referrals contained documentation and the status of their outcomes (n=11/11).

For discharged clients, documentation of a discharge plan summary with clear rationale within 30 days of discharge, including a certified letter if applicable, was present in the record (n=2/2). The discharge summary documentation and other records were sent with all discharged clients (n=2/2). For clients that were unable to be located, documentation of attempts made to contact the client were present in charts (n=2/2).

### **Challenges**

The SAO data for the agency reviewed showed that all standards were met at  $\geq 70\%$ .

There were no challenges identified for SAO.

## **Client Interviews**

### **Key Findings**

61 RWHAP B clients were interviewed over the grant year. 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://targethiv.org/sites/default/files/file-upload/resources/PatientSatisfactionSurveyKitHIVAmbCare2002\\_0.pdf](https://targethiv.org/sites/default/files/file-upload/resources/PatientSatisfactionSurveyKitHIVAmbCare2002_0.pdf)). See Attachment G for raw data.

Of the 61 clients interviewed, 40 received OAHs, 22 received OH, and 57 received Case Management services. 57 of the clients had an understanding of the Ryan White Program. 87% of the clients reported they feel comfortable filing a grievance (n=53/61), 64% have been asked to participate in a Patient/Consumer Advisory Board (n=39/61), and 74% recalled being asked to participate in a patient satisfaction survey (n=45/61).

40 RWHAP B clients were interviewed about their experiences receiving OAHs across the subrecipient sites. When asked if clients could schedule an appointment soon enough for their needs, 85% responded 'All of the Time' (n=34/40). 98% of clients agreed that their providers told them how important it was to keep their appointments 'All of the Time' (n=39/40). Most clients reported that their medical providers made sure what their lab results (such as CD4 and Viral Load) meant for their health 'All of the Time' at 98% (n=39/40).

When clients were asked if they had questions they wanted to ask providers about their HIV care but did not ask, 80% of clients interviewed stated 'Never' (n=32/40). 63% of clients reported it was 'Never' difficult to understand the providers answers to their questions (n=25/40). 95% of the interviewed clients found their providers to be accepting and non-judgmental of their life and health care choices "All of the Time" (n=38/40). 30 clients reported it was 'Never' difficult to get their HIV medication prescriptions filled and/or delivered when needed (75%, n=30/40). 93% of clients reported that their providers explained the side effects of their HIV medications in a way that was easy to understand (n=37/40). 98% of clients interviewed reported they were informed by their medical provider about how to prevent the transmission of HIV to others (n=39/40). 90% of clients reported that their medical provider talked to them about how to protect themselves from contracting or transmitting Hepatitis C (n=36/40). When asked if they were able to get the services their provider referred them to, 90% of clients reported 'All of the Time' (n=36/40). 98% of clients reported that they were never treated poorly at their clinic (n=39/40). 95% of clients felt that the staff kept their HIV status confidential (n=38/40).

57 clients were interviewed about Case Management services. Of the 57 clients, 70% stated they were aware of the different levels of case management (n=40/57). 96% of the clients interviewed agreed or strongly agreed that they work with their case manager to determine their needs (n=55/57). All clients agreed that they found it easy to talk to their case manager (n=57/57). The clients interviewed reported that they 'Agree' (16%, n=9/57) or 'Strongly Agree' (80%,

n=46/57) that their medical provider worked together with their case manager to help them (96%, n=55/57).

22 clients were interviewed about Oral Health services. 15 reported they have received services in the past year (68%, 15/22). 91% of the interviewed clients ‘Agreed’ (23%, n=5/22) or ‘Agreed Strongly’ (68%, 15/22) that they are satisfied with the OH services they received at their agency. 95% of the clients interviewed ‘Agreed’ (n=4/22) or ‘Agreed Strongly’ (n=17/22) that they receive information on how to care for their teeth and gums at every dentist visit.

When asked to think about the care at their clinic or agency, clients were asked to select from a list of words. Table 1 shows the responses with the majority of clients using positive words to describe their experiences as a RWHAP B client.

**Table 1: Client Words**

<b>When I think about my care at this clinic/agency, these words come to mind:</b>		
<b>WORD</b>	<b>NUMBER</b>	<b>RESPONSE</b>
Caring	60/61	98%
Friendly	59/61	97%
Excellent	58/61	95%
Safe	58/61	95%
Understanding	57/61	93%
Personal	56/61	92%
Warm	52/61	85%
Dignified	49/61	80%
Adequate	35/61	57%
OK	25/61	41%
Busy	11/61	18%
Humiliating	3/61	5%
Poor	1/61	2%
Rushed	1/61	2%
Scary	1/61	2%
Cold	0/61	0%
Impersonal	0/61	0%
Terrible	0/61	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 incorporating more language services for clients who don't speak English as a primary language and informing them of staffing changes at the agencies.

The PR team suggested that sites work to ensure that clients are being invited to participate in Patient/Consumer Advisory Boards and explore potential health literacy barriers with clients.

## **Corrective Action Plans**

Of the sites Peer Reviewed in 2024/2025, 13 sites were identified with challenges that required Corrective Action Plans. Corrective Action Plans were due within 30 days of receiving the final report. Challenges across these sites were focused on documentation in OAHS, MH, MCM, and NMCM.

The sites that required Corrective Action Plans for OAHS were cited for needing to address the following:

- Documentation that the client reviewed their treatment plan and/or was offered a copy of the plan
- Completing laboratory tests in accordance with RWHAP B OAHS Standards of Care
- Vaccinations based on current CDC guidelines
- Documentation of current ophthalmology exam and/or referrals
- Frequency of client visits, clients should be seen at least twice in a 12 month period
- Documentation of client history and physical exam every six months/p.r.n.
- Annual and p.r.n. TB risk factor review
- Clients with negative Hepatitis B serology must be referred for Hepatitis B vaccination series
- Oral health, nutritional, mental health, and substance abuse assessments must be completed for all clients
- Medication history should be present in charts
- Documentation of client education and prevention/risk factor reduction/counseling

The sites that required Corrective Action Plans for MH were cited for needing to address the following:

- Referral for MH services prior to initiation of services must be documented in charts
- Client progress on service plans must be reassessed every 90 days
- Screenings (PHQ-9, GAD-9, AUDIT-DAST, Rx Abuse Screener, MOCA) should be present in charts
- A complete psychosocial assessment and the result used to complete the service plan must be documented

The sites that required Corrective Action Plans for MCM were cited for needing to address the following:

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- MCM Service Plans must be completed and updated within the appropriate timeframe according to client’s Acuity level
- Acuity levels must be updated as frequently indicated according to level 1, 2, or 3
- The last page of MCM assessments must include a summary of findings

The sites that required Corrective Action Plans for NMCM were cited for needing to address the following:

- Documentation that the NMCM Service Plan/MCM Referral was completed every six months must be included in the chart
- Documentation must be present that the NMCM referred the client within two working days to MCM if the client answered ‘yes’ to questions 8-20 in the MCM Service Plan/MCM Referral section of the Eligibility Assessment Determination Form
- Include documentation of a completed NMCM Service Plan to include answers to questions 1-7, tasks, action steps, target dates, and date achieved/outcome (as applicable) in client records

### Peer Review Evaluation

Evaluations were sent to sites after each review. Ten sites responded to the survey at a 77% response rate.

