National HIV Behavioral Surveillance (NHBS)
National HIV Behavioral Surveillance (NHBS) is a CDC supplemental HIV surveillance project used to conduct behavioral surveillance among persons at high risk for HIV infection, focusing on three annual cycles: MSM, persons who inject drugs (PWID), and high-risk heterosexuals (HRH). VDH was just awarded the NHBS grant in January 2016; thus, data collection and evaluation was not available at the time of the needs assessment.

Insurance claims data
The landscape of medication claims data is changing with the advent of the ACA. As nearly three-quarters of Virginia ADAP clients are now insured, increased coordination with insurance companies is required to ensure that all needed data are received. Therefore, insurance claims data would support better assessment of health outcomes along the HIV Continuum of Care, with the addition of HIV medical care visits and ART prescriptions for all PLWH.

An All Payer Claims Database (APCD) is available in Virginia; however, the APCD only collects aggregate insurance claims data on clients and is not client-level. Therefore, insurance claims cannot be linked to the CMDB at this time on an individual level to assess health outcomes of PLWH.

Health Information Exchange/Electronic Medical Records
Virginia is currently implementing a health information exchange to link electronic medical records with VDH data. The health information exchange will assist in ascertaining additional markers for care for all PLWH; however, these data are not currently available as the implementation process is not yet complete. Section II: Integrated HIV Prevention and Care Plan

Section II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

a-c. Five-Year work plan objectives, strategies, and activities

Appendix B: Virginia Five-Year HIV Services Plan presents the NHAS goals with specific SMART objectives, associated strategies and activities in a table format. The table also includes a column entitled “Gap” to indicate if the specific activities are intended to fill gaps along Virginia’s Continuum of Care. For the most part, the “yes” response in the Gap column indicates a new activity within Virginia. If the activity is designed to expand existing programs and services, there will be a “no” response in the column.

The following table summarizes the SMART objectives and their associated strategies for each NHAS goal. Appendix B provides additional detail.

Table 23. Summary of Virginia's Five-Year HIV Services Plan by NHAS Goal

NHAS Goal/ Objective/Strategy	Description
NHAS GOAL #1:	REDUCE NEW HIV INFECTIONS
Objective 1.1	By December 31, 2021, the Commonwealth of Virginia will increase the percentage of people living with HIV who know their serostatus to at least 90 percent.
Strategy A	Expand routine testing in targeted areas of high prevalence and in areas with disparities related to social determinants of health indicators.
Strategy B	Develop innovative strategies to engage providers in both routine and risk-based testing.
Strategy C	Expand and/or develop innovative models of targeted testing to high-risk populations.
Strategy D	Identify and help facilitate systems changes to barriers that prevent third-party payment of routine HIV testing and screening.
Strategy E	Engage injection drug users in HIV and Hepatitis C virus (HCV) testing as part of DDP's Drug User Health Initiative.
Objective 1.2	By December 31, 2021, the Virginia Department of Health increase HIV testing among men to 58,350.
Strategy A	Improve current methods for engaging MSM populations in HIV prevention and testing.
Strategy B	Address Sexual Health and HIV as part of the holistic health needs of all men by facilitation of community health efforts aimed toward men.
Strategy C	Use innovative ways to reach men by introducing HIV testing for men to sites atypical of providing HIV testing for men, and by introducing HIV testing to sites/events most likely to receive men.
Objective 1.3	By December 31, 2021, the Commonwealth of Virginia will reduce the number of new HIV diagnoses by at least 25%.
Strategy A	Implement and/or expand use of biomedical interventions in high-risk populations, i.e., pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP).
Strategy B	Ensure access to free condoms to high-risk populations statewide.
Strategy C	Expand the implementation of effective behavioral interventions with PLWH and high-risk negative populations and/or in high prevalence regions.
Strategy D	Provide seamless transition programs through care coordination for recently released HIV positive offenders.
Strategy E	Expand delivery of retention and adherence services offered by providers.
Strategy F	Expand service navigation for high-risk HIV negative individuals, including linkage to primary medical care.
NHAS GOAL #2:	INCREASING ACCESS TO CARE AND IMPROVING HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV (PLWH).
Objective 2.1	By December 31, 2021, the Commonwealth of Virginia will increase the percentage of newly-diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85 percent.
Strategy A	Increase access to and utilization of patient navigation and linkage to care services for all newly-diagnosed individuals, regardless of testing site.
Strategy B	Link and engage clients in care through culturally and linguistically competent mechanisms.
Strategy C	Increase the number of newly-diagnosed individuals who complete a partner services interview with Disease Intervention Specialist to at least 80% to align with the NHAS.
Objective 2.2	By December 31, 2021, the Commonwealth of Virginia will increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90 percent.
Strategy A	Strengthen the medical case management program and referral networks.

