

2013 Virginia Jurisdictional HIV Prevention Plan Update

The Planning Process

Virginia's Jurisdictional HIV Prevention Plan was completed in September of 2012, just months after the release of the Center for Disease Control and Prevention's (CDC) HIV Planning Guidance in July of 2012. While still a functional document for the state's planning purposes; updates and additions will be incorporated to align Virginia's plan with the new Guidance. At the time of this report, Virginia's plan was in its first year of implementation and the Virginia Department of Health's (VDH) Division of Disease Prevention (DDP) has just recently begun adapting the document to reflect the necessary changes in collaboration with the Community HIV Planning Group (CHPG). It is anticipated that the 2014 Jurisdictional Plan will be fully aligned with the new Guidance. Updates for epidemiological data and resource inventories will be reported in 2014.

STAKEHOLDER IDENTIFICATION:

OBJECTIVE 1: VDH AND CHPG WILL IDENTIFY AND IMPLEMENT VARIOUS STRATEGIES TO RECRUIT AND RETAIN CHPG MEMBERS, TARGETING PARTICIPANTS THAT REPRESENT THE DIVERSITY OF POPULATIONS DEFINED IN VIRGINIA'S HIV PREVALENCE SURVEILLANCE AND EPIDEMIOLOGICAL DATA.

- ACTIVITY: IDENTIFY COMMUNITY MEMBERS, KEY STAKEHOLDERS, AND OTHER HIV SERVICES PROVIDERS INVOLVED IN HIV CARE, PREVENTION AND TREATMENT SERVICES TO PARTICIPATE IN THE PLANNING PROCESS.

VDH seeks to implement a planning process that aligns with the National HIV/AIDS Strategy and one that supports CDC's High Impact Prevention strategy. In order to achieve this goal, Virginia's CHPG consists of representatives of populations with high HIV prevalence in the state and currently engaging stakeholders across Virginia to support HIV prevention, care and treatment for its residents. Stakeholder engagement includes membership of People Living with HIV/AIDS (PLWHA), behavioral and social sciences disciplines, business and labor industries, community health care centers (CHCs), correctional facilities, faith communities, HIV clinical care providers, homeless service experts, academic institutions, psycho-social support and treatment service providers, other relevant state agencies, local and state health departments, and officials supporting efforts against transmission of HIV, tuberculosis, hepatitis and sexually transmitted diseases. Through this broad range of representation, the engagement process sought input on planning, implementation, monitoring and evaluation, which has greatly influenced planning efforts and resulted in a more coordinated approach to addressing HIV.

Historically, both VDH and the CHPG have actively identified stakeholders to engage in HIV prevention, care, and treatment planning and implementation activities, expanding these successful partnerships can increase VDH's impact on the reduction of HIV incidence and AIDS-related mortality for the Commonwealth. Expanded engagement may include input from more diverse and representative faith-based organizations, emergency management systems,

crisis response services (e.g. sexual violence, intimate partner violence and other violence crisis, mental health crisis, housing crisis, etc), health education departments in hospitals, recognized local and regional youth services (such as the Boys and Girls Club), and agencies providing services correlative to prevention and care efforts.

To ensure the planning process addresses the current and emergent needs of those most affected by HIV and AIDS, VDH and the CHPG have an active and diverse recruitment and retention process for new membership. Demographic factors utilized in the selection of new members include age, gender, sexual orientation, race, ethnicity, and geographic region. VDH and the CHPG also consider life experiences and ensure that individuals with relevant life histories are afforded opportunities for active participation in addition to those members who bring professional credentials or demographic representation. As a result of these identified priorities, the CHPG membership list is reflective of Virginia’s PLWHA demographics as well as those who offer HIV-related services. In order to ensure a consistently evolving membership, CHPG approved a by-law revision in June of 2012 limiting membership to two consecutive terms. Recognizing that some extremely marginalized populations lack vocal and effective community voices, exceptions will be permitted for members who represent populations or life experiences that recruitment efforts fail to fill. Members who have cycled off the committee may reapply for membership after being off for one year. Current members will be cycled off the committee in a staggered yearly process to ensure continuity of planning and expanded engagement potential. In April, 2013, CHPG convened its membership committee to fill eight vacancies in the planning group. The committee chose members that most accurately represented the populations in Virginia who are most affected by HIV. The table below illustrates CHPG membership as representative of the state’s HIV prevalence rates:

TABLE 1: Virginia CHPG Membership Compared with HIV Prevalence Rates (excludes state representatives)

	VA Prevalence (Percentage of cases living with HIV)	Ideal # Per VA Prevalence @ 35 members	Prior to May 2013	After May 2013 (date of new members acceptance of appointment to CHPG)
Sex (transgender women included in female)				
Male	74%	26	15	19
Female	26%	9	9	11
Priority Population				
MSM	42%	15	12	14
IDU	11%	4	4	5
Heterosexuals	19%	7	10	14
Race/Ethnicity				
Black	60%	21	11	14
White	30%	11	13	14
Hispanic	7%	2	1	2
Asian	1%	0	0	2
Health Region of Residence				

Eastern	31%	11	6	7
Central	24%	8	3	6
Northern	28%	10	5	8
Northwest	8%	3	5	5
Southwest	8%	3	3	3
Age Group				
15-29	11%	4	3	6
30-39	17%	6	5	5
40-49	35%	12	4	7
50-59	28%	10	12	10
60+	12%	4	3	4
Sero-status				
Living with HIV	33%	12	10	13

Other strategies for stakeholder engagement include population-focused regional meetings where the community HIV planner will travel to the five health regions of the state to engage the targeted communities in the planning process through the use of regional forums. CHPG members indicated the need to have more youth input in the planning process, particularly young MSM. To accommodate the schedules of these populations, regional meetings were proposed. VDH and CHPG have also begun reaching out to organizations that represent minorities in the state, such as the NAACP, to solicit input specific to the black community in certain regions of the state, particularly areas that will be served by CAPUS.

RESULTS-ORIENTED ENGAGEMENT PROCESS

OBJECTIVE 2: CHPG WILL DEVELOP A COLLABORATIVE ENGAGEMENT PROCESS AND VDH WILL IMPLEMENT THE PROCESS THAT IDENTIFIES SPECIFIC STRATEGIES TO ENSURES A COORDINATED AND SEAMLESS APPROACH TO HIV PREVENTION, CARE, AND TREATMENT SERVICES FOR VIRGINIA'S HIGHEST-RISK POPULATIONS DISPROPORTIONATELY AFFECTED BY HIV.

- **ACTIVITY: DEVELOP A COLLABORATIVE AND COORDINATED ENGAGEMENT PROCESS THAT RESULTS IN GREATER ACCESS TO HIV PREVENTION, CARE, AND TREATMENT FOR DISPROPORTIONATELY AFFECTED POPULATIONS IN ORDER TO REDUCE NEW HIV INFECTIONS IN VIRGINIA, AND TO HELP REDUCE HEALTH DISPARITIES IN DISPROPORTIONATELY AFFECTED POPULATIONS.**

Entering into year two of the current Jurisdictional Plan, members of CHPG have begun to develop an engagement plan that addresses health disparities in the state, particularly among groups that are disproportionately affected by HIV. The process being developed utilizes the Plan-Do-Study-Act Cycle. Objectives of the Jurisdictional Plan are reviewed by VDH and CHPG; experts are brought in to meetings or via social media to help educate the membership and provide input on the topic. Input is given from the membership and if necessary a workgroup

is formed to study the topic. Finally VDH acts upon the input given to accomplish the objective and the process is revisited as an evaluation method for quality improvement.

Two examples of this process are the formation of workgroups to address HIV criminalization and the development of a Statewide Hepatitis Task Force/Advisory Group allowed CHPG to engage stakeholders outside of the group. For the criminalization workgroup, SERO Project (a national advocacy group), Virginia Organizations Responding to AIDS (VORA), Equality Virginia (a statewide LGBT civil rights organization), members of regional planning councils, and DDP's HIV rapid testing coordinator and contract monitor for the HIV Prevention in Communities of Color grant were engaged to share expertise and knowledge. The Hepatitis workgroup has allowed CHPG to engage members of the medical community, Virginia HIV/AIDS Resource Centers, other DDP staff, and persons living with Hepatitis C into the planning process. CHPG has also been active in community engagement around Virginia's CAPUS grant.

CAPUS held a community engagement event in June 2013 and CHPG members were present to speak on the planning process as it pertains to care initiatives and addressing social determinants of health. CHPG has been an integral part in Virginia's CAPUS initiative, being asked for input by DDP on several occasions in the past year.

DDP has shared epidemiological data on various topics with CHPG this reporting period to facilitate discussion and input on current prevention and care issues. In this reporting period data pertaining to Virginia's treatment cascade has particularly been a focus as DDP is in the process of creating a care database that will more accurately reflect care outcomes. CHPG has provided input on definitions of lost to care, patient navigation as a method of care retention and ethical issues relating to information sharing.

The use of social media tools allow for ongoing discussion of topics covered at recent meetings as well as immediate discussion when new topics arise that need input from the group. CHPG is using Facebook to facilitate ongoing discussions regarding prevention topics. The Facebook page is a closed page that is open by invitation only to CHPG members. The use of Facebook provides a venue for ongoing engagement and helps retain member interest and investment in the planning process between meetings. Many member share prevention and care activities that are occurring around the state on this page and many solicit advice from other members regarding planning in their area. The page also allows for rapid dissemination of information to the planning group and rapid input back from the group.

