Section III: Monitoring and Improvement

a. Describe the process for regularly updating planning bodies and stakeholders on the progress of plan implementation, soliciting feedback, and using the feedback from stakeholders for plan improvements.

DDP will utilize direct email contact, the E-Bulletin, as well as the Department of Health's (DOH) website, to update the CHPG, the Norfolk TGA's Greater Hampton Roads HIV Services Planning Council, the Washington D.C. Part A Planning Council, DDP-sub-recipients, local health departments, and other stakeholders on the progress of implementing the Integrated HIV Services Plan (Plan), as well as to obtain feedback from them and utilize that feedback as part of the plan's continuous quality improvement. PLWH and HRN will receive updates via their CHPG representatives, VDH's website, and town halls.

1. **Responsibility:** DDP will continue to assume the lead responsibility for monitoring the Plan. A greater emphasis will be placed on quantifiable and qualitative data that demonstrate outcomes for each activity outlined in the Plan. VDH will report back to the CHPG and the Greater Hampton Roads HIV Services Planning Council on a quarterly basis on the progress associated with the various goals, objectives, and activities. Therefore, additional steps will be identified that need to be taken to address issues or to enhance results.

2. **Tracking Tool:** DDP's HIV Planners will develop a tool to track and monitor results of the Plan and have it reviewed by the CHPG, which includes representatives from Ryan Whites Parts A, B, C, and D and prevention sub-recipients. This tool will include the level of detail needed to accurately monitor all aspects of the plan in a simple, easy-to-follow format. It will also include tracking of progress toward meeting the SMART objectives outlined in the Plan's 5-year work plan.

3. **Monitoring Process:** Ongoing monitoring, input, and adjustment are critical to ensure that available HIV/AIDS resources in Virginia are maximized and the use of these resources are prioritized when changes to the system are needed. The HIV Services Prevention and Care Planners will evaluate Plan progress every six months, and modifications will be made as needed, based on measures indicated in the plan. This monitoring process will help VDH and all stakeholders reprioritize, adjust, or revise strategies in a timely manner in response to the evolving needs or changing profile of the HIV epidemic.

4. **Continuous Quality Improvement:** If objectives need to be adjusted based on activities and other developments over the course of the year, DDP's HIV Planners will ask the CHPG and other Planning Groups to develop and recommend changes. The CHPG and other Planning Groups will work with DDP to define a set of reports that will allow tracking of some of the measurable outcomes defined for the activities within the Plan's 5-year work plan. The HIV Planners will generate these reports quarterly and/or bi-annually depending on the outcome being measured. In addition, DDP will conduct regular client and provider surveys. These surveys will be another valuable tool

for monitoring and tracking success of the various activities in the plan. DDP will conduct these and other needs assessment activities on an ongoing basis and results will enable the HIV Planners, CHPG, and other Planning Groups to make adjustments and enhancements to the planned initiatives.

Also, the HIV Planners will compile lessons learned from the process for development of the next jurisdictional plan. They will query partners on their readiness for ongoing engagement, their needs for continued involvement, and possible "best practices" for maintaining partner relationships throughout the implementation of a joint plan.

5. **Annual Evaluation:** DDP will convene an annual "Plan Evaluation Workgroup" which will include stakeholders from all RW parts, the CHPG and prevention contractors. The results will be presented at the planning group meetings and published on VDH's website. The workgroup will review data, assess direction of stated objectives, provide explanation of outcomes, and report findings. DDP will mandate representation of PLWH as part of the Plan Evaluation Workgroup.

b. Describe the plan to monitor and evaluate implementation of the goals and SMART objectives from Section II: Integrated HIV Prevention and Care Plan.

DDP has the primary responsibility for monitoring and evaluating the implementation of Virginia's Plan. DDP Planners will monitor the Plan quarterly throughout the five-year planning period in order to assess progress toward meeting NHAS goals. DDP's HIV Planners will convene a workgroup consisting of DDP staff and members of the CHPG to review monitoring data. DDP's e2VA database, the Care Markers Database (CMDB), and EvaluationWeb will supply HIV Continuum of Care and other data needed for the evaluation process. The HIV Planners will complete a semi-annual written report on progress being made for DDP leadership and for submission to the CDC and HRSA.

Table 22 presents Virginia's Plan SMART objectives with annual targets, which are aligned with NHAS goals. Therefore, as Virginia makes progress toward meeting the SMART objectives, Virginia will also be making progress meeting NHAS goals. In order to assess the extent to which each HIV planning step is being met, the following guiding principles and monitoring questions described below will facilitate the monitoring process.