NHAS Goal/ Objective/Strategy	Description
Strategy B	Improve access to resources for transportation to core medical and support services.
Strategy C	Strengthen collaboration between HIV, Mental Health, and Substance Use.
Strategy D	Increase sub-recipient pool and referrals to dental services.
Strategy E	Develop initiatives to address stigma (e.g., HIV, LGBTQ, mental health, and/or substance use).
Objective 2.3	By December 31, 2021, the Commonwealth of Virginia will increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80 percent.
Strategy A	Increase stable housing for people living with HIV.
Strategy B	Increase the number of individuals on ART (antiretroviral therapy).
Strategy C	Educate consumers and providers on Quality Management of HIV/AIDS.
NHAS GOAL #3:	REDUCING HIV-RELATED DISPARITIES AND HEALTH INEQUITIES.
Objective 3.1	By December 31, 2021, the Commonwealth of Virginia will reduce disparities in the rate of new diagnoses by at least 15 percent in the following groups: gay and bisexual men, Black females, and persons living in the Eastern Region, Hispanics in the Northwest, and Transgender persons.
Strategy A	Engage communities with health disparities to affirm support for people living with HIV.
Strategy B	Fill gaps in targeted interventions and services to better meet the HIV prevention and care needs of vulnerable populations.
Strategy C	Integrate social determinants of health (SDH) into program planning, design, and implementation (e.g., using data to inform policy and program decisions, designing holistic programs that address SDH).
Objective 3.2	By December 31, 2021, Virginia Department of Health will increase the percentage of persons diagnosed with HIV infection (PWID, Transgender, 55 year and older, Northern, and Eastern) who are virally suppressed to at least 80 percent.
Strategy A	Expand service access using multi-modal service delivery options throughout the state.
Strategy B	Design and pilot programs that leverage use of social media and new technologies.
Strategy C	Expand peer based social support networks in the targeted populations.
Strategy D	Build on the DDP Patient Navigation Models Developed Through CAPUS and SPNS.
Objective 3.3	By December 31, 2021, Virginia Department of Health will increase the percentage of timely diagnosis to 90% among the following populations (Hispanics, PWIDs, Females, Aging Persons 55 years and older, Northwest Region, and the Northern Region)
Strategy A	Provide more HIV testing options in Northern and Northwest Health Regions.
Strategy B	Develop partnerships and coalitions to target and engage Hispanics, females, and persons over 55 years of age, PWIDs in holistic health programs, which include sexual health and HIV testing components.
Strategy C	Promote self-management skills development among people with HIV.
Strategy D	Promote public leadership by people with HIV, including gay and bisexual men, racial/ethnic minorities, transgender and gender non-conforming individuals, youth, and women.
NHAS GOAL #4:	ACHIEVING A MORE COORDINATED VIRGINIA RESPONSE TO THE HIV EPIDEMIC.
Objective 4.1	By December 31, 2021, the Commonwealth of Virginia will increase by at least two efforts to improve the programmatic coordination of HIV programs within the Virginia Department of Health and at least two external initiatives to increase coordination with regional and local partners.
Strategy A	Develop an integrated outbreak response plan that outlines how HIV prevention, care and