Multiple activities continue to be developed and implemented to engage stakeholders outside of the CHPG in a collaborative and coordinated approach to HIV prevention and care services. DDP reaches out to the community via a monthly e-bulletin and its Facebook page and is currently utilizing social media to broaden the reach of public health messages, resources, and information. DDP and the CHPG currently conduct meetings, webinars, and conferences to provide stakeholders with updated epidemiological information and communicate efforts to address disease transmission. DDP and the CHPG also participate in public hearings with HIV Care Services and make presentations on CHPG activities at prevention and care contractor

meetings. Ongoing discussions seek to identify growth opportunities with current partners to maximize HIV prevention, treatment, and care services among high-risk populations in Virginia.

By improving upon community engagement strategies, communities also have an opportunity to ask questions and voice their concerns. Engagement is demonstrated as a two-way street ensuring both dissemination and collection of information to inform planning processes. Verbal and written feedback from community members is then incorporated into CHPG planning activities. Stakeholders are encouraged to support and inform integration services in communities wherever possible to address syndemics associated with HIV. Examples of service integration include addressing chronic and marginal homelessness, providing effective and accessible HIV treatment services to PLWHA, and providing treatment at CHCs for individuals who are co-infected with HIV and other morbidities.

VDH and the CHPG participate in public hearings with HIV Care Services and make presentations on CHPG activities at prevention and care contractor meetings. On-going discussions seek to identify growth opportunities with current partners to maximize HIV prevention, treatment and care services among high-risk populations in Virginia. The flow of updated information may not filter to all areas where HIV services are provided as quickly as it is collected. Recognizing this as a gap, VDH and the CHPG plan to disseminate information more efficiently by utilizing content experts to help build capacity and ensure real-time dissemination of new information to communities. Racial and ethnic minorities, sexual minorities and faith-based communities each have particular cultures that can be better understood and utilized in prevention and care service delivery. Experts from these cultural communities serving as community “champions,” can address confounding factors associated with HIV prevention and treatment outcomes while simultaneously bolstering support for collaborator retention. Continued representation from these affected cultural communities can expand connections between stakeholders, address culturally-related issues of stigma associated with HIV, and generate greater interest in engagement activities through visible inclusion of marginalized representatives. VDH and the CHPG can utilize actively engaged stakeholders to focus expansion of collaborative efforts where access issues are most prevalent. Assuring representation may involve expanding collaboration with organizations focusing on issues related to homelessness, changing the environment of the conversation to areas where stakeholders feel more comfortable discussing and addressing HIV prevention and treatment, and ensuring integration of related services to maximize resources within jurisdictions. Additional strategies to address access may include conducting needs assessments and utilizing the results to better coordinate service delivery among related agencies.

JURISDICTIONAL HIV PREVENTION PLAN DEVELOPMENT, IMPLEMENTATION AND MONITORING

OBJECTIVE: CHPG AND VDH WILL ANNUALLY IDENTIFY AND EMPLOY VARIOUS METHODS TO ELICIT INPUT ON THE DEVELOPMENT OR UPDATE AND IMPLEMENTATION OF VIRGINIA’S JURISDICTIONAL PREVENTION PLAN FROM CHPG MEMBERS, OTHER STAKEHOLDERS AND PROVIDERS.

- ACTIVITY: INFORM AND MONITOR THE DEVELOPMENT AND UPDATES TO THE JURISDICTIONAL HIV PREVENTION PLAN TO ENSURE THE ENGAGEMENT PROCESS SUPPORTS THE PLAN AND TO ENSURE THAT THE PLAN IS PROGRESSING TOWARD A REDUCTION IN HIV INCIDENCE AND HIV-RELATED HEALTH DISPARITIES IN VIRGINIA.

Meaningful and timely communication is vital to obtaining buy-in, preserving relationships, and establishing trust with disenfranchised persons and communities. It is imperative to identify and systematically attempt to address root causes for individual and organizational success and investment in HIV prevention, treatment and care services. In order to develop and sustain effective collaborative partnerships that result in improved planning and service delivery, entities must ensure that all stakeholder needs are measured and included in all processes meant to support goal attainment. The “two-way” street mentality of information sharing and collection related to planning includes CHPG and VDH representatives serving on membership boards and other committees related to HIV services. VDH and the CHPG will identify and prioritize the most effective activities for expanding upon new and existent collaborative efforts in order to target resources where there is the greatest need. Through improved partnerships, collaborative efforts, and a renewed focus on outcome oriented processes, all partners will find value and importance to the engagement and maintenance of integrated planning and service delivery in communities and jurisdictions.

CHPG will give and solicit input on Virginia’s Plan each year in a variety of forms. Ongoing discussion at six annual meetings, online discussion in social media forums, workgroups, and community forums will all be venues for CHPG members to give input on the development, implantation and evaluation of the plan. CHPG members are tasked with engaging other stakeholders and bringing input from the community back to the membership as well on an ongoing basis. VDH regularly solicits input from the community as a whole and request CHPG membership to help with this task.

Currently Virginia’s Jurisdictional Prevention Plan is designed to cover a five-year planning period. VDH provided epidemiological data is used as the basic planning product to monitor HIV incidence and prevalence and to determine the populations most affected by HIV infection in the state. This information is provided both in a quarterly and annual format. Based on the data, a community services assessment that addresses resource inventories, needs assessments, and gaps analysis is conducted by VDH and CHPG. VDH elicits input on high-impact prevention interventions from CHPG, contractors, stakeholders and participants from targeted populations to determine effectiveness and community support for the interventions. Finally CHPG is asked to assess progress Virginia is making on the goals and objectives of the Jurisdictional Plan and the four monitoring questions in the HIV Planning Guidance.

Monitoring progress

Progress in jurisdictional planning is monitored by the creation of a yearly Stakeholder and Membership Profile each December and by responding to the four monitoring questions proposed by CDC in the HIV Planning Guidance. These questions are:

- To what extent did HIV services providers and other stakeholders inform the coordination of HIV prevention, care and treatment services participate in Virginia’s planning process?
- To what extent did the engagement process achieve a more coordinated, collaborative, and seamless approach to accessing HIV services for the highest-risk populations?
- To what extent was input from CHPG members, other stakeholders, and providers used to inform and monitor the development and implementation or update of the Virginia’s Jurisdictional Plan?
- To what extent were surveillance and service data/indicators utilized to inform and monitor the development and implementation or update of Virginia’s Jurisdictional Plan?

Documentation of the planning process and ongoing engagement activities will also serve as process monitoring methods. A letter of concurrence, concurrence with reservation, or non-concurrence will serve as the CHPG’s feedback on how successful objectives were accomplished.

Overview of Epidemiological Data

With eight million residents, Virginia represents 2.6% of the total population of the United States. In 2009, the state comprised 2.2% of all HIV disease diagnoses in the country and ranked 10th among the 40 states with established confidential name-based reporting (CDC, 2011). Since 1999, the number of HIV disease diagnoses in Virginia has remained relatively stable, between 958 and 1,111 cases newly diagnosed each year.

On average, there were 1,036 persons diagnosed with HIV disease each year in Virginia for the past 10 years, at a rate of nearly 14 new cases per 100,000 population. In 2009, there were 958 reports of HIV disease diagnosis; though data for 2009 indicated a decrease in the number of diagnoses, caution must be exercised when evaluating this trend, as year-to-year fluctuations are expected based on data in recent years. In 2009, there were 498 cases of AIDS diagnosed in Virginia, the lowest since the decline began in the early 1990s.

As of December 31, 2009, there were 22,257 people known to be living with HIV disease (PLWHA) in Virginia, at a disease rate of 282 per 100,000 population. Approximately half of this population has progressed to the AIDS stage of the disease.

Although HIV rates have significantly decreased from earlier days of the epidemic due to activities such as HIV testing, behavioral interventions, screening the blood supply, and advances in HIV therapies, challenges still remain. Approximately 20% of those infected are unaware of their HIV status. This could be attributed to a number of factors and social determinants of health including, lack of access, stigma, poverty, and discrimination. Other significant epidemiological data includes:

- One in 354 Virginia residents were known to be living with HIV disease at the end of 2009. The majority of PLWHA were male (73%), Black (60%), men who have sex with men (MSM) or MSM with a history of injection drug use (MSM-IDU) (55%), and persons between the ages of 40 and 54 as of 2009 (52%).
- The rate of new HIV disease diagnoses has increased within the young adult population in recent years; specifically, the rate among those who were 25-34 at the time of diagnosis surpassed that of those aged 35-44.
- The greatest number of new HIV disease diagnoses in 2009 occurred among men aged 20-24 at the time of diagnosis (n=147). Males in this group were 8 times more likely to be diagnosed with HIV disease than their female counterparts.

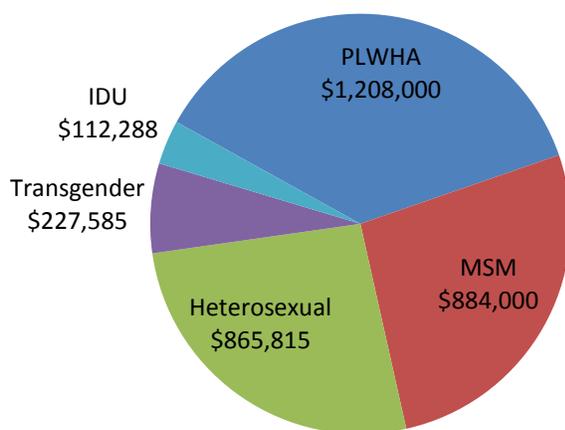
Steps to reduce HIV infections include intensifying HIV prevention efforts in communities with high prevalence, focusing on care as a prevention strategy, expanding targeted efforts using effective, evidence-based approaches, and increasing education efforts for all Americans.