**Table 2: 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: <ul style="list-style-type: none"> <li>• Very well done and informative for Carilion. Learned more here than the CM summit</li> <li>• I am very grateful that, days before the review, VCU allowed us to re-send our list of patients; VCU provided the modules that would be reviewed in each service category. We appreciated the great communication about what to expect as the next steps.</li> <li>• The introductory call was helpful and they guided us through the process. They provided necessary guidance to help us prepare.</li> <li>• Great experience.</li> <li>• Grace was very informative and forthcoming with us regarding the process of the peer review.</li> <li>• Grace was very helpful and professional.</li> <li>• The entire peer review team was professional and helpful during our Peer Review.</li> </ul>		
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

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Were you satisfied with the discussion of the findings?	10/10	0/10
Did the Peer Review team answer your questions?	10/10	0/10
Do you feel the reviewers were knowledgeable in their areas of review?	10/10	0/10
<p><b>Please give us feedback about your Peer Review experience:</b></p> <ul style="list-style-type: none"> <li>Peer review went well. I thought the peer reviewers were knowledgeable and gave us great feedback.</li> <li>This was a nice and professional experience.</li> <li>Our experience was good, but we are very tight on space. I feel that the oral health, mental health could have been done remotely.</li> <li>It was a very smooth process. The peer reviewers' knowledge, comments, and recommendations were valuable to our team. CrossOver will review some practices to ensure all RW standards are in place.</li> <li>Overall, it was a very positive experience. Sometimes, site visits can be stressful but the team was extremely easy to work with and answered our questions.</li> <li>The team was very knowledgeable and provided great information.</li> <li>Everyone was so nice and we really enjoyed having all of you.</li> <li>Very easy and insightful process.</li> <li>It was great and I think we enjoyed the experience.</li> <li>Our Peer Review enabled us to see what we missed as a team and to make best practice adjustments to be compliant with the standards and better serve our clients.</li> </ul>		
How would you rate the Peer Review experience?		
Overall Score	9.1	
<p><b>Additional Comments:</b></p> <ul style="list-style-type: none"> <li>Some of these modules can be done remotely to save time, money and space.</li> <li>Thank you for being flexible and patient when receiving CrossOver data. We appreciated all the new ideas you shared with the team during the peer review.</li> <li>Grace was extremely helpful with everything.</li> <li>Grace is so informative and stays on track with everything! She is the best!</li> <li>The medical team found some discrepancies between the RW standards and the current medical standards for HIV care.</li> </ul>		

### Summary and Key Findings

The 2024/2025 Peer Reviewers reported consistent themes throughout the reviews. These themes included the overall documentation being thorough when available which illustrated cohesion between the care teams. It was evident that all providers are committed to providing care for their clients and are willing to improve processes to meet the needs of their clients.

It was recommended by the PR OAHS team that sites develop a template for documentation that includes a checklist of necessary labs, vaccinations, assessments, exams, client education, and

counseling. It was also recommended for documentation to include that the client reviewed their treatment plan of care and was offered a copy of their treatment plan.

The PR MCM and NMCM teams commended the sites for thorough and well organized record keeping. The PR team recommended that sites develop a system to ensure that appropriate timelines and milestones are being met for MCM and NMCM standards.

The PR OH team commended the sites reviewed for OH for their thorough documentation. Referrals were completed and present in all charts reviewed. All charts contained documentation of a signed and dated baseline evaluation consisting of a complete medical history, existing oral conditions, and patient's chief complaint. Sites were commended for providing excellent OH services, including preventative and periodontal care.

The sites reviewed for MH services were advised to implement a system that utilizes a screening tool for all clients and include results in charts. They were also encouraged to include a projected number of MH sessions in client records. Lastly, sites were advised to complete reassessments with clients every 90 days throughout their treatment.

The PR team commended the site reviewed for SAO for thorough documentation. Referrals and assessments were completed and present in all charts reviewed. Clear documentation that the client participated in the service plan was present in all charts. All assessments for newly enrolled clients included documentation of substance abuse history and current status, availability of food, shelter, transportation, and financial resources, client's support system, legal issues and/or custody status, and mental health status and co-existing conditions.

In conclusion, the PR team was impressed with all of the sites and their dedication to providing quality care to their clients. Clients who were interviewed reported overall satisfaction with the care they received. They also expressed their gratitude to their care teams and the Ryan White Program.

All of the sites were commended for the care provided to clients regardless of the size of their caseload, geographic area, and access to support services. The RWHAP B sites continue to provide care and treatment services for 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 Health Services Raw Data**

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	CAHN		CAN		Carilion		COHM		Daily Planet		FAHASS		LGBT Life Center		MWHC		TRHD		VHO		Total	
	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%
<b>Initial Visits:</b>																						
A.1. Initial Medical History is documented within 30 days of client contact with provider	N/A	N/A	2/2	100%	1/1	100%	4/4	100%	14/14	100%	5/5	100%	9/9	100%	1/1	100%	1/1	100%	9/9	100%	46/46	100%
A.2. Initial Physical Examination is documented within 30 days of client contact with the provider.	N/A	N/A	2/2	100%	1/1	100%	4/4	100%	14/14	100%	5/5	100%	9/9	100%	1/1	100%	1/1	100%	9/9	100%	46/46	100%
A.3. Medication history which includes: a. drug allergies b. current medications c. drug/substance abuse	N/A	N/A	2/2	100%	1/1	100%	3/3	100%	14/14	100%	5/5	100%	9/9	100%	1/1	100%	1/1	100%	4/9	44%	40/45	89%
A.4. Initial laboratory results or orders are documented as a component of the initial assessment.	N/A	N/A	2/2	100%	1/1	100%	4/4	100%	14/14	100%	5/5	100%	9/9	100%	1/1	100%	1/1	100%	9/9	100%	46/46	100%

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A.5. Oral Health assessment/referral is documented as a component of the initial assessment.	N/A	N/A	2/2	100%	0/1	0%	3/3	100%	14/14	100%	5/5	100%	9/9	100%	1/1	100%	0/1	0%	0/9	0%	34/45	76%
A.6. Psychosocial/Mental Health assessment and/or referral documented as a component of the initial assessment.	N/A	N/A	2/2	100%	0/1	0%	4/4	100%	14/14	100%	5/5	100%	9/9	100%	1/1	100%	0/1	0%	0/9	0%	35/46	76%
A.7. Nutritional assessment is documented as a component of the initial assessment.	N/A	N/A	2/2	100%	0/1	0%	4/4	100%	14/14	100%	5/5	100%	9/9	100%	1/1	100%	0/1	0%	9/9	100%	44/46	96%
A.8. Substance Abuse assessment and/or referral is documented as a component of the initial assessment.	N/A	N/A	2/2	100%	1/1	100%	4/4	100%	14/14	100%	5/5	100%	9/9	100%	1/1	100%	1/1	100%	3/9	33%	40/46	87%
A.9. TB Risk Assessment and TB Test with performance of or referral for additional evaluation as indicated	N/A	N/A	2/2	100%	1/1	100%	4/4	100%	12/14	86%	5/5	100%	1/9	11%	1/1	100%	1/1	100%	4/9	44%	31/46	67%
A.10. If the TB test is positive, refer for chest x-rays or other necessary follow-up tests.	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	0/1	0%	0/1	0%