NHAS Goal/ Objective/Strategy	Description
	surveillance efforts work as a coordinated unit to address mobilizing the affected area's systems and personnel in order to effectively end the continuation of new infections in a timely manner.
Strategy B	Integrate Virginia's HIV Care Continuum to include a prevention element, using baseline data to be gathered from PrEP projects and data from other prevention activities.
Strategy C	Expand the availability of HIV services within the Commonwealth.
Strategy D	Improve joint planning with the Norfolk Transitional Grant Area (TGA) and the Washington DC Eligible Metropolitan Area (EMA) to improve health outcomes among people living with HIV, including AIDS in the TGA.
Strategy E	Establish active collaborative relationships with other governmental partners (e.g., Virginia Department of Behavioral Health and Developmental Services, Office of Minority Health and Health Equity, Virginia Department of Medical Assistance Services, Virginia Department of Housing and Community Development, etc.).
Objective 4.2	By December 31, 2021, VDH will increase the timeliness, completeness, and accuracy of data on persons living with and at-risk for HIV in the Commonwealth.
Strategy A	Continue to improve data quality, collection, and reporting to support HIV planning and evaluation activities within the Commonwealth.
Strategy B	Improve the accuracy and completeness of HIV surveillance data.
Strategy C	Improve the e2Virginia database.

DDP will leverage a variety of existing resources from across the state to implement its proposed plan. Appendix A: Financial Resources Inventory provides key information on HIV resources within Virginia. DDP will update this inventory on an ongoing basis throughout the five-year planning cycle. DDP has a strong, successful history of obtaining new funding for a variety of projects, including HRSA Ryan White Part F funds for Special Projects of National Significance and CDC demonstration projects. DDP has a grant writer devoted to assist with the identification of new funding opportunities and applying for new resources, as well as re-competing for existing resources. In addition, DDP has significant discretionary funds available to them through the 340B voluntary rebates from pharmacy companies as well as Medicare back billing.

In addition to financial resources, other resources needed to implement the various activities include staff time and energy, on the part of both DDP, as well as its community partner organizations. As content experts are needed, DDP will identify and engage consultants as appropriate to conduct training, needs assessment, and other activities. Lastly, a greater level of coordination of HIV services is called for through this plan, both internally within DDP and externally with other organizations. These activities will require staff time and energy both on the part of DDP and the collaborating/coordinating entities.

a. Describe the metrics (e.g., number of HIV tests performed, medical visits, mental health screenings, HIV positivity rate, etc.) that will be used to monitor progress in achieving each goal outlined in the plan. Metrics should be consistent with the most current HHS Core Indicators and the NHAS Indicators.

Attachment B: Virginia Five-Year work plan lists in detail the various metrics and data indicators

that will be used to measure progress in achieving the goals of the NHAS, as well as achieving full implementation of the plan.

The SMART objectives outlined above in Table 19 are in complete alignment with the indicators outlined in the NHAS Updated to 2020. DDP has incorporated six of the NHAS indicators, specifically Objectives 1.1, 1.3, 2.1, 2.2, 2.3, and 3.1 into its own plan.

b. Describe any anticipated challenges or barriers in implementing the plan.

DDP anticipates there will be a number of barriers and/or challenges that it faces in implementing the proposed plan. Some of them are client-level challenges and others are system or organizational-level challenges. They include but are not limited to:

- There are subgroups among PLWH who present further challenges to the system of care, notably youth, with high rates of sexually transmitted infections; the homeless and recently incarcerated populations; and MSM, notably men of color. Failure to meet the primary care, substance use, and mental health needs of these populations of PLWH will lead to reduced linkage to and retention in care;

- Although low health literacy affects individuals of every age, race, education and income level, vulnerable populations, including the elderly, minorities, immigrants, poor, homeless, incarcerated individuals, and persons with limited education are more likely to have low health literacy skills;