Allocation of Existing Prevention Resources

VDH ensures prevention resource allocation to jurisdictions with the greatest demonstrated HIV incidence burden. This includes ongoing evaluation of funding to target populations engaging in the most prevalent risk behaviors associated with HIV incidence, as well as demographic sub-populations who experience disproportionate rates of HIV and AIDS morbidity as a result of specific risk conditions. Requests for Proposals are tailored to encourage agencies applying for funding to focus on populations identified through the community planning process which includes review of epidemiological and surveillance data validated by the Commonwealth and Federal agencies.

The following chart shows the allocation of 2012 State and Federal Funds for HIV Prevention Services (including targeted testing in non-clinical settings) by the priority populations identified in collaboration with CHPG. It does not include health department resources allocated for clinical/routine testing, partner services or administrative costs:

2012 State & Federal Funds Allocation for HIV Prevention Services by Priority Population



Overall, funding for services to PLWHA increased by approximately 97% over 2011. Total funding for programs targeting HIV negative MSM increased, but the percentage of funding remained about the same, as the overall budget increased. For the first time, however, funds targeting MSM exceeded funds targeting heterosexuals. Both the percentage and total funding targeting high risk heterosexuals decreased, reflecting a shift in service priorities for PLWHA and away from group and individual level interventions serving HIV negative persons. Funding for Transgender persons was stable while allocations for services to injection drug users declined.

Prioritization of Target Populations

In 2011, the CHPG began the process of prioritizing the target populations identified through the Community Services Assessment (CSA). Although prioritizing target populations is no longer required by the Centers for Disease Control and Prevention (CDC), the CHPG found the process to be useful in identifying and confirming priority populations. After reviewing and discussing the prioritization process utilized in 2008, the CHPG recommended the addition of an HIV disease incidence indicator to the evaluation and planning process. For the indicator, VDH included any person diagnosed with HIV in the measurement period (2005-2009) regardless of disease status at the time of the incidence report. This recommendation was made to align planning with the National HIV/AIDS Strategy which includes an increased focus on jurisdictions with the greatest incidence of new HIV infections. Considering the diverse and varied populations considered for measurement as part of the planning process, the CHPG recommended the exclusion of previous “risk” and “social” indicators as subjective and difficult to measure deeming them “less useful” in a data driven process to guide prioritization. A significant change in the process was the movement to categories of behavioral risk as the primary taxonomy with demographic subpopulations with demonstrated high HIV incidence as the secondary classification.

The Epidemiological Profile Coordinator prepared data worksheets for each behavioral risk category using the most recent and validated data available. The CDC requires that PLWHA be specified as the number one priority population. In order to maximize effort and improve efficiency, the time and effort of VDH staff was spent on populations requiring evaluation and no measurement or evaluation was conducted for PLWHA. The outcomes of the prioritization process were reviewed, discussed, and approved by a majority vote of CHPG membership. The final rankings are below with the completed worksheets included in Attachment A:

<u>Population</u>	<u>Score</u>	<u>Rank</u>
People Living with HIV/AIDS*	---	1
Men who have Sex with Men	42	2
High-Risk Heterosexuals	37	3
Injection Drug Users	23	4
Transgender	16	5

**At the time of this activity, PLWHA were mandated by CDC as the number one priority population so there is no worksheet for this population.*

To begin discussions of demographic sub-populations with demonstrated high incidence, the CHPG members were asked to respond to the following questions as experts in community experience based on observational and anecdotal data (this was to ensure that despite the lag in

reported and validated data, real-time community experience would be qualitatively measured and included in the process to ensure emergent and difficult to measure aspects of HIV incidence were not ignored):

Within each of the categories above:

- Where are most of the cases (by race, by age, by sex)?
- Who should we be targeting epidemiologically?
- Where are the most cases occurring and who are they?

The Epidemiological Profile Coordinator presented data on demographic sub-populations for each behavioral risk population (shown below) and provided insight related to systematic difficulties in obtaining valid data for certain populations (such as meaningful population estimates of transgender individuals to gauge disease burden for measurement in planning and resource allocation), and informed on perceived emerging trends in Virginia and nationally.

People Living With HIV/AIDS (Demographic Subpopulations: Undiagnosed, Diagnosed but not in Care, In Care without Viral Suppression)

The CHPG discussion around PLWHA subpopulation needs primarily concerned the need for continued and improved education for those living with HIV. HIV is a complex disease, particularly for those infected, and some assume that PLWHA have an advanced understanding of all things related to HIV/AIDS. This community identified need demonstrates the belief that just because someone has HIV/AIDS does not mean they have valid, relevant, and sufficient information on how to live with and prevent HIV and AIDS related morbidity and mortality. Committee membership identified that improved access to better education, demonstrated effective skills-building interventions, and external community stigma-reduction strategies are needed to further empower PLWHA towards the goal of engagement and retention to HIV care and reduction in new HIV and AIDS incidence.

Men who have Sex with Men (Demographic Subpopulations: Black MSM aged 16-24; Black, White, and Hispanic MSM)

MSM have been a focus of HIV prevention for decades; however, service needs have expanded beyond basic HIV prevention education. CHPG membership reported that MSM who feel isolated and/or experience low self-esteem in general are more likely to engage in high-risk behaviors associated with HIV transmission. Community strategies to address internalized homophobia, skills building interventions to support improved partner communication as well as safer sex negotiation skills, and information about the relationship between risk conditions, such as substance use and disease transmission, are part of a more comprehensive approach needed to further protect this population and build upon previous community efforts. While many sexually active MSM are tested for HIV once a year or so, only a small percentage report testing every

three to six months, per CDC recommendations, and thus opportunities to link newly-infected persons into care quickly are being lost.

High-Risk Heterosexuals (Demographic Subpopulations: Black Females, Black Males, and, in Northern Virginia specifically, Hispanics)

This behavioral category contains the greatest number of individuals. Due to the diversity of individuals who comprise this behavioral risk category, education and behavioral intervention needs are diverse and broad; however, access to culturally and demographically relevant education, access to appropriate and available testing, and perceived “safe spaces” to discuss HIV/AIDS are paramount to continued and improved efforts to reduce HIV incidence.

Injection Drug Users (Demographic Subpopulations: Black Males, Black Females, and White Males – including cross-representation with MSM risk categories)

The CHPG remains confident that access to clean needles and syringes is a necessary component for HIV prevention among IDUs; however, current Virginia paraphernalia laws prevent the implementation of syringe exchange programs. While unable to provide syringes, education regarding effective syringe and equipment cleaning and safe injection practices offered in tandem with access to affordable, available and culturally competent mental health and substance abuse resources can reduce the incidence of unsafe injection practices which pose the greatest risk of transmission of any identified risk category.

Transgender Individuals (Demographic Subpopulations: Male-to-Female)

The inability to rank Transgender individuals in relationship to other populations is due to two main challenges; (1) this population is demographically defined and may actually be engaging in any of the above behavioral risk categories and (2) no commonly accepted method of data collection or population estimation is agreed upon by national experts. Without valid data upon which to make a measured evaluation, the CHPG was unable to rank this population using the same methodology for other high incidence populations. Instead, this ranking is based upon input from knowledgeable and recognized key informants from this population as well as population service providers and advocates coupled with what data was available. The CHPG is committed to continued advocacy for and dissemination of meaningful, valid, and usable data as well as advocacy for increased and improved data collection processes and projects related to Transgender individuals. Similar to MSM, the CHPG membership believed that Transgender individuals are more likely to feel isolated which results in increased risk behavior. Education regarding the risks associated with unsafe injection practices for hormone replacement therapy, non-medically administered silicone, self-medication and unsafe injection practices are all needed in addition to traditional HIV sexual risk behavior information and interventions. In addition, specific capacity for providers is key to ensuring that Transgender individuals who seek care are appropriately treated by providers regarding specific needs and risks.

Needs Assessment & Gaps Analysis

The narrowing of 10 target populations (based on the 2008 Plan) into five provided a framework that allowed for a more measured, targeted, and appropriate planning process. The CHPG membership believed a focus on behaviors with demographic subpopulations with high and disproportionate incidence would align statewide planning efforts and subsequent program implementation with more recent evidence and literature related to behavioral indicators of disease morbidity rates.

Identifying Risks and Unmet Needs of Target Populations

The CHPG reviewed unmet needs from the 2008 Comprehensive Plan and the programmatic outcomes meant to address them. Membership then applied five categories utilized by the Michigan HIV/AIDS Council to identify and organize target population needs. The categories are defined as follows:

Knowledge: Individuals have a knowledge-related need when they have inadequate or incorrect information about HIV (e.g., routes of transmission or the importance of retention in care).

Persuasion: Individuals have a persuasion-related need when they have accurate and complete knowledge about HIV but do not or cannot act on that knowledge. Persuasion-related needs often refer to how someone feels about behaviors (e.g., I hate using condoms, they just don't feel good).

Skills: Individuals have skills-related needs when they are unable to discuss or implement risk reduction strategies (e.g., I don't know how to talk to my partner about safer sex or I am unsure how to disclose my positive status to a potential sexual partner).

Access: Individuals have access related needs when they have difficulty obtaining materials, tools and/or services. Access refers to the practical matter of obtaining materials (educational materials, sterile injection equipment), or supportive services HIV counseling and testing or Partner Services). Access also encompasses the cultural, linguistic, and developmental competence of prevention materials, tools, services, and providers.

