2012 Virginia Statewide Coordinated Statement of Need and Comprehensive HIV Service Plan

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

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CARILION CLINIC

May 31, 2012

Diana Jordan, Director
Division of Disease Prevention
Virginia Department of Health
P.O. Box 2448, Room 326
Richmond, VA 23218

Dear Ms. Jordan:

The Carilion Infectious Disease Clinic (Carilion Comprehensive HIV Services-CCHS) is pleased to provide this letter of support to the Virginia Department of Health (VDH) Division of Disease Prevention (DDP) as part of Virginia's 2012 Statewide Coordinated Statement of Need (SCSN) and Comprehensive HIV Service Plan. The SCSN and Comprehensive Plan identify and address significant HIV care issues related to the needs of people living with HIV/AIDS (PLWHA) and maximize coordination, integration, and effective linkages across the Ryan White HIV/AIDS Program parts. CCHS is currently working with VDH as a part of The Special Project of National Significance (SPNS) initiative, *Systems Linkages and Access to Care for Populations at High Risk of HIV/AIDS*, an effort funded by the U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). This initiative strives to enhance strategies to identify those with undiagnosed HIV, link HIV-positive persons to care upon diagnosis, reconnect people living with HIV/AIDS (PLWHA) who have dropped out of care, and retain patients in quality HIV care services. CCHS will serve as a pilot site to hire two patient navigators for a four year period to positively impact the delivery of care and support the goals of the initiative. CCHS also works collaboratively with VDH on many aspects of care delivery to the HIV population in Virginia.

The SCSN and Comprehensive Plan serve as road map to achieving the ideal system of care for PLWHA in Virginia. The plan incorporates not only statewide and regional needs assessment data, existing resources and current barriers to care, but larger national initiatives such as, the National HIV/AIDS Strategy, the Patient Protection and Affordable Care Act (Public Law {P.L.} 111-148) as amended by the Reconciliation Act of 2010 (P.L. 111-152), the Early Identification of Individuals with HIV/AIDS, and goals and objectives for Healthy People 2020. Finally, this plan considers resources efficiently while enhancing the quality of care for PLWHA.

Thank you for the opportunity to express our support the SCSN and Comprehensive HIV Service Plan. We look forward to working with VDH on achieving the ideal system of care over the next three years.

Sincerely,

Kathy Wolford

Kathy Wolford, LCSW
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June 11, 2012

Diana Jordan, Director
Division of Disease Prevention
Virginia Department of Health
P.O. Box 2448, Room 326
Richmond, VA 23218

Dear Ms. Jordan:

The Council of Community Services (CCS) is pleased to provide this letter of support to the Virginia Department of Health (VDH) Division of Disease Prevention (DDP) as part of Virginia's 2012 Statewide Coordinated Statement of Need (SCSN) and Comprehensive HIV Service Plan. The SCSN and Comprehensive Plan identify and address significant HIV care issues related to the needs of people living with HIV/AIDS (PLWHA) and maximize coordination, integration, and effective linkages across the Ryan White HIV/AIDS Program parts. CCS has been Part B lead agent since 1991 and has collaborated with VDH on all SCSN documents to date.

The SCSN and Comprehensive Plan serve as road map to achieving the ideal system of care for PLWHA in Virginia. The plan incorporates not only statewide and regional needs assessment data, existing resources and current barriers to care, but larger national initiatives such as, the National HIV/AIDS Strategy, the Patient Protection and Affordable Care Act (Public Law {P.L.} 111-148) as amended by the Reconciliation Act of 2010 (P.L. 111-152), the Early Identification of Individuals with HIV/AIDS, and goals and objectives for Healthy People 2020. Finally, this plan considers resources efficiently while enhancing the quality of care for PLWHA.

Thank you for the opportunity to express our support the SCSN and Comprehensive HIV Service Plan. We look forward to working with VDH on achieving the ideal system of care over the next three years.

Sincerely,

Robert F. Morrow
Director of Care Services
Southwest/Piedmont HIV Care Consortium
Council of Community Services

CENTRA
Medical Group

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June 5, 2012

Diana Jordan, Director
Division of Disease Prevention
Virginia Department of Health
P.O. Box 2448, Room 326
Richmond, VA 23218

Dear Ms. Jordan:

Centra Health's Ryan White program is pleased to provide this letter of support to the Virginia Department of Health (VDH) Division of Disease Prevention (DDP) as part of Virginia's 2012 Statewide Coordinated Statement of Need (SCSN) and Comprehensive HIV Service Plan. The SCSN and Comprehensive Plan identify and address significant HIV care issues related to the needs of people living with HIV/AIDS (PLWHA) and maximize coordination, integration, and effective linkages across the Ryan White HIV/AIDS Program parts. Our program will be collaborating with the SCSN by sending our Operations Coordinator to planning meetings, as well as providing information to consumers for their participation.

The SCSN and Comprehensive Plan serve as road map to achieving the ideal system of care for PLWHA in Virginia. The plan incorporates not only statewide and regional needs assessment data, existing resources and current barriers to care, but larger national initiatives such as, the National HIV/AIDS Strategy, the Patient Protection and Affordable Care Act (Public Law {P.L.} 111-148) as amended by the Reconciliation Act of 2010 (P.L. 111-152), the Early Identification of Individuals with HIV/AIDS, and goals and objectives for Healthy People 2020. Finally, this plan considers resources efficiently while enhancing the quality of care for PLWHA.

Thank you for the opportunity to express our support the SCSN and Comprehensive HIV Service Plan. We look forward to working with VDH on achieving the ideal system of care over the next three years. With best regards, I am,

Sincerely,

Judith B Sharp

Judith B. Sharp
Ryan White Grant Writer/Grant Reporting

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June 6, 2012

Diana Jordan, Director
Division of Disease Prevention
Virginia Department of Health
P.O. Box 2448, Room 326
Richmond, VA 23218

Dear Ms. Jordan:

The Virginia HIV/AIDS Resource & Consultation Center (VHARCC) located on the campus of Eastern Virginia Medical School (EVMS) is pleased to provide this letter of support to the Virginia Department of Health (VDH) Division of Disease Prevention (DDP) as part of Virginia's 2012 Statewide Coordinated Statement of Need (SCSN) and Comprehensive HIV Service Plan. The SCSN and Comprehensive Plan identifies and addresses significant HIV care issues related to the needs of people living with HIV/AIDS (PLWH/A) and maximizes coordination, integration, and effective linkages across the Ryan White HIV/AIDS Program parts. EVMS has collaborated with VDH on the care and coordination of services for those PLWH/A in the Eastern part of the State for well over two decades and look forward to this on-going relationship to address the needs/services of those infected with HIV/AIDS.

The SCSN and Comprehensive Plan serves as a road map to achieving the ideal system of care for PLWH/A in Virginia. The plan incorporates not only statewide and regional needs assessment data, existing resources and current barriers to care, but larger national initiatives such as, the National HIV/AIDS Strategy, the Patient Protection and Affordable Care Act (Public Law {P.L.} 111-148) as amended by the Reconciliation Act of 2010 (P.L. 111-152), the Early Identification of Individuals with HIV/AIDS, and goals and objectives for Healthy People 2020. Finally, this plan considers resources efficiently while enhancing the quality of care for PLWH/A.

Thank you for the opportunity to express our support for the SCSN and Comprehensive HIV Service Plan. We look forward to working with VDH on achieving the ideal system of care over the next three years.

Sincerely,

Tanya K. Kearney

Tanya K. Kearney, MPA
Director

May 31, 2012

Diana Jordan, Director
Division of Disease Prevention
Virginia Department of Health
P.O. Box 2448, Room 326
Richmond, VA 23218

Dear Ms. Jordan:

The Virginia HIV Planning Group (HPG) is pleased to provide this letter of support to the Virginia Department of Health (VDH) Division of Disease Prevention (DDP) as part of Virginia's 2012 Statewide Coordinated Statement of Need (SCSN) and Comprehensive HIV Service Plan. The SCSN and Comprehensive Plan identify and address significant HIV care issues related to the needs of people living with HIV/AIDS (PLWHA) and maximize coordination, integration, and effective linkages across the Ryan White HIV/AIDS Program parts.

The SCSN and Comprehensive Plan serve as road map to achieving the ideal system of care for PLWHA in Virginia. The plan incorporates not only statewide and regional needs assessment data, existing resources and current barriers to care, but larger national initiatives such as, the National HIV/AIDS Strategy, the Patient Protection and Affordable Care Act (Public Law {P.L.} 111-148) as amended by the Reconciliation Act of 2010 (P.L. 111-152), the Early Identification of Individuals with HIV/AIDS, and goals and objectives for Healthy People 2020. Finally, this plan considers resources efficiently while enhancing the quality of care for PLWHA.

Thank you for the opportunity to express our support the SCSN and Comprehensive HIV Service Plan. We look forward to working with VDH on achieving the ideal system of care over the next three years.

Sincerely,

Elaine G. Martin
Health Department Co-Chair

Ruth Fordham
Community Co-Chair

INOVA® JUNIPER PROGRAM
A Service of Inova Fairfax Hospital

8001 Forbes Place, Suite 200
Springfield, Virginia 22151

June 6, 2012

Diana Jordan, Director
Division of Disease Prevention
Virginia Department of Health
P.O. Box 2448, Room 326
Richmond, VA 23218

Dear Ms. Jordan:

Inova Juniper Program is pleased to provide this letter of support to the Virginia Department of Health (VDH) Division of Disease Prevention (DDP) as part of Virginia's 2012 Statewide Coordinated Statement of Need (SCSN) and Comprehensive HIV Service Plan. The SCSN and Comprehensive Plan identify and address significant HIV care issues related to the needs of people living with HIV/AIDS (PLWHA) and maximize coordination, integration, and effective linkages across the Ryan White HIV/AIDS Program parts. As part of the Northern Virginia HIV Care Consortium, Inova Juniper Program is actively involved in Virginia's SCSN. The Consortium provides many major planning documents to the SCSN process, including needs assessments, regional health service plans and client surveys.

The SCSN and Comprehensive Plan serve as a road map to achieving the ideal system of care for PLWHA in Virginia. The plan incorporates not only statewide and regional needs assessment data, existing resources and current barriers to care, but larger national initiatives such as, the National HIV/AIDS Strategy, the Patient Protection and Affordable Care Act (Public Law {P.L.} 111-148) as amended by the Reconciliation Act of 2010 (P.L. 111-152), the Early Identification of Individuals with HIV/AIDS, and goals and objectives for Healthy People 2020. Finally, this plan considers resources efficiently while enhancing the quality of care for PLWHA.

Thank you for the opportunity to express our support the SCSN and Comprehensive HIV Service Plan. We look forward to working with VDH on achieving the ideal system of care over the next three years.

Sincerely,

Karen Berube

Karen Berube, LCSW, CSAC
Director

The Institute for Innovation in Health And Human Services
James Madison University

May 31, 2012

Diana Jordan, Director
Division of Disease Prevention
Virginia Department of Health
P.O. Box 2448, Room 326
Richmond, VA 23218

Dear Ms. Jordan,

James Madison University's Institute for Innovation in Health and Human Service, is pleased to provide this letter of support to the Virginia Department of Health (VDH) Division of Disease Prevention (DDP) as part of Virginia's 2012 Statewide Coordinated Statement of Need (SCSN) and Comprehensive HIV Service Plan. The SCSN and Comprehensive Plan identify and address significant HIV care issues related to the needs of people living with HIV/AIDS (PLWHA) and maximize coordination, integration, and effective linkages across the Ryan White HIV/AIDS Program parts. As representatives of the Northwest Ryan White Consortium, a predominantly rural region, the SCP has done an excellent job representing the diversity of rural and urban needs in Virginia.

The SCSN and Comprehensive Plan serve as road map to achieving the ideal system of care for PLWHA in Virginia. The plan integrates not only statewide and regional needs assessment data, existing resources and current barriers to care, but larger national initiatives such as, the National HIV/AIDS Strategy. The plan also incorporates the Patient Protection and Affordable Care Act (Public Law {P.L.} 111-148) as amended by the Reconciliation Act of 2010 (P.L. 111-152), the Early Identification of Individuals with HIV/AIDS, and goals and objectives for Healthy People 2020. Finally, this plan coordinates resources efficiently while enhancing the quality of care for PLWHA.

Thank you for the opportunity to express our support the SCSN and Comprehensive HIV Service Plan. We look forward to working with VDH on achieving the ideal system of care over the next three years.

Sincerely,

Jane Hubbell

Gary Race
Co-Lead Agents Ryan White Northwest Region

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James Madison University
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Mary Washington Healthcare

May 31, 2012

Diana Jordan, Director
Division of Disease Prevention
Virginia Department of Health
P.O. Box 2448, Room 326
Richmond, VA 23218

Dear Ms. Jordan:

Mary Washington Healthcare is pleased to provide this letter of support to the Virginia Department of Health (VDH) Division of Disease Prevention (DDP) as part of Virginia's 2012 Statewide Coordinated Statement of Need (SCSN) and Comprehensive HIV Service Plan. The SCSN and Comprehensive Plan identify and address significant HIV care issues related to the needs of people living with HIV/AIDS (PLWHA) and maximize coordination, integration, and effective linkages across the Ryan White HIV/AIDS Program parts.

The SCSN and Comprehensive Plan serve as road map to achieving the ideal system of care for PLWHA in Virginia. The plan incorporates not only statewide and regional needs assessment data, existing resources and current barriers to care, but larger national initiatives such as, the National HIV/AIDS Strategy, the Patient Protection and Affordable Care Act (Public Law {P.L.} 111-148) as amended by the Reconciliation Act of 2010 (P.L. 111-152), the Early Identification of Individuals with HIV/AIDS, and goals and objectives for Healthy People 2020. Finally, this plan considers resources efficiently while enhancing the quality of care for PLWHA.

Thank you for the opportunity to express our support the SCSN and Comprehensive HIV Service Plan. We look forward to working with VDH on achieving the ideal system of care over the next three years.

Sincerely,

Keli E. Nibblins, RN, BSN
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City of Norfolk
Ryan White Title I Program

May 31, 2012

Diana Jordan, Director
Division of Disease Prevention
Virginia Department of Health
P.O. Box 2448, Room 326
Richmond, VA 23218

Dear Ms. Jordan:

The City of Norfolk Ryan White Part A Program is pleased to provide this letter of support to the Virginia Department of Health (VDH) Division of Disease Prevention (DDP) as part of Virginia's 2012 Statewide Coordinated Statement of Need (SCSN) and Comprehensive HIV Service Plan. The SCSN and Comprehensive Plan identify and address significant HIV care issues related to the needs of people living with HIV/AIDS (PLWHA) and maximize coordination, integration, and effective linkages across the Ryan White HIV/AIDS Program parts. The City of Norfolk Ryan White Part A Program collaborates on many projects with VDH including this project and will continue to do so.

The SCSN and Comprehensive Plan serve as road map to achieving the ideal system of care for PLWHA in Virginia. The plan incorporates not only statewide and regional needs assessment data, existing resources and current barriers to care, but larger national initiatives such as, the National HIV/AIDS Strategy, the Patient Protection and Affordable Care Act (Public Law {P.L.} 111-148) as amended by the Reconciliation Act of 2010 (P.L. 111-152), the Early Identification of Individuals with HIV/AIDS, and goals and objectives for Healthy People 2020. Finally, this plan considers resources efficiently while enhancing the quality of care for PLWHA.

Thank you for the opportunity to express our support the SCSN and Comprehensive HIV Service Plan. We look forward to working with VDH on achieving the ideal system of care over the next three years.

Sincerely,

Christine M. Carroll, Program Manager
City of Norfolk Ryan White Part A

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Northern Virginia Regional Commission

June 11, 2012

Diana Jordan, Director
Division of Disease Prevention
Virginia Department of Health
P.O. Box 2448, Room 326
Richmond, VA 23218

Dear Ms. Jordan:

Northern Virginia Regional Commission is pleased to provide this letter of support to the Virginia Department of Health (VDH) Division of Disease Prevention (DDP) as part of Virginia's 2012 Statewide Coordinated Statement of Need (SCSN) and Comprehensive HIV Service Plan. The SCSN and Comprehensive Plan identify and address significant HIV care issues related to the needs of people living with HIV/AIDS (PLWHA) and maximize coordination, integration, and effective linkages across the Ryan White HIV/AIDS Program parts. NVRC, in its role as fiduciary agent for the Part B Northern Virginia HIV Consortium, looks to the Virginia Comprehensive Plan and SCSN to help steer HIV/AIDS resources to the services and geographic areas where they are most needed.

These documents assess needs, information on existing resources, and barriers to care within the larger context of the expectations of the National HIV/AIDS Strategy, HIPAA, EIIHA, and Healthy People 2020. The resulting SCSN and Comprehensive Plan provide the "blueprint" for achieving the ideal system of care for PLWHA in Virginia.

Thank you for the opportunity to express our support the SCSN and Comprehensive HIV Service Plan. We look forward to working with VDH on achieving the ideal system of care over the next three years.

Sincerely,

Michelle Simmons
Director, Human Services

UNIVERSITY of VIRGINIA HEALTH SYSTEM

The DEPARTMENT *of* INTERNAL MEDICINE

May 31, 2012

Diana Jordan, Director
Division of Disease Prevention
Virginia Department of Health
P.O. Box 2448, Room 326
Richmond, VA 23218

Dear Ms. Jordan:

The University of Virginia Ryan White Infectious Diseases Clinic is pleased to provide this letter of support to the Virginia Department of Health (VDH) Division of Disease Prevention (DDP) as part of Virginia's 2012 Statewide Coordinated Statement of Need (SCSN) and Comprehensive HIV Service Plan. The SCSN and Comprehensive Plan identify and address significant HIV care issues related to the needs of people living with HIV/AIDS (PLWHA) and maximize coordination, integration, and effective linkages across the Ryan White HIV/AIDS Program parts.

The SCSN and Comprehensive Plan serve as road map to achieving the ideal system of care for PLWHA in Virginia. The plan incorporates not only statewide and regional needs assessment data, existing resources and current barriers to care, but larger national initiatives such as, the National HIV/AIDS Strategy, the Patient Protection and Affordable Care Act (Public Law {P.L.} 111-148) as amended by the Reconciliation Act of 2010 (P.L. 111-152), the Early Identification of Individuals with HIV/AIDS, and goals and objectives for Healthy People 2020. Finally, this plan considers resources efficiently while enhancing the quality of care for PLWHA.

Thank you for the opportunity to express our support the SCSN and Comprehensive HIV Service Plan. We look forward to working with VDH on achieving the ideal system of care over the next three years.

Sincerely,

Gregory Townsend, MD, Associate Director
Principle Investigator Parts C and B

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May 31, 2012

Diana Jordan, Director
Division of Disease Prevention
Virginia Department of Health
P.O. Box 2448, Room 326
Richmond, VA 23218

Dear Ms. Jordan:

The Virginia Commonwealth University School of Medicine's HIV/AIDS Center Ryan White Part C EIS Program is pleased to provide this letter of support to the Virginia Department of Health (VDH) Division of Disease Prevention (DDP) as part of Virginia's 2012 Statewide Coordinated Statement of Need (SCSN) and Comprehensive HIV Service Plan. The SCSN and Comprehensive Plan identify and address significant HIV care issues related to the needs of people living with HIV/AIDS (PLWHA) and maximize coordination, integration, and effective linkages across the Ryan White HIV/AIDS Program parts. The VCU Part C Program has a long and successful history of close collaboration with VDH on many initiatives to improve the quality of health and related services for persons living with HIV/AIDS in the Central Region of Virginia, including joint funding of HIV specialty clinics in community based settings, which has enabled us to increase access to medical care.

The SCSN and Comprehensive Plan serve as road map to achieving the ideal system of care for PLWHA in Virginia. The plan incorporates not only statewide and regional needs assessment data, existing resources and current barriers to care, but larger national initiatives such as, the National HIV/AIDS Strategy, the Patient Protection and Affordable Care Act (Public Law {P.L.} 111-148) as amended by the Reconciliation Act of 2010 (P.L. 111-152), the Early Identification of Individuals with HIV/AIDS, and goals and objectives for Healthy People 2020. Finally, this plan considers resources efficiently while enhancing the quality of care for PLWHA.

Thank you for the opportunity to express our support the SCSN and Comprehensive HIV Service Plan. We look forward to working with VDH on achieving the ideal system of care over the next three years.

Sincerely,

Veronica A. Ayala-Sims, MD
Assistant Professor, Internal Medicine
Principal Investigator, VCU Ryan White Part C EIS Program
Principal Investigator, VCU HIV/AIDS Center Ryan White Part B Program

VCU Health System

Virginia Commonwealth University

MCV Hospitals and Physicians

Diana Jordan, Director
Division of Disease Prevention
Virginia Department of Health
P.O. Box 2448, Room 326
Richmond, VA 23218

Dear Ms. Jordan:

The Women and Children's Care Program of VCU (a Ryan White Part B and D funded support program) is pleased to provide this letter of support to the Virginia Department of Health (VDH) Division of Disease Prevention (DDP) as part of Virginia's 2012 Statewide Coordinated Statement of Need (SCSN) and Comprehensive HIV Service Plan. The SCSN and Comprehensive Plan identify and address significant HIV care issues related to the needs of people living with HIV/AIDS (PLWHA) and maximize coordination, integration, and effective linkages across the Ryan White HIV/AIDS Program parts. Linkage to care and identification of those with poor access to highly specialized HIV care is an important objective for the WACC Program and we believe that we will need to work closely with all agencies to achieve this objective.

The SCSN and Comprehensive Plan serve as road map to achieving the ideal system of care for PLWHA in Virginia. The plan incorporates not only statewide and regional needs assessment data, existing resources and current barriers to care, but larger national initiatives such as, the National HIV/AIDS Strategy, the Patient Protection and Affordable Care Act (Public Law {P.L.} 111-148) as amended by the Reconciliation Act of 2010 (P.L. 111-152), the Early Identification of Individuals with HIV/AIDS, and goals and objectives for Healthy People 2020. Finally, this plan considers resources efficiently while enhancing the quality of care for PLWHA.

Thank you for the opportunity to express our support the SCSN and Comprehensive HIV Service Plan. We look forward to working with VDH on achieving the ideal system of care over the next three years.

Sincerely,

Suzanne R. Lavoie, MD

Women's and Children's Care (WACC)
Ryan White Part D
Department of Internal Medicine
Dept. of Pediatric Infectious Diseases

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Acknowledgements

The Virginia Department of Health would like to acknowledge the contributions of all who participated in the development of the 2012 Statewide Coordinated Statement of Need and Comprehensive HIV Service Plan. Without this participation, the process would not have been successful. Thanks to all who assisted with this project!

Carilion Clinic
Kathy Wolford

Centra Health
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Judi Sharp

Eastern Virginia Medical School
Tanya Kearney

Greater Hampton Roads HIV Health Service Planning Council
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HIV Planning Group
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Metropolitan Washington Regional Health Services Planning Council
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National Association of People with AIDS Consumer Advocacy Project
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Virginia Commonwealth University
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Part One: 2012 Virginia Statewide Coordinated Statement of Need (SCSN)

Introduction

More than 1.3 million individuals in the United States (US) have been infected with the Human Immunodeficiency Virus (HIV) since 1981, when the first cases of Acquired Immune Deficiency Syndrome (AIDS) were first reported. It is estimated that one third of people living with HIV/AIDS (PLWHA) have since died. Early in the epidemic, HIV infection was viewed as a death sentence. In recent years, treatment advances have extended the life expectancy for many PLWHA (CDC, 2011). The Centers for Disease Control (CDC) estimates that approximately 50,000 new infections occur each year in the US and that an estimated 21% of infected persons are unaware of their serostatus (CDC, 2010). Lack of awareness of one's HIV status can lead to advanced disease and between 35 to 45 percent of people with newly-diagnosed HIV infection develop AIDS within one year of diagnosis. Persons who know their HIV status are less likely to pass on the disease, and studies show that patients on antiretroviral therapy (ART) are less infectious (Gardner, McLees, Steiner, Del Rio, & Burman, 2011). These data support the need for enhanced strategies to identify those with undiagnosed HIV, link HIV-positive persons to care upon diagnosis, reconnect PLWHA who have dropped out of care, and retain patients in quality HIV care services.