- People who are managing multiple chronic diseases and/or multiple insurance systems are also likely to have greater difficulty understanding health messages;

- There is a need for an increased sense of empowerment among PLWH to reach needed self-health management goals that will support treatment adherence, retention, and viral suppression;

- There is a need for enhanced public communication strategies – phone, twitter, internet searches etc. to expand access to information;

- Transportation continues to be a challenge for many PLWH in getting to their medical appointments to link to an be retained in HIV medical care;

- There are limited opportunities for persons at risk for HIV to access information and testing; and

- There is a lack of communication between case managers and HOPWA, which needs to expand in order to increase support for housing.

B. Collaborations, Partnerships, and Stakeholder Involvement

a. Describe the specific contributions of stakeholders and key partners to the development of the plan.

In the formulation of this integrated plan, DDP collaborated extensively with the Community HIV Planning Group (CHPG); Part A/B/C/D providers in Virginia, including the Norfolk TGA and Washington D.C. EMA; and agencies serving persons at high risk for HIV as well as PLWH, in order to create a plan responsive to their needs. In addition, DDP conducted several focus groups and semi-structured interviews (provider and consumer). The questions for the focus groups, interviews and surveys were developed by HCS and HPS. Before the tools were utilized, a review of the questions was conducted by other DDP units. The provider survey was an online survey made available on Survey Monkey. This tool was vetted by the DDP and other stakeholders, including sub-recipients, who participated in a test run of the tool. Feedback was incorporated into the final version. The consumer survey was distributed at a two-day consumers training on quality management of HIV/AIDS, which targets PLWH. NVRC and NovaSalud assisted with the recruitment of Latino participants for the focus group, which targeted Latino PLWH and HRN. Participants for the other focus groups and interviews were recruited mainly by DDP through pre-planned meetings, which brought together PLWH and HRN. The following examples describe how their input has been solicited in each step of the planning process since the development of the last Comprehensive HIV Plan and Statewide Coordinated Statement of Need. Their ongoing participation and input is vital to assessing the needs of the state's HIV health service delivery system, which resulted in this plan—the *Virginia Integrated HIV Services Plan (2017-2021).*

Virginia Community HIV Planning Group: The CHPG is the legislatively mandated Part B planning group in Virginia. It meets six times per year and is comprised of members of priority populations for HIV prevention and care, as well as organizations that provide services to these populations. The CHPG has convened three work groups over the past five years, including a group that examined the effects of Virginia's HIV Criminalization laws on HIV partner services and disclosure of status; a workgroup on Drug User Health that focused on Virginia's need for syringe exchange and other services for PWID and a racial disparities workgroup to examine the disparity between minority MSM and white MSM in the utilization of health care and HIV testing services. CHPG also compiled a needs assessment for each priority population and health region of Virginia, provided input on prioritizing populations and subpopulations, and has helped construct the strategies and activities for meeting the goals in the integrated plan.

Table 24 presents a list of topics discussed during regular CHPG meetings to solicit stakeholder input, including that from PLWH since 2013. These informational presentations and discussions provided important input regarding needs, barriers, and gaps in the current HIV services portfolio. For example, the discussion regarding sexual assault and HIV has led DDP to engage content experts to deliver training to the HIV workforce on trauma-informed care to strengthen their skills in this area. The training will be delivered in October 2016.