Supportive

Norms: Individuals have the need for more supportive community norms when they are unable to initiate or sustain safer behaviors because other people in their community do not value those behaviors (e.g. stigma reduction across all communities).

These categories allowed the CHPG to group and categorize the core need behind statements documented during brainstorming activities. For example, a need that was initially stated as “some PLWHA don’t inform their partners of their status because they don’t know how to do so” would be categorized as a “Skills” need and labeled as “Disclosure Skills” during this process. The CHPG broke into small groups over several meetings to generate needs for each target population. Small groups presented their lists to the full CHPG for review and feedback on additional needs for inclusion or clarification on the needs identified. VDH staff then consolidated overlapping needs and attempted to standardize how the needs were expressed. Some needs were moved from one category or another to better fit the category description.

This process of filtering statements into comparable categories allowed for the subsequent qualitative evaluation of needs statements in order to accurately compare and report identified gaps in prevention services. These needs were then grouped and those needs which could be addressed through prevention services were presented for further analysis by the CHPG membership.

Assessing the Status of Needs and Ranking Unmet Needs

The CHPG reviewed three models to determine how best to prioritize needs and reached consensus on using a two-step process: 1) criteria-based scoring (completed in small groups) followed by 2) multiple-votes technique (completed individually). This process allowed the CHPG to perform a quantifiable and objective review of the needs.

Step One - Criteria-Based Scoring (completed in small groups)

The CHPG broke into small groups to rank the needs of each population. The results of the group work were compiled by CHPG membership facilitators and VDH staff and the highest-ranked needs were documented for each of the evaluated populations. The four criteria were:

- How *directly* does this need impact HIV transmission?
- To what extent is this need *currently* being addressed or met?
- Does this need address a specific subpopulation *at increased risk for HIV*?
- Does this need address the needs of *multiple populations*?

Step Two – Multiple-Votes Technique (completed individually)

Each CHPG member received one worksheet per evaluated population with the highest ranking needs from the Criteria-Based Scoring. Each member was given multiple votes per population to spread out amongst the needs they believed, based on the presented qualitative data, were the most important. Members could use as few or as many votes from their allotment as they desired on the list of needs.

The top unmet needs voted upon by the CHPG membership and organized by evaluated population, are listed below.

Ranked Unmet Needs by Evaluated Population

The CHPG membership identified two key needs that are applicable to all evaluated populations: (1) HIV education and (2) Culturally appropriate services – including linguistically appropriate services. The presented lists of unmet needs are not ranked in any particular order.

People Living With HIV/AIDS

- Linkage and Retention to HIV Care
- Strategies to Improve Adherence to Antiretroviral Therapy (ART)
- Disclosure Skills
- Basic HIV Disease Information and Terminology
- Condom Use and Negotiation Skills
- Stigma-Reducing Initiatives (internal and external to the population)
- Information about Available Services/Resources/Eligibility/Safe Places
- PLWHA Empowerment Strategies
- Knowledge and Experience of HIV as a Chronic/Manageable Disease

Men who have Sex with Men

- Improved Personal and Communal Responsibility for HIV Prevention and Transmission Relationship of Substance Use Risk Conditions to HIV and STI transmission
- Strategies to Address Internalized Homophobia
- Supportive Families and Institutions in Marginalized Communities to Combat Homophobia
- Negotiation and Communication Skills Pertaining to Condom Use, Sexual Risk Taking and Setting Limits
- Relationship of Low Self-Esteem, Isolation, and Marginalization to Sexual Risk Taking

High-Risk Heterosexuals

- Faith Community Involvement in Combating Stigma and Reorienting Community
- Norms for Testing, Disclosure and Support; Especially in Black/African-American Communities
- Adolescent Rights to Appropriate and Accessible HIV Education, Testing and Care
- Comprehensive HIV Prevention Education for Adolescents; Especially in Schools
- Stigma-Related Barriers in Relationship to HIV Transmission, Late Testing, and Poor Rural Access to Care
- Importance of HIV Testing for Pregnant Women and Continued Prevention of Perinatal Transmission

- Empowerment of Women in Order to Take Responsibility for Condom Use

Injection Drug Users

- Increased Availability of Publicly-Funded Substance Abuse and Mental Health Treatment Services
- Sterile Syringe and Injection Equipment Resources
- Harm Reduction Skills Including Safer Injection Practices and Appropriate Cleaning Methods for Syringes/Injection Equipment
- Work to Decriminalize Possession of Paraphernalia

Transgender Individuals

- Knowledge of Risks Associated with Non-Medically Monitored or Supervised Hormone Replacement, Silicone Usage, and Self-Medication
- Reorienting Internal Community Beliefs Affirming Gender Through Sexual Behavior
- Safe Injection Practices
- Improved Medical Provider Capacity to Screen and Treat for Prevalent HIV Risk Conditions in the Trans-Community (e.g. Lethal Industrial Grade Silicone Usage)

Existing Resources

VDH re-organized the Resource Inventory in 2011 in order to better reflect the National HIV/AIDS Strategy and the changes in CDC's grant program. The inventory (included as Attachment B) provides information about programs available in 2011 and 2012 and is separated into five spreadsheets:

1. HIV Testing
2. High-Risk Negatives
3. Comprehensive Prevention for Positives
4. Public Information
5. Community Mobilization/Condom Distribution

The inventory is then organized first regionally and then by agency listing the programs and services that are being offered, funded target populations, and related scale of intervention reach. The accuracy depends heavily on agencies submitting current and timely information. This inventory is not necessarily comprehensive; however, it is the belief of VDH that despite the incomplete scope of the information, it does provide an accurate snapshot of most available services. As an addition the Division of Disease Prevention's (DDP) online resource and referral database showing HIV services and organizations in Virginia is included as Attachment C. Together these two documents present the most accurate and available information on the location, scope, and availability of known HIV-related services in the Commonwealth.

Prevention Activities and Strategies

The CHPG membership convened to review current interventions (Attachment D) organized by target population (Attachment E) and to evaluate the efficacy of these interventions to reduce new HIV incidence and ensure that PLWHA receive optimal care. Discussions were guided by criteria established from the National HIV/AIDS Strategy and FOA PS 12-1201 including:

- Need to scale-up interventions for PLWHA.
- Ensure culturally appropriate interventions and services are available for HIV negative persons at highest risk for HIV including: including MSM, Blacks, Latinos, Injection Drug Users, and Transgender persons.
- Fund effective interventions that can reach a sufficient number of people in order for the diffusion of HIV prevention behaviors to occur in targeted populations. This will entail: 1) decreasing group and individual multi-session interventions, and 2) increasing community-level and single session interventions.
- Utilize a mix of individual and group level interventions to keep PLWHA engaged in care and adherent, and to retain disclosure skills.
- Ensure all Virginians have access to local HIV testing and treatment resources that are culturally acceptable, affordable and offer the highest standards of care.
- Reduce stigma and discrimination associated with HIV status and sexual orientation that serve as barriers to HIV testing and treatment.
- Increase number of PLWHA diagnosed early in the disease process, linked to, and retained in HIV care.
- Collaborate with HIV Care Services (HCS) to increase number of PLWHA receiving prevention and care services in supportive environments in order to achieve an undetectable viral load.

Recommended Interventions and Services by Population

Interventions and Services Recommended for People Living with HIV

- HIV Counseling, Testing and Referral (Undiagnosed)
- Partner Notification Services
- Referral and Linkage to Mental Health and Substance Abuse Assessment and Services
- Linkage and Retention in Care Strategies
 - Anti Retroviral Treatment and Access to Services (ARTAS)
 - Patient and Peer Navigation
 - Use of New Media (texting etc.) to assist with retention in care
- Medication and Treatment Adherence Counseling and Support
- Comprehensive Risk Counseling and Services (CRCS)

- Referral and Linkage to Housing Services
- Behavioral Interventions:
 - CLEAR
 - Healthy Living Project
 - Healthy Relationships
 - Together Learning Choices (TLC)
 - WILLOW
- Condom Distribution
- Use of Social Media to promote awareness of services
- Information and Referral Services (hotline, searchable resource and referral database)
- Social Marketing Campaigns to address HIV stigma and promote HIV care

Interventions and Services Recommended for HIV Negative Persons and Those with Unknown HIV Status by Population

Men Who Have Sex with Men

- HIV Counseling, Testing and Referral
 - More frequent testing needed for sexually active men
- Partner Services
- Behavioral Interventions
 - CLEAR
 - Community Promise*
 - D-Up! (young Black gay men)
 - Many Men, Many Voices (Black gay men)
 - MPowerment*
 - Popular Opinion Leader
 - RISE
 - Personalized Cognitive Counseling
- Condom Distribution
- Use of Social Media, Marketing Campaigns and Community Mobilization to
 - Promote HIV testing
 - Address HIV stigma and discrimination
 - Create community norms around holistic health care, condom use, etc.
- Information and Referral Services (hotline, searchable resource and referral database)
- Outreach
 - Both Traditional and On-line

*CHPG members noted that the community-level interventions Community Promise and MPowerment require a large investment of resources and staff. These interventions can be difficult for small agencies and/or agencies in rural areas to implement.