NHAS Goal 1: Reducing New Infections

Guiding Principle:
In order to reduce new infections, efforts directed toward HIV positive persons to achieve viral suppression, increasing HIV testing among men, the increased utilization of PrEP by high risk negative individuals, increased condom distribution among persons living with HIV and those at high-risk, and access to sterile needles for those who inject will be the primary focus.

Monitoring questions

- To what extent was success achieved in health care settings in promoting routine testing and integrating HIV screening into work flow?
- To what extent did non-clinical HIV testing services effectively target communities with the greatest disease prevalence?
- To what extent did non-clinical HIV testing services effectively target communities with the greatest disease burden?
- To what extent was condom distribution expanded in the state?
- To what extent was access to sterile needles for injection drug users achieved?
- To what extent was success achieved in ensuring that every individual with a positive HIV test was offered partner services?
- To what extent was PrEP utilized by persons practicing high-risk behaviors?
- To what extent was success achieved in reaching viral load suppression for PLWH?

NHAS Goal 2: Increase access to care and optimize health outcomes

Guiding Principle

All PLWH in VA should have access to, and be retained in culturally appropriate, coordinated HIV care and treatment.

Monitoring questions

- To what extent did facilities providing routine testing successfully achieve establishing linkage to care networks across prevention, care and social service systems?
- To what extent was success achieved in settings offering non-medical testing in establishing linkage to care networks across prevention, care and social service systems?
- What success was achieved in using monitoring and surveillance data for identifying clients with unsuppressed viral load and/or insufficient engagement in HIV medical care?
- To what extent were systems successfully established across prevention and care systems for engaging PLWH who have never been in care?
- To what extent were systems established across prevention and care systems for re-engaging PLWH who have fallen out of care?
- What success was achieved in developing capacity for implementing HIV treatment adherence strategies for funded jurisdictions?

NHAS Goal 3: Reduce HIV-related health disparities

Guiding Principle:

All PLWH should have access to equitable, appropriate, and effective HIV care that is free of stigma and discrimination, regardless of their age, gender, sex, socio-economic status, race, sexual orientation, or gender identity.

Monitoring questions

- To what extent were available data and existing research utilized in assisting the identification of Virginia's populations experiencing HIV related health disparities?

- To what extent were jurisdictions assisted in identifying, developing, and implementing strategies to reduce HIV related stigma and discrimination?
- To what extent where community-level approaches identified and implemented for reducing HIV infection in high-risk communities?
- To what extent were health outcome disparities reduced in identified populations?

NHAS Goal 4: Achieve a coordinated response to the HIV epidemic in VA

Guiding Principle:
In order to achieve a coordinated response to HIV, mechanisms must be streamlined for monitoring and reporting on progress toward achieving the goals. Emphasis therefore must be placed on coordination of activities within, and between state and non-state agencies, as well as all level of governments. DDP must approach these efforts in an integrated fashion, utilizing prevention, care and surveillance teams to achieve these outcomes.

Monitoring questions
- To what extent was collaboration strengthened within the DDP and VDH in developing coordinated strategies for HIV care and prevention?
- To what extent was collaboration strengthened between VDH and other external stakeholders like CBOs, other state agencies, alcohol and drug programs, housing, and other support services?
- To what extent were data collection requirements streamlined among providers, including creating shared, standardized data collection forms where possible?
- What new strategies or improvements occurred as a result of collaborations?