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A.11. Documentation referral to the Local Health Department for individuals with presumptive active TB.	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	N/A	N/A	N/A
A.12. Documentation of TB-related treatment and follow-up in the treatment plan	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	N/A	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.	N/A	N/A	N/A	N/A	N/A	N/A	1/1	100%	N/A	N/A	1/1	100%	4/4	100%	N/A	N/A	N/A	N/A	N/A	N/A	6/6	100%	
<b>Follow up Visits:</b>																							
B.1. History, q. 6 months, or p.r.n.	14/14	100%	33/33	100%	4/12	33%	12/13	92%	23/23	100%	14/14	100%	13/15	87%	13/13	100%	11/12	92%	14/14	100%	151/163	93%	
B.2. Physical Exam, q. 6 months, or p.r.n.	14/14	100%	33/33	100%	4/12	33%	12/13	92%	22/23	96%	14/14	100%	13/15	87%	13/13	100%	11/12	92%	14/14	100%	150/163	92%	
B.3. Has client been seen at least twice in the past 12 months?	14/14	100%	33/35	94%	4/12	33%	12/12	100%	23/23	100%	14/14	100%	12/15	80%	13/13	100%	11/12	92%	14/14	100%	150/164	91%	
B.4. Refer clients not following up with Outpatient Ambulatory Health Services for six (6) months to case management or patient navigator	1/1	100%	18/18	100%	5/8	63%	N/A	N/A	14/14	100%	3/3	100%	12/13	92%	3/3	100%	3/3	100%	N/A	N/A	59/63	94%	

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services for re-engagement in care.																						
B.5. Laboratory Testing, q. 6 months, or p.r.n *	14/14	100%	32/32	100%	9/12	75%	13/13	100%	23/23	100%	14/14	100%	13/15	87%	13/13	100%	12/12	100%	14/14	100%	157/162	97%
B.6. Medication history which includes new: 1. Drug allergies 2. Current medications 3. Drug/substance abuse 4. Treatment adherence	14/14	100%	34/34	100%	12/12	100%	13/13	100%	23/23	100%	14/14	100%	14/15	93%	13/13	100%	12/12	100%	5/14	36%	154/164	94%
B.7. Oral health assessment, referral, and annual/routine dental care	14/14	100%	26/34	76%	1/12	8%	13/13	100%	23/23	100%	14/14	100%	15/15	100%	13/13	100%	4/12	33%	0/14	0%	123/164	75%
B.8. Nutritional assessment or referral?	10/14	71%	34/34	100%	1/12	8%	13/13	100%	23/23	100%	14/14	100%	15/15	100%	13/13	100%	8/12	67%	14/14	100%	145/164	88%
B.9. Current (in last year) ophthalmology exam or referral if CD4 < 100 or hx of DM or HTN	12/13	92%	4/20	20%	N/A	N/A	2/2	100%	1/3	33%	14/14	100%	4/4	100%	11/13	85%	1/1	100%	0/3	0%	49/73	67%
B.10. Documentation of current breast exam, where applicable in the client's record?	0/3	0%	2/4	50%	3/5	60%	2/3	67%	0/1	0%	4/4	100%	5/5	100%	3/3	100%	3/6	50%	0/1	0%	22/35	63%
B.11. Is there documentation of follow up from referrals in the client's record?	7/10	70%	18/19	95%	5/5	100%	8/8	100%	16/16	100%	10/10	100%	12/12	100%	13/13	100%	2/2	100%	N/A	N/A	91/95	96%

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Laboratory Reports/ Other Tests Documentations:																						
C.1. CD4, q. 12 months, or p.r.n.	14/14	100%	35/35	100%	10/12	83%	13/13	100%	24/24	100%	14/14	100%	14/15	93%	13/13	100%	12/12	100%	14/14	100%	163/166	98%
C.2. Viral Load (HIV/RNA), q. 6 months, or p.r.n.	14/14	100%	34/34	100%	8/12	67%	13/13	100%	24/24	100%	14/14	100%	13/15	87%	13/13	100%	12/12	100%	14/14	100%	159/165	96%
C.3. CBC, q. 12 months, or p.r.n.	14/14	100%	35/35	100%	12/12	100%	13/13	100%	24/24	100%	14/14	100%	14/15	93%	13/13	100%	12/12	100%	14/14	100%	165/166	99%
C.4. Chemistry Panel, q. 6 months, or p.r.n.	14/14	100%	34/34	100%	10/12	83%	12/13	92%	24/24	100%	14/14	100%	13/15	87%	13/13	100%	11/12	92%	14/14	100%	159/165	96%
C.5. Toxoplasmosis Antibody Titer at baseline if CD4< 100.	6/8	75%	11/11	100%	11/11	100%	8/8	100%	2/5	40%	1/1	100%	N/A	N/A	10/10	100%	1/1	100%	0/1	0%	50/56	89%
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))	12/13	92%	24/25	96%	11/12	92%	8/8	100%	19/19	100%	4/4	100%	10/10	100%	10/10	100%	11/11	100%	4/5	80%	113/117	97%
C.7. Lipid Panel (annually)	14/14	100%	35/35	100%	4/12	33%	13/13	100%	17/24	71%	14/14	100%	14/15	93%	12/13	92%	11/11	100%	6/14	43%	140/165	85%
C.8. Urinalysis (baseline & annually or if on TDF-tenofovir)	14/14	100%	33/35	94%	5/7	71%	9/13	69%	7/23	30%	14/14	100%	14/15	93%	13/13	100%	12/12	100%	2/12	17%	123/158	78%

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C.9. Liver/Hepatic Panel (baseline; q. 6 months, annually)	14/14	100%	35/35	100%	10/12	83%	12/13	92%	24/24	100%	14/14	100%	12/14	86%	13/13	100%	11/12	92%	14/14	100%	159/165	96%
C.10. Glucose (if not in Chem Panel; baseline & annually); Hemoglobin A1C q 6 months or p.r.n.	14/14	100%	30/35	86%	6/12	50%	11/13	85%	17/17	100%	14/14	100%	13/15	87%	13/13	100%	11/12	92%	0/14	0%	129/159	81%
C.11. Hepatitis A serology at baseline	14/14	100%	35/35	100%	12/12	100%	13/13	100%	6/23	26%	14/14	100%	2/15	13%	13/13	100%	10/12	83%	7/12	58%	126/163	77%
C.11a. If negative, patient referred for Immunization	5/6	83%	8/13	62%	N/A	N/A	1/2	50%	1/3	33%	6/6	100%	N/A	N/A	7/7	100%	1/2	50%	2/2	100%	31/41	76%
C.12. Hepatitis B serology at baseline and p.r.n. ongoing risk factor behavior	13/13	100%	33/35	94%	12/12	100%	13/13	100%	17/23	74%	14/14	100%	12/15	80%	13/13	100%	12/12	100%	10/13	77%	149/163	91%
C.12a. If negative patient referred for Immunization	5/5	100%	7/8	88%	2/2	100%	4/5	80%	2/3	67%	9/9	100%	0/2	0%	8/8	100%	4/4	100%	3/6	50%	44/52	85%
C.13. Hepatitis C serology at baseline and p.r.n. ongoing risk factor behavior for treatment	14/14	100%	35/35	100%	12/12	100%	13/13	100%	22/24	92%	14/14	100%	14/15	93%	13/13	100%	12/12	100%	8/13	62%	157/165	95%
C.13a. If positive, patient evaluated and /or referred	1/1	100%	3/3	100%	1/1	100%	2/2	100%	1/1	100%	N/A	N/A	N/A	N/A	1/1	100%	3/3	100%	1/1	100%	13/13	100%
C.14. STD risk assessment evaluated at each visit (e.g. Syphilis, Gonorrhea, Chlamydia)	14/14	100%	35/35	100%	11/12	92%	12/13	92%	20/24	83%	14/14	100%	15/15	100%	13/13	100%	12/12	100%	12/14	86%	158/166	95%