High Risk Heterosexuals*

- HIV Counseling, Testing and Referral
- Partner Services
- Behavioral Interventions
 - Community Promise
 - Nia
 - Popular Opinion Leader
 - Real AIDS Prevention Project
 - RESPECT (single session)
 - Safe in the City
 - SISTA
 - VOICES/VOCES
- Condom Distribution
- Use of Social Media, Marketing Campaigns
 - to promote HIV testing
 - to address HIV stigma and discrimination
- Community Mobilization
 - to engage African Americans
 - to encourage African American clergy and congregations to combat HIV stigma
- Information and Referral Services (hotline, searchable resource and referral database)
- Outreach

*CHPG members noted the lack of effective behavioral interventions for older adults (50+); however, this population was not selected as a priority population within the jurisdictional plan. The CHPG also noted a lack of culturally competent interventions for Latinos. The CHPG and HIV prevention contractors discussed that while SISTA and Nia are group-level, multiple session interventions, they offer opportunities to recruit individuals for HIV testing. SISTA remains in demand among African American women, and Nia is the only group-level intervention available for African American men who have sex with women. Given the disproportionate burden of HIV among these populations, DDP will continue to support these interventions; however, funds for these interventions have been reduced. Both criticism and praise were expressed by the CHPG for the single session interventions Safe in the City and VOICES/VOCES. HIV Prevention contractors report that these interventions are essential recruitment strategies for their HIV testing.

Injection Drug Users*

- HIV Counseling, Testing and Referral
- Partner Services
- Information and Referral Services (hotline, searchable resource and referral database)
- Outreach
- Condom Distribution
- Referral and Linkage to Mental Health and Substance Abuse Assessment and Services especially among PLWHA and individuals being released from incarceration
- Hepatitis B and C screening

*No specific behavioral interventions were recommended by the CHPG. CHPG members noted an ever shifting landscape related to types of substances being used, how drugs are used, use versus abuse, population and geographic differences etc. These factors create challenges for making recommendations or critiquing a menu of interventions that may or may not be relevant to injection drug users and other substance users at risk for HIV infection. There is great variability in the capacity of peers and outreach workers in the areas of harm reduction (safe injection practices, accessing clean needles without syringe exchange programs, motivational interviewing, stages of change etc.) The group recommended that a more in-depth needs assessment and analysis of services be conducted before measured recommendations can be made.

Transgender Persons

- HIV Counseling, Testing and Referral
- Partner Services
- Information and Referral Services (hotline, searchable resource and referral database)
- Outreach
- Referral and Linkage to Mental Health and Substance Abuse Assessment
- Condom Distribution
- Behavioral Interventions*
 - SISTA Adaptation
 - Voices Adaptation
 - Trans Academy (POL Adaptation)
 - RISE Adaption (proposed)
- Transgender Service Navigation**
 - Work with Transgender communities and service providers to link HIV, health, mental health, employment, housing and other services and assist clients in accessing these services, regardless of HIV status.
- Transgender Cultural Competency Training**

- For HIV prevention and care providers, primary care providers, shelters, mental health and substance abuse service providers, law enforcement and other agencies that may interface with transgender persons.

*CHPG members noted an ongoing concern that there are no effective behavioral interventions developed for transgender persons. All behavioral interventions are adaptations of interventions developed for other populations.

**Transgender persons report pervasive discrimination in many areas that affect health equity including education, housing and employment that negatively impact HIV-related risk taking, prevention, access to health care, HIV testing, linkage to HIV care and retention in HIV care. CHPG also discussed syndemic issues, such as Substance Abuse-Violence-AIDS (SAVA), particularly noting that transgender persons, or persons perceived to have gender variance, are very disproportionately victimized by violence, with few or no services for transgender survivors of violence, that impact mental health and substance use/abuse.

Scalability of Activities

Through HIV Prevention contracts, VDH is ensuring delivery of high-impact HIV prevention services. Each Contractor is assigned a Contract Monitor who offers guidance, ensures fidelity to model implementation, and provides oversight to the programs. Although ultimate responsibility for program outcomes lies with the Contractor, Contract Monitors are charged with ensuring that each agency receives the technical assistance and guidance necessary to succeed and that state resources are effectively and appropriately utilized at the local level in accordance with the CHPG planning priorities. Each Contractor is required to collect and report on outcomes for every intervention they implement.

Division of Disease Prevention 2013 projected scale*	
	Number of individuals to be reached
Interventions	
MSM	14,697
High Risk Heterosexuals	52,281
Injection Drug Users	1,400
Transgender Individuals	1,275
Incarcerated	494
Post-Incarcerated	166
LGBTQ Youth	3,690
Homeless	452
Non-specific negatives	250
Prevention for Positives (PLWHA)	4,134
Total	78,839
HIV Testing	
HIV Tests Projected in 2013-2014	66,250
Number of tests by key population**	
MSM	4,607
High Risk Heterosexuals	54,091
Injection Drug Users	928
Transgender Individuals	137
Incarcerated Testing	2,241
Projected condoms to be distributed in 2013-2014	1,750,000
*Numbers may be duplicated as individuals may receive services from multiple reporting agencies.	
** Tests broken out by key population will not account for the total of tests to be performed.	
Numbers may also be duplicated as individuals may fit under more than one category.	

Relevant Goals & Timelines

VDH developed the following HIV prevention goals to be responsive to priorities and needs identified in conjunction with the CHPG and other stakeholders, and to support Virginia's response to the National HIV/AIDS Strategy (NHAS). These strategies will be implemented over the grant period (2012-2016) and will be monitored and updated no less than annually. Specific measurable objectives are included in the Comprehensive Program Plan that is submitted to CDC as a part of the Virginia PS12-1201 annual grant application and are available by contacting Elaine Martin at Elaine.Martin@vdh.virginia.gov.

National HIV/AIDS Strategy Goal 1 - Reduce new HIV infections

- Lower the annual number of new infections by 25%
- Reduce HIV transmission by 30%
- Increase the percentage of PLWHA who know their serostatus from 79% to 90%

NHAS Goal 1, Step 1: Intensify HIV prevention efforts in the communities where HIV is most heavily concentrated.

Virginia Strategies:

- Increase the availability of Counseling, Testing, and Referral Services to demographic populations with disproportionate HIV incidence and those known to be at highest risk (Transgender Male-to-Female, MSM, IDUs, African Americans, and Hispanics)
- Increase opportunities to provide Partner Services through enhanced collaboration with community-based partners.
- Increase the number of STI patients who are screened for HIV and notified of results.
- Increase number of HIV tests conducted through the Expanded Testing Program sites (both clinical and non-clinical settings).
- Expand availability of prevention services in Northern Virginia to better align with burden of the HIV epidemic in Virginia.
- Expand testing opportunities for Latinos in order to facilitate earlier diagnosis and linkage to care.
- Expand HIV prevention services for PLWHA including adherence counseling for ART and other approaches that support clients in retention to clinical care with the goal of achieving sustained viral load suppression.
- Increase the availability of condoms for PLWHA and populations and jurisdictions at increased risk of infection.
- Provide access to resources for HIV post-exposure prophylaxis medications for individuals who experience an unprotected sexual act and cannot otherwise afford the medications.

NHAS Goal 1, Step 2: Expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches.

Virginia Strategies:

- Address the lack of long-term sustained HIV prevention service infrastructure in the Northern Virginia region through the provision of capacity building and guidance on resource allocation to ensure high impact outcomes.
- Conduct a review of current efforts to address risk behaviors and conditions in IDU populations to inform intervention selection.
- Provide clinical training for physicians on pre-exposure prophylaxis (PrEP) for MSM at high risk of contracting HIV/AIDS as well as non-occupational post-exposure prophylaxis (nPEP).
- Increase funding for, and enhance existing, HIV prevention services for young Black MSM including behavioral interventions, expanded access to condoms, and improved collaboration among providers to ensure retention in care.

NHAS Goal 1, Step 3: Educate all Americans about the threat of HIV and how to prevent it.

Virginia Strategies:

- Educate all Virginians about the threat of HIV, the ways it is transmitted, and how to prevent it using culturally-appropriate methods.
- Utilize social media to provide education and service availability information to Virginians about HIV to normalize and promote HIV testing.
- Provide HIV information specifically to youth utilizing communication styles to which they are most responsive (social media, text messaging, etc.).
- Use trained PLWHA as speakers to engage and inform communities on the real world impact of living with HIV.

National HIV/AIDS Strategy Goal 2 - Increase access to care and improve health outcomes for people living with HIV

- Increase the proportion of newly diagnosed patients linked to clinical care from 65% to 85%
- Increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care from 73% to 80%
- Increase the number of Ryan White clients with permanent housing from 82% to 86%

NHAS Goal 2, Step 1: Establish a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV.

Virginia Strategies:

- Build the capacity of Disease Intervention Specialists to facilitate active linkages to care and other services
- Improve linkages of newly diagnosed and/or lost to care HIV-positive individuals to HIV care services.
- Utilize new HIV testing protocols to immediately link HIV-infected individuals to HIV care (i.e. rapid-rapid testing algorithms).
- Utilize surveillance reporting to better identify individuals who are lapsing in their care.
- Expand and increase use of health system navigation services and Anti-Retroviral Treatment and Access to Services (ARTAS) to improve retention efforts.
- Ensure data collection and security measures are in place to accommodate increased data tracking and reporting needs for tracking linkages to care.

NHAS Goal 2, Step 2: Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV.