Nationally, racial and ethnic minorities are disproportionally affected by HIV/AIDS. In 2009, while Blacks made up12% of the US population, they represented 44% of new HIV infections. Latinos accounted for 16% of the population but 20% of new HIV infections. Blacks and Latinos accounted for 57% and 13%, respectively, of deaths due to HIV in 2007. HIV was the 4th leading cause of death for Black men and women, ages 25-44 in 2007, the highest of any racial or ethnic group. Women of all races and ethnicities represented 23% of new infections in 2009, with Black women accounting for 57% (CDC, 2012). In Virginia (VA), racial and ethnic minorities are also disproportionally affected by HIV/AIDS. In 2009, while Blacks were 20% of the US population, they represented 61% of all HIV diagnoses infections. During that same time, Latinos accounted for 7% of the population but 9% of all HIV infections. From 2005-2009, new diagnoses found 77% of women were Black; 12% were White; and 8% were Hispanic (Chen et al, 2010).

Black gay and bisexual men in the US, ages 13-29, had a 48% increase in new HIV infections between 2006 and 2009. Gay and bisexual men, ages 13-29, of all races and ethnicities were the only group to experience an increase in HIV infections during that same time. Gay and bisexual men of all ages are estimated to account for 2-6% of the male US population (CDC, 2011; Lieb et al., 2011) but 61% of new HIV infections in 2009 (CDC, 2011). Mirroring the national trend, VA has been experiencing a dramatic rise in HIV cases among young black men who have sex with men (MSM). From 2005-2009, there was a 64% increase in HIV cases among black MSM ages 13-29. During that same time HIV diagnoses among Black MSM increased by 26% (Chen et al, 2010).

In response to the epidemic, the Ryan White (RW) Comprehensive AIDS Resources Emergency (CARE) Act was passed in 1990, and has been the largest federally funded program specifically

created to provide services for PLWHA in the US and the third largest federally funded source of HIV care behind Medicare and Medicaid (Kaiser, 2011). RW legislation has been amended and reauthorized four times (1996, 2000, 2006, and 2009) to reflect new and emerging needs (HRSA, 2011). The RW HIV/AIDS Program (Public Law 111- 87, October 30, 2009) is designed to assist individuals living with HIV/AIDS who lack the financial and/or health coverage resources to treat their HIV disease. Funds are distributed across the US through "Part" areas. VA receives funds through Parts A, B, C, D, and F from the US Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA). According to the Virginia Client Reporting System (VACRS), the RW Part B database, Part B currently serves approximately 4,000 PLWHA each year (VACRS, 2012). It is important to note that no one RW Part accounts for all of a PLWHA's HIV care. HIV care is also provided through a network of private physician practices, local health districts, Veterans Administration facilities, the University of Virginia (UVA) telemedicine, the VA Department of Corrections (DOC) telemedicine program in partnership with the Virginia Commonwealth University Infectious Disease Clinic (VCU-IDC), local correctional facilities, and indigent care programs throughout the state. Current RW part areas of VA and corresponding grantees for those parts are listed in Table 1.

Table 1. Ryan White Programs in Virginia (2012)

Ryan White Part	Description of eligible grantees	Grantees
Part A	Funds eligible metropolitan areas (EMAs), those with a cumulative total of more than 2,000 reported AIDS cases over the most recent 5-year period, and transitional grant areas (TGAs), those with 1,000-1,999 re-ported AIDS cases over the most recent 5-year period. At least 75% of all Part A funds must be expended for core medical services*. Funds are also available for Minority AIDS Initiative (MAI) that strengthens organizational capacity to expand HIV-related services in minority communities.	City of Norfolk (Coverage area: Chesapeake, Gloucester, Hampton, Isle of Wight, James City, Mathews, Newport News, Norfolk, Poquoson, Portsmouth, Suffolk, Virginia Beach, Williamsburg, and York) City of Washington, District of Columbia (DC) (Virginia localities covered: Alexandria, Arlington, Clarke, Culpeper, Fairfax, Fairfax (City), Falls Church, Fauquier, Fredericksburg, King George, Loudon, Manassas, Manassas Park, Prince William, Spotsylvania, Stafford, and Warren)
Part B	Funds States. This includes base and supplemental grants, AIDS Drug Assistance Program (ADAP), ADAP supplemental grants, ADAP emergency, and Emerging Communities (EC) grants. In Virginia, the majority of services are provided through four regional consortia and a network of direct contractors that plan and deliver HIV care. At least 75% of	Virginia Department of Health (VDH)

	all Part B funds must be expended for core medical services*. Funds are also available for MAI that strengthens organizational capacity to expand HIV-related services in minority communities.	
Part C	Funds Early Intervention Services (EIS) to reach people newly diagnosed with HIV and ambulatory care.	Carilion Centra Health Inova Health System, Juniper Program Mary Washington Healthcare UVA VCU
Part D	Funds family-centered primary and specialty medical care and support services for women, infants, children, and youth with HIV/AIDS.	Inova Health System, Juniper Program VCU
Part F	Funds: Special Projects of National Significance (SPNS) that funds innovative models of care and supports the development of effective delivery systems for HIV care. AIDS Education & Training Centers (AETC) that provide education and training for health care providers who treat people with HIV/AIDS. Funds oral health through the Dental Reimbursement Program and the Community-Based Dental Partnership Program.	Carilion (SPNS) Inova Health System, Juniper Program (AETC and SPNS) VCU (AETC and SPNS) Virginia Department of Health (SPNS)
* Core services include outpatient and ambulatory medical care (including labs); oral health services; health insurance premium and cost-sharing assistance; hospice care; mental health services; medical nutrition therapy; medical case management; and other services. The remaining 25% can be spent on support services including non-medical case management; outreach; medical transportation; linguistic services; and other support services.		

a. Description of populations with HIV/AIDS in Virginia, including Virginia Epi Profile

The VA Department of Health (VDH) released the 2011 HIV/AIDS Epidemiology (Epi) Profile with the purpose of providing the city and county governments, community-based organizations (CBOs), health care planners, and educators with the data they need to plan and evaluate HIV/AIDS prevention and care services. The populations discussed in the Profile follow those determined by the VA HIV Planning Group (HPG) as being priority populations or populations of special interest for HIV prevention and care services. The Epi Profile discusses the disproportionate impact of HIV/AIDS on various risk populations and can be accessed online at:

http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Profile2011.htm

With eight million residents, VA represents 2.6% of the total population of the US. 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 VA 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 VA 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.

- 1 in 354 Virginians are known to be living with HIV disease.
- 1 in 237 men in VA are known to be living with HIV disease.
- 1 in 679 women in VA are known to be living with HIV disease.

The first cases of AIDS in VA were reported in 1982; the epidemic peaked in the early 1990's with more than 1,200 new AIDS diagnoses per year. The number of new AIDS diagnoses each year declined through 2006 with a rate of 7.3 per 100,000 population. In 2007, the rate of new AIDS diagnoses increased to 10.6 per 100,000, only to subsequently decline to levels comparable to 2006 in recent years. As of December 2009, 19,462 persons had been diagnosed with AIDS in VA since the beginning of the epidemic, with 498 cases of AIDS diagnosed that year, the lowest since the decline began in the early 1990's. As of the same time, 11,829 persons known to have HIV disease and who had VA as their last known place of residence have died. While HIV and AIDS were contributing factors in some of these deaths, others were the result of unrelated causes, including motor vehicle crashes and other illnesses or injuries.

Advances in medical therapies have resulted in people living longer with HIV disease. As of December 31, 2009, there were 22,257 PLWHA in VA, at a disease rate of 282 per 100,000 population. Approximately half of this population has progressed to the AIDS stage of the disease. The majority of PLWHA were male (73%), Black (60%), MSM, or MSM with a history of injection drug use (MSM-IDU) (55%), and between the ages of 40 and 54 (52%).

The average rate of HIV disease diagnoses was 20 per 100,000 among men and 6.7 per 100,000 among women. Men accounted for 74% of the new diagnoses between 2005 and 2009. The largest percentage (77%) of male diagnoses in this period were among MSM. 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 age group were eight times more likely to be diagnosed with HIV disease than their female counterparts.

While comprising only 20% of VA's total population, non-Hispanic Blacks represented nearly two out of three recent HIV diagnoses. In 2009, Black men and women were, respectively, seven and 26 times more likely to be diagnosed than non-Hispanic White men and women. Hispanics accounted for 9% of the total diagnosed cases in 2009 and were three times more likely to be diagnosed than their White counterparts.

The following figures compare the numbers and estimated rates of HIV disease diagnoses among high-risk populations in the US (from the National HIV/AIDS Strategy (NHAS)) and VA. Similar to the US as a whole, the populations at highest risk of HIV disease in VA are:

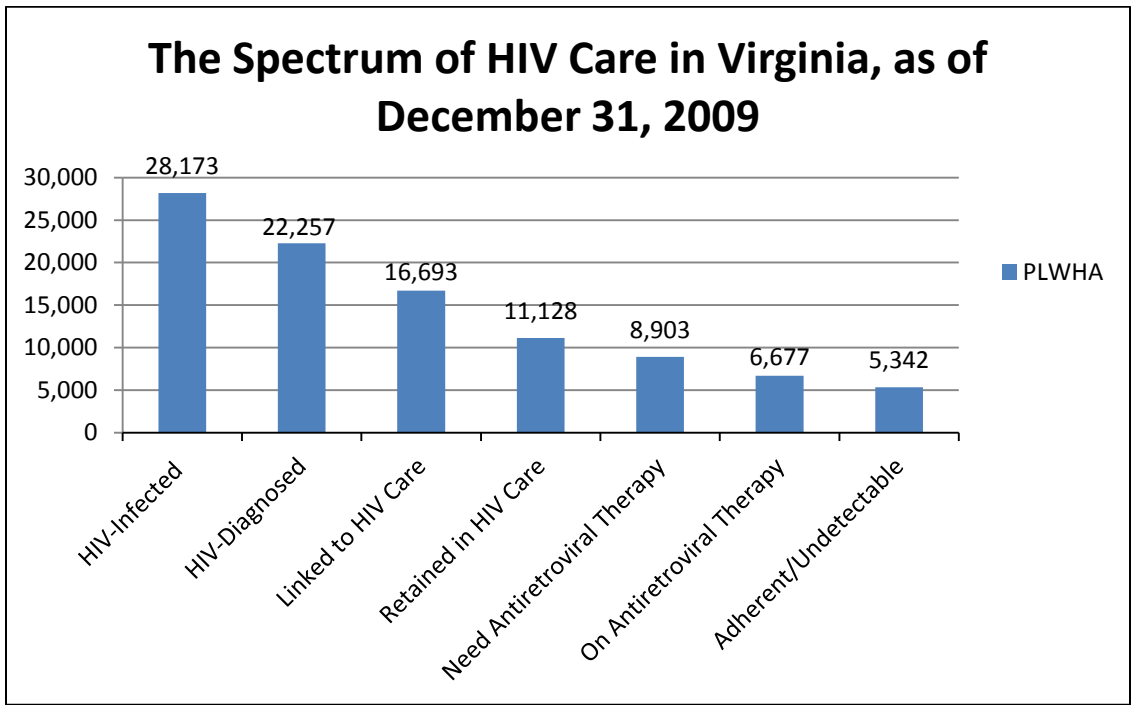
MSM (including gay and bisexual men): According to recent estimations, MSM comprised approximately six percent of the male population in VA (Lieb et al., 2011) but represented 77% of all HIV disease diagnoses among men in 2005-2009 (another 3% were MSM with a history of IDU).

Black men and women: While representing only 20% of the state population, Blacks represented 61% of all new HIV disease diagnoses and 60% of all those living with HIV/AIDS at the end of 2009. Among Blacks, MSM are at the greatest risk for HIV, followed by heterosexual women and men.

Hispanic/Latino men and women: Between 2005 and 2009, the rate of HIV disease diagnoses among Hispanic men and women in VA were three and eight times higher than that of White counterparts. Among Hispanics, 75% of diagnoses among men were MSM, and 93% of diagnoses among women were attributed to heterosexual contact.

IDU: Although they account for a relatively small part of US and VA populations, they are disproportionately represented in the HIV epidemic. People who use non-injection drugs are also at risk for HIV and should be targeted with prevention efforts (Qtd in Chen et al, 2011).

Figure 1.



Using the epidemiological data above and the framework for the spectrum of HIV care outlined by Gardner et. al, it is estimated that there are approximately 28,173 PLWHA in VA, leaving an unaware population of about 5,916 or 21% of the HIV-infected population and a not linked to care population of 5,564 persons. Figure 1 summarizes then categorizes the spectrum of HIV care in VA. Of those diagnosed, three-quarters are linked to care, but only half are retained in

care. These numbers are congruent with the 2009 Unmet Need Framework, which indicated that approximately 50.8% of PLWHA were not receiving primary medical care services in VA. This was based on the criteria of no evidence of CD4, viral load, highly active antiretroviral therapy (HAART), or HIV-related medical visit from January 1 to December 31, 2009. Further information on the 2010 Unmet Need Framework for VA, which is the most recent, can be found in the 2012 Statewide Comprehensive Plan (SCP).

b. Description of needs which obstruct access to care for HIV-Positive individuals, including gaps and overlaps in care, as well as priorities in addressing underserved populations

PLWHA face a number of gaps and barriers to accessing medical care. Care locations may be difficult to reach and/or services may not be offered at days or times convenient to the individual. Reaching a care site can be exacerbated by a lack of resources for transportation. Federal funding reductions have impacted the availability of supportive services, including food banks and support groups, as funds are shifted to ensure PLWHA have access to primary medical care and medications. Those attempting to access care may be discouraged by facing potential waiting lists for services or by service providers who cannot meet all of the individual's needs. Providers may not have the cultural competency to effectively communicate with a client and their families. PLWHA may also lack knowledge of existing services, how to access services or may have difficulty navigating complex care or service systems. These difficulties can lead to frustration with providers.

Rural areas of VA experience disparity in access to medical care, with medical providers primarily located in the larger cities and towns. Transportation to medical care continues to be an issue across the state. In rural areas, travel distances to access medical care can be lengthy while in urban and suburban settings, although clients may not experience lengthy distances, accessibility to care and means of transportation are still challenges. Public transportation is unevenly distributed and those unable to access public transportation typically take expensive taxis to medical appointments. The Brookings Institution recently ranked the top 100 metropolitan areas by transit accessibility. The Richmond and VA Beach-Norfolk-Newport News areas ranked 92nd and 78th respectively (Brookings, 2011).

Access to dental care services is inconsistent throughout the state and, in many areas of VA; it is also difficult to access mental health and substance abuse services without private insurance or another payer source. PLWHA consistently identify stigma and lack of opportunities for social networking (e.g. support groups) as issues in communities where people are hesitant to share their HIV status.

In public hearings held in November and December 2011 in the Central and Southwest regions of VA, public comment largely focused on the impact of reductions of federal, state, and local resources. In November 2010, VA ADAP reduced the medication formulary, limited enrollment, and transitioned 247 clients to alternative forms of medication access, primarily pharmaceutical industry Patient Assistance Programs (PAPs). These measures were a result of unprecedented increases in new clients and monthly medication costs. Attendees felt that changes in how

PLWHA access medications and the availability of services cause an extreme strain on PLWHA, service providers, and grantees and that PLWHA could feel apathetic towards care.

c. Description regarding the needs of individuals who are aware of their status but not in care (emphasis on outreach, referral and linkage to care needs)

PLWHA who are aware of their status but are not in care have a number of needs related to outreach, referral and linkage to care. Specifically, PLWHA often have multi-layered problems or concerns and, as initial issues are addressed, deeper and more complex issues surface. As more direction is assumed in their own medical care, individuals may experience increased domestic or family problems, crises of faith, employment instability due to illness or the need to attend medical care, recurring addictions or other high-risk behaviors, or surges of depression related to fears about the future. These experiences can lead to avoidance of care, or complete dissociation from those involved in their HIV care system.

There are many challenges for PLWHA, including but not limited to:

- Adhering to sometimes difficult treatment regimens;
- Dealing with side effects of medications;
- Managing the high costs of care and medications;
- Dealing with other competing life events;
- Dealing with stigma, particularly in rural areas; and
- Recognizing denial in self and/or others.

Many PLWHA may have other co-morbid diagnoses, such as substance use, hepatitis, mental illness, or tuberculosis (TB). The needs assessments in VA consistently indicate a high likelihood for depression among persons with HIV, particularly women in rural areas, creating a need for mental health and counseling services. Also, a significant proportion of our target populations are likely to be uninsured or underinsured and have low incomes, creating needs for supportive services such as transportation, food, housing, and/or job assistance training. As the nation moves toward 2014 and health insurance possibly becomes more widely accessible, uninsured PLWHA may require education on how to utilize insurance to enhance their quality of life.

In addition, some barriers that may impede successful linkages include:

- Not offering services at times or days convenient for clients;
- Locations that are difficult for clients to reach;
- Having waiting lists and not being able to meet all the needs of a client;
- Lack of providers' cultural competence skills, impairing effective communication with clients and their families;
- Lack of resources for transportation to care and other services;
- Lack of knowledge that services exist and/or how to successfully access existing services;
- Difficulty in navigating complex care or service systems, creating frustration with providers;
- Lack of understanding by clients about need for care even when not acutely ill;

- Competing priorities (housing, employment, etc) for PLWHA; and
- Co-occurring conditions including substance abuse and mental health issues.

Late diagnosis is frequent, especially of socio-economically disadvantaged persons who need immediate care. There is a significant percentage of the out-of-care population that consists of poor and disenfranchised, who often do not access health care except in emergencies. While publicly funded services are available to help these individuals access treatment and medications, their lack of regular contact with the health system in general may act as a barrier to seeking HIV services.

Many test sites and Disease Intervention Specialists (DIS) provide "passive" referrals (without establishing follow-up norms). This practice does not support vulnerable populations in navigating complicated systems, understanding intimidating disease concepts, and overcoming numerous barriers to care. In addition, challenges associated with referring individuals into care include transient individuals relocating or seeking services in other states, individuals who indicate that because they do not feel sick, they do not perceive a need for the referral, and individuals who do not follow through on referral but cannot be located, and those who may not be ready for medical services immediately following diagnosis.

The DIS, who are based in each region of the state, contact all newly-diagnosed HIV-positive individuals, regardless of report source, to provide education, partner services (PS), and make referrals for HIV care. Referrals given typically include contact information for a case manager, medical provider and/or a CBO. The DIS also routinely test partners of known positives as well as those that are high risk; reaching the population that is currently unaware of their status.

Some groups (such as sex industry workers, incarcerated populations, and undocumented immigrants) lack familiarity and comfort with the health care system, which may contribute to an unwillingness or reluctance to enter care. There is also a group of PLWHA who are aware of their status but choose not to be in care. Estimations for this group are difficult, given current data collection methods. One method for potentially reaching these individuals is to expand the settings used by RW Parts A and B where needs assessments are administered. RW may not fund all of the types of services utilized by PLWHA. Individuals may be out of medical care for any number of reasons but still may need housing assistance or attend a support group. In this instance, including Housing Opportunities for Persons with AIDS (HOPWA) programs and non-RW funded PLWHA support groups in the cadre of settings where needs assessments are administered will increase data collection on the needs of these individuals.

d. Description of the needs of individuals who are unaware of their HIV status (emphasis on outreach, counseling and testing, referral and linkage to care needs)

VA's regulations require reporting of all positive HIV infections, CD_4 counts, and viral load tests to VDH. However, some providers are reluctant to allow surveillance staff into their offices to review charts and obtain all necessary information. Similarly, laboratories must also report test results but do not collect and report CDC case-defining variables such as race, residence of diagnosis, and mode of transmission. Therefore, data about newly-diagnosed individuals is

incomplete, making it difficult to accurately characterize and successfully target these populations for interventions to increase knowledge of HIV status.

Staffing shortages at local health departments (LHDs) impede follow up on individuals who test but do not receive results, as well as partners of those who test positive. State budget reductions and limits on filling vacant positions have decreased the number of DIS in the state. Currently, approximately forty DIS are available to conduct PS for all HIV-positive test results and Total Early Syphilis (TES). Of those forty DIS, thirty cover numerous LHDs (35 Health Districts) across the state working large case loads and the other ten are VA Epidemiology Response Team (VERT) staff members who can be deployed anywhere in the state. With the expansion of HIV testing to routine health care settings and increased early syphilis incidence in the Northern, Eastern, and Central parts of the state, demand for DIS expertise has increased.

Logistics of testing create another challenge. While VDH has recruited several clinics and emergency departments to incorporate point of care rapid testing into routine delivery of services, sites report difficulty implementing this service due to competing staff demands, time required to perform testing and the need to monitor the proficiency of the testers. Funding for staff to perform testing is another challenge with sites rarely able to take this task on without additional funding. While agencies have expressed an interest, there currently is not enough money to fund all agencies that would be able to do testing in the needed areas.

Co-occurring conditions can compete for an individual's attention and may lower prioritizing knowledge of their HIV status. Examples of these include mental illness, substance abuse, unstable housing, lower socioeconomic status, and involvement with the criminal justice system. There are multiple challenges involved in the provision of test results. It can be difficult to locate individuals, especially transient individuals, those who move across state lines, those who actively avoid contact with the health care delivery system due to undocumented immigration status, and/or those who refuse additional services including results. Real and perceived stigma related to HIV status creates a disincentive to obtain test results. Stigma and discrimination are particular concerns across the state especially in areas with lower HIV prevalence and in some subpopulations. For example, Hispanic or Latino men disclose their HIV-positive status less frequently than White men. Spanish-speaking Latinos disclosed less frequently than English-speaking Latinos. This may indicate that cultural stigma issues, including negative views of homosexuality, traditionally found in Latino culture, may account for these lower frequencies (Zea, Reisen, Poppen, Echeverry, & Bianchi, 2004). Other cultural groups may have similar stigma and discrimination issues that impact disclosure to sexual partners or an individual's decision whether or not to engage in medical care.

Late diagnosis is frequent, especially of socioeconomically disadvantaged persons who need immediate care. There is a significant percentage of the out-of-care population that consists of poor and disenfranchised populations, who often do not access health care except in emergencies. While publicly funded services are available to help these individuals access treatment and medications, their lack of regular contact with the health system may act as a barrier to seeking HIV services.

These "HIV unaware" individuals most likely have never been tested and are engaging in behaviors that put themselves, and others, at risk for HIV and other sexually transmitted infections. Additionally, HIV positive individuals who engage in HIV care and treatment are more likely to be virally suppressed, which further reduces transmission to others and enhances the quality and years of life for that individual.

VDH funds HIV testing through LHDs, some CBOs, and other community settings. However, HIV testing provided through other mechanisms (such as private providers) is only reportable if the results are confirmed positive. There are many challenges in identifying individuals that are at high risk for and/or infected with HIV but are unaware of their HIV status, are aware of their HIV infection but have never been referred to care, or are aware but have refused referral to care. One of the biggest challenges is the disparate data systems that are used to collect relevant HIV screening/testing/behavioral data. HIV screening data is collected on patients seen in LHDs and some CBOs and hospitals regardless of the test result which helps to identify behavioral differences between those that test positive and those that test negative. These data also help to identify certain factors that may increase a person's risk of acquiring or transmitting HIV.

HIV screening is not conducted by all VA providers and the providers that are conducting the screening are often not targeting enough high-risk individuals. This has yielded a lower positivity rate than expected which limits the usefulness of the following data. Of the 71,750 HIV screening tests conducted in 2009, only 226 (0.3%) were newly identified HIV positive cases and of those 19 (0.03%) were not advised of their positive HIV status at the time the paperwork was submitted. While follow-up should be continued with these individuals, it will not significantly reduce the estimated 21% PLWHA that are unaware of their HIV status. In addition, until recently, VA was unable to determine whether any of the HIV-positive individuals not post-test counseled were later contacted as the patient names were not collected in the HIV screening database.

It is difficult to know if the individuals who are "HIV unaware" match the characteristics of individuals who are aware of their status and are reported to VDH. By comparing morbidity, screening, and prevention intervention data, it is possible to see if there is inconsistency between the characteristics of individuals who test HIV-positive and those who are being tested and/or targeted by prevention programs. While the majority of persons diagnosed with HIV/AIDS are male (77%), screening programs are reaching higher proportions of females (58%) than males (42%). Prevention program data is more in line with morbidity (56% male, 42% female). Prevention programs need to increase outreach and testing activities to men and, especially MSM, across the state. To some extent, screening data is skewed because a large number of tests are performed in family planning and sexually transmitted disease (STD) clinics, which serve higher percentages of women. There is still a gap between morbidity and screening/prevention services for the MSM population.

e. Description of needs of special populations including but not limited to: adolescents, IDU, homeless and transgender

Adolescents

Within the category of adolescents, there are two age groups as defined by the CDC. Pediatric HIV cases are defined as individuals known to have been infected with HIV before age 13. The group "Youth" is defined as persons between ages 13 and 24. There are two primary areas identified as pediatric-specific needs in care for minors living with HIV/AIDS in the available literature. First, for adolescents, there is a need to address service gaps and streamline the transition from the pediatric infectious disease clinic setting to the adult infectious disease clinic setting. This transition can be overwhelming and intimidating for an adolescent living with HIV/AIDS, as the environment of a pediatric clinic is quite different than what is found with adult clinics (Fair, Sullivan, & Gatto, 2010). Examples of transition issues include the shift from provider/parent ownership of the child's medical care to the adolescent taking responsibility for their medical care; adapting to the adult clinic's larger and busier setting than what is generally found with pediatric clinics; assessing the adolescent's readiness to change and take on responsibility for medical care (including medication management, where adherence is an issue); and engage in new screenings and services, such as mental health or substance use (Fair et al., 2010).