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C.14a. Asked about STD symptoms at each visit	14/14	100%	35/35	100%	11/12	92%	12/13	92%	16/21	76%	14/14	100%	15/15	100%	13/13	100%	12/12	100%	13/14	93%	155/163	95%
C.15. VDRL/ RPR initially and q12 months with reports on the record where applicable?	13/14	93%	33/35	94%	11/12	92%	13/13	100%	22/24	92%	8/14	57%	15/15	100%	13/13	100%	12/12	100%	14/14	100%	154/166	93%
C.16. TB risk factors reviewed annually and p.r.n	14/14	100%	34/34	100%	11/12	92%	8/13	62%	23/24	96%	14/14	100%	2/15	13%	13/13	100%	12/12	100%	4/14	29%	135/165	82%
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?	14/14	100%	29/29	100%	11/12	92%	12/13	92%	9/18	50%	14/14	100%	2/10	20%	11/11	100%	12/12	100%	4/8	50%	118/141	84%
C.17. Women with HIV Infection Aged < 30 years: Pap test should occur within 12 months (BII) of initial dx.	N/A	N/A	1/1	100%	N/A	N/A	1/1	100%	1/1	100%	N/A	N/A	4/4	100%	1/1	100%	N/A	N/A	N/A	N/A	8/8	100%
C.17a. 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)?	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	1/1	100%	N/A	N/A	N/A	N/A	1/1	100%

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C.17b. Women with HIV Aged ≥30 years: Has a cervical cancer screening in WWH; Pap testing only, or Pap testing and HPV co-testing prn?	3/3	100%	5/7	71%	6/6	100%	2/2	100%	5/5	100%	1/2	50%	0/1	0%	2/2	100%	3/5	60%	0/1	0%	27/34	79%
C.18. Mammogram annually > 50 years with dates and results in the record?	3/3	100%	3/5	60%	2/2	100%	2/2	100%	1/1	100%	4/4	100%	N/A	N/A	2/2	100%	3/5	60%	N/A	N/A	20/24	83%
C.19. Chest x-ray at baseline for patients with positive TB testing or prn for underlying lung disease	1/1	100%	1/1	100%	1/1	100%	1/1	100%	1/1	100%	1/1	100%	1/1	100%	12/12	100%	1/1	100%	0/1	0%	20/21	95%
C.20. Documentation of LTBI treatment regimen, initiation date and completion date?	1/1	100%	N/A	N/A	1/1	100%	1/1	100%	1/1	100%	1/2	50%	0/1	0%	3/3	100%	N/A	N/A	N/A	N/A	8/10	80%
C.21. Special Studies-other testing based on individual needs. Dates and results in the record (as applicable)	12/12	100%	13/13	100%	1/2	50%	7/7	100%	5/5	100%	14/14	100%	12/12	100%	13/13	100%	2/2	100%	N/A	N/A	79/80	99%
C.22. Pre-Conceptual Discussion and Counseling for all women of childbearing age at baseline and	1/2	50%	10/10	100%	4/4	100%	1/1	100%	2/2	100%	4/4	100%	5/5	100%	1/1	100%	1/1	100%	N/A	N/A	29/30	97%

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routinely thereafter.																							
<b>Medications:</b>																							
D.1. Are all current medications documented in the client's record?	14/14	100%	35/35	100%	12/12	100%	13/13	100%	24/24	100%	14/14	100%	15/15	100%	13/13	100%	12/12	100%	14/14	100%	166/166	100%	
D.2. Is medication adherence assessment with documentation done at each visit?	14/14	100%	35/35	100%	12/12	100%	13/13	100%	24/24	100%	14/14	100%	15/15	100%	13/13	100%	12/12	100%	14/14	100%	166/166	100%	
D.3. Are medication side effects assessed and documented?	14/14	100%	35/35	100%	12/12	100%	12/12	100%	24/24	100%	14/14	100%	15/15	100%	13/13	100%	12/12	100%	N/A	N/A	151/151	100%	
D.4. Has HAART been offered to the client, when applicable?	2/2	100%	35/35	100%	12/12	100%	12/12	100%	24/24	100%	14/14	100%	15/15	100%	13/13	100%	12/12	100%	N/A	N/A	139/139	100%	
D.5. Is the client currently on HAART?	14/14	100%	34/34	100%	12/12	100%	12/12	100%	24/24	100%	14/14	100%	15/15	100%	13/13	100%	12/12	100%	14/14	100%	164/164	100%	
D.6. Is HAART consistent with current PHS Guidelines?	14/14	100%	31/35	89%	12/12	100%	12/12	100%	24/24	100%	14/14	100%	15/15	100%	13/13	100%	12/12	100%	14/14	100%	161/165	98%	
D.7. Is the client on PCP prophylaxis if CD4<200?	0/1	0%	1/1	100%	1/2	50%	1/1	100%	3/3	100%	1/1	100%	1/1	100%	N/A	N/A	N/A	N/A	14/14	100%	22/24	92%	

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D.8. Is the client on Toxoplasmosis prophylaxis if CD4<100?	0/1	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3/3	100%	1/1	100%	N/A	N/A	N/A	N/A	N/A	N/A	3/3	100%	7/8	88%
D.9. Is the client on MAC prophylaxis if CD4<50?	0/1	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/2	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	100%	1/4	25%
D.10. 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 chemoprophylax is against disseminated Mycobacterium Avium Complex (MAC) disease if they have CD4 counts <50cells/mm3(A D)?	N/A	N/A	N/A	N/A	0/1	0%	N/A	N/A	N/A	N/A	0/1	0%	4/4	100%	N/A	N/A	N/A	N/A	0/1	0%	4/7	57%	
<b>Documentation:</b>																							
E. 1. Is an appropriate outcome based medical plan of treatment developed with the client and present in the client's record?	14/14	100%	35/35	100%	12/12	100%	13/13	100%	23/23	100%	14/14	100%	15/15	100%	13/13	100%	12/12	100%	14/14	100%	165/165	100%	