Table 24. List of Presentations and Topics Discussed During CHPG Meetings (2013-Present)

TOPIC	ORGANIZATIONS/INDIVIDUALS THAT COLLABORATED
Sex workers	• HIPS- Washington DC • Nationz Foundation, Richmond • 2 individual sex workers
Offender Population	• Virginia Department of Corrections
Substance Abuse and HIV/Hepatitis C	• Department of Behavioral Health and Developmental Services • NASTAD
Sexual Assault and HIV	• Division of Prevention and Health Promotion's Department of Sexual and Domestic Violence • Bon Secours' Forensic Nursing Department • Victim Assistance Network • Virginia Action Alliance • Virginia Department of Justice • Virginia Victims Compensation Fund
Mental Health Services	• Access AIDS Care, Norfolk • AIDS/HIV Services Group- Charlottesville • Department of Corrections • VCU Infectious Disease Clinic • Richmond Behavioral Health Authority • Department of Behavioral Health and Developmental Services
Social Marketing	• Kaiser Family Foundation
HIV Criminalization	• SeroProject • Pennsylvania/Mid-Atlantic AETC

Ryan White Part A Organizations: There are two Part A jurisdictions that serve PLWH in Virginia: (1) Norfolk TGA and (2) Washington, D. C. EMA. The Norfolk TGA area overlaps with Virginia's Eastern Region and includes one county in North Carolina. The Washington, D.C. EMA serves the portion of Virginia that comprises the Northern health region in addition to several counties in the Northwest region. These two jurisdictions are home to the most number of PLWH in the state. DDP hosted a meeting in July 2016 with both Part A grantees to discuss DDP's progress on the plan, including the needs assessment activities being conducted. In April 2016, the Norfolk TGA asked to be included in the statewide plan. They provided extensive needs assessment data to describe service needs, barriers, and gaps in their region. NVRC assisted with bringing together Latinos living in the northern region for the focus group. All participants of the focus group, which targeted Latinos, resided in the northern region. There are plans to conduct a more representative needs assessment of Latinos in Virginia. Due to time constraints, it was not possible for this Plan. However, VDH is already in contact with other providers like Cross Over Ministries and Valley AIDS Network to plan more focus groups, which focus on Latino PLWH and those at risk for HIV. The Washington, D.C. EMA is developing its own plan. It exchanged financial resources information with DDP to add to Virginia's Financial Resources Inventory (Appendix A).

Ryan White Part B Contracted Organizations: DDP conducted a provider survey in May/June 2016, which it distributed via email to its contracted providers.

HOPWA Grantees: In preparation of this plan, DDP contacted two HOPWA grantees to obtain a better initial understanding of their programs and services. This served a two-fold purpose, to collect first Financial Resources Inventory information from them, and second, to understand better the services provided through HOPWA to understand how they are leveraged to serve PLWH in Virginia, specifically in the Northern and Eastern Regions. As a result, a small ad-hoc work group will explore the issue of housing services and make recommendations to VDH on identification of needs and resources to meet them.

b. Describe stakeholders and partners not involved in the planning process, but who are needed to more effectively improve outcomes along the HIV Care Continuum.

Stakeholders not adequately involved in the creation of this planning document are mentioned below:

- *Male to female transgender persons:* CHPG lost representation of the male to female transgender population in 2014 and had no representatives from this community until August 2016.

- *Military and Veterans:* DDP has had limited engagement of activity duty and veteran military personnel, which in a state with a large military presence leaves many of the Commonwealth's citizens unrepresented.

- *Lawmakers:* Several key planning objectives focus on policy and law, such as syringe exchange. DDP and CHPG has had limited input from the legal community in the development of this planning document.

- *Undocumented persons:* While indirect input from Virginia's undocumented population has come from contractors who provide services to these individuals, direct guidance and input was not received from this population.

- *The Asian and Asian American community:* Virginia's population of persons identifying as Asian or Asian American is growing rapidly, particularly in Northern Virginia. While HIV prevalence is not high in this population in Virginia, representation from Asian/Asian Americans would benefit the planning process.

- *People Who Inject Drugs in the Southwest Health Region:* Efforts to engage PWIDs in the Central, Eastern and Northern Health Regions have been fairly successful. With the high prevalence of Hepatitis C in the Southwest Health Region among PWIDs, representation from this group would be beneficial, particularly from the counties that CDC has determined are vulnerable to HIV outbreak.