Virginia Strategies:

- Increase testing in both clinical sites and non-clinical settings.
- Identify opportunities such as scholarships, grants, and financial incentives that will allow providers who are not infectious disease specialists, e.g., primary care, substance abuse, mental health, and oral health providers, to be trained to provide HIV prevention services to their patients.
- Expand opportunities for healthcare provider trainings on the provision of care to sexual and behavioral minorities at risk for HIV (e.g., Transgender, MSM, and IDU) to increase the likelihood that patients will have open, honest communications with providers and be retained in care.
- Through the CHPG, collaborate with HIV Care Services to identify barriers and solutions to increasing the number of culturally competent providers in both urban and rural areas.
- Work to reduce barriers for CHCs to facilitate additional primary care and HIV medical care for PLWHA.

NHAS Goal 2, Step 3: Support people living with HIV with co-occurring health conditions and those who have challenges meeting their basic needs, such as housing.

Virginia Strategies:

- Continue supporting medication access through PAPs, ADAP, PCIP, etc. to ensure clients do not go without medications due to lack of funds.
- In collaboration with HIV Care Services expand state-funded housing resources for PLWHA.

- Promote the Virginia HIV/STD/Viral Hepatitis Hotline to the community as resource for the identification of health and support service resources.
- In collaboration with HIV Care Services, provide education, training, and support to PLWHA (and the agencies providing them with services) to enable them to obtain health insurance and to utilize expanded preventive care options as a whole as they become available through the Affordable Care Act.
- Collaborate with HCS and state agency partners to make substance abuse and mental health services more available and accessible to PLWHA.

<p>National HIV/AIDS Strategy Goal 3 - Reduce HIV-related health disparities</p> <ul style="list-style-type: none"> • Improve access to prevention and care services for all Americans • Increase the proportion of HIV-diagnosed gay and bisexual men with undetectable viral load by 20% • Increase the proportion of HIV-diagnosed Blacks with undetectable viral load by 20% • Increase the proportion of HIV-diagnosed Latinos with undetectable viral load by 20%
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NHAS Goal 3, Step 1: Reduce HIV-related mortality in communities at high risk for HIV infection.

Virginia Strategies:

- Increase the number of persons who know their HIV status by increasing the availability, accessibility and acceptability of HIV testing to all Virginian’s who engage in high risk behaviors.
- Increase access to HIV, STI and viral hepatitis testing, treatment, care and support services in Virginia.
- Support integration of HIV testing and prevention services for Hepatitis, STIs, and TB in non-healthcare settings by seeking opportunities for collaboration on large and small scales.
- Continue to support and expand re-entry programs to ensure linkages to care and services for individuals newly released from incarceration and other state custody and support public health solutions to reduce recidivism.
- Increase the capacity of CBO’s to implement interventions and strategies (such as ARTAS) that encourage engagement and retention in care.
- Working with HIV Care Services, seek innovative methods to improve HIV primary care service delivery in areas that are medically underserved, by implementing techniques such as tele-medicine, mobile testing and care units, and expanding medical providers skilled in HIV treatment in those areas.
- Collaborate with agencies that provide socio-economic, educational, developmental, parenting and other skill development to improve the lives of persons living with HIV.

NHAS Goal 3, Step 2: Adopt community-level approaches to reduce HIV infection in high-risk communities.

Virginia Strategies:

- Encourage the broadening of programs for incarcerated individuals to include those on probation and parole through partnerships with probation and parole districts
- Utilize improvements in electronic laboratory reporting and electronic medical record transmission to assess community viral load for utilization in prevention planning efforts.
- Increase community mobilization amongst disproportionately impacted populations.

NHAS Goal 3, Step 3: Reduce stigma and discrimination against people living with HIV.

Virginia Strategies:

- Require HIV prevention contractors to include stigma reduction strategies in their work plans.
- Provide training to prevention and care providers on how to incorporate stigma reduction in all aspects of their programs and services.
- Deliver HIV/STI prevention messages through a variety of media to encourage/normalize HIV testing and treatment; reduce HIV risk among high risk populations; and to promote availability of services.
- Improve and expand public education and stigma reduction activities, such as HIV Stops with Me, in rural areas.

Appendix: Mid-Year Progress on Prevention Goals
January 1, 2013-June 30, 2013

NHAS GOAL 1, STEP 1- INTENSIFY HIV PREVENTION EFFORTS IN THE COMMUNITIES WHERE HIV IS MOST HEAVILY CONCENTRATED.

VIRGINIA'S PROGRESS:

In the first half of 2013, the Division of Disease Prevention (DDP) focused on the expansion of HIV testing, partner services and condom distribution in order to intensify prevention activities in areas with high HIV incidence. A special focus was given to increasing services in the Northern Health region, where prevention resources are lacking. The Northern Health region lies within the Washington, DC metropolitan area and has the second highest prevalence rate for HIV in the state with approximately 7,100 persons in the region living with HIV. Of particular concern is the Latino population living in the Northern Health Region due to a history of late-stage HIV diagnosis at their first positive HIV test. Other strategies for addressing prevention efforts include increasing access to non-occupational post-exposure prophylaxis (nPEP) and adherence services for persons living with AIDS/HIV (PLWA/H).

STRATEGY AND ACTIVITIES:

Increase the availability of CTR to demographic populations with disproportionate HIV incidence and those known to be at high risk.

Progress:

- CAPUS grant enables DDP to increase Counseling Testing and Referral services (CTR) in high poverty/high minority communities in VA.
- Expanded testing program has allowed increased access to free testing through community health centers and CSB's. New contractors brought on board include: Virginia Beach CSB, FAHASS (testing at community health centers) and Albemarle County Regional Jail. Testing is being increased at Riverside Regional Jail, Horizon Behavioral Health and the University of Virginia.
- Request for Proposals (RFP) for men who have sex with men (MSM) grant in NOVA was awarded to a contractor that provides prevention and CTR to Latino MSM and transgender Latino women.

Increase opportunities to provide Partner Services through enhanced collaboration with community-based partners.

Progress:

- Expanded Community-Based Organization (CBO) partner service providers offering partner services by adding one agency in the Northwest Health Region.
- DDP providing trainings for other CBOs to enable them to provide partner services in 2014.

Increase the number of STI patients who are screened for HIV and notified of results.

Progress: Data forthcoming

Increase number of HIV tests conducted through Expanded Testing Program sites (both clinical and non-clinical)

Progress:

- Added two clinical sites in first half of 2013
 - one Emergency Room in Northwest Health Region
 - one Regional Jail also in the Northwest Health Region.
- New testing targets set for current grantees with quarterly feedback being provided to assess program progress. In 2012, the number of tests provided through the Expanded Testing Program increased by more than 2,000 tests.

Expand the availability of prevention services in Northern Virginia to better align with the burden of HIV epidemic in Virginia.

Progress:

- Award of MSM grant in Northern Health Region.
- Contractual agreement with INOVA Juniper in Northern Health Region to continue prevention services offered by a contractor that closed in 2013.
- Award of additional MSM dollars to support Rainbow Collective for community mobilization in Northern Virginia
- New Comprehensive HIV/AIDS Resources and Linkages for Inmates (CHARLI) contract awarded in Northern Virginia.
- Funding provided to Rainbow Tuesday's Clinic in Northern Health Region (Alexandria VA) to support Chlamydia and Gonorrhea NAAT for rectal/pharyngeal specimens.

Expanded testing opportunities for Latinos in order to facilitate earlier diagnosis and linkage to care.

Progress:

- Award to contractor providing services to Latino population in Northern Health Region.
- Focus on Latino testing and patient navigation services in Northern Health Region for CAPUS grant.

Expand HIV prevention services for PLWHA including adherence counseling for Anti-Retroviral Treatment (ART), and other approaches that support client in retention to clinical care with the goal of achieving sustained viral load suppression.

Progress:

- Supported Anti-Retroviral Treatment and Access to Services (ARTAS) training for state contractors.
- CAPUS- patient navigation focused on retention in care services.
- SPINS- patient navigation focused on retention in care services.
- SPNS PNs have been trained on HIV medical and life cycle; HIV treatment and adherence; Sexually Transmitted Infections (STIs); Motivational Interviewing and client centered approaches; assessing barriers to care; field safety; rapid HIV testing; self-care; and client perspectives. During this grant year, VDH also incorporated two additional components to the Patient Navigation training including enhanced Motivational Interviewing training and Fidelity Monitoring to evaluate the effectiveness of Motivational Interviewing skills in the Patient Navigation model.

- In negotiation with VCU/MCV for traveling adherence counselor for medical sites off of the main VCU campus.
- Funding for “Prevention for Positives” services will have tripled from 2011 to 2014.

Increase the availability of condoms for PLWHA and populations and jurisdictions at risk of infection.

Progress:

- Increased the amount of condoms distributed in the state by 30% over previous year. This percentage is projected to increase over the next two years with a target of doubling the number of condoms distributed by health department, prevention and care providers and community partners from baseline of 2,000,000 condoms to 4,000,000 condoms.

Provided access to resources for HIV nPEP medication for individuals who experience an unprotected sexual act and cannot otherwise afford the medication.

Progress:

- Developed information for web site that links to funding sources for victims of sexual assault- in approval process now.
- Working with AID Education and Training Centers (AETC) to develop a tutorial for emergency room clinicians.

NHAS GOAL 1, STEP 2: EXPAND TARGETED EFFORTS TO PREVENT HIV INFECTION USING A COMBINATION OF EFFECTIVE, EVIDENCE-BASED APPROACHES.