Second, for all pediatric patients, there is a need to tailor and monitor pharmaceutical doses, as existing and new medications become available to this population, to ensure safe and effective dosing. This is particularly important during adolescence, as the physiological and psychological changes that accompany the onset of puberty can complicate dosing and drug effects (Rakhmaninia, Capparelli, & van den Anker, 2008).

Substance abuse is also a concern for adolescents in general. In 2009, the Youth Risk Behavior Surveillance System found that 24.8% of young people recently consumed at least five or more alcoholic drinks and 20.8% had used marijuana (CDC, 2011). Casual or regular substance abuse users are more likely to engage in risky behaviors (Kaiser, 2002), which lead to further transmission among HIV-positive youth and sexual or needle-sharing partners. A 2010 study which found no increased incidence of substance abuse between HIV-positive youth and uninfected youth of the same age corroborates similar findings from 2003. The 2003 study, however, indicated that HIV-positive youth may have greater need for mental health services than uninfected youth, in part because of emotional or physical abuse (Johnson et al, 2003; Williams et al, 2010).

Those under 13 comprise 0.2% of the PLWHA population in VA, but those between 13 and 24 are 17.3% of the PLWHA population and the majority of these (70%) are male. Black youth represent 76% of new diagnoses even though they account for only 24% of the youth population in VA. Nationally, the number of new HIV infections among persons between 13 and 29 increased by 21% between 2006 and 2009 (Prejean, Song, Hernandez, et al., 2011). In 2010, VA ADAP served 188 persons 24 and younger at a total cost of $850,652. Those between 13 and 24 were 97% of the costs, averaging $996 a month for ADAP, for an average annual cost per person of $11,952.

IDU

IDUs are less likely to receive primary medical care soon after diagnosis (Turner, Cunningham, Duan, et al., 2000; Samet, Freeberg, Stein, et al., 1998), and are less likely to receive HAART (Knowlton, Hoover, Chung, et al., 2001). In addition, IDUs experience high rates of co-morbid psychological disorders, and they are less likely to be employed or insured; yet IDUs are more likely to be hospitalized, as compared to non-IDUs (Purcell, Metsch, Latka, et al., 2004). Explanations include that IDUs reject or avoid certain medical services, for concern that they will be confronted about their drug use, or that certain service providers are not tolerant of the IDU lifestyle. Additionally, Hepatitis B (HBV) and Hepatitis C (HCV) are significant problems amongst IDUs because both are transmitted through infected blood. In 2002, the CDC estimated that within five years of beginning injection drug use, 50-70% of IDUs become infected with HBV and 50-80% becomes infected with HCV. Treatment for HBV and HCV among IDUs can be complicated because of co-morbid conditions or unstable living environments (CDC, 2002).

One study found that IDUs were less likely to receive early intervention program assistance, as they were less likely to be exposed or referred to the program (Molitar et al., 2005). However, this study found that of those IDUs that did make it into the program to receive referrals, they had the highest referral rates and higher linkage rates, as compared to non-IDUs. In addition, it would appear that addressing ancillary areas first, such as social services and housing, increased the likelihood that an IDU would seek medical care (Molitor et al., 2005). This study found that female and male IDU clients had the highest referral rates for social services and housing; and the highest linkage rates for social services, as compared to non-IDU. For this to occur, significantly more points of contact were needed between the IDUs and the patient navigator (PN). Reasons for the increased number of contacts include inconsistent contact information and tenuous housing situations typically associated with IDUs; as well as convincing IDUs that PN programs, such as the one in this study, are tolerant of their lifestyle.

The availability of clean needles or syringes could potentially reduce the risk of HIV among IDUs. However, VA law prevents funding any needle exchange programs. Finally, the literature appears to support linking incarcerated, opiate-dependent IDUs with methadone treatment once released, as this may decrease the risk of HIV transmission, as well as decrease the risk of overdose (Rich, McKenzie, Shield, et al., 2005). Nationally, IDUs with HIV are mostly male (62%) and Black (58%) (CDC, 2009). In VA however, non-Hispanic Blacks comprised most (75%) IDU cases with Blacks accounting for 75% of all IDU cases among males, and 77% of the cases in females. Blacks also made up a majority (52%) of HIV diagnoses in the MSM-IDU risk category. Overall, 35% of IDU diagnoses were among 40-49 year-olds; those who were 50 or older at the time of diagnosis accounted for another 32% (Chen et al, 2010). This corroborates CDC data that seems to indicate either a tendency for IDUs to continue high-risk behaviors at older ages or for testing and diagnosis to occur later in life (CDC, 2009).

Homeless

The homeless population, as a whole, is thought to engage in more high-risk HIV behaviors than what is found with other groups. Specifically, homeless individuals are more likely to engage in

risky sexual practices and intravenous drug use (Allen, Lehman, Green, et al., 1994; Metraux, Metzger, & Culhane, 2004; Rahav, Nuttbrock, Rivera, & Link, 1998). Many homeless are not insured, and often access emergency room care, rather than clinic care. It should be noted that some sex workers fall under this category of "homeless". Homeless individuals often also face high rates of heart and liver diseases, cancer, pneumonia, skin infections, TB, and STDs (National Coalition for the Homeless, 2009).

Similar to, and often overlapping with IDUs, there is a need to address housing situations of the homeless PLWHA in order to improve medical care use and health outcomes. The lack of stable housing negatively impacts the level of HIV medical care (Aidala, Lee, Abramson, Messeri, & Siegler, 2007). It is difficult to maintain contact with the homeless population, as they are transient and do not have stable housing and means of being contacted. Research findings also suggest many homeless people spend the majority of their time and energy trying to obtain the necessary things to live, such as food and shelter (or drugs, in some instances); thus, there is little effort in seeking out medical care and adhering to treatment for their HIV (Gelberg, Gallagher, Anderson, & Koegel, 1997). One study suggests housing as a "core service needed to achieve optimal clinical outcomes for persons living with HIV/AIDS" (Aidala et al., 2007). A second study supports this notion, suggesting that providing housing for homeless PLWHA will improve the health of the individual, which will, in turn, decrease the risk of HIV transmission to the more general population (Kidder, Wolitski, Campsmith, & Nakamura, 2007).

Because of the delay, or lack of testing and medical treatment for HIV/AIDS, homeless PLWHA are more likely to learn of their serostatus later in the progression of the virus, and are more vulnerable to opportunistic infections (OI). For those in treatment for HIV/AIDS, there are several barriers unique to the homeless population. For example, keeping medications in a secure and/or refrigerated location is difficult for the homeless. Homeless individuals are usually unemployed, so there are little or no financial resources for their medical care. In addition, the homeless tend to lack transportation, even in metropolitan areas that have public transportation. As a third barrier, co-morbid psychiatric and substance use disorders are also often present and can interfere with medical care. Therefore, access to mental health and substance use treatment services may be useful.

In VA, the homeless population was estimated to number up to 45,125 in 2010 (.6%). Among homeless persons, the prevalence of HIV is between 3%-20%, with some subgroups having much higher burdens of disease. Data from VACRS shows that in 2010, 7.3% of RW clients reported either "temporary" or "unstable" as their housing status. A Bureau of Justice report released in 2004, states that at least 10% of individuals being released from jails and prisons each year were homeless in the months prior to their incarceration. Homeless populations have been found to have lower rates of antiretroviral usage and adherence to antiretroviral regimens than those PLWHA with stable living situations (Kidder et al., 2007).

Transgender

National data suggest that only 30-40% of transgender individuals regularly access medical care (Feldman & Bockting, 2003). A major barrier to accessing medical care is the lack of

compassionate medical providers trained to work with the transgender population (AIDS Alert, 2011). Other barriers to medical care include fear of social stigma and the fact that many transgender individuals may share needles for injection drug use, and/or hormone use (Sanchez, Sanchez, & Danoff, 2009). With respect to those within the transgender population that are HIV-positive, programs addressing needle use safety and the transmission risks associated with needle sharing may be useful.

The VA Transgender Health Initiative Study (THIS) found that 24% of transgender Virginians surveyed felt discriminated against by a health care provider because of their transgender status or gender expression. Respondents additionally felt discrimination for the same reason in either seeking employment (20%), maintaining employment (13%) or in seeking or maintaining housing (9%). On a related note, 25% of those surveyed reported being homeless at some point in their lives. Common barriers to accessing medical care for all those surveyed included an inability to pay for services, health insurance not covering a service or lack of knowledge about the availability of services (Xavier, Honnold, Bradford, 2007). THIS also found that, of those who reported their HIV status, 10.5% were HIV-positive which was similar to the positivity rates found in May 2011 at the two Transgender Health Clinics in VA (Xavier et al, 2007; Chen et al, 2010).

The ideal resolution for addressing the risks of HIV transmission, along with a holistic health approach within the transgender population (needle sharing, substance use, mental health issues), is the implementation of competent and compassionate care by medical staff with specialized training in the needs of the transgender population.

MSM

The literature seems to focus on young, black MSM and Latino MSM, or MSM of color (Phillips et al., 2011; Magnus et al., 2010; Hidalgo, et al., 2011). Much of the adolescent information located in the first section of this document is thus relevant.

Also similar to the transgender population, young MSM face barriers to care that include competent and compassionate medical care providers. Medical settings that are cognizant of the holistic needs of MSM of color would be useful in educating clients on risk behaviors. The use of motivational interviewing techniques in providing this education is also needed. This would engage and empower the individual and has been shown to change behaviors over time. Additional barriers can include psychosocial issues, such as sexual identity crisis, mental health issues such as depression or anxiety, and substance use.

Interventions and care for this population include those that help identify and link HIV-positive MSM to care. Because young MSM are thought to be the least likely group of youth to return for test results after HIV testing (Hightow et al., 2003), implementation of rapid testing is ideal. Once tested, linking a young MSM to care services should include a holistic approach to address not only the medical management of their disease, but also address other facets of their life that can benefit the individual (e.g., mental health and substance use issues), as well as reduce the risk of transmission to the public.

More than half (55%) of PLWHA in VA in 2009 were MSM or MSM-IDUs. The majority of MSM PLWHA were black (48%) and lived in the Northern (32%) or Eastern regions (30%). Black MSM between 13 and 29 experienced an increase of 62% in new HIV diagnoses between 2005 and 2009 in VA, which is similar to the national trend. There is some evidence that MSM may be underrepresented in the RW system, as MSM represented only 38% of cases in VACRS in 2010. MSM and MSM-IDU also had 45.6% met need in 2010, which is slightly lower than the state average of 48.4%.

While VA-specific cost data on care for MSMs is not available, studies have found that those who present late for care (with CD4 counts less than 200) are more likely to be MSMs. Those presenting late for care had costs that are twice that of those with initial CD4 counts over 200 ($18,448 vs. $8,455 annually) (Krentz, Auld, & Gill, 2004).

For health education, young Latino MSM may need bilingual health educators. This is discussed in more detail in the "Latino" section.

Blacks (excluding young Black MSM)

More than any other racial or ethnic group, Blacks have higher rates of STDs, which can lead to increased instances of HIV. Occurrences of stigma, substance abuse, and poverty, limited access to health care, housing, and transportation are common in the Black community, as is true for other racial and ethnic groups (Kaiser, 2012). The other Black population that is addressed in the literature is African-born Blacks. They have similar issues to other targeted populations including fear of stigmatization. Unique to this group of African-born PLWHA, however, is the incorporation of religious and cultural perspectives on HIV. Interviews with a group of African-born individuals in Minnesota revealed that many referred to HIV as "wasting" or "slimming" disease, therefore they may not understand the reality of HIV; prevention through behavioral modification beyond medication use is not well-established; and openness regarding partner's high-risk behaviors is not prevalent (Malitz & Eldred, 2007).

Linking African-born PLWHA to testing and prevention/care services is crucial, in order to educate this population about HIV/AIDS, modes of transmission, and addressing gender roles. Cultural and religious sensitivities also need to be considered.

Latino/as

Lack of insurance, cultural traits that conflict with current HIV/AIDS testing/treatment efforts, and linguistics are considered major barriers to accessing HIV/AIDS testing, prevention, and care services for many Latino men and women. Cultural factors that need to be addressed include the large presence of MSM and IDUs within the Latino population that may go unreported, as these activities go against the mainstream culture of Latino religious values. Also, there is the presence of "machismo" within the population, where the male dominates and "protects" the home (Rios-Ellis et al., 2008). Latinas may be at a higher risk for contracting the

virus from an HIV-positive male, because there may be fewer instances of condom negotiation or openness about a partner's high-risk behaviors (Rios-Ellis et al., 2008).

Because many undocumented citizens are Latino, they "fall through the cracks" of the public health system, and it may take a concentrated effort to reach this population, depending on geographical locations. Testing efforts need to be adapted to reach this population. As for linking and retaining to care, one study found that peer navigators worked well for linking young Latino MSM with and without co morbid IDU (Molitor et al., 2005). Language barriers can be addressed by providing Spanish-speaking health educators.

Latinos represented 9% of the new HIV diagnoses in VA from 2005-2009, and are almost 8% of the VA population. They tend to be diagnosed at a later age than the rest of the population, with their average age of diagnosis between 35 and 39, while the majority of all diagnoses in VA occur between 20 and 24. Over half of the PLWHA in VA who were Hispanic at the end of 2009 were diagnosed with AIDS (55%). Latinos are overrepresented in the RW system, with 13.6% served in 2010. 272 Latinos were served by ADAP in 2010.

Older Individuals (Age 50 and above, as defined by the CDC)

As a whole, the population of the US is aging, and there is a shortage of physicians with specialty training in gerontology. Epidemiologically, for PLWHA, there are two groups that fall under the category of "older": individuals that are HIV positive and have entered this age group, and those who contract HIV once they have entered this age group. Antiretroviral medications and medical care/medication adherence are thought to be the underlying reasons for increased longevity for those who contract HIV at a younger age.

For those who contract HIV later in life, an overall lack of information, and even acknowledgement of risk, contribute to the increased rates of HIV infection, primarily due to unprotected sex and injection drug use (Lindau et al., 2007; Linsk 2000). Historically, older adults are not a primary target group for prevention messages, and physicians are slow to test for HIV when symptoms arise (Chiao, Ries, & Sande, 1999), due to the assumptions that older individuals are not an "at-risk" group. This delay in testing and the subsequent delay in treatment are quite detrimental, as newly HIV-diagnosed, older individuals have "shorter AIDS-free intervals as well as shorter survival periods" than those who are diagnosed at a younger age (CDC, 2008). This is likely due, in part, to normal declines in immunological functioning exacerbated by the presence of HIV (Adler et al., 1997) and/or drug action issues with medications (pharmacokinetics and pharmacodynamics; Zelentez & Epstein, 1998). A 2007 study found that, despite drug action issues, older individuals sustained high therapy adherence (Silverberg et. al, 2007).

For treatment needs, care providers need to be trained to inquire and recognize health behaviors that may place an older individual at-risk. For example, being cognizant of the relationship status of a patient and recognizing if they are in a monogamous relationship, or may be entering the dating environment. In addition, reviewing HIV risk behaviors at regularly scheduled doctor visits can be helpful in informing patients of risks and how those risks can be avoided. Finally, for prevention and treatment needs of this age group, programs should be mindful of cultural

beliefs and values; and not just in a generational-sense. By 2030, the number of older Black and Latino older adult populations will increase by 265% and 530%, respectively (Coccimiglio, 1997). Thus, cultural ideologies must be addressed in the care of an HIV-positive individual. New diagnoses of HIV among those 50 and older accounted for 15.5% of all new diagnoses in VA between 2005 and 2009, with 62% of these cases among non-Hispanic Blacks. Thirty-seven percent of PLWHA in VA at the end of 2009 were 50 or older, with rates 20 times higher for Black females than white females. The RW service system served 1,961 persons 50 and older in 2010 (30.6%).

Formerly Incarcerated

In 2010, there were approximately 37,776 individuals confined in VA DOC facilities, 26,772 confined in local/regional jails, and an additional 59,517 on Probation and Parole (P&P) in VA. In 2010, VA DOC reported that the cost of housing one inmate was $24,024 for the year and the amount expended for medical services for each inmate was $4,827, but at the facilities that provide mainly medical services to inmates the average cost per inmate per year ranged from $26,331 to $36,337 (VA DOC, 2010). During that same period of time, clinicians at the VCU-IDC provided primary HIV care to approximately 400 incarcerated PLWHA via a telemedicine arrangement with VA DOC. Males comprise 88% of current state prisoners, with 51% of all state prisoners in 2010 being black males.

According to VA DOC, the top ten release locations in the state are in the three regions with the highest burden of HIV infection: Eastern (Chesapeake, Hampton, Newport News, Norfolk, Portsmouth, VA Beach); Northern (Fairfax and Prince William counties); and Central (city of Richmond). Between 2006 and 2008, approximately 12,750 inmates were released back into the community each year. VDH estimates that of those, approximately 625 were PLWHA. When adding jail inmates and individuals on P&P to this estimate, the potential number of PLWHA who are involved with the criminal justice systems becomes 2,060. Managing disease and minimizing risk behaviors are difficult during the important transition period from incarceration to the community. Similar concerns about service gaps and risks of the transition period have been noted in other areas, such as housing, substance abuse treatment, and mental health care.

The extent to which HIV-infected inmates experience ART interruption following release from prison has been studied and found to be very prevalent. Such interruption results in higher risks of health consequences, infectiousness, and treatment resistance. VDH has implemented programs to help address risk for treatment interruption. From April 1, 2010-March 31, 2011, VDH served 97 PLWHA in its Seamless Transition Program (STP), which began in 2000 through collaboration with VA DOC. STP includes pre-release planning with communication between VDH and VA DOC so that medical care and ADAP referrals are established. At the time of release, inmates are provided with a 30-day supply of medications from VA DOC. At the time clients make first contact with their LHD, ADAP provides an additional month of HIV-related medications for individuals meeting ADAP eligibility, to allow time for ex-offenders to complete their linkage to care and other services. VDH is developing strengthened follow-up strategies to ensure linkage to, engagement with, and retention in community-based care and services.

VDH also funds the Comprehensive HIV/AIDS Resources and Linkages for Inmates (CHARLI) program that provided transitional case management and discharge planning for 77 inmates in 2010. Of these, 57% were black males, and 6.5% were between 13 and 24 years of age. In addition, many of the CHARLI clients had housing issues, with over 50% reporting temporary or unstable housing situations at the time of intake into the program.

VDH also funds the Bridge Program at VCU-IDC, which targets HIV-positive individuals newly released from VA DOC who choose VCU-IDC for primary HIV care. The Bridge Program provides mental health assessment and follow-up services regardless of whether the individual has a previously diagnosed mental illness. In 2010, 32 clients were served in the Bridge Program, of which 78% were black males and 47% had an AIDS diagnosis.

Most HIV-positive inmates will qualify for ADAP and RW-funded services upon their release from incarceration. While some individuals are eligible for Social Security Disability (SSDI) or Supplemental Security Income (SSI) and Medicaid or Medicare, it may take several months to have those benefits reinstated. Continuity of care from incarceration to the community can cost several thousand dollars per month.

f. Description regarding any shortfalls in healthcare workforce

Having sufficient numbers of doctors, dentists, nurse practitioners, licensed clinical social workers and other health professionals in VA is of primary importance for PLWHA to have access to quality care and to meet the demand associated with both having increased numbers of insured PLWHA and those who will still be uninsured. There is a shortage of health care workers in the US. With the increase in older Americans, this shortfall is estimated to worsen. The shortage of health care workers affects less populated rural areas more because medical coverage is more likely to be sparse, as compared to urban areas. Additional factors that affect the healthcare workforce for PLWHA include: an increase in the demand for HIV services, a diminishing number of physicians, and other care providers with a specialty in HIV care, and issues with reimbursements and funding (HRSA, 2010).

With the development of pharmacotherapies that are capable of prolonging the progression of HIV to AIDS, thus extending the lives of PLWHA, access to medical services and medications are crucial to the quality of life of PLWHA. For an HIV-positive individual, quality of medical care is directly related to increasing the time between diagnosis and progression to AIDS. Conversely, those who are diagnosed late, or are not engaged in HIV care, are more likely to progress to AIDS faster, as compared to those who enter HIV care early.

Access to quality HIV medical care may decline, as approximately one-third of current providers will retire within the next ten years (Carmichael et al., 2009). Medical students today are reluctant to specialize in HIV care for reasons that include issues related to reimbursement levels/medical school loan debts (HRSA, 2010; Carmichael et al., 2009), and a general reluctance to work with HIV-positive patients due to stigma and discomfort discussing sex behaviors, drug use, etc. (HRSA, 2010). The low reimbursement amount for HIV-positive clients makes it difficult for physicians to earn enough of a salary to pay back medical school loan debt. Considering physicians graduate with about $100,000-$200,000 in debt, it may not be financially feasible for some new physicians to work with a population where many patient

services are covered, or partially-covered, by public funds. Developing reimbursement mechanisms that support the costs of HIV care could assist with this issue and attract new physicians (Carmichael et al., 2009).

Recruiting new physicians with adequate training into the field is imperative, yet results may not be evident for years. In addition to increasing the number of healthcare workforce members, a more short-term solution is to find a more effective way to use the existing staff and infrastructure in a clinic. For example, HRSA recommends that, rather than place the day-to-day care of a patient on the physician, a team approach would be ideal, strategically delegating aspects of care to other members within the clinic (HRSA, 2010). Coined "task shifting", the primary physician maintains the overall medical care of the client, while other members of the clinic staff, such as nurse practitioners or physician assistants, are responsible for aspects of the patient's care that may include "basic guideline-related care" and coordinating other services, such as mental health or case management (HRSA, 2010). Those sites that coordinate and provide multiple services for PLWHA are known as "medical homes" (HRSA, 2010; Carmichael et al., 2009).

VA has about the same physician and dentist population ratio, on average, as the US in general and has more registered nurses, nurse practitioners, and physicians assistants (VHRI, 2010). It is important to note that these figures represent the health care workforce across all specializations and are not specific to those providing care for PLWHA. The Bureau of Labor Statistics (BLS) predicts that, nationally, 3.2 million new wage and salary jobs will be created between 2008 and 2018. This is primarily due to rapid growth in the elderly population. Ten of the twenty fastest growing occupations are related to healthcare. Many job openings should arise in all healthcare employment settings as a result of employment growth and the need to replace workers who retire or leave their jobs for other reasons (BLS, 2012). Even with new job availability, shortfalls are expected in nearly every category of the health care work force (VHRI, 2010).

g. Description of how the input from RW Parts, AETCs, PLWHA, and providers has been incorporated into the SCSN

Input from both PLWHA and RW providers were essential in developing the SCSN and SCP. Public participation in the RW Part B planning process is received on an ongoing basis at state, regional, and local meetings. Since early 2011, shortly after funding challenges with ADAP began, PLWHA and health care provider input has dealt primarily with access to medications no longer on the ADAP formulary and for PLWHA who are on the ADAP wait list. Focus groups with PLWHA and health care providers, conducted across VA in November and December 2011, echoed this sentiment. Additionally, information received also highlighted the impact that other issues, such as concerns with housing or employment, have on the quality of life for PLWHA.

In December 2011, VDH began a needs assessment in the Central region of VA beginning with a PLWHA survey administered at clinic sites, HOPWA providers, support groups, and other PLWHA-specific gatherings. Survey data was analyzed with findings from the most recent Part A and Part B regional needs assessments to determine cross-cutting issues facing PLWHA in VA. Data for the needs assessments are largely derived from the results of PLWHA surveys and

focus groups. A total of 1,273 PLWHA participated in the needs assessments. The top five services listed as being needed by PLWHA are found, in order, in Table 2.

Table 2. Overall Needs from Regional PLWHA Needs Assessments
Ambulatory/Outpatient Medical Care
Oral Health
Medications/ADAP
Housing Assistance
Mental Health

The same needs assessments were also analyzed to determine gaps in services across VA. These needs are defined as a service that an individual indicated as needed but was unable to obtain because either the service was not available or the individual did not know how to access it. It is important to note that gauging needs not met is uneven across the state, as different regions of VA has access to different levels of resources. The top five services that PLWHA were unable to obtain are found, in order, in Table 3.