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E.1.a. Is there documentation that the client reviewed the plan and/or was offered a copy of the plan?	1/14	7%	34/35	97%	5/12	42%	13/13	100%	20/23	87%	14/14	100%	15/15	100%	13/13	100%	2/12	17%	5/14	36%	122/165	74%
E.2. Is Client Education documented in the client's record?	14/14	100%	34/35	97%	12/12	100%	13/13	100%	17/23	74%	14/14	100%	15/15	100%	13/13	100%	12/12	100%	3/14	21%	147/165	89%
E.3. Are progress notes present, current, legible, signed and dated in the client's record?	14/14	100%	35/35	100%	12/12	100%	13/13	100%	24/24	100%	14/14	100%	15/15	100%	13/13	100%	12/12	100%	14/14	100%	166/166	100%
E.4. Is there documentation of a Prevention/Risk factor reduction/ Counseling message at each visit?	14/14	100%	34/35	97%	11/12	92%	13/13	100%	18/23	78%	14/14	100%	15/15	100%	13/13	100%	11/12	92%	2/14	14%	145/165	88%
<b>Immunizations:</b>																						
F.1. Influenza (annually)	10/14	71%	16/31	52%	10/12	83%	8/13	62%	10/22	45%	5/14	36%	5/15	33%	11/13	85%	8/12	67%	5/9	56%	88/155	57%
F.2. Pneumovax 23	13/14	93%	23/30	77%	11/12	92%	9/13	69%	6/22	27%	5/14	36%	1/15	7%	12/13	92%	11/12	92%	4/7	57%	95/152	63%
F.3. Prevnar 13	9/14	64%	24/32	75%	11/12	92%	9/13	69%	9/22	41%	1/14	7%	1/15	7%	12/13	92%	12/12	100%	9/12	75%	75/159	47%
F.4. Hepatitis B series -if serology is negative -is series completed?	9/10	90%	15/18	83%	9/10	90%	8/9	89%	11/17	65%	3/11	27%	1/10	10%	9/9	100%	4/9	44%	6/10	60%	75/113	66%
F.5. Tetanus/Diphtheria (or Tdap x 1) (every/ ten years)	13/14	93%	21/32	66%	11/12	92%	9/13	69%	14/22	64%	5/14	36%	1/15	7%	10/13	77%	9/12	75%	8/12	67%	101/159	64%

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F.6. COVID-19 vaccinations based on current CDC guidelines?	11/14	79%	19/32	59%	9/12	75%	12/13	92%	14/22	64%	8/14	57%	5/15	33%	6/13	46%	5/12	42%	1/11	9%	90/158	57%	
F.7. HPV and meningococcal vaccinations based on current CDC guidelines?	7/8	88%	3/31	10%	6/12	50%	12/13	92%	7/19	37%	1/14	7%	1/15	7%	9/11	82%	0/11	0%	0/12	0%	46/146	32%	
F.8. Others	7/8	88%	14/20	70%	2/8	25%	8/11	73%	1/8	13%	3/10	30%	1/11	9%	6/12	50%	5/9	56%	2/2	100%	49/99	49%	
<b>Third-Party Payer:</b>																							
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	N/A	N/A	N/A	15/15	100%	13/13	100%	12/12	100%	14/14	100%	54/54	100%
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	N/A	N/A	N/A	15/15	100%	13/13	100%	12/12	100%	14/14	100%	54/54	100%
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	N/A	N/A	N/A	15/15	100%	13/13	100%	12/12	100%	14/14	100%	54/54	100%
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	N/A	N/A	N/A	15/15	100%	13/13	100%	12/12	100%	14/14	100%	54/54	100%

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G.5. Are there current medication records, ADAP and non-ADAP (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	N/A	N/A	N/A	15/15	100%	13/13	100%	12/12	100%	14/14	100%	54/54	100%
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	N/A	N/A	N/A	15/15	100%	13/13	100%	12/12	100%	14/14	100%	54/54	100%
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	N/A	N/A	N/A	15/15	100%	13/13	100%	12/12	100%	14/14	100%	54/54	100%

**Attachment B: Peer Reviewed Site Oral Health Raw Data**

	ARE		CAHN		CAN		Carilion		CrossOver		Daily Planet		FAHASS		MWHC		TRHD		Total	
	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%
1. Is there a referral in the client record?	11/11	100%	12/12	100%	13/13	100%	10/10	100%	12/12	100%	16/16	100%	4/4	100%	10/10	100%	7/7	100%	95/95	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?	11/11	100%	12/12	100%	13/13	100%	10/10	100%	12/12	100%	16/16	100%	4/4	100%	10/10	100%	7/7	100%	95/95	100%
3. Is there appropriate dental education material apparent in the waiting room or noted in the client's record that materials were offered?	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	7/7	100%	7/7	100%
4. Is there documentation that the Ryan White overseeing agency has given consent for the dental services?	11/11	100%	12/12	100%	13/13	100%	10/10	100%	12/12	100%	16/16	100%	4/4	100%	10/10	100%	7/7	100%	95/95	100%
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?	11/11	100%	12/12	100%	13/13	100%	10/10	100%	12/12	100%	16/16	100%	4/4	100%	10/10	100%	7/7	100%	95/95	100%
<b>Is there documentation in the client's record signed and dated of a baseline evaluation that consists of</b>																				
6. A completed medical history	11/11	100%	12/12	100%	13/13	100%	10/10	100%	12/12	100%	16/16	100%	4/4	100%	10/10	100%	7/7	100%	95/95	100%
7. Existing oral conditions	11/11	100%	12/12	100%	13/13	100%	10/10	100%	12/12	100%	16/16	100%	4/4	100%	10/10	100%	7/7	100%	95/95	100%
8. Patient's chief complaint	11/11	100%	12/12	100%	13/13	100%	10/10	100%	12/12	100%	16/16	100%	4/4	100%	10/10	100%	7/7	100%	95/95	100%
9. Medical alert, if appropriate	10/10	100%	7/7	100%	1/1	100%	5/5	100%	5/5	100%	11/11	100%	3/3	100%	2/2	100%	1/1	100%	45/45	100%

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10. Radiographs appropriate for an accurate diagnosis and treatment	11/11	100%	12/12	100%	13/13	100%	2/5	40%	12/12	100%	16/16	100%	2/2	100%	10/10	100%	7/7	100%	85/88	97%
11. Drug history	11/11	100%	12/12	100%	2/2	100%	6/6	100%	12/12	100%	12/12	100%	3/3	100%	9/9	100%	7/7	100%	74/74	100%
<b>Is there documentation of a treatment plan in the client's record showing concurrence with the dentist and client to address</b>																				
12. Cavities	3/3	100%	6/6	100%	6/6	100%	3/3	100%	11/11	100%	12/12	100%	2/2	100%	6/6	100%	4/4	100%	53/53	100%
13. Missing teeth	4/4	100%	5/5	100%	2/2	100%	4/4	100%	5/5	100%	5/5	100%	1/1	100%	4/4	100%	1/1	100%	31/31	100%
14. Periodontal conditions	1/1	100%	5/5	100%	3/3	100%	N/A	N/A	5/5	100%	4/4	100%	1/1	100%	3/3	100%	2/2	100%	24/24	100%
a. Are diagnoses made for each quadrant or sextant to address periodontal conditions?	1/1	100%	5/5	100%	1/1	100%	N/A	N/A	5/5	100%	4/4	100%	1/1	100%	3/3	100%	2/2	100%	22/22	100%
b. If periodontal disease exists, has a full mouth probing been performed every six months?	1/1	100%	5/5	100%	1/1	100%	N/A	N/A	5/5	100%	3/3	100%	N/A	N/A	3/3	100%	2/2	100%	20/20	100%
c. Has a full mouth series of radiographs been conducted to substantiate periodontal disease?	1/1	100%	5/5	100%	3/3	100%	N/A	N/A	5/5	100%	4/4	100%	N/A	N/A	3/3	100%	2/2	100%	23/23	100%
15. Did the client have extractions in the previous 12 months?	2/11	18%	2/12	17%	5/13	38%	0/9	0%	2/12	17%	2/14	14%	0/2	0%	1/10	10%	1/7	14%	15/90	17%
a. Does the client have a need for replacement teeth?	1/2	50%	2/2	100%	1/3	33%	N/A	N/A	2/2	100%	1/2	50%	N/A	N/A	1/1	100%	0/1	0%	8/13	62%
b. Has a removable prosthesis for tooth replacement been considered?	N/A	N/A	2/2	100%	1/1	100%	N/A	N/A	1/1	100%	1/1	100%	N/A	N/A	1/1	100%	N/A	N/A	6/6	100%
c. Has a fixed prosthesis for tooth replacement been considered?	1/1	100%	N/A	N/A	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	2/2	100%
d. If implants are needed, has a cone beam analysis been 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	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?	11/11	100%	12/12	100%	13/13	100%	10/10	100%	12/12	100%	16/16	100%	2/2	100%	9/9	100%	7/7	100%	92/92	100%