VIRGINIA’S PROGRESS:

Virginia’s strategies to expand evidence-based approaches to HIV prevention include a regional and population specific approach. Problems with sustained prevention efforts in the Northern Health Region, which were previously discussed, are being systematically addressed by DDP. While more providers of prevention services are still needed in that region, capacity building efforts by DDP are showing progress toward increasing the amount and variety of services being provided. Prevention services focused on MSM in the northern region and statewide have also been a focus of DDP in the first half of 2013. Strides have been made engaging young Black MSM in prevention and planning efforts statewide and engaging Latino MSM in the northern region. CAPUS funding focused on care and prevention for minority populations, SPNS focused on retaining PLWH/A in care and a directly-funded CDC prevention contractor in the Eastern health region all enhance DDP’s efforts to reach MSM PLWH/A and high-risk negative MSM, particularly MSM of color.

STRATEGY AND ACTIVITIES:

Address the lack of long-term sustained HIV prevention service infrastructure in the Northern Virginia region through the provision of capacity building and guidance on resource allocation to ensure high impact outcomes.

Progress:

- The award of a Northern Health Region grant to focus on MSM
- Continuation of services by contracting with INOVA Juniper to assume services provided by a contractor that closed.

Conduct a review of current efforts to address risk behaviors and conditions in IDU populations to inform intervention selection.

Progress:

- DDP is participating in NASTAD project focused on prevention services for IDUs
- IDU specific work group in formation in collaboration with CHPG.

Provide clinical training for physicians on pre-exposure prophylaxis (PrEP) for MSM at high risk of contracting HIV/AIDS as well as non-occupational post-exposure prophylaxis (nPEP).

Progress:

- nPEP training materials/curriculum and funding sources in progress with collaboration by AETCs

Increase funding for, and enhance existing, HIV prevention services for young Black MSM including behavioral interventions, expanded access to condoms, and improved collaboration among providers to ensure retention in care.

Progress:

- CDC directly funded project in Norfolk addressing YBMSM,
- Increase the number of YBMSM that participate in the planning process both on CHPG and DDP's work group THU FAM.
- Expanding funding for MSM programs throughout the state.
- CAPUS and SPNS patient navigation address YBMSM in care.
- Increased HIV testing in areas disproportionately affected by HIV, targeting minority populations at high-risk.
- Input from CDC directly funded prevention project at CHPG meetings for planning purposes.
- SPNS PN is being expanded to Lynchburg, an underserved high-minority population area of the state.

NHAS GOAL 1, STEP 3: EDUCATE ALL AMERICANS ABOUT THE THREAT OF HIV AND HOW TO PREVENT IT.

VIRGINIA'S PROGRESS:

DDP has made substantial progress toward the goal of providing educational materials to Virginians during the first half of 2013. DDP is in the progress of updating educational brochures and has competed informing people about STDs. The brochure in HIV testing, designed to educate individuals about the different types of testing available, and why HIV testing should be a part of regular health care screening is in the final approval process. DDP's social media campaigns for all awareness days appear on the department's Facebook page and

are distributed to contractors for use as educational tools for their communities. CHPG members have been presented with information on effective prevention programs, Virginia's treatment cascade, the Affordable Health Care Act and other topics in order for them to disseminate that information back in their communities as well.

DDP has offered capacity building assistance and training for contractors on using new technology, such as phone apps to reach targeted populations in order to educate and encourage participation in testing and prevention activities. Community mobilization efforts with young Black MSM also have educational components in order to have peers teach peers on topics regarding HIV and HIV testing.

VIRGINIA'S STRATEGIES AND ACTIVITIES:

Educate all Virginians about the threat of HIV, the ways it is transmitted, and how to prevent it using culturally-appropriate methods.

Progress:

- Updating brochures at DDP on Sexually Transmitted Diseases and HIV testing.
- Facebook page for DDP/Hotline provide general education on HIV and HIV testing.

Utilize social media to provide education and service availability information to Virginians about HIV to normalize and promote HIV testing.

Progress:

- Facebook pages for DDP have highlighted awareness day campaigns.
- Trainings on social media techniques and technology at contractors meetings and CHPG.
- Kaiser Family Foundation/CDC Greater than AIDS campaign, utilized by DDP and its contractors, helps normalize HIV testing.

Provide HIV information specifically to youth utilizing communication styles to which they are most responsive (social media, text messaging, etc.).

Progress:

- Trainings at contractors meetings on phone apps used by MSM in order to inform them about HIV testing events and locations.
- Greater than AIDS campaign is population focused.
- Community mobilization efforts focusing on youth involvement, notably THU FAM, DDP's young Black MSM advisory council.

Use trained PLWHA as speakers to engage and inform communities on the real world impact of living with HIV.

Progress:

- CAPUS engagement meeting used PLWHA to educate the community regarding HIV care and adherence issues.
- Townhall meetings that Care Services and Prevention collaborate on to gather information from PLWHA.

- Community Advisory Committee with SPNS, PLWHA are also involved in the other planning groups, such as CHPG, THU FAM and contractor's advisory groups.

NHAS Goal 2, Step 1: Establish a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV.

VIRGINIA'S PROGRESS:

With the awarding of the CAPUS grant and ongoing SPNS project, DDP has had great success developing data systems that monitor care and developing interventions and strategies that expedite newly diagnosed, (and previously diagnosed but lost to care individuals) into HIV treatment and care. The development and use of the rapid-rapid protocol for HIV testing in community settings is being piloted in selected locations. Monitoring and evaluation of the pilot has shown the protocol to be successful for expediting newly diagnosed patients into care.

Patient navigation (PN) efforts also made possible by CAPUS and SPNS are also showing success in early stage evaluation of keeping PLWHA in care once initially engaged. Training of Disease Intervention Specialist (DIS) at local health departments in providing active referrals to care for clients they encounter also help achieve this goal.

DDP and Care Services have worked in conjunction with HIV Surveillance to develop a comprehensive care marker database that allows VDH to more accurately determine if PLWHA in the state are retained in care. This system also allows VDH to better determine if a client is lost to care or has just changed care providers. The care marker database is instrumental in the development of an accurate treatment cascade for the state.

Virginia Strategies and Activities:

Build the capacity of Disease Intervention Specialists to facilitate active linkages to care and other services.

Progress:

- Provided training on active referrals to DIS to expedite newly diagnosed individuals into care.
- DIS and patient navigation working together under CAPUS and SPNS on partner services.

Improve linkages of newly diagnosed and/or lost to care HIV-positive individuals to HIV care services.

Progress:

- PN is a retention strategy in both CAPUS and SPNS grants, and is now available in all five health regions.

- SPNS began with PN services in Central and Southwest (Roanoke) in 2013, expansion for SPNS will be with Centra Health in Lynchburg.

Utilize new HIV testing protocols to immediately link HIV-infected individuals to HIV care (i.e. rapid-rapid testing algorithms).

Progress:

- Rapid/rapid algorithm was developed and implemented using the Plan, Do, Study, Act approach in one test site.
- Expansion to other sites to follow in late 2013/early 2014.

Expand and increase use of health system navigation services and Anti-Retroviral Treatment and Access to Services (ARTAS) to improve retention efforts.

Progress:

- Development of a data system (Care Marker Data System) that combines existing systems into one for enhanced analysis.
- ARTAS training provided by DDP in July 2013
- Development of care continuum (treatment cascade) to monitor progress on goals.
- New internal DDP process to identify whether newly diagnosed individuals were linked to care

Ensure data collection and security measures are in place to accommodate increased data tracking and reporting needs for tracking linkages to care.

Progress:

- Care and Surveillance are developing/have developed protocols with new care marker database to insure confidentiality of patient data.
- VDH protocols for system security have been implemented.
- New Care Coordination Agreements in use in SPNS sites allows client to consent to patient navigation and lost to care services.

NHAS Goal 2, Step 2: Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV.

VIRGINIA'S PROGRESS:

In the first half of 2013, DDP has shown an increase in HIV testing services compared to the same time period in the previous year. Testing increases have occurred in both clinical and non-clinical sites. Expanded testing initiatives are offering diversity in clinical testing settings by adding regional jails, emergency rooms, mental health and substance abuse treatment centers and community health care centers as contractors.

Educational efforts for care providers are offered in collaboration with AETCs in Virginia. DDP is currently working with AETCs to provide care providers with easy reference materials for nPEP. Strategies are being developed to expand educational efforts with clinicians to encompass topics related to culturally competent care for targeted populations.

Virginia Strategies and Activities:

Increase testing in both clinical sites and non-clinical settings.

- HIV testing has increased approximately 7% at mid-year 2013, when comparing to first six-months of 2012.

Identify opportunities such as scholarships, grants, and financial incentives that will allow providers who are not infectious disease specialists, e.g., primary care, substance abuse, mental health, and oral health providers, to be trained to provide HIV prevention services to their patients.

- DDP and Care Services have disseminated educational opportunities for care providers to become more educated on HIV topics via email announcements of upcoming webinars.
- AETC's have provided provider trainings on HIV in early 2013.

Expand opportunities for healthcare provider trainings on the provision of care to sexual and behavioral minorities at risk for HIV (e.g., Transgender, MSM, and IDU) to increase the likelihood that patients will have open, honest communications with providers and be retained in care.

- Strategies for the provisions of these trainings are currently under review.
- DDP's Transgender health expert will be speaking at a training for health care providers and non profits in November 2013.
- DDP will continue to offer the course, Addressing Sexual Diversity in HIV/STD Service delivery to its own staff and to community partners annually.

Through the CHPG, collaborate with HIV Care Services to identify barriers and solutions to increasing the number of culturally competent providers in both urban and rural areas.

- CAPUS engagement exercise
- Funding in CAPUS to support health care provider assessment and training.