Table 3. Top Needs (Not Met) from Regional PLWHA Needs Assessments
Housing Assistance
Oral Health
Food Assistance
Legal Services
Emergency Financial Assistance

Many of the services listed as needs not met are typically outside of the scope of services available at many RW providers. While these services are important to many PLWHA, they may have lower priority in times when funding plateaus or is reduced and service priorities are primary medical care, medication access, and medical transportation. As VA moves closer possibly to insuring more PLWHA, funds may be available for some of these support services. This is, in part, because through paying for health insurance for eligible PLWHA, services such as primary medical care, medication, and mental health services may be covered by insurance, freeing funds for other services.

A statewide, cross-part provider survey was developed to collect input from all RW parts and on what they felt were the most important needs for PLWHA in light of reduced federal, state, and local resources. This information is valuable because grantees and providers engage individuals at a variety of points on the continuum of care and can provide a perspective on service needs in ways that are holistic but cognizant of current resources. Twenty-seven responses were received to the survey, with an estimated response rate of 84%. The top five services listed as most important by VAs RW grantees, Part B lead agents, and service providers are found, in order, in Table 4.

Table 4. Top Needs from Virginia RW Grantee and Provider Survey
Ambulatory/Outpatient Medical Care
Medications/ADAP
Mental Health
Oral Health
Transportation

A group of 22 representatives from across VA volunteered to attend a SCSN/SCP planning meeting on January 27, 2012. Representation was achieved from each Part C and D grantee, as well as AETCs, HPG, Norfolk Part A grantee, Norfolk and Washington, DC Part A Planning Councils and PLWHA. This meeting was held to outline the overall vision for the system of HIV care in VA, discuss PLWHA need information, and review proposed goals and objectives for the 2012 SCP. The assembled group was diverse in background and experiences and represented the various points of engagement on the continuum of HIV care. Input received at this meeting guided the development of both the SCSN and SCP documents.

Overarching themes became apparent as the meeting progressed and served as points to begin crafting the 2012 SCP for building the system of HIV care in VA:

- The impact of increasing insurance coverage on the HIV-positive community, not only among PLWHA, but also among grantees, service providers and other stake holders, and how that will impact cutbacks at the state, federal and local level;
- Having culturally competent approaches to health literacy about wellness and insurance, including the incorporation of relevant technology to that end;
- Reassessing approaches to determining PLWHA need, how needs assessments may change with increased insurance coverage, and the potential for standardization across regional needs assessments;
- Increasing coordination amongst stakeholders regarding data tracking and collection;
- Expanding infrastructure to meet emerging needs through capacity building, expanded coordination between grantees, and the cultivation of new providers.

Part Two: 2012 Virginia Comprehensive HIV Service Plan

Introduction

Development of the 2012 SCP for the RW Part B Program in VA began by assessing the current system of care in VA and the impact of budget reductions on programs that increase health outcomes and the quality of life for PLWHA. Taking these important factors into consideration, VA envisioned an ideal system of care and a road map to achieve that vision over the next three years. This road map incorporates not only statewide and regional needs assessment data, existing resources and current barriers to care, but larger national initiatives such as, the NHAS, the Patient Protection and Affordable Care Act (PPACA) (Public Law {P.L.} 111-148) as amended by the Reconciliation Act of 2010 (P.L. 111-152), the Early Identification of Individuals with HIV/AIDS (EIIHA), and goals and objectives for Healthy People 2020. This plan considers resources efficiently while also enhancing the quality of care for PLWHA.

A stakeholder meeting was convened in January 2012 by VDH, as grantee of RW Part B in VA, and included participation from all RW Parts, as well as PLWHA and the HPG. This meeting reviewed need data for the 2012 SCSN and played a strong role in the development of goals and objectives for the SCP. Consensus reached at this meeting was that VA will, through coordinated delivery of quality care and support programs, continue to meet the current and emerging needs of PLWHA in VA.

Development of the SCP is situated at a unique point because of the implementation of initiatives related to the PPACA. Action steps taken within this strategic plan will allow VA to more easily transition to an environment where more PLWHA may obtain health insurance. While this change is positive for the health of PLWHA, it can also increase anxiety because PLWHA served by RW may not have familiarity with insurance systems. Goals, objectives, and action steps presented in this document work to alleviate this impact not only PLWHA, but also service providers and RW grantees around the state. In summary, the 2012 SCP puts forth the following vision:

> To create a system of care in VA that meets the goals of the NHAS by: reducing geographic and demographic disparity in access to services among PLWHA; empowering PLWHA with knowledge toward a better quality of life; enabling grantees and other stewards of HIV/AIDS funding to speak with a coordinated voice; replicating strengths and sharing lessons learned across disciplines; and affirming, through the provision of services, the philosophy of treatment as prevention.

1. Where are we now?

a. Description of local HIV/AIDS epidemic, at a minimum should include:
   - CY 2010 Epi Profile

VA is a medium-sized southeastern state that consists of 95 counties and 39 independent cities. The population in VA reached 8.0 million in 2010, accounting for 2.6% of the nation's total

population of 308.8 million (US Census, 2010). There were 23,042 PLWHA in VA as of December 31, 2010, representing 0.29% of the total VA population and 2.9% of the nation's total HIV cases (CDC, 2011). The majority of PLWHA in VA were men (73.5%), Black (60.5%) and diagnosed between the ages of 20 and 39 (66.8%). Mirroring a national trend, VA has been experiencing a dramatic rise in HIV cases among young Black MSM. From 2004-2009, there was a 90% increase in HIV cases among Black MSM ages 13-24 in VA, while cases among White MSM declined. The MSM risk factor accounted for 73.9% of all HIV cases diagnosed in Black persons aged 15-24 in 2010 in VA. MSM accounted for 53% of all those living with HIV in the US at the end of 2006, even though it is estimated that MSM represent between 2-6% of the male US population (CDC, 2010; Lieb, et al., 2011).

The majority of new HIV disease diagnoses in VA are among persons who are Black (63.4% in 2010). Black persons comprise only 20% of VA's population; however, they represent nearly two out of three new cases of HIV disease. Black females are 21 times more likely to be diagnosed with HIV than White females and Black males seven times more likely as compared to White males. Hispanics accounted for 9.5% of the total diagnosed cases in 2010 and were three times more likely to be diagnosed than their White counterparts.

The largest proportion of the 11,609 cases of people living with HIV (not AIDS) (PLWHnA) were males (71.9%), Blacks (62.7%), 40 to 59 years old (56.6%, age as of December 31, 2010), living in the Eastern health region (34.2%), and were MSM (41.2%). Similar proportions were also observed among the 11,433 cases of people living with AIDS (PLWA): 75.2% were males, 58.4% Blacks, 69.5% between 40 and 59 years old, 31.1% living in the Northern region, and 42.4% were MSM.

Newly-diagnosed HIV/AIDS cases in VA decreased 1.7% from 2009 to 2010. The majority of cases diagnosed in 2010 were males (74.6%) and Black (63.3%). Newly-diagnosed AIDS cases increased by 7.2% from 2009 to 2010; in the same period, newly-diagnosed cases of HIV (not AIDS) decreased by 6.8%. Newly-diagnosed cases increased 7.3% for those reported with a risk of infection as MSM, and 15.7% for those that reported heterosexual contact.

During 2010, 68,681 individuals were tested for HIV in VA through the HIV Counseling, Testing, and Referral (CTR) program. Of these, 354 tested positive for HIV infection and 312 were made aware of their status. Among those receiving a positive test result, 262 were referred to medical care.

In summary:

- Black and Hispanic women are twenty-one and eight times more likely to be diagnosed with HIV than White women in VA
- Between 2005 and 2009, one in approximately every 2,450 Black Virginians was diagnosed with HIV compared to one in every 19,670 White Virginians
- At the end of 2009, persons who are Black accounted for the majority (60.5%) of living cases of HIV/AIDS followed by White persons (30.6%) and Hispanics (6.5%).
- A disproportionate number of MSM continue to be heavily impacted. In VA, 65.2% of the diagnosed cases of HIV/AIDS among men, in 2010, were among MSM.

- At the end of 2010, an estimated 9,628 MSM were living with HIV/AIDS; this accounts for more than half of males living with HIV/AIDS (56.8%) and for more than one third of all PLWHA (41.8%) through 2010.

    - Unmet Need Estimate for 2010

VA currently assesses unmet need based on the determination of persons "in care" as indicated by having either a viral load, CD4, evidence of ART administered, or an HIV/AIDS-related health care visit during the 12-month period from January 1 to December 31, 2010 out of the total number of PLWHA in VA. To assess care as defined above, VA utilized data from multiple sources. In 2010, data was obtained and analyzed from eight different sources, including:

1. eHARS - Electronic HIV/AIDS Reporting System (VDH HIV/AIDS surveillance database)
2. VACRS - RW Part B database
3. MMP - Medical Monitoring Project
4. LabCorp - Laboratory Corporation of America (CD4 and Viral Load testing)
5. Mayo Laboratory (CD4 and Viral Load testing)
6. ADAP - Part B medication dispensing database
7. CAREWare
8. Medicaid

Evidence of care obtained from the eHARS surveillance data included all persons with a CD4 count or viral load during the calendar year (CY) 2010. ART information collected in eHARS could not be used however, because it does not include treatment or medical visit dates.

Additional evidence of care was obtained by comparing all PLWHA recorded in eHARS with the other data sources listed above. The VACRS database collects data on all clients served with RW Part B consortia and MAI funds as well as some data from Parts A, C, and D. Since 2006, data were also included on all laboratory tests in the state, including viral loads and CD4 counts. These data sets include demographic data, data related to accessing care (CD4, viral load, ART, or medical visit date) and a unique identifier that uses an algorithm of first and third letters of names and other variables such as date of birth. The algorithm was recreated so that exact matches of cases can be performed and to avoid any potential duplication of unmet need estimations. All questionable matches resulting from this process were manually reviewed.

Data obtained from the remaining data sources were patient-level data that met the care definition as described above, and included names and dates of birth, or unique identifiers. These data were merged using the same principles to the dataset of PLWHA from eHARS. To determine the number of PLWHA, VA used the eHARS dataset and included all PLWHnA and PLWHA residing in VA with a mortality status of living as of December 31, 2010. PLWHA diagnosed elsewhere but now residing in VA were included, while PLWHA diagnosed in VA, but now residing elsewhere were excluded from the count.

The eHARS database is used as the basis for determining the unmet need estimations, based on the above care-related variables. Factors contribute to the under-representation of the number of individuals receiving care, including underrepresentation of data for persons receiving care in the private and insured sector, as well as from the Veterans Administration. As more data sources are explored and electronic laboratory reporting becomes the norm, this estimate will be more accurate.

As of December 31, 2010, there were 23,042 people living with HIV disease in VA. The 2010 Unmet Need Framework indicates that approximately 11,896 (51.6%) of PLWHA are not receiving primary medical care services in VA. This is based on the criteria of no evidence of CD4, viral load, HAART, or HIV-related medical visit from January 1, to December 31, 2010. Individuals with unmet need are more likely to be male (of any race or ethnic group), over age 40, from the Northern, Eastern or Central regions, without an AIDS diagnosis and have a transmission mode of MSM, IDU or MSM-IDU. Unmet Need by Locality in 2010 for PLWHA shows a percentage of care up to 50% for most areas in VA, which is consistent with the current Unmet Need Estimate.

While VDH has been unable to obtain information from some key points of care (Medicare health maintenance organizations, private practices, Veterans Administration, and military providers), consensus is that the true estimate of Unmet Need will decrease as these data are obtained. VDH plans to continue strengthening relationships with the additional data sources developed in 2010 as well as initiate relationships with sources that have not previously provided data for the Unmet Need calculation. In this way, VDH will be able to make a more accurate determination of true unmet need in VA.

- EIIHA/Unaware estimate for CY 2009

The CDC's Estimated Back Calculation (EBC) Methodology serves as the foundation for VA's estimate of the number of unaware of their status for CY 2009. Using the EBC Methodology, the number of living HIV-positive individuals in VA who were unaware of their status as of December 31, 2009 is 5,916.

VA Undiagnosed = ***.21/.79 X 22,257 = 5,916***

To successfully find HIV-positive individuals who are unaware of their status and help them get tested and into care will be more challenging, but approaches are being implemented. It is assumed that some HIV-positive individuals who are unaware of their status are likely to be similar in characteristics to certain groups of PLWHA who know their status. The demographic profiles including place of residence of these groups, using surveillance data, supplemented by needs assessment data will be reviewed:

- The met need population (people in care)
- The unmet need population (people out of care)
- Recently tested/diagnosed individuals (diagnosed in past 12 months)
- Recently tested/diagnosed people with HIV/non-AIDS (diagnosed in past 12 months)

- Late-diagnosed individuals – people diagnosed with AIDS at the time of testing or within 12 months
- National data on HIV-positive incidence rates among specific groups (e.g., incarcerated, IDU) and the size of these populations in VA service areas

Based on these analyses, an adjusted estimate will be made of the number of HIV-positive individuals who are unaware of their status in the VA service area. As people are tested and brought into care, VA will continue to monitor their characteristics in order to refine current efforts.

b. Description of current continuum of care, at a minimum should include:
    - RW funded – HIV care and service inventory (by service category, organized by core and support services)

As discussed in the 2012 SCSN, RW funds core medical and support services in VA through Parts A-D. RW funded services for the 2012-2013 fiscal years (FYs) are listed in Table 5. It is important to remember that the availability of services may vary with PLWHA needs in different regions of the state. Services not funded by RW in VA may be available through other programs, such as indigent care or HOPWA.

Table 5. Ryan White Funded Services in Virginia (2012)

CORE MEDICAL SERVICES	Part A	Part B	Part C	Part D
Outpatient /Ambulatory Health Services	X	X	X	X
ADAP Treatments	X	X		
AIDS Pharmaceutical Assistance (local)	X	X	X	X
Oral Health Care	X	X	X	X
Early Intervention Services	X		X	
Early Intervention Services (MAI)	X	X		
Health Insurance Premium & Cost Sharing Assistance	X	X	X	
Home Health Care				
Home and Community-based Health Services				X
Hospice Services				
Mental Health Services	X	X	X	X
Medical Nutrition Therapy	X		X	X
Medical Case Management (including Treatment Adherence)	X	X	X	X
Substance Abuse Services–outpatient	X	X		

SUPPORT SERVICES	Part A	Part B	Part C	Part D
Case Management (non-Medical)		X	X	X
Child Care Services		X		X
Emergency Financial Assistance				
Food Bank/Home-Delivered Meals	X		X	
Health Education/Risk Reduction		X		X
Housing Services				
Legal Services				
Linguistics Services	X			X
Medical Transportation Services	X	X	X	X
Outreach Services	X			X
Outreach Services (MAI)	X	X		
Psychosocial Support Services		X		X
Referral for Health Care/Supportive Services				
Rehabilitation Services				
Respite Care				X
Substance Abuse Residential				
Treatment Adherence Counseling		X		X

- Non RW funded—HIV care and service inventory (organizations and services)

VDH maintains a web-based HIV/AIDS and STD referral and resource database that allow individuals to find care and support services in their area. The database is populated both through public solicitations and VDH research and, as such, is frequently updated. A resource inventory, from the HIV/AIDS and STD referral and resource database, current as of March 2012, can be found in Attachment 4. The current database can be accessed at:

http://bit.ly/vdhrrg

VDH also provides a statewide toll-free line staffed by trained counselors to answer questions and provide crisis intervention, referrals, and written educational materials regarding STDs, HIV/AIDS, and Viral Hepatitis. The VA HIV/STD/Viral Hepatitis Hotline can be reached at:

1-800-533-4148

Additional resources in locating non-RW funded HIV care and services include, but are not limited to:

- Federally funded health center locator through: http://findahealthcenter.hrsa.gov/Search_HCC.aspx
- HIV/AIDS Service Provider Locator through: http://www.aids.gov/locator/
- Virginia 2-1-1 through either dialing, toll free, 2-1-1 or http://www.211virginia.org/

    - How RW funded care/services interact with non-RW funded services to ensure continuity of care

In order to bridge service gaps and achieve parity/equity in health care access, RW partners with HIV counseling and testing and prevention programs, the correctional system, medical and social service providers, LHDs, and CBOs that reach targeted populations. Both CHARLI and STP help soon to be released inmates access HIV services and care before and after they leave the correctional system. Expanded HIV testing in hospital emergency rooms, partnerships with community health centers (CHCs) and free clinics, and outreach and linkage to care programs offers opportunities to identify, engage, reengage, and maintain HIV positive individuals in care and treatment. LHDs provide HIV and STD testing and treatment, partner notification services, and access to an array of health prevention, screening, and medical services.

Some service needs such as non-HIV related transportation, housing, inpatient hospitalization, and eye glasses cannot be met with RW Part B funding. RW Part B works with housing programs such as HOPWA, PAPs, and public and private community organizations and agencies to link clients to non-RW funded resources that play a critical role in health maintenance and treatment adherence. Agencies that receive non-RW funding for substance abuse and mental health leverage these dollars to provide additional services for their RW Part B clients. The Department of Social Services (DSS) and Department of Medical Services (DMAS) administer social safety net programs and enroll eligible clients in Medicare and Medicaid. HIV planning bodies and client groups such as RW Part A Planning Councils, HPG, and Client Advisory Boards (CABs) also provide insight into ways to streamline and enhance client participation in HIV medical care, treatment, and services.

    - How the service system/continuum of care has been affected by state and local budget cuts, as well as how the RW Program has adapted

Providing quality HIV care to PLWHA is the purpose of RW. It is important to understand how this mission has been affected in light of cutbacks in federal, state, and local resources and the impact of the PPACA. From April 2009-March 2010, VA ADAP experienced extraordinary growth in program utilization, enrollment, and expenses. The increasing demand is explained by several environmental factors:

- In VA, the percent of uninsured persons is estimated at 13.5%, while among those under 65, the percentage is 13.2% (VA Health Care Foundation, 2011). Almost one-third of those living below the Federal Poverty Level (FPL) in VA are uninsured, while Hispanics had the highest uninsured rate (33.2%) compared to other racial/ethnic groups. VA

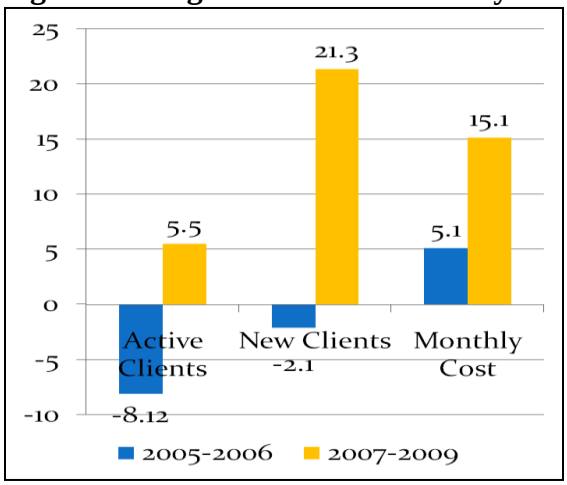
residents who were not U.S. citizens were much more likely to be uninsured (32%) than citizens (11.5%).

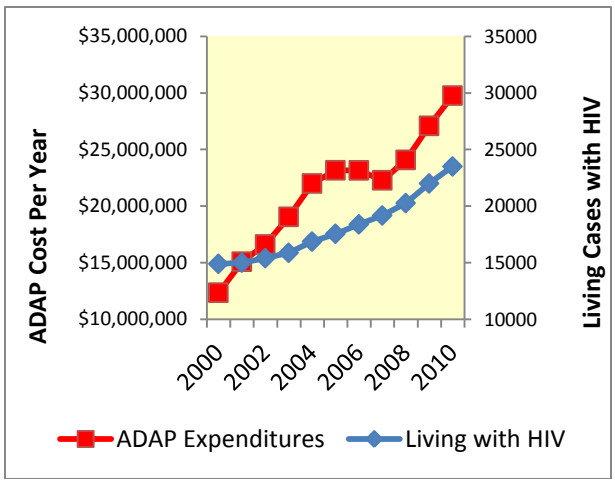
- In VA, Medicaid provides the VA HIV/AIDS Waiver which offers limited services to avoid hospitalization or nursing home placement for PLWHA experiencing medical and functional symptoms associated with HIV/AIDS. In addition to meeting financial eligibility guidelines, PLWHA must have had an inpatient hospital admission within three months of the request for Waiver services. Non-Waiver Medicaid clients must meet both income (less than 80% of federal poverty level (FPL)) and categorical eligibility criteria (pregnant, under 18 years old, elderly, or disabled/blind). Benefits are limited, with VA ranking thirtieth nationwide in per capita payments per disabled enrollee (Kaiser, 2011), forty-second in eligibility and thirty-eighth in scope of services (Public Citizen, 2011). Of the RW population in CY 2011, 55.23% reported no form of insurance, including Medicare and Medicaid.
- The unemployment rate in VA reached a 10-year high of 7.3% in 2010, which was slightly lower than the previous high of 7.8% in 1983, lowering both income levels and percentage of people with health insurance (BLS, 2012). While the most recent unemployment rate is estimated at 5.6% (BLS, 2012), unemployment rates may not fully account for underemployed individuals, which can also impact numbers of people with health insurance.
- While eligibility for VA ADAP requires income be at or below 400% of the FPL, 56% of ADAP, clients were at or below 100% of FPL in CY 2011 (77% were below 200% FPL).
- The release of new HIV Treatment Guidelines calling for earlier initiation of antiretroviral treatment, issued in April 2012. The guidelines offer recommendations with regard to initiation of antiretroviral therapy in treatment-naive patients including the initiation of ART for all HIV-infected individuals and emphasize that effective ART have also been shown to prevent transmission of HIV from an infected individual to a sexual partner and that ART should be offered to patients who are at risk of transmitting HIV to sexual partners (DHHS, 2012).
- In accordance with heightened national testing and linkage to care efforts promoted in the NHAS and guidance from CDC, the various units within the VDH Division of Disease Prevention (DDP) have collaborated to promote and initiate partnerships among DDP-provided services, identify baseline data and innovative strategies to reduce the number of people who become infected with HIV, increase access to care, and reduce HIV-related health disparities. This partnership sets out a new strategic framework to increase coordination within intersecting activities. All of these activities contribute to the goal of guaranteeing that individuals at-risk for HIV or those who have HIV/AIDS have access to, and receive, optimum prevention, health care and support services that extend and improve quality of life.

ADAP has experienced double-digit growth over the last several years in the areas of new clients and monthly costs. Specifically, data analysis demonstrates that from 2007 to 2009 client enrollment and monthly medication costs steadily increased by 21% and 15% respectively (see Figure 2). This steep increase is mirrored in the dramatic increase of program expenditures. Unfortunately, during this time of unprecedented growth, state medication dollars were reduced by $60,000.

Unable to meet increased demand for medication, ADAP enrollment in VA was restricted in November 2010 to children at or under the age of 18, pregnant women and individuals being treated for a current OI. Prior to closing enrollment, several cost containment strategies were implemented related to the management of client enrollment, medication dispensation, and program eligibility. At this time the implementation of an ADAP wait list was also necessary. Through careful and precise management of the wait list, ADAP enrollment criteria increased in both November and December 2011, and in April 2012, to include, as of the writing of this plan, individuals with a CD4 count at or below 500.

Figure 2. Virginia ADAP: Trends by Clients, Annual Cost, and Living HIV Cases





No new cost-containment strategies were instituted in FY 2011. However, in response to a reduction in overall RW Part B funding and a continued ADAP shortfall, VDH worked with contractors and consortia lead agencies to identify cost-savings within their budgets and work plans, which would allow for RW Part B funding to be reallocated for the purchase of medications for ADAP clients. VDH staff worked closely with contractors and lead agents to identify program components that could be reduced or eliminated with a focus on preserving core medical services. Most support services have been eliminated for FY 2012.

ADAP has been disproportionately impacted compared to the trends of those living with HIV/AIDS in recent years, with the number of ADAP clients served (3,958), demonstrating that VA ADAP provides treatment access to 17.7% of known living HIV/AIDS cases. ADAP medication expenditures have increased more rapidly than the number of people living with HIV, as illustrated above. While the number of living cases increased 6.8% from CY 2009 to CY 2010, ADAP expenditures increased 12% for that same time period. The steep increase in ADAP monthly cost and newly enrolled clients is mirrored in a dramatic increase of annual program expenditures, which outpaced resources until a waiting list was instituted in 2010.