- Other state agencies: The Departments of Education, Social Services, Justice, Juvenile Justice, Medical Assistance Services and Housing would all be beneficial

partners for HIV planning in the Commonwealth but have had limited input in this planning document.

c. Provide a letter of concurrence to the goals and objectives of the Integrated HIV Prevention and Care Plan from the co-chairs of the planning body and the health department representatives (*Appendix C*)

See Letters of Concurrence from the Norfolk TGA (Part A) and the Community HIV Planning Group, both of which are chaired or co-chaired by the single signee.

C. People Living With HIV (PLWH) and Community Engagement

a. Describe how the people involved in developing the Integrated HIV Prevention and Care Plan are reflective of the epidemic in the jurisdiction.

DDP seeks to implement an integrated planning process that reflects guidelines established by CDC's 2012 Planning Guidance and one that supports CDC and HRSA's recommendation of parity and inclusion of those most affected by HIV. In order to achieve this goal, Virginia relies heavily on its Community HIV Planning Group (CHPG) membership to be reflective of Virginia's HIV epidemic. Table 21 illustrates CHPG membership in relation to Virginia's 2014 HIV prevalence data.

Table 25. CHPG Membership Compared to Virginia Prevalence Rates in 2014

	2014 HIV Prevalence in Virginia	Target Membership (N=35 members)	Actual Membership As of August 2016	
Sex	Percent	Number	Number	Percent
Male	74%	26	23	69.7%
Female	26%	9	10	30.3%
Priority Population				
MSM	47%	16	17	51.5%
PWID	9%	3	2	6.1%
Heterosexuals	19%	7	14	42.4%
Transgender	data incomplete	data incomplete	2	6.1%
Race/Ethnicity				
Black	60%	21	18	54.5%
White	30%	11	14	42.4%
Hispanic	8%	3	3	9.1%
Asian	1%	0	0	0.0%
Health Region of Residence				
Eastern	31%	11	10	30.3%
Central	23%	8	12	36.4%
Northern	29%	10	9	27.3%
Northwest	8%	3	1	3.0%
Southwest	8%	3	3	9.0%
Age Group				
15-29	11%	4	7	21.2%
30-39	16%	6	5	15.2%
40-49	29%	10	9	27.3%
50-59	31%	11	7	21.2%
60+	14%	5	7	21.2%
Sero-status				
Living with HIV (Bylaws mandate 30%)		11	14	42.4%

The CHPG consists of representatives from populations with high HIV prevalence and from stakeholders across Virginia that provides and/or supports HIV prevention, care and treatment services for its Virginia's residents. Stakeholder engagement includes PLWH, 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, psychosocial 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 STDs. Through this broad range of representation, DDP seeks input on planning, implementation, monitoring and evaluation, and integration of services to provide a coordinated approach to addressing HIV.

b. Describe how the inclusion of PLWH contributed to the plan development.

In the formulation of this integrated plan, DDP collaborated extensively with the CHPG; Consumer Advisory Groups; focus groups and semi-structured interviews (provider and consumer); Part A providers in Virginia, including the Norfolk TGA and Washington D.C. EMA Planning Councils; and agencies serving at persons at high risk for HIV as well as PLWH, in order to create a plan representative of their needs. The following examples describe their input during the planning process over the past five years.

Community HIV Planning Group: The CHPG is a mixed group of PLWH and stakeholder organizations. As seen in Table 21, PLWH comprise 42.4% of the CHPG membership. The activities of the CHPG have already been described in this section of the plan, under *B. Collaborations, Partnerships, and Stakeholder Involvement*.