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17. Has the treatment plan been evaluated by another dental provider to address the necessity for treatment?	11/11	100%	12/12	100%	13/13	100%	10/10	100%	12/12	100%	16/16	100%	4/4	100%	10/10	100%	7/7	100%	95/95	100%
18. Is there documentation signed and dated that all services provided are recorded?	11/11	100%	12/12	100%	13/13	100%	9/10	90%	12/12	100%	16/16	100%	3/3	100%	10/10	100%	7/7	100%	93/94	99%
19. Is there signed and dated documentation in the client's record of prescriptions and drugs dispensed?	8/8	100%	7/7	100%	7/7	100%	N/A	N/A	10/10	100%	3/3	100%	N/A	N/A	8/8	100%	4/4	100%	47/47	100%
20. Is there signed and dated documentation in the client's record that post operative instructions were given for surgical procedures?	6/6	100%	2/2	100%	6/6	100%	N/A	N/A	4/4	100%	2/2	100%	N/A	N/A	2/2	100%	3/3	100%	25/25	100%
21. Is there documentation signed and dated in the client's record of all pre-medications and local anesthetic used?	8/9	89%	10/10	100%	12/12	100%	0/1	0%	11/11	100%	6/6	100%	0/2	0%	9/9	100%	5/5	100%	61/65	94%
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	N/A	N/A	N/A	N/A
<b>Is there documentation signed and dated on the client's record of</b>																				
Medical history	11/11	100%	12/12	100%	13/13	100%	10/10	100%	12/12	100%	16/16	100%	4/4	100%	10/10	100%	7/7	100%	95/95	100%
Physical examination	11/11	100%	12/12	100%	13/13	100%	10/10	100%	12/12	100%	16/16	100%	4/4	100%	10/10	100%	7/7	100%	95/95	100%
Laboratory reports	2/2	100%	N/A	N/A	0/1	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/2	50%	N/A	N/A	3/5	60%
Medications	8/9	89%	12/12	100%	13/13	100%	10/10	100%	11/11	100%	16/16	100%	N/A	N/A	10/10	100%	7/7	100%	87/88	99%
Treatment plan of care	11/11	100%	12/12	100%	13/13	100%	10/10	100%	12/12	100%	16/16	100%	4/4	100%	10/10	100%	7/7	100%	95/95	100%
Interim progress notes	8/8	100%	5/5	100%	2/2	100%	N/A	N/A	6/6	100%	3/3	100%	2/2	100%	7/7	100%	2/2	100%	35/35	100%
Referrals and follow-ups	11/11	100%	12/12	100%	11/11	100%	5/5	100%	12/12	100%	14/14	100%	3/3	100%	6/6	100%	7/7	100%	81/81	100%

**Attachment C: Peer Reviewed Site Mental Health Raw Data**

	Carilion		CrossOver		DPHS		FAHASS		Total	
	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%
<b>Newly Enrolled</b>										
1. Is there documentation of referral for Mental House Services documented prior to initiation of service?	3/10	30%	9/9	100%	13/13	100%	8/8	100%	33/40	83%
2. Is there documentation of screening (PHQ-9, GAD-9, AUDIT-DAST, Rx Abuse Screener, MOCA) in the client's record?	0/10	0%	10/10	100%	13/13	100%	5/8	63%	28/41	68%
3. Is there documentation of the Service Plan in the client's record signed and dated by the service provider?	8/10	80%	9/9	100%	7/8	88%	8/8	100%	32/35	91%
4. Does the Service Plan include a diagnosed mental illness or condition?	8/10	80%	10/10	100%	13/13	100%	8/8	100%	39/41	95%
5. Does the Service Plan include Service modality (individual, group, or both)?	8/10	80%	10/10	100%	13/13	100%	8/8	100%	39/41	95%
6. Does the Service Plan include treatment goals?	8/9	89%	10/10	100%	7/8	88%	8/8	100%	33/35	94%
7. Does the Service Plan include start dates for mental health services?	7/10	70%	10/10	100%	13/13	100%	8/8	100%	38/41	93%
8. Does the Service Plan include a projected end date for services?	7/10	70%	9/9	100%	N/A	N/A	6/8	75%	22/27	81%
9. Does the Service Plan include a number of sessions?	8/10	80%	9/9	100%	N/A	N/A	0/8	0%	17/27	63%
<b>Ongoing Clients</b>										
10. Does the Service Plan include reassessment dates of client progress every 90 days?	0/12	0%	7/7	100%	N/A	N/A	N/A	N/A	7/19	37%

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11. Is there documentation of a complete psychosocial assessment and the result used to complete the service plan?	4/12	33%	10/10	100%	3/5	60%	8/8	100%	25/35	71%
12. Is there documentation of mental health services provided in the client's record?	11/11	100%	4/4	100%	13/13	100%	8/8	100%	36/36	100%
13. Is there documentation of consultation with medical staff, mental health, pharmacy, and other support services as needed?	3/3	100%	4/4	100%	13/13	100%	8/8	100%	28/28	100%
14. Is there documentation of referrals made and status of outcome in the client's record?	2/3	67%	1/1	100%	6/6	100%	N/A	N/A	9/10	90%
<b>Discharge</b>										
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?	N/A	N/A	2/2	100%	3/3	100%	2/2	100%	7/7	100%
16. If the client was transferred, is there documentation of discharge summary and other records sent with the patient?	N/A	N/A	N/A	N/A	N/A	N/A	2/2	100%	2/2	100%
17. If unable to locate the client, is there documentation of attempts made?	N/A	N/A	N/A	N/A	1/1	100%	N/A	N/A	1/1	100%