In 2012, VDH plans to expand insurance continuation to provide cost-sharing for ADAP clients eligible for the Pre-Existing Condition Insurance Plan (PCIP). VA anticipates that client enrollment in PCIP will help to reduce the ADAP waiting list. PCIP is an available insurance option established through the PPACA. Eligible persons must be: 1) a citizen or legal resident of the US; 2) without health insurance for at least the last six months; and 3) have a pre-existing

condition or have been denied coverage because of a health condition. PCIP will provide comprehensive medical coverage to clients, including prescription drug coverage. VDH conducted research to ensure the HIV care and treatment would be as comprehensive as the current ADAP formulary under PCIP. The research shows that the PCIP formulary is currently more expansive than the VA ADAP formulary. VDH will review the availability of all ADAP medications through the PCIP twice yearly.

Beginning January 1, 2012, the maximum annual out-of-pocket for PCIP is $4,000 for in-network coverage under the PCIP standard plan. Average annual premiums vary by age, ranging from $1,100 to $3,500. Projections assume clients will be enrolled into the standard plan. These projections show that for an average client, even without rebate income, PCIP is cost-effective at a projected annual cost of $6,016 for a typical treatment regimen (three antiretrovirals (ARVs)), compared to $11,328 for direct purchase ADAP. With the expected partial-pay rebate income, PCIP can serve three clients for every one client served under traditional direct purchase ADAP. VDH will monitor expenditures under both programs monthly to ensure that these strategizes continue to be the most cost-effective option. By enrolling ADAP clients onto PCIP, VA will be closer to meeting its major goals toward Healthy People 2020.

In preparation for the implementation of PCIP, VDH is conducting a multi-phased statewide educational campaign to educate PLWHA, health care providers, and other stakeholders on PCIP. Information provided in the initial phases provides a baseline understanding of PCIP, eligibility and its relationship to ADAP. The second phase of the campaign will include specifics, such as the transaction mechanism that will be utilized by clients when going to a pharmacy or medical provider. PLWHA will also be included in the education plan (using PLWHA co-facilitators at educational events when possible) and will be crucial to the process. As the implementation of other PPACA-related initiatives becomes clearer, the educational campaign will evolve accordingly.

- For jurisdictions that lost a TGA, describe the impact on services (only Puerto Rico, NY, NJ and California grantees should respond)

Not applicable for VA.

c. Description of need, at a minimum should include:
    - Care needs

Changes in medication access for many PLWHA in VA have occurred since the ADAP funding challenges began in 2010. Receiving HIV medications from ADAP but needing multiple PAPs to obtain medications for other conditions, like high cholesterol or diabetes, can cause frustration or confusion for PLWHA. Formulary changes and the need for PLWHA to rely on philanthropic access points, like PAPs and Welvista, mean that there are multiple access points for medications. ADAP clients generally obtain HIV medications at a LHD but may receive other medications through a number of different venues.

As stated previously, the formulary for PCIP is more expansive than what is available through ADAP and covers many health conditions. Medications can also be accessed through retail or

mail-order pharmacies. This means insured PLWHA could choose where and how they obtain medications. This solution will not address the concerns of all PLWHA as some are not eligible for PCIP but it is projected to assist a large number of RW clients.

PLWHA frequently cite the need for co-location of services, for example accessing a provider for HIV treatment and a dental provider at the same location. This can reduce transportation as a barrier to care because PLWHA are able to access multiple services from one location. RW clients often are only seen at funded clinic sites and may not be able to see another provider because of a lack of insurance or stigma regarding their HIV-positive status. Client needs also expand beyond the scope of what RW is able to provide in a resource-limited environment. In the 2012 SCSN, top unmet service needs for PLWHA in VA included assistance for housing and food. While these services may be available through other programs, knowledge regarding accessibility remains inconsistently available in the community. Other services, like optometry, are only available to PLWHA if they are insured or have the financial means to pay for out-of-pocket expenses.

- Capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities and rural communities

Capacity development needs within VA include, but are not limited to, access to high-quality medical care, building a system of support services, such as transportation and housing, as well as increasing dental, mental health, and substance abuse services. As mentioned in the 2012 SCSN, the need for transportation to medical care for PLWHA varies across VA. In rural areas the distance is greater which can lead to higher transportation costs and long travel times for a PLWHA accessing care. While distances are not as great in urban areas, travel times can be just as long depending on the method employed by a PLWHA to get to an appointment.

For populations such as MSM, Transgender, Latino/as, or African-born Blacks, a primary capacity development includes the training of culturally competent and empathetic care providers across the state that can provide services across the spectrum of HIV care. This is essential to prevention messages, as well as to engaging and retaining HIV-positive individuals in care. VA, and the nation, will soon experience a decline in the number of HIV specialty-trained healthcare workers, as existing practitioners reach retirement age, and few newly trained practitioners specialize in HIV care, including care for special populations within the HIV-positive community.

d. Description of priorities for the allocation of funds based on the following:
    - Size and demographics of the population of individuals with HIV/AIDS
    - Needs of individuals with HIV/AIDS

Clinical outcomes of programs and the results of the Unmet Need framework are used along with consortia regional needs assessments, annual public hearings, the SCSN, and SCP to ensure available RW Part B dollars are used effectively. This includes establishing service priorities, providing guidance on how best to meet these priorities, providing baseline data for evaluation, and helping providers improve service access and quality.

In the Southwest region of VA, outreach and linkage to care services are conducted through a MAI contractor, to identify, refer, and link to care low-income PLWHA who are newly diagnosed, lost to care, or out of care. The primary goals of the program is to (1) locate and link eligible individuals to HIV-related primary care, ADAP, and other medication access programs, medical case management services, and mental health and substance abuse services as needed; (2) initiate PS, including, but not limited to, solicitation and notification; and (3) facilitate STD, hepatitis and TB screening.

VDH was also recently awarded funding for a four-year SPNS grant for a Systems Linkages and Access to Care for Populations at High Risk of HIV Infection project. The project will develop and implement a health care model to engage HIV-positive individuals in care, targeting those who are unaware of their status, those who are aware but not in care and those who are at risk of falling out of care. This project will utilize active referrals and strengthening of partnerships to improve continuous engagement and retention into primary medical care for PLWHA. The overarching goals of this project are to increase the percentage of newly-diagnosed clients who engage in care within three months post-diagnosis, to increase the retention rate in care, and to develop a referral system to maximize linkage resources while coordinating and streamlining client services. Planning for this project began in FY 2011 and initial pilot tests will take place in FY 2012. This project will be piloted in the Central and Southwest health regions, which comprise both urban and rural areas, consistent with the HIV epidemic in VA.

e. Description of gaps in care

Geographic, socio-economic, and cultural factors contribute to gaps in service provision. Services are more available and accessible in the mainly urban sections of the Commonwealth than in the small, isolated rural communities throughout VA. The state has experienced difficulty recruiting and retaining medical, dental, mental health and substance abuse treatment providers. This is especially true of small practices or agencies in rural areas or practitioners that are unwilling to participate in RW Part B's reimbursement-based structure or to see PLWHA. Reduced numbers and availability of care providers adds to waiting time for appointments, potentially discouraging client initiation and maintenance in HIV-related services. The dearth of public transportation, long distances to care, and limited hours of clinic operation (no evening or weekend hours) may limit access to primary medical care, antiretroviral treatment, and dental, mental health, and substance abuse services.

PLWHA concerns about perceived or actual stigma and discrimination by health care and service providers, disclosure of their HIV status to community members, and language and cultural barriers also act as impediments to accessing care. Those who are underinsured or have policies with high premiums, deductibles, and co-pays may be unable to afford care. Other factors that contribute to HIV-related service gaps include unemployment, lack of understanding about the disease process and how to navigate the system of care, being unaware of HIV support and treatment resources, concern about revealing one's immigration status, HIV-related morbidity, and substance use and mental health issues.

f. Description of prevention and service needs

From a programmatic perspective, the primary service need is to continue to utilize RW funds in the most efficient manner available. This need is underscored by limited ADAP funding resources and the increasing numbers of individuals needing assistance with co-occurring conditions that may or may not be related to HIV (housing, loss of employment, etc). Participants in both 2011 RW Part B public hearings in VA voiced concerns regarding funding reductions at the federal, state, and local level and how those are reconciled with initiatives to seek to bring more PLWHA into the care system.

While the numbers of PLWHA that need assistance are controlled by factors out of the control of safety net programs like RW, enhanced collaboration is needed across RW Parts and non-RW funded agencies to increase the capacity to serve those in need and for RW programs to maintain and improve upon the stewardship of allocated funds. Currently, collaboration regularly occurs with both Part A areas serving VA. The Washington DC EMA and Norfolk TGA have contributed funds to assist VA ADAP. Most Part C clinics in VA also receive funding through RW Part B and work to align service allocations to maximize coverage to PLWHA. Non-RW funded agencies that provide services to PLWHA sometimes assist in regional needs assessment activities and allow RW programs to reach out to clients for education regarding service or program changes. While not all PLWHA reached in these efforts currently utilize RW services, they can act as dissemination points to other members of the community.

RW programs continue to look for new and innovative ways to provide services that increase program effectiveness and efficiency. An expected way for RW Part B to do this is to expand the ability for PLWHA to obtain comprehensive health insurance. Barriers to clients obtaining insurance now include, but are not limited to:

- the expense of insurance coverage for individuals with HIV and other co-morbidities,
- navigating the insurance application process, and,
- instances of low literacy, needs related to employment and/or housing, stigma, mental health and substance abuse issues

With the emergence of affordable coverage like PCIP and the potential for more options for insurance coverage in 2014, these barriers may be alleviated by RW programs enrolling eligible clients in applicable insurance and assisting with the associated costs.

A community services assessment (CSA) identifies the HIV prevention needs of populations at risk for HIV; the current prevention interventions in place to address these needs; and the met and unmet needs of these populations. This includes a needs assessment, resource inventory, and gap analysis. In 2010, as in 2008, the HPG conducted the needs assessment and gap analysis together.

Prior to initiating work on the CSA, the HPG determined that using a behaviorally-based set of priority populations would be helpful to the assessment process. The five target populations identified were: PLWHA, MSM, IDU, High Risk Heterosexuals (HRH), and Transgender individuals. The narrowing of ten target populations (based on the 2008 Comprehensive HIV Prevention Plan) into five categories provided a framework to better discuss target population needs.

The HPG reviewed unmet needs from the last CSA and what had been done to address them. They then applied five categories utilized by the Michigan HIV/AIDS Council to identify and organize target population needs. The categories were defined as:

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

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).

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 (brochures, syringes), or supportive services (HIV counseling and testing). Access also encompasses the cultural, linguistic, and developmental competence of prevention materials, tools, and services.

Supportive Norms: Individuals have the need for more supportive community norms when an individual is unable to initiate or sustain safer behaviors because other people in their community do not value those behaviors.

These categories allowed the HPG to better determine the core need behind statements that came up during brainstorming. 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 identified as a "Skills" need and reframed as "Disclosure Skills" during this process. Utilizing a framework of needs helped guide the generation of needs and allowed for the selection of needs that could be impacted directly by the delivery of HIV prevention services.

The HPG broke into small groups over several meetings to generate needs for each target population. Small groups presented their lists to the full HPG 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.

Priority Needs by Population

When identifying needs that were particular to target populations, HPG also identified two key needs that are applicable to all target populations: HIV education and the need for culturally and linguistically appropriate services. They have not been included below unless they are specifically tied to a population.

PLWHA

Key subpopulations: unaware; not in care; and in care, but not suppressed

- Linkage to care
- Basic HIV 101, HIV medical terms such as viral load and CD4
- Information about available services/resources/eligibility/safe places
- Accept that HIV can be a manageable disease, and life can have quality and meaning
- Condom use and negotiation skills
- Disclosure skills
- Stigma-reducing programs
- Empower PLWHA to be advocates in their communities, churches, etc.

Education, skills-building, and stigma-reduction are needed to empower PLWHA. HIV health care settings are ideal for delivering prevention messages. However, somewhere between 25-50% of physicians within these clinic settings do not address "safer sex" prevention messages; and even fewer reinforce these messages during subsequent visits, with about 64-85% reporting they don't emphasize these messages with existing patients (Gerbert, Brown, Volberding, et al., 1999; Marks, Richardson, Crepaz et al., 2002; Metsch, Pereyra, del Rio, et al., 2004). This demonstrates a gap between what is recommended by public health authorities, such as the CDC, and what actually happens in the clinic setting.

MSM

Key sub-populations: Young Black (16-24), Black, White, and Latino

- How drug use is related to HIV/STD transmission
- How low self esteem, isolation and other factors can impact sexual risk taking
- Take personal responsibility for protecting self and others
- Address internalized homophobia among Black MSM
- Negotiation and communication skills around condom use, sexual risk taking and limits, and rejection
- Supportive families and institutions in minority communities to combat homophobia

MSM have been a focus of HIV prevention for decades, but the need for education is expanding beyond just HIV education. MSM who feel isolated and/or have low self-esteem in general are more likely to engage in higher risk behavior. Addressing internalized homophobia, increasing communication and negotiation skills, and educating about the relationship between drugs and disease transmission are part of a more comprehensive approach needed to reach this population.

HRH

Key sub-populations: Black Females, Black Males, and Latino/as (Northern VA specific)

- The rights of youth to access HIV education, testing and care
- Importance of HIV testing for pregnant women and prevention of perinatal transmission
- Comprehensive HIV prevention education for youth, especially in schools

- Church involvement in combating stigma and setting norms around testing, disclosure and support, especially in the Black communities
- Address stigma, secrets, denial and how they impact HIV transmission, late testing and lack of access to care in rural areas

This is perhaps the largest population and, thus, may have larger concentrations of populations that were formerly addressed individually, such as Youth, Blacks, Latino/as, Women, and Older Adults. Because of this, the need for education is broad. Access to education, testing, and safe spaces to discuss HIV/AIDS are paramount.

IDU (Needle Sharing)

Key sub-populations: Black Males, Black Females, and White Males

- Syringe resources
- Harm reduction skills including safer injection practices and cleaning syringes/injection equipment
- Substance abuse and mental health treatment on demand
- Work to decriminalize possession of drug paraphernalia to increase ability to obtain clean syringes.

The HPG remains committed to the need for access to clean needles or syringes; However, VA paraphernalia laws prevent the implementation of syringe exchange programs. Education regarding how to clean needles or syringes and access to mental health and substance abuse resources, can facilitate IDUs' ability to access treatment and care services.

Transgender

Key sub-population: Male-to-Female

- Risks associated with hormones, silicone usage, and self-medication
- Sex should not be the only means of affirming one's identify as a man or woman
- Safe injection practices
- Medical guidance for healthcare staff to ensure proper handling and treatment of transgender individuals and to screen for possible health concerns like injected industrial grade silicone

Data regarding the Transgender population in general remains limited, as does specific data related to HIV/AIDS. The HPG is committed to being a resource for usable data and a force pushing for more accurate data collection for Transgender individuals. Like MSM, Transgender individuals are more likely to feel isolated which can lead to high risk behavior. Education regarding not just HIV, but the risks associated with hormones, silicone usage, and self-medication as well as safe injection practices, is needed. Education for providers is also a key to ensuring that Transgender individuals who seek care are treated by providers who are knowledgeable of their needs and risks.

g. Description of barriers to care, at a minimum should include current:
    - Routine testing (including any state or local legislative barriers)

In 2008, VA law was changed to allow routine opt-out testing in medical settings without separate informed consent, and the existing perinatal testing law was changed to require routine opt-out testing of all pregnant women. In July 2011, all inmates leaving state correctional facilities are provided with routine opt-out HIV testing prior to their release. It is anticipated that there will be an increased need for centralized coordination to link the offender to an advocate for assistance with basic life needs such as housing, transportation, and applying for other public assistance programs. VDH, through implementation of the SPNS Systems Linkages and Access to Care initiative, will establish a care model to connect an offender to a case manager, PN, or other advocate such as the CHARLI workers located, as of this writing, at four CBOs across the state. Designated program staff will be able to oversee the successful linkages into medical care, access to medications and on-going retention, monitoring health outcomes for this population.

- Program related barriers

From a programmatic standpoint, availability of funding/resources can act as a barrier to care. Medical, pharmaceutical, and support services needs are growing at a time when funding has reached a plateau, or even decreased, in some areas.

As previously mentioned, for the past two FYs, VA has encountered statewide ADAP funding challenges. These challenges led to the implementation of cost-containment strategies including program enrollment restrictions and the need to institute a wait list for ADAP services in FY 2010 and 2011. The drivers behind increased program expenditures leading to the inability to meet client demand included significant state budget reductions, increased program demand due to rises in unemployment, heightened national efforts on HIV testing and linkages into care, and new HIV Treatment Guidelines calling for earlier therapeutic treatments for HIV infection. VDH data analysis demonstrates that from 2007 to 2009, client enrollment and monthly medication costs steadily increased by 21% and 15% respectively.

The previously mentioned challenges for ADAP could not be solved solely by the cost-containment measures instituted in FY10. In response to the continued ADAP funding challenges, Part B HIV service providers responded to requests from VDH to review service utilization and expenditures and identify non-critical areas where their budgets could be reduced and funds could be reallocated toward the purchase of ADAP medications. VDH worked with contractors to ensure minimal interruption to core services during this time.

VA ADAP maintained cost-containment measures into FY 2011. In November 2011, ADAP enrollment criteria were changed to include those with CD4 counts at or below 200 and subsequently were since changed to include those clients with a CD4 count at or below 350. In April 2012, enrollment was expanded to include new and wait-listed clients with a CD4 count at or below 500. These changes in enrollment criteria have been managed incrementally by VA ADAP to ensure the sustainability of re-enrolling clients onto ADAP. Through careful and precise management of the ADAP wait list, program restrictions, and updates to enrollment criteria to expand access, VA ADAP has been able to reduce the wait list from a historic height of 1,112 clients to 584 clients as of June 14, 2012. Additionally, since opening enrollment in

November 2011, the program has transitioned approximately 687 new or wait-listed clients onto ADAP as the same date.

- Provider related barriers

Health care providers face a set of barriers that can include reimbursement issues, funding limitations, navigating multiple data systems, staff turnover, stigma, and cultural competence. Payers may not reimburse at a level that will cover costs required to provide a service. Over time, the feasibility of providing a particular service may lessen. For example, a physician's office may not receive reimbursement from a payer source that adequately covers all of the cost of service provision (salary, rent, utilities, supplies, etc.). This may lead providers to no longer offer specific services under specific payer sources.

Adequate resources and funding for programs/providers are a necessary component of RW service delivery. Funds are utilized to support program staff time, services, and supplies. If changes occur in funding streams, the availability of services can be impacted and providers will face barriers to providing care. Providers are often required to input data into various data systems which can be time consuming and require work duplication. For example, RW Part B funded providers typically enter RW service data into either VACRS or CAREWare. Elements of this data are also entered in electronic medical records systems which often do not interface with either of the aforementioned data bases. Some providers also have separate financial systems which require data entry as well. While funding concerns and multiple data systems can add stress to providers, complex organizational systems can lead to burnout over time.

Providing care for the chronically ill can also act as a significant stressor and can lead to compassion fatigue. Manifestations of this can be seen through sleep problems, depression, and other issues. Both burnout and compassion fatigue can become reasons for staff turnover. These issues can be addressed through work load reassignment, organizational flexibility, mentoring, and training (Slaton, Carson, & Carson, 2011; Maytum, Heiman, & Garwick, 2004).

Providers may also exhibit stigma toward PLWHA. Services may be refused or delivered in an unequal way because of bias regarding HIV, sexual orientation, identity, or some other component of an individual's life (Kinsler, Wong, Sayles, & Davis, 2007). Providers also may lack cultural competency to deliver care in a method that is respectful of language, identity, or culture. In these instances, PLWHA may feel the provider is not prepared to treat their HIV. Trainings are routinely offered through AETCs that educate providers on HIV care and cultural competency.

- Client related barriers

PLWHA face a number of gaps and barriers to accessing medical care. Reaching a care site can be exacerbated by a lack of resources for transportation to care. Those attempting to access care may be discouraged by facing potential waiting lists for services or service providers not being able to meet all of the individual's needs. With the aforementioned changes to ADAP and RW services since November 2010, PLWHA may feel frustrated with or confused by the system of care which could lead to apathy. PLWHA may also lack knowledge of existing services, how services are

accessed, or have difficulty navigating complex care or service systems. Other needs, like housing, employment, or food, may compete for priority for PLWHAs and may make engagement in medical care less of a priority. Co-occurring conditions, like substance abuse or mental health concerns, may also serve as a barrier to care and can exacerbate any of the above.

In general, PLWHA no longer have as many options for health care coverage as they had in the 1990's. Early in the epidemic, many programs provided presumptive eligibility to individuals with an HIV/AIDS diagnosis. Now that more people are living well and longer with HIV, thanks to the advancement of ART, HIV is no longer considered a presumptive disability. As a result, PLWHA have to rely more heavily on programs like RW, community and social services, and private insurance for health care coverage. In addition to the barriers to care described in the 2012 SCSN, there are some additional barriers to care for PLWHA in VA:

- In VA, the DMAS administers the Medicaid program. The biggest gaps in covered services for adult PLWHA are dental (not reimbursed for anyone over the age of 18), case management (not covered at all), and transportation (only covered for medical appointments). The majority of medically indigent PLWHA who are not already receiving SSI and/or SSDI are not eligible for Medicaid in VA because HIV is not considered to be a disabling condition.
- For those individuals who receive benefits through the Veterans Administration, there are still barriers and gaps to care. PLWHA who are obtaining their care through the Veterans Administration have difficulty getting dental services (only emergency services are covered). In addition, coordination of services between Veterans Administration and RW providers does not always happen.
- For those individuals who live in rural areas, many CHCs do not provide HIV care and there are very few health care providers in their local communities who could provide HIV care.
- Another barrier for these PLWHA is lack of public transportation and/or lack of a personal vehicle to transport them to care sites.
- For PLWHA across the state, stigma and fear of disclosure of their HIV status continue to be significant factors in determining whether or not they engage in the HIV care system.

h. Evaluation of 2009 Comprehensive Plan

    - Successes

In evaluating the 2009 SCP, VA first looked back at the environment in which the plan was formulated. When the plan was developed in 2008, RW legislation was on the cusp of reauthorization and amidst increased national efforts to develop plans to reengage those that had fallen out of care. With that in mind, the plan sought to assess the needs of PLWHA across the spectrum of care and began to address the philosophy of care as prevention. The 2012 plan seeks to replicate those intentions and will build on what was a strong foundation to take the RW community in VA towards a world where PLWHA continue to be empowered to have healthy lives.

Goal I sought to guarantee that PLWHA have access to, and receive, optimum prevention, care, and support services to improve quality of life. This goal has been accomplished, in part, through the activities of the of the Quality Management (QM) Program. The program has progressed from an informal Quality Assurance (QA) program to a highly-functioning Quality Improvement (QI) program incorporating all of its stakeholders. VDH has utilized the "Plan," "Do", "Study," and "Act" (PDSA) framework to address all disciplines involved in the provision of HIV care. The QM Program consists of a series of interrelated ongoing activities and tools including the development of a strategic QM plan, the development of performance standards and measurements, trainings in collaboration with the AETCs and VA HIV/AIDS Resource and Consultation Centers (VHARCC), data collection, technical assistance (TA) and analysis of Needs Assessment and client outcomes and satisfaction data.

The mission of the VDH QM Program is to promote continuous quality improvement by meeting the RW HIV/AIDS Treatment Extension Act of 2009 requirements for QM. These requirements include: 1) measuring how well HIV health services meet the most recent Public Health Service (PHS) Guidelines, and 2) developing strategies for improving access to quality HIV health services. The VDH QM Program envisions optimal health for all people affected by HIV/AIDS, supported by a health care system that assures ready access to comprehensive, competent, quality care that transforms lives and communities.

VDH also has participated in state and national programs to enhance the quality of care of PLWHA. The HRSA Patient Safety and Clinical Pharmacy Services Collaborative (PSPC) with the Eastern Virginia Medical School (EVMS) is a national effort to improve the quality of care through the integration of health care providers and clients in the provision of clinical pharmacy services. The EVMS team was recognized by HRSA for being a leader in this effort. VDH staff are active in the both the VA and DC Cross-Part Collaboratives which seek to strengthen regional capacity across all RW Parts in the state and Washington DC EMA, respectively.