Work to reduce barriers for CHCs to facilitate additional primary care and HIV medical care for PLWHA.

- Insurance Specialist Position in HIV Care Services, to help with implementation of Affordable Care Act.

NHAS Goal 2, Step 3: Support people living with HIV with co-occurring health conditions and those who have challenges meeting their basic needs, such as housing.

VIRGINIA'S PROGRESS:

Support services for PLWHA in Virginia have been enhanced through collaborative effort between DDP and Care Services. VDH has also addressed changes forthcoming with the Affordable Care Act and Medicaid Expansion impact on HIV care for Virginians. Several

learning session have been offered throughout the state for clients and contractors on the changes expected. PN under CAPUS and SPNS have also been trained to aid clients with insurance filing needs when the transition occurs.

DDP is addressing co-infection with Viral Hepatitis and HIV by offering rapid Hepatitis C testing in community settings. DDP's Facebook page has also disseminated information on Hepatitis during awareness month and the HIV/STD hotline is being utilized to answer questions regarding Hepatitis and also recently, Tuberculosis.

Mental health and housing support services are being address through CAPUS and SPNS. CAPUS has a housing component for recently released inmates with HIV that is being piloted at one site in the Eastern region. Mental health infrastructure is a component of SPNS with a focus on the expansion of services for PLWHA. CHPG also has begun exploring mental health services as they apply to prevention for both HIV positive and high-risk negative individuals.

Virginia Strategies and Activities:

Continue supporting medication access through PAPs, ADAP, PCIP, etc. to ensure clients do not go without medications due to lack of funds.

- Ongoing medication access support through ADAP and other medication initiatives such as PAPs.
- ACA and Medicaid expansion trainings throughout state with clients and providers of services
- ADAP waiting list abolished in 2012
- 450 Ryan White/ADAP clients enrolled in Pre-existing Condition Insurance Plan

In collaboration with HIV Care Services expand state-funded housing resources for PLWHA.

- Housing project with CAPUS program for newly-released inmates with HIV being piloted in the Eastern Health Region.

Promote the Virginia HIV/STD/Viral Hepatitis Hotline to the community as resource for the identification of health and support service resources.

- Facebook page
- Facebook and Google ads
- Greater than AIDS advertising will be co-branded with DDP's hotline services
- Hotline utilized for first time to assist with responding to questions from the public about a TB case.
- Survey conducted to determine methods for making the searchable database more user friendly. Alternatives being investigated.

In collaboration with HIV Care Services, provide education, training, and support to PLWHA (and the agencies providing them with services) to enable them to obtain health insurance and to utilize expanded preventive care options as a whole as they become available through the Affordable Care Act.

- Several regional trainings have occurred.
- Education provided to contractors at both care and prevention contractor meetings.
- CHPG presentation on ACA.
- As of August 7, 2013, over 650 stakeholders attended HCS facilitated sessions of the ACA.
- Patient navigators being trained to assist clients with insurance access.

Collaborate with HCS and state agency partners to make substance abuse and mental health services more available and accessible to PLWHA.

- There is a mental health component to SPNS (Central and Roanoke) which seeks to increase the mental health infrastructure to keep clients in care. MH for SPNS is also being expanded to Charlottesville through UVA

NHAS Goal 3, Step 1: Reduce HIV-related mortality in communities at high risk for HIV infection.

VIRGINIA’S PROGRESS:

Virginia’s strategy to reduce HIV-related mortality in communities at high-risk for infection includes increased HIV testing for early identification of HIV, high-impact prevention strategies, increased prevention services for PLWHA, increased access to care and support services for PLWHA, adherence services, addressing co-morbidities and focusing on the psycho-social factors that contribute to the infection and prevent persons from seeking testing and care. Expansion of HIV testing focusing on minority populations at high-risk for infection is greatly enhanced by the CAPUS grant, which will provide new testing sites in areas of high-minority populations and also high-poverty (a social determinant of health that correlates with areas of high HIV prevalence in Virginia).

Virginia Strategies and Activities:

Increase the number of persons who know their HIV status by increasing the availability, accessibility and acceptability of HIV testing to all Virginian’s who engage in high risk behaviors.

- HIV testing has increased 7% in first half of 2013 over the previous year’s numbers,
- Two additional expanded testing sites in clinical setting have been added in 2013.
- Anti-stigma/normalization campaigns have been initiated in several areas of the state and on DDPs Facebook advertising.

Increase access to HIV, STI and viral hepatitis testing, treatment, care and support services in Virginia.

- Expanded testing programs are offering rapid Hepatitis C testing.
- CAPUS testing initiatives in underserved areas will increase access to HIV testing..
- New Hepatitis C testing grant for IDU was awarded to DDP.

Support integration of HIV testing and prevention services for Hepatitis, STIs, and TB in non-healthcare settings by seeking opportunities for collaboration on large and small scales.

- Rapid Hep C testing is occurring at CBOs

Continue to support and expand re-entry programs to ensure linkages to care and services for individuals newly released from incarceration and other state custody and support public health solutions to reduce recidivism.

- CHARLI contract awarded in Northern Health Region expanding services for inmates in that part of the state.
- Increases in federal funding for Virginia have allow expansion of prevention and testing efforts throughout the state.
- Care Coordination program through SPNS which assists clients released with ADAP.

Increase the capacity of CBO's to implement interventions and strategies (such as ARTAS) that encourage engagement and retention in care.

- ARTAS training to be delivered July, 2013 for CBOs
- Patient Navigation in CAPUS, SPNS provides PN services throughout the state.
- Community Health Worker training through IPHI to be offered to other patient navigators throughout the state. Statewide network and support system under development.

Working with HIV Care Services, seek innovative methods to improve HIV primary care service delivery in areas that are medically underserved, by implementing techniques such as tele-medicine, mobile testing and care units, and expanding medical providers skilled in HIV treatment in those areas.

- CAPUS will address some of these issues particularly with testing.
- Examples are implementation of mobile dental van in the Richmond area, telemedicine site at Harrisonburg CHC. There is also development of a telemedicine program in the southern most area of Central which is traditionally underserved.

Collaborate with agencies that provide socio-economic, educational, developmental, parenting and other skill development to improve the lives of persons living with HIV.

- Educational campaign that began with PCIP and expanded to the ACA had components to help talk with clients about health literacy and introducing or re-familiarizing health insurance

NHAS Goal 3, Step 2: Adopt community-level approaches to reduce HIV infection in high-risk communities.

VIRGINIA'S PROGRESS:

Community mobilization efforts have shown good success engaging at-risk populations in HIV prevention strategies. THU FAM is DDP's young Black MSM advisory council which has recently begun mobilization efforts throughout the state to gain input from other young Black MSM who cannot attend regular meetings. Sisters Promoting Hope is a mobilization effort for

African American women to encourage HIV testing and holistic wellness within that population. Recently, Sisters Promoting H.O.P.E. had a health conference which drew many women from all parts of the state to Richmond which resulted in a large number of women getting tested during the event. Trainings were provided for attendees to teach them out to engage other women, particularly minority women in preventative health measures, including HIV testing. Feedback from participants in both mobilization and prevention education strategies is always solicited to improve delivery. Community input helps DDP and its contractors better serve the populations at risk for HIV in Virginia.

Virginia Strategies and Activities:

Encourage the broadening of programs for incarcerated individuals to include those on probation and parole through partnerships with probation and parole districts

- CHARLI includes these populations now

Utilize improvements in electronic laboratory reporting and electronic medical record transmission to assess community viral load for utilization in prevention planning efforts.

- Treatment cascade will give viral suppression data.
- ELR reporting in early stages or implementation.
- Care marker database in place to provide VL data.

Increase community mobilization amongst disproportionately impacted populations.

- Sisters Promoting Hope mobilization effort for African American women.
- THU FAM mobilization effort for young Black MSM.
 - Eastern Virginia and Central Virginia have developed local initiative including safe spaces (i.e. community or drop in centers) that provide both services and social outlets for young Black MSM.
- Upcoming in 2013 trainings on community mobilization at contractor's meeting.

NHAS Goal 3, Step 3: Reduce stigma and discrimination against people living with HIV.

VIRGINIA'S PROGRESS:

Stigma reduction activities have been included as DDP requirements for contractors for the CAPUS grant and the HIV Prevention in Communities of Color grants. Trainings on anti-stigma media campaigns and informal conversations with contractors have been provided at quarterly contractor's meetings. DDP's utilization of the Greater than AIDS campaign and the Women's Empowerment campaign also help address the topic of stigma reduction in the state. DDP has been supportive of various gay pride events throughout the state, supplying the events with wristbands, button, brochures that promote health and empowerment within those communities. CHPG also has begun examining anti-stigma strategies to provide input to DDP.

Virginia Strategies and Activities:

Require HIV prevention contractors to include stigma reduction strategies in their work plans.

- CAPUS work plan requirement
- HPACC workplan requirement

Provide training to prevention and care providers on how to incorporate stigma reduction in all aspects of their programs and services.

- Grantee contractor meetings
- Informal conversations with contractors

Deliver HIV/STI prevention messages through a variety of media to encourage/normalize HIV testing and treatment; reduce HIV risk among high risk populations; and to promote availability of services.

- Greater than AIDS campaign, Women's Empowerment campaign, Pride event campaigns/notices with materials such as wristbands, buttons etc

Improve and expand public education and stigma reduction activities, such as HIV Stops with Me, in rural areas.

- Supporting rural Pride events,
- CAPUS in southern (rural Central, Southwest, rural Eastern) and Northwest Health Regions.