**Attachment D: Peer Reviewed Site Medical Case Management Data**

	ARE		CAHN		CAN		Carilion		COHM		Daily Planet		FAHASS		MWHC		NH		Serenity		TRHD		VHO		Total		
	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	
<b>Newly Enrolled Clients (within previous 12 months)</b>																											
1. Was the initial assessment completed within 30 days of (NMCM) intake?	6/6	100%	15/15	100%	9/9	100%	5/5	100%	9/9	100%	13/13	100%	12/12	100%	4/4	100%	N/A	N/A	9/9	100%	3/3	100%	7/7	100%	92/92	100%	
<b>Newly Enrolled and Ongoing Clients</b>																											
<b>MCM Assessment</b>																											
2. Was at least one face-to-face Assessment completed with the client?	9/10	90%	34/35	97%	30/30	100%	9/9	100%	5/5	100%	13/14	93%	16/16	100%	18/18	100%	11/11	100%	9/10	90%	12/12	100%	14/18	78%	180/188	96%	
3. Does the last page of the MCM Assessment include a summary of findings?	8/10	80%	32/33	97%	30/30	100%	9/9	100%	10/10	100%	13/14	93%	11/16	69%	17/18	94%	11/11	100%	1/10	10%	12/12	100%	12/13	92%	166/186	89%	

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4. Does the MCM Assessment include an assessment of Treatment Adherence?	10/10	100%	27/28	96%	30/30	100%	7/8	88%	10/10	100%	14/14	100%	14/16	88%	18/18	100%	10/11	91%	8/10	80%	11/11	100%	13/13	100%	172/179	96%	
5. If Treatment Adherence was identified as a need in the MCM Assessment, is it included in the Service Plan?	3/4	75%	13/14	93%	12/13	92%	2/2	100%	4/4	100%	6/6	100%	6/9	67%	8/11	73%	9/9	100%	3/4	75%	6/6	100%	13/13	100%	85/95	89%	
<b>Acuity Scale</b>																											
6. Does the client have an Acuity Scale completed and documented reflecting their current Acuity level?	10/10	100%	33/34	97%	30/30	100%	9/9	100%	10/10	100%	12/14	86%	16/16	100%	15/16	94%	11/11	100%	10/10	100%	12/12	100%	18/18	100%	186/190	98%	

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7. Has the client's acuity level been updated as frequently indicated in each Acuity level according to level 1, 2, or 3?	9/10	90%	23/31	74%	16/29	55%	8/8	100%	9/9	100%	4/9	44%	13/16	81%	16/17	94%	10/10	100%	6/9	67%	12/12	100%	14/14	100%	140/174	80%	
8. Is there documentation that clients with Acuity level 1 have been referred back to NMCM?	N/A	N/A	10/10	100%	1/1	100%	1/1	100%	6/7	86%	N/A	N/A	2/8	25%	4/4	100%	2/2	100%	N/A	N/A	2/2	100%	3/3	100%	31/38	82%	
<b>Service Planning</b>																											
9. Is there documentation of a completed and dated MCM Service Plan (except for Acuity	10/10	100%	30/32	94%	28/30	93%	9/9	100%	10/10	100%	14/14	100%	8/9	89%	13/14	93%	11/11	100%	9/10	90%	12/12	100%	14/14	100%	168/175	96%	



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12. Is there documentation that the client was offered or received a copy of the Service Plan?	10/10	100%	31/32	97%	28/30	93%	9/9	100%	10/10	100%	8/14	57%	8/9	89%	14/17	82%	10/11	91%	7/10	70%	12/12	100%	16/16	100%	163/180	91%	
<b>Service Plan Implementation</b>																											
13. Are the goals and progress on attaining goals documented in the progress notes? (Levels 2 & 3)	9/10	90%	28/32	88%	28/30	93%	8/8	100%	10/10	100%	14/14	100%	7/10	70%	15/15	100%	11/11	100%	9/9	100%	12/12	100%	16/16	100%	167/177	94%	
14. Is the timeline for goals set within the appropriate timeframe for the acuity level?	6/10	60%	27/32	84%	23/30	77%	9/9	100%	10/10	100%	13/13	100%	7/9	78%	17/17	100%	11/11	100%	10/10	100%	12/12	100%	7/17	41%	152/180	84%	
15. Is the Service Plan completed and updated within	5/10	50%	23/30	77%	17/30	57%	9/9	100%	9/9	100%	3/11	27%	6/9	67%	16/17	94%	11/11	100%	2/8	25%	12/12	100%	17/17	100%	130/173	75%	





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<p>21. Is there documentation that a certified letter was mailed to the client's last known mailing address within five business days after the last phone attempt notifying the client of pending inactivation?</p>	N/A	N/A	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	N/A	N/A	N/A	N/A	1/1	100%
<p>22. Is there documentation that a certified letter was mailed to the client's last known mailing address within five business days of discharge, noting</p>	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	N/A	N/A	N/A	N/A	N/A	N/A

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the reason for discharge and possible alternative resources ?																			
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**Attachment E: Peer Reviewed Non-Medical Case Management Raw Data**

	ARE		CAHN		CAN		Carilion		COHM		Daily Planet		FAHASS		MWHC		NH		Serenity		TRHD		VHO		Total		
	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	Raw Value	%	
<b>Newly Enrolled Clients (within the previous 12 months)</b>																											
1. Is there documentation of initial contact with the client within three business days?	1/1	100%	2/2	100%	N/A	N/A	1/3	33%	N/A	N/A	6/7	86%	5/6	83%	N/A	N/A	N/A	N/A	3/3	100%	1/1	100%	4/5	80%	23/28	82%	
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?	1/1	100%	0/2	0%	N/A	N/A	1/3	33%	N/A	N/A	5/5	100%	2/6	33%	N/A	N/A	N/A	N/A	2/3	67%	1/1	100%	4/5	80%	16/26	62%	
3. Is there documentation of a completed and dated eligibility/intake review form within 10 business days of the first contact with client?	1/1	100%	2/2	100%	N/A	N/A	2/3	67%	N/A	N/A	7/7	100%	5/6	83%	N/A	N/A	N/A	N/A	3/4	75%	1/1	100%	5/5	100%	26/29	90%	
4. Is there documentation of expedited eligibility/intake for newly diagnosed, pregnant, or recently released from incarceration?	1/1	100%	N/A	N/A	N/A	N/A	2/2	100%	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	2/2	100%	6/6	100%	

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<p>5. Is the intake completion is delayed because of missing documents during the 30-day calendar period, is there documentation that the Non-Medical Case Manager/Eligibility/Intake Specialist notified the client at least three times, on different days, about what documents are missing?</p>	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	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	100%	
<p>6. Was the final notification in writing and does it include information that client files will be closed if the missing documentation is not provided (Exception for clients with documentation that they do not wish to receive mail)</p>	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	N/A	N/A	N/A	N/A	N/A	
<p><b>Newly Enrolled and Ongoing Clients</b></p>																										
<p>7. Is there a completed and dated Eligibility Assessment Determination Form (including income, # in household, verification of HIV + status, Virginia residency and uninsured/underinsured status) reviewed and recertified every 24 months?</p>	11/13	85%	53/54	98%	33/35	94%	33/39	85%	14/14	100%	17/18	94%	14/15	93%	37/37	100%	0/10	0%	10/10	100%	12/12	100%	28/28	100%	262/285	92%
<p>8. Is there documentation of a signed and dated Informed Consent and Release of Information? And documentation that the client received a copy of the Grievance Procedures, Confidentiality Statement?</p>	13/13	100%	52/54	96%	33/35	94%	33/39	85%	14/14	100%	13/18	72%	15/15	100%	37/37	100%	10/10	100%	10/10	100%	11/12	92%	28/28	100%	269/285	94%