Table 26. Yearly Targets for SMART Objectives

NHAS Goal and SMART Objective		Baseline	2017	2018	2019	2020	2021
1. Reduce New HIV Infections.							
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%.		86.3%	90%	90%	90%	90%	90%
1.2 By December 31, 2021, the Virginia Department of Health increase HIV testing among men to 58,350.		33,341	38,323	43,305	48,287	53,269	58,250
1.3 By December 31, 2021, the Commonwealth of Virginia will reduce the number of new HIV diagnoses by at least 25%.		950	902	854	806	758	713
2. Increase Access To Care And Improve Health Outcomes For People Living With HIV.							
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.		69%	75%	75%	80%	85%	85%
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.		42%	54%	66%	78%	85%	90%
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.		38%	50%	60%	70%	80%	80%
3. Reducing HIV-related disparities and health inequities. [Note: Targets are expressed as rate/100,000 population]							
3.1 By December 31, 2021, the Commonwealth of Virginia will reduce disparities in the rate per 100,000 population of new HIV diagnoses by at least 15% in the following groups:	Gay and bisexual men (Decrease by 13/year)	443.3	430.3	417.3	404.3	391.3	376
	Black females (Decrease by 0.5/year)	16	15.5	14	14.5	13	13.6
	Persons living in the Eastern Region (Increase by 0.5/year)	17.8	18.3	18.8	19.3	19.8	20.4
	Hispanics in the Northwest (Decrease by 0.2/year)	5.5	5.3	5.1	4.8	4.5	4.7
	Transgender persons (≥ 13 yrs) (Decrease by 2/year)	54.1	52.1	50.1	48.1	46.1	46
3.2 By December 31, 2021, the VDH will increase the percentage of persons diagnosed with HIV infection who are virally suppressed to at least 80%:	Injection Drug Users (PWID)	34	50	60	70	80	90
	Transgender Persons	46	50	60	70	80	90
	Northern Region	35	50	60	70	80	90
	Eastern Region	26	50	60	70	80	90
	55 years and older	37	50	60	70	80	90
3.3 By December 31, 2021, the VDH will increase the percentage of timely diagnosis to 90% among the following populations:	Hispanics	65	70	75	80	85	90
	Northwest Region	70	74	78	82	86	90
	Northern Region	75	78	81	84	87	90
	Aging Persons	60	66	72	78	84	90
	Injection Drug Users	60	66	72	78	84	90
	Females	70	74	78	82	86	90
Achieve a More Coordinated Virginia Response to the HIV Epidemic							
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 Services and at least two external initiatives to increase coordination with regional and local partners.		Annually, DDP will document achievement of this objective as new programmatic efforts are implemented.					
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.		67%	70	75	80	85	90

c. Describe the strategy to utilize surveillance and program data to assess and improve health outcomes along the HIV Care Continuum, which will be used to impact the quality of the HIV service delivery system, including strategic long-term planning.

Data is integral to Virginia's long-term planning efforts as well as ensuring that persons at high risk for HIV and PLWH have the best possible health outcomes. The HIV Care Continuum provides a common set of indicators that Virginia can use to gauge its own progress and how it is doing compared with the nation as a whole. DDP has led and participated in key initiatives that improve the quality of its HIV surveillance data. These include: (1) the Black Box Project spearheaded by Georgetown University; and (2) DDP's implementation of a robust Data to Care Program. Through secure sharing of multi-jurisdiction (i.e., Virginia, Maryland, and District of Columbia) surveillance data, the Black Box Project successfully identified PLWH who had migrated to other jurisdictions outside Virginia and these individuals were removed from Virginia's surveillance system. The Data to Care Program is designed to identify PLWH who are not in care using HIV surveillance data and then to re-engage them in care. Using HIV surveillance, care, prevention and other data sources, VDH currently generates lists of PLWH who have evidence of care through a CD4 count or viral load lab test, HIV medical care visit, or ART prescription reported in the reference year but no evidence of care in the following calendar year. Out of Care lists are then distributed to linkage personnel at VDH-contracted local health departments, medical facilities, and community-based organizations (CBOs) for client follow-up and linkage and reengagement services if a client is not currently engaged in HIV care. The results have shown that the majority (as many as 75%) of PLWH who are not in care are actually in care and that there are other issues that impact the care status (e.g., not all laboratories in Virginia are reporting viral load results to VDH as required, especially private laboratories). Thus, Data to Care has become as much a tool to clean Virginia's HIV surveillance data as it has been re-engage PLWH who are genuinely not in care.

Surveillance and program data are utilized in multiple frameworks to better assess and improve health outcomes along Virginia's HIV Continuum of Care. By identifying demographic, geographic, and other disparities in the HIV Continuum of Care, programs and interventions can be developed and implemented within populations or areas of greatest need.

VDH's strategy of data integration also plays an immense role in assessing and improving health outcomes along the HIV Continuum of Care. The utilization of multiple data sources of both internal and external programs and initiatives support HIV Continuum of Care outcomes, as the data provides additional evidence of care for PLWH in Virginia. Continued expansion of data integration, such as expansion of the Black Box Project, incorporation of additional data sources (i.e., Department of Motor Vehicles to update address information), and bidirectional feedback of program data like Data to Care outcomes into HIV surveillance, will facilitate improved health outcomes by more accurately defining and evaluating the HIV epidemic in Virginia.