Public Hearings: DDP routinely conducts public hearings annually to ask for input on improving care and prevention strategies and activities throughout the state. The hearings are held in three of the five health regions, and rotate each year so that PLWH and other community members are each afforded the opportunity to have their voice heard. Public hearings have helped DDP restructure the format in how medical case management services were delivered in the Southwest Region, helped address transportation needs in the Eastern Region and informed DDP on various other issues that PLWH face in the Commonwealth. Information gathered from public hearings has been incorporated into the need assessment section of this planning document. In the year preceding submission of the Plan, in lieu of public hearings, DDP conducted semi-structured interviews and focus groups, and sent written surveys with consumers and providers

Individual and Small Group Engagement Sessions: There are many at risk sub-populations and PLWH that are not represented adequately in traditional community engagement settings. Therefore it was decided in the revision of the 2013 Jurisdictional Plan to have DDP's HIV planners facilitate small forums in which information can be gathered to help represent these groups in the planning process. From 2013 to 2016, DDP's HIV Planners engaged PLWH and those at high risk who are substance users, sex workers, military personnel, undocumented immigrants, migrant farmworkers, community health workers, young MSM from 16-18, and homeless individuals. Information gleaned from these meeting has been compiled and included in the needs assessment section of this plan. In total, 31 small group engagement sessions were held to ascertain the needs of these populations. They helped to guide the formation of the specific strategies and activities needed to address identified needs, barriers, and gaps in Virginia's HIV services portfolio (see Appendix B: HIV Services Five-Year Work Plan).

CAPUS, SPNS, and Latino Engagement Meetings: DDP has hosted engagement meetings that coincide with specific funding awards. Both HRSA Special Projects of National Significance (SPNS) and Virginia's CDC-funded Care and Prevention in the United States (CAPUS) demonstration projects hosted day long events in order to gather information from their respective targeted communities in order to formulate strategies to achieve the goals of each funded project. These projects targeted PLWH, as well as high-risk individuals. Through this input process, DDP improved care and prevention strategies that have since become institutionalized. For example, Virginia's statewide partnership with Walgreens piloted the

pharmacy-based testing program under CAPUS and patient navigation for PLWH was piloted under SPNS. Both of those strategies now receive continuing funding through other DDP funding sources. The CAPUS engagement meeting had high turnout from the Latino population, and many members of that population voiced concerns specific to Latinos in Virginia. As a result, DDP organized another day long engagement meeting focused specifically on the Latino population where issues such as health literacy, delivery of services in Spanish, and serving undocumented individuals was discussed and incorporated into this planning document.

Community Advancement Project (CAP): DDP's advisory board of MSM and Transgender women of color is in its eighth year of existence. The CAP consists of both PLWH and those at high-risk for HIV. It provides input regarding the needs of MSM and Transgender women of color around the Commonwealth. The CAP has regional meetings throughout the year and a statewide meeting annually. CAP members have been instrumental in providing input for DDP on topics such as stigma, PrEP and nPEP, ACA, media campaigns and materials, and racial disparities in health access. The group also serves as "PrEP ambassadors" for the state, promoting the use of the biomedical intervention among young minority MSM. Their input has also been incorporated into this planning document.

Community Advisory Boards (CABs) and Forums with PLWH: DDP's HIV Care Services and regional planning councils (Norfolk TGA and Washington, D.C. EMA) heavily rely on the guidance of PLWH to participate in the development of local, regional and statewide planning efforts to improve services. Several Community Advisory Boards of PLWH, including those facilitated by DDP and its contractor have provided extensive input into the development of this planning document, which is discussed in sections throughout the plan.

Sisters Promoting H.O.P.E. is a community mobilization effort for Black women jointly led by DDP and faith-based organizations. DDP receives input from this advisory committee on improving engagement with and services for African American women. The group hosts annual meetings for African American women and beginning in 2014, women living with HIV.

Specific engagement of PLWH, in addition to the above, included a brief needs assessment conducted in May/June 2016. Results of the needs assessment have guided the formulation of objectives, strategies, and specific activities outlined in Appendix B (Virginia Five Year HIV Services Plan). Also, in July of 2016, DDP partnered with Virginia Commonwealth University (VCU) to host a two-day forum for PLWH. The forum solicited input from PLWH in the forms of structured interviews and small group forums. This input was also instrumental in the formulation of strategies and activities found in this planning document.

c. Describe the methods used to engage communities, people living with HIV, those at substantial risk of acquiring HIV infection and other impacted population groups to ensure that HIV prevention and care activities are responsive to their needs in the service area.