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9. Is there documentation that the NMCM referred the client within two (2) working days to MCM if the client answered "yes" to questions 8-20 in the Medical Case Management Service Plan / MCM Referral section of the Eligibility Assessment Determination Form?	2/4	50%	10/17	59%	2/14	14%	3/8	38%	4/4	100%	5/9	56%	6/8	75%	9/14	64%	6/6	100%	4/5	80%	1/1	100%	11/12	92%	63/102	62%
10. Is there documentation that client was screened using the NMCM Service Plan / MCM Referral Form?	11/13	85%	46/54	85%	22/35	63%	33/39	85%	14/14	100%	15/18	83%	14/15	93%	37/37	100%	7/10	70%	10/10	100%	12/12	100%	26/28	93%	247/285	87%
11. Is there documentation that the NMCM Service Plan / MCM Referral was completed every 6 months?	7/11	64%	25/37	68%	4/32	13%	6/24	25%	14/14	100%	13/18	72%	7/11	64%	14/20	70%	1/10	10%	2/6	33%	12/12	100%	6/10	60%	111/205	54%
12. Is there documentation of a completed NMCM Service Plan to include answers to questions 1-7, tasks, action steps, target dates, and date achieved/outcome (if applicable)?	11/13	85%	18/40	45%	14/34	41%	21/34	62%	14/14	100%	11/15	73%	13/15	87%	28/32	88%	7/10	70%	10/10	100%	12/12	100%	14/16	88%	173/245	71%

**Attachment F: Peer Reviewed Substance Abuse Outpatient Raw Data**

	Daily Planet		Total	
	Raw Value	%	Raw Value	%
<b>Newly Enrolled Clients (within previous 12 months)</b>				
1. Is there documentation of referral for outpatient substance abuse services documented in the client's record?	7/7	100%	7/7	100%
2. Is there documentation of an assessment in the client's record?	7/7	100%	7/7	100%
3. Does the assessment include documentation of substance abuse history and current status?	7/7	100%	7/7	100%
4. Does the service plan include documentation of medical history and current health status?	7/7	100%	7/7	100%
5. Does the assessment include documentation availability of food, shelter, transportation, and financial resources?	7/7	100%	7/7	100%
6. Does the assessment include documentation of the client's support system?	7/7	100%	7/7	100%
7. Does the assessment include documentation of the client's legal issues and/or custody status?	7/7	100%	7/7	100%
8. Does the assessment include documentation of mental health status and co-existing conditions?	7/7	100%	7/7	100%
9. Is there documentation of the treatment plan in the client's record?	6/7	86%	6/7	86%
<b>Ongoing Clients</b>				
10. Is there documentation of a treatment plan in the client's record that is signed and dated?	11/11	100%	11/11	100%
11. Is there documentation of a complete psychosocial assessment and the result used to develop the service plan?	11/11	100%	11/11	100%

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12. Is there documentation that the client participated in the development of the service plan?	11/11	100%	11/11	100%
13. Is there documentation of mental health services provided in the client's record?	11/11	100%	11/11	100%
14. Is there documentation of consultation with medical staff, mental health, pharmacy, and other support services as needed?	11/11	100%	11/11	100%
15. Is there documentation of referrals made and the status of outcome in the client's record?	11/11	100%	11/11	100%
<b>Discharge</b>				
16. Is there documentation of discharge plan summary and summary in the client's record with clear rationale within 30 days of discharge, including certified letter, if applicable	2/2	100%	2/2	100%
17. If the client was transferred, is there documentation of discharge summary and other records sent with the patient?	2/2	100%	2/2	100%
18. If unable to locate the client, is there documentation of attempts made?	2/2	100%	2/2	100%

**Attachment G: Peer Review Client Interviews Raw Data**

<b>Section B: Overall Experiences and Satisfaction</b>	<b>Raw Value</b>	<b>Percentage</b>
B1. The RW Grievance/Complaint Procedure has been explained to me (yes)?	49/61	80%
B2. Do you feel safe/comfortable filing a complaint/grievance?	53/61	87%
B3. I have been asked to participate in a patient satisfaction survey at this agency.	45/61	74%
B4. I have been asked to participate in a Patient/Consumer Advisory Board	39/61	64%

<b>Section C: Primary Medical Care</b>	<b>All the Time</b>	<b>Most of the Time</b>	<b>Sometimes</b>	<b>Rarely</b>	<b>Never</b>
C1. When I needed an appointment, I could schedule one soon enough for my needs	34/40 (85%)	3/40 (7.5%)	3/40 (7.5%)	0/40 (0%)	0/40 (0%)
C2. My providers told me how important it was to keep my appointments	39/40 (97.5%)	0/40 (0%)	1/40 (2.5%)	0/40 (0%)	0/40 (0%)



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C9. My providers talked to me about how to avoid passing HIV to other people	39/40 (97.5%)	1/40 (2.5%)	0/40 (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	36/40 (90%)	2/40 (5%)	2/40 (5%)
C12. At any point, did you feel you were treated poorly at your clinic?	1/40 (2.5%)	39/40 (97.5%)	0/40 (0%)

<b>D. Case Management</b>	<b>Raw Value</b>		<b>%</b>	
D1. I am aware of the different levels of case management	40/57		70%	
D7. I want to be more involved in making decisions about my service plans and goals	35/57		61%	
	<b>Disagree Strongly</b>	<b>Disagree</b>	<b>Agree</b>	<b>Agree Strongly</b>
D2. I work with my case manager to determine my needs	1/57 (2%)	1/57 (2%)	14/57 (24%)	41/57 (72%)
D3. I find it hard to talk to my case manager	57/57 (100%)	0/57 (0%)	0/57 (0%)	0/57 (0%)
D4. When I needed an appointment, I could see my case manager soon enough for my needs	1/57 (2%)	1/57 (2%)	9/57 (16%)	46/57 (80%)

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D5. I feel comfortable sharing my feelings and problems with my case manager	1/57 (2%)	1/57 (2%)	4/57 (7%)	51/57 (89%)
D6. My case manager and HIV medical care providers worked together to help me	1/57 (2%)	1/57 (2%)	9/57 (16%)	46/57 (80%)

<b>Section E. Oral Health</b>	<b>Less than 1 year</b>	<b>1 to 2 years</b>	<b>3 to 5 years</b>	<b>More than 5 years</b>
E1. I have received care here for oral health for...	5/22 (23%)	5/22 (23%)	4/22 (18%)	8/22 (36%)
E2. My last visit for oral health was...	15/22 (68%)	7/22 (32%)	0/22 (0%)	0/22 (0%)
	<b>Disagree Strongly</b>	<b>Disagree</b>	<b>Agree</b>	<b>Agree Strongly</b>
E3. I am satisfied with the oral health services I receive at this agency	0/22 (0%)	2/22 (9%)	5/22 (23%)	15/22 (68%)
E5. At every dentist visit I receive information on how to care for my mouth, teeth, gums and what to look for in my mouth	0/22 (0%)	1/22 (5%)	4/22 (18%)	17/22 (77%)
	<b>1 time a year</b>	<b>2 times a year</b>	<b>3+ times a year</b>	<b>When I feel the need</b>
E4. I see the dentist	7/22 (32%)	6/22 (27%)	3/22 (14%)	6/22 (27%)