Goal II was focused on increasing client input into the development, provision, and planning of equitable services for PLWHA. This goal was achieved through increased PLWHA participation on planning and QM groups. VDH also utilizes PLWHA input in programmatic development processes. PLWHA and health care provider questions and/or experiences with health insurance that were the products of regional meetings, focus groups, and key informant interviews were instrumental in developing an educational campaign about PCIP. Components of the presentation actively addressed concerns voiced regarding insurance coverage and quality of life issues. Additionally, the campaign actively seeks to bring PLWHA information in forums like CABs and support groups to increase turnout. Needs assessment tools were developed for implementation in the Central region with direct PLWHA input to ensure cultural competency and effectiveness. These tools will be part of the process when beginning to standardize needs assessment questions across the state.

Participation in these various activities is solidified by sharing program outcomes and the results of feedback through regional and local meetings. Without this mechanism to demonstrate how input is being utilized, PLWHA may not feel motivated to continue participation. It is incumbent on RW grantees and providers to continue these practices because PLWHA offer a level of expertise that is invaluable in creating clear and coordinated programmatic messages.

VDH staff also use the previously mentioned forums to communicate important changes in how PLWHA access care. When a wait list was instituted for ADAP, staff presented information at regional meetings to directly address questions regarding medication access. These methods will be continued in the future to empower PLWHA towards a better quality of life.

Increased collaboration amongst RW Parts, HIV Prevention, and non-RW programs to reduce gaps in the continuum of care was the purpose of Goal III. As stated in the SCSN, no one RW Part typically serves all the needs of PLWHA. Varying levels of coordination have occurred in the past to ensure the continuum of care. However, funding reductions have reemphasized this point as coordination can both maximize resource availability to PLWHA and the allocation of funds by grantees and service providers. For example, providers covering parts of an area also serviced by another provider will frequently meet to determine which services and resources should be provided to reduce effort duplication. Providers that receive multiple funding streams can move funding to accommodate service reductions in another area. While some territorial boundaries and/or resource limitations continue to exist that prevent optimal collaboration, progress has occurred to increase service availability to PLWHA in light of budget reductions.

VDH implemented online resources, the VA HIV/AIDS and STD Resource and Referral Database and the VA Transgender Resource and Referral List, to increase awareness of service availability regardless of funding. Service providers are encouraged to update information annually with VDH. The 2-1-1 and VDH HIV/AIDS and STD Hotline serve as additional reference points for the public to find services. RW Part B service providers also contract with outside agencies to facilitate referrals for service like mental health, substance abuse, or oral health. These agreements can enhance service accessibility to PLWHA and continue to grow the network of care.

- Challenges

There are two primary challenges in the evaluation of the 2009 SCP. The first challenge is that some goals, objectives, or action steps lacked clarity and/or feasibility. Goal II was to include client input into the development, provision and planning of equitable services for at-risk individuals and PLWHA. An objective for this goal was to increase and strengthen opportunities for clients to participate in planning care and provide input access. One action item to achieve this goal was to develop and administer a statewide out of care needs assessment. Administering an assessment to individuals deemed out of care requires that out of care individuals be surveyed in a quantity that makes data analysis representative of the larger out of care population. A way this action step could have been enhanced was to expand current needs assessment strategies and encourage the inclusion of questions determining if a respondent is out of care and what has kept them in or out of care. Administering a needs assessment at clinic sites implies that respondents will be accessing clinic services and, thus, are likely to be in care and receiving coverage through private insurance or an assistance program, like RW. Expanding the survey locations to non-RW funded agencies or attending PLWHA meetings or support groups or utilizing respondent-driven sampling methods are some ways to gather data on accessibility concerns and causes for being in or out of care.

The other identified challenge was that the document was not written to communicate and compensate for changes in the original plan. The creation of a living document should be part of the strategic planning process. A document of this type shows the planning process in motion by organizing the plan from a vision to action steps meant to accomplish goals and objectives. Building the plan with a logic model requires three questions to be answered:

- What problem needs to be addressed?
- What programs or efforts will be implemented?
- What will change if the problem is successfully addressed?

Answers to those questions guide the planning process and will answer additional questions:

- What resources are required to address the problem?
- Who is being served?
- What is the service mechanism?
- What is the desired outcome?
- What outcome was achieved?
- What is the impact?

The use and evaluation of this process will help create goals and objectives that are refined and focused because of previous successes and challenges. When planning, timelines may not adhere to original schedules because of issues in the design, implementation or evaluation phases of a development cycle. Because of this, plans should be monitored to include time for the necessary adjustments that arise so other impacted areas of the strategic planning process are understood.

2. Where do we need to go?

a. Plan to meet 2009 challenges identified in the evaluation of the 2009 Comprehensive Plan

Meeting the above challenges is crucial to the design and implementation of the 2012 SCP and in the provision of RW services for PLWHA in VA. A logic-based foundation with regular updates and refinement based on programmatic or unforeseen changes is essential. VA will post online updates every six months on progress towards goals, objectives, and action steps. In designing the goals, objectives and action steps found in sections below, VA assessed the current continuum of care and issues that PLWHA face to knowing their serostatus, engaging in care, and being retained in care.

The plan will be assessed regularly to compensate for new developments, including the development of the health care exchanges or the decision of the Supreme Court that will occur in 2012. Understanding what insurance coverage will be available for clients and how RW Part B can assist both eligible and ineligible clients will be a significant component to the provision of RW services in the future. Services covered by insurance and cost structures could be different from what is available through PCIP. The large scale implementation of the PPACA may have

unanticipated impacts on services or systems that have yet to be discovered. Being able to adjust and add objectives and/or action steps to compensate will be crucial.

Garnering public input into the development of any plan provides valuable insight and awareness that plan designers may lack. If an individual or group feels that their involvement is not important to the process or respected, those resources could be lost for periods of time. Accordingly, having a living document adds to the accountability of the plan designers and can increase stakeholder buy-in. Stakeholders may not be able to attend community meetings that act as a forum regarding aspects of the plan. Online updates are one way to disseminate information in a more robust way so the most recent plan updates are available and the plan itself is not viewed through a time-specific lens.

b. 2012 proposed care goals

The four proposed care goals for the 2012 SCP are designed to help VA achieve the ideal system of care over the next three years. The goals seek to close gaps in care for PLWHA already engaged in care, address the challenges of identifying and engaging those either unaware of their HIV status or aware but not in care. While the four goals are addressed below, the full work plan with goals, objectives, and action steps is found in Attachment 1.

Goal One: Provide a system of care that identifies individuals who are unaware of their HIV status, engage these individuals in care and address the challenges associated with the EIIHA and continues to meet the current and emerging needs of PLWHA through the coordinated delivery of quality care and support programs.

Goal Two: Ensure that the VA RW Part B program is sustainable and that program direction is aligned with both the NHAS and the PPACA to maximize program effectiveness to community stakeholders.

Goal Three: Include community input into the development, provision, planning, and dissemination of equitable services for at-risk individuals and PLWHA.

Goal Four: Expand current programmatic infrastructure to meet emerging needs, including preparation for the PPACA, so PLWHA are able to seamlessly access medical care as the health care environment changes.

c. Goals regarding individuals aware of their HIV status, but are not in care (UNMET NEED)

All four goals address serving individuals who are aware of their HIV status, but are not in care. Specifically, Goal One is aimed at increased data sharing with VDH units that can provide a more accurate picture on PLWHA and reducing health disparities among communities disproportionally affected by HIV. Collaboration amongst internal and external community partners can increase analysis of the spectrum of HIV care in VA and will impact rates for linkage and retention in care.

Building from Goal One, Goal Two maximizes program effectiveness. Since November 2010, the ADAP formulary has been reduced and ADAP enrollment has been limited. The priorities for services for RW Part B in VA have been primary medical care, medication access, and transportation and have meant difficult reductions in supportive services across the state. Service limitations may frustrate PLWHA. By finding new ways to deliver HIV care in more cost-effective methods (for example: implementing PCIP for eligible ADAP clients), it may be possible to reduce the aforementioned restrictions on supportive services.

Goal Three affirms that the HIV community is an invaluable resource for understanding cross-cutting issues for PLWHA not in care. PLWHA, health care providers, and other community stakeholders engage individuals in ways that grantees may not. Having a community perspective allows VDH to understand issues facing PLWHA in care and to obtain the buy-in of the gate keepers and opinion leaders in the community. Community members involved in planning services also can serve as dissemination points to hard to reach individuals or to those who are unable to participate themselves.

With both a changing health care environment and more insured PLWHA, infrastructure needs to be built and partnerships established to ensure PLWHA have access to care. It is believed that limited access points or awareness about services may serve as a barrier for PLWHA to get in care. Goal Four addresses this concern and expands upon already existing networks, like partnerships with some CHCs, to build capacity for PLWHA to have more options for care.

d. Goals regarding individuals unaware of their HIV status (EIIHA)

Goals One and Three specifically address individuals unaware of their HIV status. In Goal One, VDH will raise awareness about HIV testing and linkages to care through collaboration with community partners. Partner testing will be increased in the Central and Southwest regions through the SPNS System Linkages grant. These action steps are designed to increase numbers of PLWHA who are aware of their status. Numbers of newly diagnosed PLWHA that are engaged in care will be increased through the SPNS grant, which will expand to most areas of VA by 2014-2015. Health disparities among disproportionally affected populations will be decreased through increased collaboration between HIV Care Services (HCS) and HIV Prevention Services (HPS) at VDH to identify gaps or areas in need of expansion. VDH will monitor new directives from the CDC for potential impacts on RW Part B programs. Goal Three will utilize PLWHA newly identified through linkage to care activities to participate in focus groups or key informant interviews. These sessions will assist in the assessment of further barriers to care and the changing needs of PLWHA as they engage in the continuum of care. Newly identified PLWHA may have a different perception of their needs than stakeholders that regularly engage in the planning and provision of care and prevention activities and can offer local-level data to refining linkage to care and other programmatic activities.

e. Proposed solutions for closing gaps in care

One solution that will lead to closing gaps in care is to provide insurance coverage to eligible PLWHA. In 2012, VA will begin to enroll eligible ADAP clients onto PCIP, which is a more cost effective and expansive means of providing medications and medical care to clients. PCIP

currently offers both more medications than what is available on the ADAP formulary and more covered services than what PLWHA are typically able to take advantage on through RW and existing safety-net programs. By implementing PCIP coverage for eligible ADAP clients, it is projected that expenditures for RW services covered by insurance will decrease. This may allow VA to provide additional funds to other primary and support service categories beyond current funding levels because needs for primary medical care, medications, mental health, and substance abuse would be met through insurance.

Not all services that are available through RW (e.g., medical transportation, medical case management, oral health) are typically offered insurance, like PCIP. However, RW can fund these categories in order to provide wrap-around services for insured PLWHA. One instance in which this presently occurs is that RW-eligible PLWHA's who have Medicaid can receive medical case management through RW Part B in VA. Additionally, not all ADAP clients will be eligible for PCIP or for insurance coverage scheduled to be available in 2014. VDH has done data analysis on the current ADAP clients and PLWHA on the ADAP wait list and estimate that 75-80% would be eligible for PCIP. ADAP eligibility criteria have increased in November and December 2011, and April 2012, partially because of pending PCIP implementation. Costs incurred for clients on PCIP (premiums, co-pays, deductibles, and co-insurance) are less than the cost for the average drug regimen for an ADAP client. Additionally, rebate revenue will result from using ADAP funds for medication copayments. In this way, VA is able to more efficiently provide services. As more individuals are enrolled onto PCIP, additional assessments will be done to assess if ADAP eligibility can be increased further. PCIP serves as a bridge until 2014 when health insurance may be more available. As specifics of coverage are known, VA will analyze options to see where insurance can be provided to eligible PLWHA.

Closing gaps in care will continue to be a priority as more PLWHA become insured. Current assessment tools and strategies will need to change to meet this task. Once insured, PLWHA may find a need for additional assistance in areas of health literacy or the availability of wrap-around services. As stated earlier, support service availability may increase as funds are used to provide insurance coverage, which may increase services available for the uninsured. Annual focus groups and interview of PLWHA and health care professionals will be used to understand concerns beyond what may be found in surveys or public meetings.

f. Proposed solutions for addressing overlaps in care

As indicated in the 2012 SCSN, different RW Parts are funded throughout VA. Many of these providers serve overlapping geographic regions. In order to address potential overlaps, VDH proposes to continue and expand attendance at regional planning meetings and invite providers to participate in Part B planning activities. VDH collaborates routinely with agencies that receive more than Part B funding to ensure that RW dollars are used effectively. These activities can also facilitate the sharing of best practices in service provision and will increase the quality of care for PLWHA.

Another mechanism to address overlaps in care is to increase data matches between RW Part B and programs like Medicaid, Medicare, and the Veterans Administration. Coordination between these programs would reduce instances of an insured PLWHA receiving service through a

safety-net program, like RW, when another payer source is available. This coordination would not limit the availability of services, like case management, for RW-eligible PLWHA on Medicaid. Data matches between RW Parts can be enhanced by expanding data input or import into VACRS for all RW providers. This would increase data analysis for service utilization trends at the state, regional or provider levels. Features in VACRS, like the multiple provider report, can allow VA to see if clients receive services at multiple locations, which would also add to understanding utilization trends.

g. Provide a description detailing the proposed coordinating efforts with the following programs (at a minimum) to ensure optimal access to care:

- Part A Services

In the Eastern region of VA, Part A and Part B providers collaborate to coordinate services throughout the region and have coordinated Requests for Proposals (RFPs) in the past. For instance, Part B services cover areas of the Eastern region that Part A does not cover. Additionally, a VDH staff person currently sits the Norfolk TGA Part A Planning Council. These efforts are proposed to continue.

In the Northern region, Part A and B providers meet through the Northern VA HIV Consortium to coordinate services. Additionally, VA serves in a leadership capacity in the RW DC EMA Cross-Part Collaborative, a team consisting of representatives from across all RW Parts as well as PLWHA representatives. This collaborative is increasing coordination, communication, and data sharing in the Washington DC EMA. Representatives from both Part A areas of VA are active in statewide planning and quality management activities and a VDH staff person sits on the Metropolitan Washington Regional Health Services Planning Council. All of the coordinating efforts listed above are proposed to continue as well.

- Part C Services

Five of the six funded RW Part C sites in VA also receive RW Part B funding. The sixth funded Part C site collaborates with dually funded Part A and B agencies and participates in state planning activities. VDH predominantly collaborates with Part C sites once a client has already been identified as HIV-positive to ensure the client is linked and retained in medical care. There is significant coordination between Parts B and C through the VA Cross-Part Collaborative. This group meets quarterly to develop and improve a quality continuum of care statewide to meet the identified needs of PLWHA. VDH also presents information to Part C CABs and medical providers to raise awareness of programmatic changes.

- Part D Services

Part D leadership is active is statewide Part B planning, QM, and SPNS Systems Linkages and Access to Care activities. Both of the funded RW Part D sites receive Part B funding. Funding received by the Part D programs, actively works towards shared goals between Parts B and D. There is close collaboration to eliminate duplicated efforts to ensure that resources are allocated in the most effective manner. These efforts are proposed to continue.

- Part F Services

VDH works closely with the local Pennsylvania/Mid-Atlantic AETC's local performance sites in planning educational conferences and videoconferencing for local ADAP Coordinators, medical providers, case managers, and other professionals working with PLWHA. The AETCs offers didactic onsite clinical trainings to service providers at area clinics and medical centers several times a year on the treatment of HIV to ensure clients receive medication therapies consistent with current DHHS treatment guidelines. AETCs also coordinate logistics and serve as trainers for activities related to the SPNS grant. Additionally, VDH collaborates with the AETCs to provide regional QM trainings each year. The above activities are proposed to continue over the time period of the SCP.

- Private Providers Non-RW Funded

With the implementation of PCIP and other PPACA-related initiatives, VDH anticipates more interaction with private providers and will educate linkage, surveillance, and prevention programs to interface with that sector. SPNS affiliated linkage programs could also benefit from having private providers involved with those activities, and as such, private providers will be invited to participate.

- Prevention Programs including Partner Notification Initiatives and Prevention with Positives Initiatives

VA has an integrated prevention and care planning body to assist with the coordination of linkages between prevention and care. The HIV Prevention and HIV Care Planners attend meetings jointly to identify areas of collaboration. VDH utilizes four CBOs that conduct HIV testing to provide partner elicitation and testing for people testing HIV positive. The CBOs have achieved a partner index double that of health department-based PS, thereby increasing the number of people unaware of their status who are offered HIV screening.

Since the fall of 2010, the VDH DDP has been conducting presentations on the NHAS and the Engagement in Care model to convey to prevention providers, DIS, other health department staff, and clinical providers, the importance of linkages to care and its connection to achieving undetectable viral loads that result in decreased HIV transmission. DDP work groups have been examining the role of DIS in linking patients to care and are exploring options to better document the linkage process including establishing methods of communication and releases between providers so that linkage to care can be documented.

- Substance Abuse Treatment Programs/Facilities

Substance Abuse treatment in VA is provided through Community Service Boards (CSBs) and private providers/facilities. RW Parts A and C in VA also partner with these providers when referring clients for services. A proposed coordinating effort will include CSBs and private providers/facilities in PCIP and PPACA-related initiative education activities. In-network agencies could see their revenue increase with the addition of more insured clients.

- STD Programs

The VDH DDP includes the Field Services (FS) unit. FS is responsible for the administration of the CDC Comprehensive STD Prevention Systems, Expanded HIV Testing, and Adult Viral Hepatitis Prevention cooperative agreements and has as its primary goal the reduction and prevention of the incidence of STDs including HIV infection. This is achieved through consultation and TA in planning and conducting prevention activities, program evaluation, and training. Diagnostic and therapeutic services are supported through a contract with the state laboratory and the provision of laboratory testing supplies. FS also provides assistance and support in the intervention and prevention of HIV and STD infections through DIS-funded service agreements. The VERT provides onsite assistance to LHDs experiencing increases in STDs. Proposed coordinating efforts include collaboration on the SPNS Systems Linkages and Access to Care Initiative.

- Medicare

VA actively coordinates efforts with Medicare by screening PLWHA accessing RW Part B services for eligibility for any other benefit programs, including Medicare, SSI, SSDI, Veterans health care benefits, or private insurance programs, every six months. ADAP clients who qualify for Medicare Part D prescription drug coverage can access medications through the Medicare Part D Patient Assistance Program (MPAP). Funds are available to pay Part D premiums, deductibles, and co-payments. Data sharing will be explored with the Centers for Medicare and Medicaid Services (CMS) in order to share data on ADAP clients with Medicare Part D.

- Medicaid

As stated above, RW Part B clients are assessed for other payer sources including Medicaid every six months. This helps to ensure that RW is the payer of last resort and complies with HRSA Monitoring Standards. VDH receives Medicaid eligibility data and submits ADAP claims to Medicaid for retroactive reimbursement for those clients who were Medicaid eligible when their ADAP prescriptions were filled. These coordinating efforts are proposed to continue. New efforts will include inviting Medicaid staff to participate in statewide planning initiatives and expanding data sharing.

- Children's Health Insurance Program

In VA, the Children's Health Insurance Program is called the Family Access to Medical Insurance Security Plan (FAMIS). FAMIS is a federal/state program that provides low-cost health insurance for children in families that earn too much for Medicaid but do not have private health insurance. A proposed coordinating effort would be to ensure RW clients that become eligible for FAMIS are assisted with the application and transition process as needed.

- Community Health Centers

CHCs are an ideal location to serve PLWHA because many function as a "one-stop shop" for comprehensive primary health care. Nationally, the PPACA provides additional dedicated funding to expand the reach of CHCs through 2015. VDH already contracts with some CHCs to provide RW services. A proposed coordinating effort with CHCs is to build partnerships with the Virginia Community Healthcare Association (VCHA) to increase the presence of Part B at these locations and to educate CHCs on programmatic changes, such as increased insurance coverage for PLWHA. In early 2012, a survey, created by DDP, was distributed among 25 CHCs regarding the PPACA, services for STDs, including HIV, TB, and related training needs. This survey represents a first step of coordinating efforts.

h. For jurisdictions that lost a TGA, describe the measures to ensure continuity of care in the former TGA (California, New Jersey, New York, Puerto Rico)

Not applicable for VA.

i. For the states which contain the jurisdictions listed below, describe the role of the RW program in collaborating with the Enhanced Comprehensive HIV Prevention Planning and Implementation for MSAs Most Affected by HIV/AIDS (ECHPP) initiative. (NYC, Los Angeles, Washington DC, Chicago, Atlanta, Miami, Philadelphia, Houston, San Francisco, Baltimore, Dallas, San Juan, PR)

Not applicable for VA.

3. How will we get there?

a. Strategy, plan, activities (including responsible parties) and timeline to close gaps in care

As stated in the SCSN, PLWHA face a number of gaps in medical care, including awareness of available services, service location, transportation to and from the site, as well as cultural competency of providers. The strategy to close these gaps in care includes implementation of insurance coverage for PLWHA, facilitation of educational programs on HIV care, standardization of needs assessment efforts across VA, and to co-locate care and prevention services wherever possible. Efforts related to these activities will integrate RW programming with PPACA-related initiatives to build a system of HIV care that facilitates greater accessibility for PLWHA.

Beginning in 2012, VDH will implement PCIP coverage for eligible ADAP clients which will expand access to medications and medical care for those individuals. Some newly insured individuals will be interviewed as a method of evaluation of the transition process and to assess health literacy regarding health insurance. An intensive educational campaign will continue to increase awareness of PLWHAs and community stakeholders on programmatic updates related to the PPACA and to work with service providers to address the needs of the newly insured and those who remain without insurance. Increased collaboration will also occur between HCS and HPS to identify expansions needed for EIS. RW Part B will coordinate collaboration on

standardizing core needs assessment questions that will inform statewide needs data collection and develop new data sharing agreements with agencies that serve PLWHA.

All Goals/Objectives work to close gaps in care.

b. Strategy, plan, activities (including responsible parties) and timeline to address the needs of individuals aware of their HIV status, but are not in care (with an emphasis on retention in care)

In 2012 and 2013, through the SPNS initiative, VDH will establish a process that works with the VA DOC that links HIV-positive inmates to HIV care as they are released from correctional facilities. This process will be part of a centrally managed care coordination model that oversees the new active referral process, patient navigation system, and coordination of services for released inmates. Care coordination will expand the available resources to DOC as referrals are made for medical and support services. The initial appointment follow-up process with be strengthened to ensure a newly released inmate makes their initial appointment which, in the past, has been an area where an individual could "fall through the cracks," as DOC does not have the capability to track an inmate post-release.

As stated previously, all RW Part B and some data from Parts A, C and D are stored in VACRS. In 2012, HIV Prevention data will also begin to be tracked in VACRS as well. Initial data will capture HIV-positive test results from CBOs. This will allow for linkage and retention tracking as individuals migrate to RW-funded care sites. Potential linkage and retention data not captured will continue when PLWHA receive care through non-RW funded providers, as these providers do not input data into VACRS.

To address this barrier and to expand upon existing data sources used to calculate unmet need, VA will obtain data from electronic lab reporting (ELR), which is scheduled to expand in VA in 2013 to all large medical centers. ELR involves the electronic transmission of laboratory reports of reportable conditions (including HIV) to public health agencies, like VDH, in accordance with current law and practice. In 2012, work has already been done to establish agreements with many medical sites for ELR. Over the course of the SCP technical infrastructure will need to be expanded to bring this to fruition.

In addition to improving lab reporting, establishing a data sharing agreement with the Veterans Administration to obtain evidence of care for PLWHA will improve the unmet need estimate. This will be explored by VDH in 2012-2013. The 2010 Unmet Need Estimate indicated that one potential indicator for a PLWHA not likely to be in care is living in either the Central, Eastern, or Northern regions. It is believed that some PLWHA in these regions access care through the Veterans Administration and would not be accounted for in the estimate. By adding to the data sources for unmet need, VA can better understand the numbers of PLWHA that show no evidence of being in HIV care and can work to identify, link and retain those who are truly not in care.

An additional method to meet the needs of PLWHA, who are aware of their HIV but are not in care, is to expand the settings where needs assessments activities are conducted. PLWHA may

or may not access medical care through a RW-funded medical provider, which is a typical method of how PLWHA are reached in RW-funded needs assessment activities. Additionally, clinic sites that see RW Part B clients also typically see PLWHA who may have Medicaid, private insurance or some other form of support. As needs assessments are unrolled, it should be explicitly stated by those conducting the assessments that they are for all PLWHA, not just those accessing RW services. This effort will also enhance data collection on service gaps and will work to reduce those gaps. As such, in 2012 and 2013, VDH will coordinate efforts between Parts A and B in VA to standardize the needs assessment process and recommend that the locations of assessment activities be expanded.