Many engagement methods have already been described earlier in this section. To ensure the planning process addresses the current and emergent needs of those most affected by HIV, DDP and the CHPG use epidemiological data along with biographical data in the membership

selection process. Demographic factors utilized in the selection of new members include age, gender, sexual orientation, race, ethnicity, and geographic region. DDP and CHPG also consider life experiences and ensure that individuals with relevant life histories are afforded opportunities for active participation, as well as, those who bring workforce credentials. As a result of these identified priorities, the CHPG membership list is very reflective of Virginia's HIV prevalence.

Other strategies for the engagement of PLWH and those at high-risk include population-focused regional meetings where the HIV planners travel to the five health regions of the state to engage the targeted communities in the planning process through the use of regional forums, interviews and focus groups. This strategy allows for targeted input on the development of strategies and activities to address the integrated needs of hard-to-reach populations, such as active drug users, sex workers, and men who engage in sex with men but do not identify as gay or bisexual. DDP has used this strategy since 2014 in order to help determine barriers to accessing services for these populations.

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 discussions and activities. Stakeholders are encouraged to support and inform integration services in communities wherever possible to address syndemic diseases associated with HIV.

d. Describe how impacted communities are engaged in the planning process to provide critical insight into developing solutions to health problems to assure the availability of necessary resources.

DDP has broadened the scope of engagement to focus on gaining community input to address key health problems during the past three years. CHPG meetings were restructured to become topic specific forums where community partners and members of impacted communities were invited in to participate with CHPG membership in tackling specific issues. Three of the issues outlined in Table 20 are described in more detail below.

1. *HIV Criminalization and its impact on partner services and linkage to care:* DDP invited a national organization that focuses on HIV criminalization issues, along with an individual charged with the felony to participate in a discussion with CHPG on how state laws that make disclosure mandatory in many instances are a barrier for individuals to know their status, or in the case of new diagnosis, prevent individuals from confirmatory testing or entering care for fear their partners will take legal action against them. The issue of ongoing partner notification and how criminalization laws impact the ability of PLWH to use this service is also impacted by fear of prosecution.

2. *nPEP for Victims of Sexual Assault:* DDP invited members from the forensic nursing community, advocate organizations for victims of sexual assault, the state Criminal Compensation Fund, and the state Department of Justice to a forum to ascertain the issues that exist with getting nPEP into the hands of sexual assault victims in emergency room situations. Virginia's Criminal Compensation Fund will pay for nPEP, but only if the

victim files a police report and submits receipts to be reimbursed. Cost then becomes a prohibitive issue for many victims. Follow up care was also stated as an issue in that emergency room (ER) doctors were hesitant to prescribe the medication without having qualified doctors to refer to after release from the ER. During the forum, these issues were addressed and input from CHPG and the community partners initiated activities to help explore direct billing from pharmacies to the Criminal Compensation Fund, and nPEP training for local health department clinicians to serve as follow up care providers.

3. *Prevention and Care Issues pertaining to Sex Workers:* DDP hosted a CHPG meeting to address specific barriers to providing prevention and care to persons who exchange sex for money or drugs. An organization from Washington D.C. that provides services to sex workers, several members of the sex worker community, together with CHPG, discussed gaps and barriers to services for this population. Several needs and activities discussed at this forum have been incorporated into this integrated plan.

Other topics discussed in this format by CHPG and community members included care coordination for inmates re-entering society, expedient linkage to care, prevention and care issues of persons with substance abuse and mental health disorders, and the unique needs of PWID. Strategies formed by this collaboration of persons impacted by HIV that address specific issues that prevent marginalized communities from accessing quality prevention and care services have helped guide integrated planning activities found in this document.