See the following Goals/Objective for related activities and timeline: 1-II, 1-III, 1-IV, 1-VIII, 3-II, and 4-III.

c. Strategy, plan, activities (including responsible parties), and timeline to address the needs of individuals unaware of their HIV status (with an emphasis on identifying, informing, referrals, and linkage to care needs)

The previously mentioned SPNS grant will target HIV-positive individuals who are unaware of their status, individuals who are aware of their status and not in care and those who are in care but are at risk of falling out of care. The project will utilize active referrals and strengthening of partnerships to improve engagement and retention into primary medical care for people diagnosed with HIV and AIDS. In 2012 and 2013, an active referral system will be implemented that more effectively utilizes DIS in the Central and Southwest regions of VA that changes the process at the time of HIV diagnosis to an active referral to HIV care. At the same time, a PN system will be expanded or established in those regions that utilizes motivational interviewing techniques to help patients work through barriers to retention in care and refers patients to a newly established mental health network. These efforts will be evaluated for statewide replication in 2014.

VA has developed a multi-faceted, interdisciplinary plan for addressing individuals who are unaware of their HIV status to make them aware and refer them to care. The plan focuses on identifying HIV-unaware individuals by working in collaboration with RW Parts A, B, C, and D providers, CBOs, medical providers, the DOC, HIV Counseling and Testing programs, HIV/STD/TB Prevention programs, Surveillance, DIS, LHDs, and CHCs. Once identified, VDH works closely with service providers to help them develop strategies to convey test results in a confidential and appropriate manner. For those who test positive, VDH has strategies in place that address treatment engagement and adherence to assist those new to care in engaging the continuum of HIV-related services in VA.

Successful identification of HIV-unaware individuals, making them aware of their HIV-positive status, and linking them to care is where units within the DDP (FS, HPS, HIV Surveillance, and Health Informatics and Integrated Surveillance Systems (HIISS)) at VDH intersect with HCS through an internal work group known as the DDP partnership. Before the partnership, these services had not historically been formally coordinated with RW care services due to, among other things, separate and exclusive funding requirements. Thus, the proposed plan represents a renewed partnership effort to re-engage in active, deliberate coordination of activities to identify

those individuals who are unaware of their HIV status, make them aware of their status, and bring them into care.

By March 2013, DDP, in collaboration with the VA RW Cross-Parts Collaborative and other community partners, will implement a widespread information campaign to raise awareness regarding HIV/AIDS testing and linkages with an emphasis for the campaign on key dates, which may include: National Latino HIV/AIDS Awareness Day (October 15th), World AIDS Day (December 1st), and National Black HIV/AIDS Awareness Day (February 7th).

In 2012 and 2013, VDH will work to establish data sharing across prevention, surveillance, and care units to gather more up-to-date and accurate information on PLWHA. Different information and variables could be drawn from various databases since the focus is on patients with HIV/AIDS infection who are unaware and therefore not in care.

CTR forms are used to collect negative and positive test results, as well as risk behaviors and linkage to care data for positives. In order to improve data quality, the HIV CTR data managers, in collaboration with program staff, will hold a yearly webinar for all sites and review the HIV CTR procedures and protocols document. With changes in personnel at LHDs and CBOs, webinars are needed twice a year along with updated documentation for reference. Common errors encountered during the QA process are also addressed in the webinar.

By March 2013 and ongoing, VDH will coordinate collection of required state and federal HIV CTR data including HIV test results, documentation of rapid and conventional testing quality assurance, and monitoring of service provider trainings.

See the following Goals/Objective for related activities and timeline: 1-III, 1-VII, 1-IV, and 1-VIII

d. Strategy, plan, activities (including responsible parties) for addressing the needs of special populations including but not limited to: adolescents, IDUs, homeless and transgender

Adolescents

VA has seen a dramatic increase in HIV incidence among young (13-29) Black MSM from 2005-2009. During that period, there was an increase of 64% among that group (Chen et. al, 2011). A strategy to address the needs of this group is to explore any opportunity to collaborate with HPS to fill any identified gaps and/or needed expansion related to EIS. The following HPS programs could be utilized in this effort, as well as others:

- HIV Prevention Among Communities of Color (HPACC) – conduct HIV prevention interventions to communities of color at increased risk for HIV infection.
- African American Faith Initiative (AAFI) – provides support through a community-mobilization approach within religious institutions to train clergy and provide congregation education about HIV prevention as well as mentoring other churches in the development of HIV prevention and support programs.

- AIDS Services and Education Grants (ASE) – intended to support outreach, innovative HIV prevention interventions for hard to reach populations and supportive services for persons living with HIV.
- MSM HIV Prevention – created to address a significant disparity between the impact of the epidemic on gay and bisexual men and the amount of funding being targeted to this community, including young black MSM and MSM IDU.
- Primary Prevention With People Living with HIV (P4P) – supports primary HIV prevention (prevention of new HIV infections) by working with HIV-infected individuals; Comprehensive Risk Counseling and Services is provided to individuals identified as engaging in high-risk behaviors that may transmit HIV or those with mental health, substance abuse or medication adherence difficulties.

See Goal 1, Objective III for timeline.

Homeless

Nationally, it is estimated that 1.6 - 3.5 million people experience homelessness in a given year, and estimation in January of 2009 identified 35,652 - 44,565 individuals in VA who were anticipated to experience homelessness in 2009 (National Coalition for the Homeless, 2009; DHCD, 2010). The HIV prevalence among the national homeless population is approximately 3% to 20% (National Coalition for the Homeless, 2009), which would put the estimated HIV cases among homeless in VA between 1,070 and 8,913 cases. A strategy supported by the available literature is to assist homeless individuals with housing which will improve the accessibility of medical care. Without housing, homeless individuals do not have a secure location to store medications, an address to receive medications via mail, and may need to spend more resources to obtain food and shelter. To begin to address the needs of homeless PLWHA, in 2012, VDH will begin to collaborate with organizations and individuals that serve the homeless in order to collect baseline data on treatment adherence and related service gaps. Through this collaboration, further strategies on making HIV care more accessible to homeless PLWHA will be developed. See Goal 1, Objective VIII for timeline.

IDU

As indicated in the SCSN, while needle exchange is not available in VA, IDUs will benefit from harm reduction strategies like education on syringe cleaning. HPS is exploring the utilization of these harm reduction strategies in prevention efforts. To enhance the accessibility of care for IDU, referral resources will be available for primary medical care, mental health, and substance abuse. As part of the previously mentioned SPNS Systems Linkages grant, in 2012 and 2013 resources used to refer PLWHA into care and support services will be refined to make a living resource tool that can be utilized by PLWHA, service providers, and community stakeholders. See Goal 1, Objectives III and IV for timeline.

Transgender

VA benefitted from THIS which was conducted from 2002-2006 with the aim of developing a comprehensive plan for the needs of transgender individuals. To address the needs of HIV-positive transgender individuals, VDH will engage in a new transgender needs assessment.

Development of the needs assessment will begin in late 2012, with initial data being collected in 2013. Research findings will be compared to THIS findings and epidemiological data to determine service gaps and continuing or emerging issues facing the transgender community.

A mixed methodology of surveys, focus groups, and interviews will be utilized. Survey tools will be developed from items used in THIS. This survey will not solely focus on those that are HIV-positive but will seek to determine larger issues for the transgender community. Limitations regarding access to care are not only driven by positive serostatus but are informed by economics, sociology, and cultural constraints. Need data can also inform accessibility issues for all Virginians and can inform service programming and collaboration to provide compassionate care to transgender individuals. See Goal 1, Objective VIII for timeline.

e. Provide a description detailing the activities to implement the proposed coordinating efforts with the following programs (at a minimum) to ensure optimal access to care:

- Part A Services

VDH will continue to be active in both Part A Planning Councils and maintain open communication with Part A on all programmatic updates. Collaboration will continue with agencies receiving both Part A and B funds to ensure that efforts and services are not duplicated. Part A clients, service providers, and stakeholders will be included in all Part B educational campaigns. As SPNS grant activities expand to Part A service areas in 2014-15, efforts will be made to coordinate with existing EIS programs.

- Part C Services

VDH intends to continue current collaborative efforts with Part C sites and to ensure services are not duplicated between Parts B and C. Regardless of funding links, Part C clients, providers, and stakeholders will be engaged in Part B educational campaigns. Two Part C sites are also involved with SPNS activities. As these efforts expand statewide in 2014, additional Part C sites are expected to become involved.

- Part D Services

Service agreements with both Part D sites are expected to continue. Both Part D programs are active in statewide planning and quality improvement activities. Central region Part D staff participates in the SPNS grant. PNs in the Central region of VA will work under the direction of the Central Part D Principal Investigator. Part D clients, providers, and stakeholders will also be included in statewide educational activities.

- Part F Services

VDH will partner with the AETCs to offering training and logistical support related to the SPNS grant in 2012, 2013, and 2014. Additionally, as the statewide educational campaign regarding PPACA-related initiatives expands, service providers in need of HIV training will be referred to

the AETCs to enhance the network of sites that provide services to PLWHA. VDH staff will also serve as speakers for AETC trainings.

- Private Providers Non-RW Funded

Non-RW funded private providers will be engaged in the SPNS grant via the collaborative learning format taking place in 2012 and 2013. These providers are possible care access points for individuals either new or lost to care that will be engaged through the SPNS project. As the SPNS initiative expands statewide in 2014, efforts that were successful in partnering with these providers will be assessed for further replication. Private providers that serve PLWHA will also be targeted in the educational campaign for PCIP and other PPACA-related initiatives, which will take place in 2012, 2013 and 2014.

- Prevention Programs including Partner Notification Initiatives and Prevention with Positives Initiatives

Under the new Comprehensive HIV Prevention for Health Department Cooperative Agreement from the CDC, DDP HPS will be increasing funding for community-based HIV test sites to enhance linkages to care efforts. Potential models may include peer/PNs, strengths-based case management etc. In addition, new funds will be directed to P4P interventions including linkages to and retention in care, behavioral risk reduction interventions for people with HIV and sero-discordant couples, medication adherence counseling, and motivational interviewing. Current contracts will be expanded to serve additional people living with HIV and a new RFP will be issued in 2012 to provide services in areas of the state without the P4P program. Emphasis will be placed on co-locating services within HIV care sites.

VA is working on implementing a rapid-rapid HIV testing protocol in community-based organizations so that individuals with a presumptive positive HIV diagnosis can be referred into care on the day of testing. This will require cooperative between community and clinical sites to ensure that people with HIV are successfully linked and retained in care.

- Substance Abuse Treatment Programs/Facilities

To include substance abuse treatment programs and facilities in the educational campaign for PCIP and other PPACA-related initiatives, VDH will assess which of these facilities and programs receive referrals from RW service providers. Those programs will be invited to local educational programs so newly-insured PLWHA may be able to access services. At the same time, other agencies providing this service that are in-network for PCIP or other insurance coverage in 2014 will be determined and made available to both PLWHA and referring providers.

- STD Programs

As part of the aforementioned SPNS grant, VDH will create an active referral process to accelerate client entry into care; VA will utilize the ability of the DIS to contact all newly-diagnosed Virginians according to Section 32.1-35 of the *Code of Virginia*. The DIS, who are

based in each region of the state, contact all newly-diagnosed HIV-positive individuals to provide education, partner elicitation services, and make referrals for HIV care. DIS and FS staff will also be trained on PCIP and other PPACA-related initiatives that improve upon the accessibility of care for PLWHA in VA. There will also be increased collaboration between HCS and FS regarding PPACA implementation to share best practices and strategies for preparing for programmatic changes and educating community stakeholders.

- Medicare

Eligible clients with Medicare Part D receiving wrap-around services will continue to access medications statewide through either mail-order pharmacy or the retail pharmacy of their choice. All current ADAP clients and individuals on the ADAP wait-list are assessed and re-screened for ADAP eligibility every six months. Clients are assessed for Medicare, Medicaid, and other medication payer sources. VDH will work to establish a data sharing agreement between Medicare and RW Part B that will provide service information for ADAP clients with Medicare Part D.

- Medicaid

In addition to screening RW clients for other payer sources, including Medicaid, and continuing the existing data sharing agreement, VDH will pursue having a Medicaid representative attend statewide planning activities. As Medicaid income eligibility increases, communication from VDH on potential numbers of clients that may transition to Medicaid from RW will occur. In order to not disrupt existing client-provider relationships, RW Part B providers are required, per their contract, to accept Medicaid. Educational efforts will also take place to inform the community on the impact of increased Medicaid eligibility on RW clients. Services, like case management, will continue to be available for Part B eligible clients that transition to Medicaid.

- Children's Health Insurance Program

RW clients becoming eligible for FAMIS will be assisted with program applications and in the transition to that program. Please see the previous section for more information.

- Community Health Centers

VDH already contracts with some CHCs around the state for RW Part B and will explore expanding RW Part B service delivery to additional sites. To expand the presence of Part B services at CHCs, VA will attend statewide meetings of the VCHA to build partnerships and familiarity with these agencies. Education on PPACA-related initiatives that impact the ability of PLWHA to access medical care will be provided as well. Information from the previously mentioned CHC survey will also be utilized to guide interaction. VDH also encourages Part B subcontractors to enter into agreements with CHCs to enhance the availability of services to PLWHA.

f. How the plan addresses Healthy People 2020 objectives

Each of the Leading Health Indicators (LHI) has one or more objectives from Healthy People 2020 associated with it. As a group, the LHI reflect the major health concerns in the US at the beginning of the 21st century. VDH allocates RW Part B funds in a manner that supports progress toward two of Healthy People 2020's major goals: (1) to increase the quality and years of a healthy life and (2) to achieve health equity by eliminating health disparities and improving the health of all groups. This document pertains to the following objectives:

HIV-1: Reduce the number of new HIV diagnoses among adolescents and adults.
HIV-4: Reduce the number of new AIDS cases among adolescents and adults.
HIV-9: Increase the proportion of new HIV infections diagnosed before progression to AIDS.
HIV-10: Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards.
HIV-11: Increase proportion of persons surviving more than 3 years after a diagnosis of AIDS.
HIV-12: Reduce deaths from HIV infection.
HIV-13: Increase the proportion of persons living with HIV who know their serostatus.

VA responds to these objectives in many ways. RW Part B will continue to collaborate with state and federal partners to reach those at risk for HIV and link them to care. Provision of access to primary medical care, supportive services, and treatment for low-income individuals living with HIV/AIDS enables these individuals to live healthier lives and delay the onset of disease progression. The implementation of centralized eligibility determination for ADAP services ensures that eligible clients are appropriately assessed and that follow-up is conducted consistently throughout the state to ensure enrollment into the program. The centralization of lab services provides consistent client access statewide. Increased outreach to link clients who have either never entered care, left care, or have a difficult time maintaining participation in care, to ADAP and other medical services will contribute to increased benefit from available treatment. QM and program monitoring activities evaluate and support the effectiveness and impact of these services.

g. How this plan reflects the Statewide Coordinated Statement of Need

Issues raised in the 2012 SCSN reflect findings from regional needs assessments and other statewide activities, like public hearings and community meetings. The 2012 SCSN serves as the starting point for the creation of the 2012 SCP and is used to identify problems such as lack of sufficient information about available services, lack of coordination of services, barriers to adequate transportation, and service gaps for certain populations such as the recently incarcerated. These service gaps result in clients either under-utilizing care or not accessing care. The proposed plan will help to address these problems by enhancing access to and coordination of care across agencies, empowering PLWHA to continue to be involved in planning services, and to build a stronger network of grantees, health care providers and PLWHA in a changing health care environment.

h. How this plan is coordinated with and adapts to changes that will occur with the implementation of the Affordable Care Act

One of the primary features of the PPACA is to expand the availability of insurance coverage for all Americans, regardless of the existence of a pre-existing condition. While many of the features of the PPACA are scheduled to take effect in 2014, PCIP is available currently to provide affordable insurance for individuals, including PLWHA, that have had difficulty becoming insured because of a pre-existing condition. As stated earlier, VA will begin enrollment of eligible ADAP clients into PCIP in 2012. PCIP is a bridge program until other insurance options are scheduled to be available. When details of those options are available, VA will assess what insurance assistance can be provided to eligible PLWHA.

Many PLWHA in VA have never been insured or have not been insured in some time. Changes will occur to how PLWHA access medications and the types of medical services that are available for insured PLWHA. Health literacy will be a critical issue so PLWHA are able to maximize the care that is available. An education campaign is currently taking place through RW Part B to educate the HIV/AIDS community on these changes. The campaign is designed to make PLWHA familiar with the idea of insurance, in particular PCIP, and how access to medical care can expand with an insured status. Service providers and other stakeholders are also being educated on these changes. The goal of this campaign is for individuals who receive information to serve as potential dissemination points to other community members.

Regional needs assessments for RW Part B occur every two years. Needs assessments for RW Part A are on a similar schedule. There is a small amount of comparable need data gathered across the regions and Parts. For example, not every assessment asks if a respondent is insured, what motivates them to go to care sites, or what makes it difficult to access care. There is the need to establish a core set of questions for assessment surveys that will make aggregating need data easier. This set of questions will not prevent needs assessments from being tailored to regional differences. Each area of VA is unique and faces its own challenges. This aim seeks to facilitate the analysis of need information at the state level.

As more PLWHA begin enrolling in insurance programs, this data will be useful as the PPACA is widely implemented. Lessons learned regarding accessibility are valuable regardless of the type of health insurance for a PLWHA. Access to care issues for insured individuals can be used to modify educational campaigns and program implementation to mitigate barriers. For example, in the current PCIP educational campaign, PLWHA will regularly discuss challenges they or someone else encounters having health insurance. Educational approaches can be modified to address particular questions or concerns when similar information is heard across the state. Capturing this data with a large scale tool, like a survey, can be of use as the health care environment changes with the roll-out of the PPACA. Further refinement will be required in 2014, with the expansion of Medicaid. ADAP and RW clients that become Medicaid eligible may have changing needs regarding service availability. This data will be invaluable in assessing the impact of the PPACA-related initiatives on PLWHA and how this informs larger accessibility questions for PLWHA.

i. Describe how the comprehensive plan addresses the goals of the National HIV/AIDS Strategy, as well as which specific NHAS goals are addressed

The three primary goals of the NHAS are:

- Reducing HIV incidence
- Increasing access to care and optimizing health outcomes
- Reducing HIV-related health disparities

The vision of the 2012 SCP is to create a system of care in VA that is inherently designed to meet the goals of the NHAS. This document serves to expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches planned by individuals with multidisciplinary backgrounds. A seamless system will be established to link people to continuous and coordinated quality care and to support PLWHA with co-occurring health conditions and those who have challenges meeting basic needs. Goals directly relate to the NHAS goal of, "increasing access to care and optimizing health outcomes" by intensifying HIV prevention efforts in communities where HIV is most prevalent. The reduction of HIV incidence is also illustrated, as early HIV medical care also provides additional opportunities for prevention counseling, which may further reduce HIV transmission (Fagan, Bertolli, & McNaghten, 2010). Additionally, these goals directly relate to the NHAS goal of, "increasing access to care and optimizing health outcomes". Health disparities will be reduced through the implementation of health insurance coverage for eligible clients and collaboration between HCS and HPS on EIS activities.

j. Discuss the strategy to respond to any additional or unanticipated changes in the continuum of care as a result of state or local budget cuts

Activities undertaken with the ADAP funding challenges are immediately applicable to scenarios of state or local budget cuts. In the event of additional or unanticipated changes as a result of state or local budget cuts, the VDH budget would first be assessed to improve efficiency before taking measures that would impact clients or service providers. If additional steps needed to be implemented, expenditure patterns would be compared to service utilization to ensure all allocated funds are being utilized.

An additional strategy to respond to unanticipated funding challenges will be to diversify funding streams. Currently, HCS is funded primarily through HRSA. VDH has infrastructure in place to meet and exceed the reporting requirements associated with RW. There is also a demonstrated history of leadership and performance on state and national initiatives related to HIV care that would make VDH strong applicants for additional, competitive sources of funding. While there are no current plans as of this writing to apply for additional funding, it is an option that could be implemented.

VA plans to continue close collaboration with internal and external partners that serve PLWHA. In most areas of VA, no one RW Part accounts for the care for a single PLWHA. As cuts occurs that impact service availability in an area, grantees should communicate programmatic changes and work together to find if alternatives are available. This will also allow grantees to coordinate voices to government bodies about service needs, which was an area of interest at the January 2012 meeting regarding the SCSN and SCP.

4. How will we monitor progress?

a. Describe the plan to monitor and evaluate progress in achieving proposed goals and identified challenges. The plan should also describe how the impact of the EIIHA initiative will be assessed. A timeline for implementing the monitoring and evaluation process should be clearly stated. The monitoring and evaluation plan should describe a process for tracking changes in a variety of areas with a focus on the following:
    - Improved use of RW client level data
    - Use of data monitoring service utilization
    - Measurement of clinical outcomes

To monitor and evaluate this plan, VDH will implement a progress review of goals, objectives, and action steps every six months. Upon this review, updates will be posted electronically on the VDH website to demonstrate progress towards goal achievement. Plan items that require modification will also be addressed during this review. This review process will allow internal and external stakeholders to understand where VA is in working towards building a sustainable system of care that effectively addresses the needs of PLWHA through community collaboration and resource allocation.

VA has a statewide system for RW services data reporting, VACRS, which houses data from all RW Parts in the state, including the Part A areas in the Northern region and the TGA area in the Eastern region as well as the Part C and D that are funded throughout the state. VACRS runs reports at the provider, regional, and state levels for user-specified time periods and also allows users to run the HRSA quality measures for specified time periods and specified funding streams (all RW Parts, only Part B, only Part A, etc.). VACRS also recently implemented an "At Risk of Falling out of Care" report in response to provider concerns. This report allows providers to see a list of their current active clients, their last service date at the provider site, their last medical service date at any RW site, their last case management service date at any RW site, their last lab data date at any site, and their last support service date at any RW site. This report helps providers in assessing if a client is at risk of being lost to care and will assist in retaining clients in care over time.

VDH currently sends data reports quarterly to the Northern consortia lead agency which detail ADAP data for the VA portion of the Washington DC EMA, as well as ADAP waiting list data for the region. These reports include client numbers by county, gender, age, race/ethnicity, and poverty levels. Reports covering the same information for the Eastern region are provided to the Eastern consortia lead agency. These reports are provided to the Part A Planning Councils by the lead agencies.

In 2012 and 2013, additional HIV Prevention data will begin to be included in VACRS. Data collected will primarily include HIV-positive test results from CBOs. This data will allow VA to follow a PLWHA from the time of a positive result to linkage to a RW care site. The prevention unit at VDH currently uses VACRS to enter data for one of their programs, which targets those who are re-entering the community from incarceration. VACRS produces a report so that the prevention staff can see if clients have been linked to care in the RW system. HCS works with other units at VDH to share HIV data for planning and analysis and has access to real-time

eHARS data. This allows for data matching with ADAP and services data to add in demographic and medical data. Data are also shared with the surveillance team from HCS and used as a basis for case investigation.

Additionally, the overarching purpose of RW Part B QM efforts are to: ensure the highest quality care is provided to clients; prevent, identify, and solve problems over time through continuous performance measurement; enable monitoring of HIV-related illnesses and trends in the local epidemic through use of demographic, clinical and service utilization data; assess client needs and build QM capacity within RW Part B-funded agencies statewide; and monitor and evaluate key indicators and measures to detect trends and identify opportunities to improve quality of care and delivery of services. All of the above data analysis contributes to evaluation of program effectiveness and efficiency.

Vision statement: To create a system of care in Virginia (VA) that meets the goals of the National HIV/AIDS Strategy (NHAS) by: reducing geographic and demographic disparity in access to services among people living with HIV/AIDS (PLWHA); empowering PLWHA with knowledge toward a better quality of life; enabling grantees and other stewards of HIV/AIDS funding to speak with a coordinated voice; replicating strengths and to share lessons learned across disciplines; and affirming , through the provision of services, the philosophy of treatment as prevention.

Goal One: Provide a system of care that identifies individuals who are unaware of their HIV status, engage these individuals in care and address the challenges associated with the Early Identification of Individuals with HIV/AIDS (EIIHA) and continues to meet the current and emerging needs of PLWHA through the coordinated delivery of quality care and support programs.

Objective	2012	2013	2014
I. Include individuals from multicultural and multidisciplinary backgrounds and settings to plan and implement interventions aimed at identifying HIV-positive individuals who are unaware of their status.	Engage and establish a multidisciplinary Planning Group and Collaborative for the Special Projects of National Significance (SPNS) Systems Linkages and Access to Care grant from various areas of the HIV care system. SPNS activities will begin in the Central and Southwest regions of VA.	Utilize the multidisciplinary composition of the SPNS Systems Linkages Planning Group and Collaborative to identify what interventions are most effective in accelerating patient linkage to care post HIV diagnosis. Assess effectiveness of piloted interventions in preparation for statewide implementation.	Engage the multidisciplinary SPNS Systems Linkages Planning Group to review and evaluate the effectiveness of the tested systems linkages interventions. Begin statewide implementation of successful interventions.

II. Reduce duplication of effort between various programs and funding streams to maximize resources and increase numbers of PLWHA who are aware of their status.	Collaborate with community partners and implement a widespread information campaign to raise awareness regarding HIV/AIDS testing and linkages with an emphasis for the campaign on key dates.	Continue collaboration and informational campaign. Assess strengths and weaknesses and adjust campaign as needed.	Continue collaboration and informational campaign. Assess strengths and weaknesses and adjust campaign as needed.
	Increase partner elicitation and testing in the Central and Southwest regions at Infectious Disease clinics.	Continue and assess year one activity and prepare for further implementation in other areas of VA.	Continue and expand activity into other regions of VA.
	Utilize Care Coordinators (CC) who will establish connection between Department of Corrections (DOC) discharge planners, the inmate, and the medical care facility/Patient Navigator. Conduct monthly case reviews for patients that fall out-of-care. Collaborate with existing community organizations to locate out-of-care patients. Establish referral resource to be utilized in the field.	Continue and assess year one activity. Make revisions as needed.	Continue and assess years one and two activities. Make revisions as needed.
	Collect linkages data and analyze for baseline outcome data.	Continue data collection, analyze outcome of efforts and compare to previous results.	Continue data collection, analyze outcome of efforts and compare to previous results.

III. Reduce health disparities among populations disproportionately affected by HIV (Blacks, Latino/Latina, MSM and IDU), through ensuring the availability of culturally competent counseling, testing and referral services.	Increase collaboration with HIV Prevention Services (HPS) to fill any identified gaps and/or needed expansion of Early Intervention Services (EIS) programs provided by HPS. Monitor increases in both positive test results in different populations and increased referrals to ADAP as a result of identified newly-diagnosed HIV cases and expanded case definitions.	Expand relationships with correctional facilities, community-based organizations, hospitals, and other organizations that interact with high-risk populations. Continue to monitor referrals.	Evaluate year one and two activities. Continue to investigate referrals.
	Analyze new prevention directives from the Centers for Disease Control (CDC) and potential impacts to care service delivery. Make programmatic recommendations and/or updates as needed.	Continue year one activities to assess new CDC directives and subsequent programmatic impacts.	Continue year one activities to assess new CDC directives and subsequent programmatic impacts.
IV. Increase the percentage of newly-diagnosed PLWHA who engage in care within three months post-diagnosis.	Utilize Planning Group of SPNS Systems Linkages grant to implement strategies across the spectrum of care beginning in the Central and Southwest regions.	Pilot test of SPNS System Linkage interventions in the Central and Southwest regions of VA. Begin evaluation for possible replication statewide.	Continue evaluation of SPNS Systems Linkages interventions to determine changes in unaware population.

V. Increase retention rate in HIV care after initiation.	Review current literature on measuring retention and/or engagement in HIV Care.	Revise statewide measures on retention in care. Compare with retention measures in other states.	Compare old and new measures, revise as needed.
VI. Improve data sharing across prevention, surveillance, and care units at the Virginia Department of Health (VDH) to gather more up-to-date and accurate information on PLWHA.	Facilitate and establish data sharing across prevention, surveillance, and care units to gather more up-to-date and accurate information on HIV/AIDS patients. Revision of Counseling, Testing, and Referral (CTR) Form to include more data on linkage to services for HIV negative persons and more data on linkage to medical care for positives.	HIV CTR data managers, in collaboration with program staff, will hold a yearly webinar for all sites and review the HIV CTR procedures and protocols document to improve data quality.	Continue year two activities and investigate opportunities for further data sharing.
VII. Assess continuing and emerging access to care issues to improve service planning and collaboration among community partners.	Begin design of statewide Transgender needs assessment.	Implement needs assessment utilizing mixed methodology. Begin data analysis.	Continue data analysis and compare with previous research findings.
	Collaborate with community partners that serve the homeless to compile data on treatment adherence.	Use data gathered to integrate with larger access to care issues gathered from regional needs assessments.	

Goal Two: Ensure that the VA RW Part B program is sustainable and that program direction is aligned with both the NHAS and the Patient Protection and Affordable Care Act (PPACA) to maximize program effectiveness to community stakeholders.			
Objective	**2012**	**2013**	**2014**
I. Ensure system of care is sustainable, compatible with the NHAS, the PPACA, and addresses PLWHA needs.	Implement enrollment of eligible AIDS Drug Assistance Program (ADAP) clients in the Pre-Existing Condition Insurance Plan (PCIP). Continue to offer RWPB services to clients not eligible for PCIP and to enrolled PCIP clients that need wrap-around services.	Continue year one activity. Evaluate process, revise as needed. Design system that is compatible with health insurance exchanges. Begin planning and start enrollment of eligible clients into health insurance exchanges.	Evaluate years one and two. Continue eligible client enrollment into health insurance exchanges.
	Monitor the PPACA-related initiatives to evaluate RW Part B capability with health insurance exchanges.	Continue Year one activity. Once health insurance exchange information is available, adjust system of care to match 2014 changes.	Evaluate activity from years one and two. Utilize this evaluation in future program design.
II. Be a voice in increasing internal and external stakeholder knowledge of the PPACA and potential impacts to RW service delivery.	Develop and implement statewide educational campaigns on the PPACA and changes to RW Part B in VA. Campaign would have three components: general information, PLWHA specific, and provider specific.	Update educational materials as needed to reflect most up-to-date information.	Update educational materials as needed to reflect most up-to-date information.

	Assess effectiveness of educational campaigns and evaluate feedback to continuously assess potential barriers to both PLWHA and health care professionals. Share findings and subsequent programmatic updates.	Ongoing. Use findings to inform programmatic updates. Share outcomes with stakeholders to close feedback loop.	Ongoing. Use findings to inform programmatic updates. Share outcomes with stakeholders to close feedback loop.
III. Align RW Part B programming to work with increasing numbers of insured HIV-positive individuals and to continue to serve the needs of the uninsured PLWHA who fall outside of emerging systems.	Work with contractors and community partners to ensure program offerings match with having increased numbers of insured clients and for those who are still uninsured.	Assess successes or difficulties and make additions as needed.	Assess successes or difficulties and make additions as needed.
	Conduct focus groups and/or listening sessions to understand the changing and unchanging needs of clients and service providers to assess how RW Part B can provide or facilitate assistance.	Use findings to inform programmatic updates. Share outcomes with stakeholders to close feedback loop.	Use findings to inform programmatic updates. Share outcomes with stakeholders to close feedback loop.
	Collect data on services utilized by clients enrolled in PCIP program.	Review percentage of persons enrolled in insurance programs (PCIP) compared to those eligible for programs over time. Continue data collection from year one.	Collect service utilization for clients enrolled in health insurance exchanges, compare findings to year one and two data.

IV. Ensure HIV health services provided to PLWHA under RW Part B meet or exceed the most recent Public Health Service guidelines.	Update Quality Management Plan. Disseminate quality expectations for providers and services.	Assess year one activities. Continue with successes and update as needed. Plan for year three.	Assess activities from years one and two. Continue with successes and update as needed. Plan for year subsequent years.

Goal Three: Include community input into the development, provision, planning, and dissemination of equitable services for at-risk individuals and PLWHA.

Objective	2012	2013	2014
I. Increase and strengthen opportunities for direct PLWHA input into the delivery of services.	Utilize regular regional focus groups and other more personalized strategies to facilitate client input and report results to all participants.	Utilize social networking strategies with participants who have responded to previous activities to facilitate entry into prevention and care services.	Evaluate focus groups, social networking activities and continue those that are effective; revise others as needed.
	Recruit PLWHA to co-facilitate client focused events on important programmatic updates.	Continue year one action. Assess successes and barriers and refine approach.	Continue year two actions. Assess successes and barriers and refine approach.

II. Increase and expand opportunities for stakeholders to participate in care planning and provide input on implementation barriers.	Establish small battery of core needs assessment questions and share amongst RW Part A grantees and RW Part B lead agencies. Encourage use of core questions to make analysis of state need information uniform and more efficient in establishing PLWHA needs. Solicit recommendations from community stakeholders on core questions.	Review biennial needs assessments. Assess question batteries utilized by RW Part B lead agencies and RW Part A, reassess question battery as needed.	Review biennial needs assessments. Assess question batteries utilized by RW Part B lead agencies and RW Part A, reassess question battery as needed.
	Design tools and methods to collect data from PLWHA reengaged through Linkage to Care activities to assess barriers to care.	Implement tools and use findings as an additional informational tool to reassess linkage strategies.	Continue year one and two activities and use findings as an additional informational tool to reassess linkage strategies.
III. Identify key community members that could be utilized to assist with recruiting/accessing PLWHA or others affected by HIV for social networking activities to help plan services.	Refine ongoing communication mechanism to provide outcomes of projects to participants and to utilize to identify individuals to participate in planning and implementation of services. Recruit PLWHA to serve on advisory, planning, quality improvement groups.	Assess how many new PLWHA have joined planning groups since year 1 via membership rolls. Collect and analyze findings. Share best practices across the state. Evaluate effectiveness of communication mechanism and adjust as needed.	Assess how many new PLWHA have joined planning groups since year 2 via membership rolls. Collect and analyze findings. Share best practices across the state. Evaluate effectiveness of communication mechanism and adjust as needed.

Goal Four: Expand current programmatic infrastructure to meet emerging needs, including preparation for the PPACA, so PLWHA are able to seamlessly access medical care as the health care environment changes.

Objective	2012	2013	2014
I. Identify and train new providers to meet the needs of both insured and uninsured PLWHA.	Evaluate in-network/out-of-network providers for PCIP. Inform providers of in-network application process via educational campaign. Refer providers for AIDS Education Training Center assistance regarding HIV care.	Continue year 1 activities and adjust to include health insurance exchange information.	Continue year 2 activities and adjust to include health insurance exchange information.
II. Identify and engage emerging and existing resources (Medicaid, Community Health Centers, etc) as PPACA unrolls to maximize accessibility of care for PLWHA.	Attend meeting of the Virginia Community Healthcare Association and offer education and training related to the CHC survey. Invite a state Medicaid representative to RW Part B planning activities.	Assess year 1 activities for progress. Continue or adjust as needed.	Assess year 2 activities for progress. Continue or adjust as needed.
III. Improve data sharing across grantees and community organizations to gather more up-to-date and accurate information on PLWHA, including tracking similar data as more PLWHA are insured.	Establish data sharing agreement with Veterans Administration, Medicaid, and Medicare to improve service utilization data on PLWHA.	Continue year 1 activities as needed. Evaluate quality of data shared. Utilize data to inform PLWHA need/retention analysis.	Assess year 2 activities for progress. Continue or adjust as needed.

Attachment 2: Acronyms

AAFI	African American Faith Initiative
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education Training Center
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
ASE	AIDS Services and Education Grants
BLS	US Bureau of Labor Statistics
CAB	Client Advisory Board
CARE	Comprehensive AIDS Resources Emergency
CBO	Community-based Organization
CC	Care Coordinator
CDC	Centers for Disease Control
CHARLI	Comprehensive HIV/AIDS Resources and Linkages for Inmates
CHC	Community Health Center
CMS	Centers for Medicare and Medicaid Services
CSA	Community services assessment
CSB	Community Service Board
CTR	Counseling, Testing, and Referral
CY	Calendar year
DC	District of Columbia
DDP	Division of Disease Prevention
DHHS	US Department of Health and Human Services
DIS	Disease Intervention Specialist
DMAS	Department of Medical Services
DOC	Department of Corrections
DSS	Department of Social Services
EBC	Estimated Back Calculation
EC	Emerging Communities
eHARS	Electronic HIV/AIDS Reporting System
EIIHA	Early Identification of Individuals with HIV/AIDS
EIS	Early Intervention Services
ELR	Electronic lab reporting
EMA	Eligible Metropolitan Area
Epi	Epidemiological
EVMS	Eastern Virginia Medical School
FAMIS	Family Access to Medical Insurance Security
FPL	Federal Poverty Level
FS	Field Services
FY	Fiscal Year

HAART	Highly active antiretroviral therapy
HBV	Hepatitis B
HCS	HIV Care Services
HCV	Hepatitis C
HIISS	Health Informatics and Integrated Surveillance Systems
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons with AIDS
HPACC	HIV Prevention Among Communities of Color
HPG	HIV Planning Group
HPS	HIV Prevention Services
HRH	High Risk Heterosexual
HRSA	Health Resources and Services Administration
IDU	Injection drug user
LHD	Local health department
LHI	Leading Health Indicator
MAI	Minority AIDS Initiative
MMP	Medical Monitoring Project
MPAP	Medicare Part D Patient Assistance Program
MSM	Men who have sex with men
NHAS	National HIV/AIDS Strategy
OI	Opportunistic infection
P&P	Probation and Parole
P4P	Primary Prevention With People Living with HIV
PAP	Patient Assistance Program
PCIP	Pre-Existing Condition Insurance Plan
PDSA	Plan, Do, Study, Act
PHS	Public Health Service
PL	Public Law
PLWA	People living with AIDS
PLWHA	People living with HIV/AIDS
PLWHnA	People living with HIV not AIDS
PN	Patient Navigator
PPACA	Patient Protection and Affordable Care Act
PS	Partner Services
PSPC	Patient Safety and Clinical Pharmacy Services
QA	Quality Assurance
QI	Quality Improvement
QM	Quality Management
RFP	Request for Proposals
RW	Ryan White
SCP	State Comprehensive Plan
SCSN	Statewide Coordinated Statement of Need
SPNS	Special Projects of National Significance

SSDI	Social Security Disability
SSI	Supplemental Security Income
STD	Sexually Transmitted Disease
STP	Seamless Transition Program
TA	Technical assistance
TB	Tuberculosis
TES	Total Early Syphilis
TGA	Transitional Grant Area
THIS	Transgender Health Initiative Study
US	United States
UVA	University of Virginia
VA	Virginia
VACRS	Virginia Client Reporting System
VCHA	Virginia Community Healthcare Association
VCU-IDC	Virginia Commonwealth University Infectious Disease Clinic
VDH	Virginia Department of Health
VERT	Virginia Epidemiology Response Team
VHARCC	Virginia HIV/AIDS Resource and Consultation Center

Attachment 3: Bibliography

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Attachment 4: Non-Ryan White Funded Resource Inventory

Agency Name	Address	City	State	Zip Code	Phone	Service
AAA Taxi Service	112 North Crater Road	Petersburg	VA	23804	(804) 862-8111	Medical Transportation
ACCESS AIDS Care	248 W. 24th Street	Norfolk	VA	23517	(757) 640-0929	Childcare Services, Case Management, Counseling, Emergency Financial Assistance, Food Pantry, Health Education/Risk Reduction, Medical Transportation, Outreach, and Treatment Adherence
ACCESS AIDS Care: Granby Street Location	3309 Granby Street	Norfolk	VA	23504	(757) 625-6992	Childcare Services, Case Management, Counseling, Emergency Financial Assistance, Food Pantry, Health Education/Risk Reduction, Medical Transportation, Outreach, and Treatment Adherence
ACCESS AIDS Care: Hampton Office	218 South Armistead Avenue	Hampton	VA	23669	(757) 222-5511	Childcare Services, Case Management, Counseling, Emergency Financial Assistance, Food Pantry, Health Education/Risk Reduction, Medical Transportation, Outreach, and Treatment Adherence
Access Now	2201 W Broad Street, Suite 205	Richmond	VA	23220	(804) 622-8145	Outpatient Health Facilities and Services
Accomack County Health Department	P.O. Box 177	Accomack	VA	23301	(757) 787-5880	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Action in Community Through Service	3900 Acts Lane	Dumfries	VA	22026	(703) 221-5983	Food Pantry
Adolescent Health Center	3701 W. Braddock Road	Alexandria	VA	22304	(703) 519-6006	Counseling, Health Education/Risk Reduction, Health Insurance Premium Assistance, HIV Testing, Mental Health, Outpatient Health Facilities/Services, Reproductive Health, STD Screening/Treatment, Substance Abuse, and Treatment Adherence

AIDS Response Effort	333 West Cork Street, Suite 740	Winchester	VA	22601	(540) 536-5293	Case Management, Counseling, Dental, Emergency Financial Assistance, Health Education/Risk Reduction, Health Insurance Premium Assistance, HOPWA, Inmate Pre/Post Release, Interpretation/Translation, Medical Transportation, Mental Health, Substance Abuse, and Treatment Adherence
AIDS/HIV Services Group	P.O. Box 2322	Charlottesville	VA	22902	(434) 979-7714	Case Management, Counseling, Dental, Emergency Financial Assistance, Health Education/Risk Reduction, Health Insurance Premium Assistance, HOPWA, Inmate Pre/Post Release, Mental Health, Outreach, Prescription Medication Services, Substance Abuse, and Treatment Adherence
Alexandria City Health Department	4480 King Street	Alexandria	VA	22302	(703) 838-4400	Dental, Early Intervention Services, Health Education/Risk Reduction, Health Insurance Premium Assistance, HIV Testing, Immunizations, Outpatient Health Facilities, Prescription Medication Services, Reproductive Health, and STD Screening/Treatment
Alexandria Community Services Board	720 N. Saint Asaph Street, 4th Floor	Alexandria	VA	22314	(703) 746-3400	Case Management, Counseling, Early Intervention Services, Health Education/Risk Reduction, Mental Health, Substance Abuse, and Treatment Adherence
Alexandria Neighborhood Health Services, Inc.	2 E. Glebe Road	Alexandria	VA	22305	(703) 535-5568	Case Management, Counseling, Dental, Emergency Financial Assistance, HIV Testing, Mental Health, Outreach, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Alleghany Highlands Community Services Board	205 E. Hawthorne Street	Covington	VA	24426	(540) 965-1180	Case Management, Counseling, Health Insurance Premium Assistance, Mental Health, Reproductive Health, Respite Care, Substance Abuse, and Treatment Adherence
Alleghany Highlands Free Clinic	P.O. Box 216	Low Moor	VA	24457	(540) 862-6673	Case Management, Counseling, Health Education/Risk Reduction, Mental Health, Outpatient Health Facilities/Services, STD Screening/Treatment, and Substance Abuse
Alleghany/Covington Health Department	P.O. Box 747	Covington	VA	24426	(540) 962-2173	Case Management, Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment

Amelia County Health Department	P.O. Box 392	Amelia	VA	23002	(804) 561-2711	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, STD Treatment, and Treatment Adherence
Amelia Healthcare Center	8920 Otterburn Road	Amelia Court House	VA	23002	(804) 561-5150	Counseling, Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Home/Community Base Services, Interpretation/Translation, Mental Health, Outpatient Health Facilities, Reproductive Health, STD Treatment, and Substance Abuse
American Civil Liberties Union-AIDS Project	125 Broad Street, 18th Floor	New York	NY	10004	(212) 549-2627	Counseling
Americare In Home Nursing	6800 Backlick Road	Falls Church	VA	22041	(703) 912-2080	Home Health
Amherst County Health Department	P.O. Box 250	Amherst	VA	24521	(434) 946-9408	Case Management, Counseling, Early Intervention Services, Health Education/Risk Reduction, Health Insurance Premium Assistance, Immunizations, and STD Screening/Treatment
Appalachia Family Health Center	507 W. Main Street	Appalachia	VA	24216	(276) 565-2760	Health Education/Risk Reduction, HIV Testing, Outpatient Health Facilities/Services, Reproductive Health, and STD Screening/Treatment
Appomattox County Health Department	P.O. Box 355	Appomattox	VA	24522	(434) 352-2313	Health Education/Risk Reduction, Immunizations, Reproductive Health, and STD Screening/Treatment
Arlington County Community Services Board	1725 N. George Mason Drive	Arlington	VA	22205	(703) 228-5150	Counseling, Health Insurance Premium Assistance, Mental Health, and Substance Abuse
Arlington County Health Department	2100 Washington Boulevard, 2nd Floor	Arlington	VA	22201	(703) 228-1300	Anonymous HIV Testing, Health Education/Risk Reduction, Immunizations, and STD Screening/Treatment
Arlington Department of Human Services	3033 Wilson Boulevard	Arlington	VA	22201	(703) 228-1200	HIV Testing and STD Screening/Treatment
Ashland Christian-Disciples of Christ Mental Health Clinic	302 S. James Street	Ashland	VA	23005	(804) 752-3456	Case Management, Mental Health, Nutrition Therapy, Outpatient Health Facilities, Outreach, Substance Abuse, and Treatment Adherence
Atlantic Community Health Center	8034 Lankford Highway	Oak Hall	VA	23416	(757) 414-0569	Dental, Early Intervention Services, HIV Testing, Outpatient Health Facilities, Prescription Medication Services, and STD Screening/Treatment

Augusta Regional Free Clinic	P.O. Box 153	Fishersville	VA	22939	(540) 332-5606	Case Management, Dental, HIV Testing, Mental Health, Outpatient Health Facilities, Outreach, Prescription Medication Services, and Substance Abuse
Augusta/Staunton Health Department	P.O. Box 2126	Staunton	VA	24402	(540) 332-7830	Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Interpretation/Translation, Outreach, Reproductive Health, and STD Screening/Treatment
Baileys Health Center	6196 Arlington Boulevard	Falls Church	VA	22044	(703) 327-3446	Case Management, Health Education/Risk Reduction, HIV Testing, Mental Health, Nutrition Therapy, Outpatient Health Facilities/Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Bath County Health Department	P.O. Box 120	Warm Springs	VA	24484	(540) 839-7246	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Bayview Community Health Center	22214 South Bayside Road	Cheriton	VA	23316	(757) 331-1086	Health Education/Risk Reduction, HIV Testing, Prescription Medication Services, and STD Screening/Treatment
Beach Health Clinic	3396 Holland Road, Suite 102	Virginia Beach	VA	23452	(757) 428-5601	Outpatient Health Facilities
Bedford County Health Department	P.O. Box 148	Bedford	VA	24523	(540) 586-7952	Health Education/Risk Reduction, HIV Testing, Immunizations, Outreach, Reproductive Health, and STD Screening/Treatment
Behavior and Stress Management	3236 Boulevard Street, Suite B	Colonial Heights	VA	23834	(804) 520-7500	Counseling, Health Education/Risk Reduction, Interpretation/Translation, Mental Health, Substance Abuse, and Treatment Adherence
Bland County Health Department	P.O. Box 176	Bland	VA	24315	(276) 688-4651	Dental, Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Bland County Medical Clinic	12301 Grapefield Road	Bastian	VA	24314	(276) 688-4331	Case Management, HIV Testing, Nutrition Therapy, Outpatient Health Facilities/Services, and STD Screening/Treatment
Blue Ridge Behavioral Healthcare	301 Elm Avenue, SW	Roanoke	VA	24016	(540) 345-6891	Case Management, Counseling, Mental Health, and Substance Abuse

Blue Ridge Medical Center, Inc.	4038 Thomas Nelson Highway	Arrington	VA	22922	(434) 263-4000	HIV Testing, Home/Community Based Services, Mental Health, Outpatient Health Facilities, Prescription Medication Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Bon Secours Home Care	8580 Magellan Parkway	Richmond	VA	23227-1149	(804) 627-5200	Home Health
Bon Secours Home Health and Hospice	485 Rodman Avenue	Portsmouth	VA	23703	(757) 391-6000	Home Health, Home/Community Based Services, Hospice, and Respite Care
Botetourt County Health Department	P.O. Box 220	Fincastle	VA	24090	(540) 473-8240	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Boydton Community Health Facility, Inc.	P.O. Box 540	Boydton	VA	23917	(434) 738-6102	Dental, HIV Testing, STD Screening/Treatment, and Substance Abuse
Bristol City Health Department	205 Piedmont Avenue	Bristol	VA	24201	(276) 642-7335	Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Brock Hughes Free Clinic	PO Box 392	Wytheville	VA	24382	(276) 233-0558	Counseling, Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Home/Community Base Services, and Rehabilitation/Habilitation Services
Brunswick County Health Department	1632 Lawrenceville Plank Road	Lawrenceville	VA	23868	(434) 848-2525	Health Education/Risk Reduction, Immunizations, Reproductive Health, and STD Screening/Treatment
Buchanan County Health Department	P.O. Box 618	Grundy	VA	24614	(276) 935-4591	Case Management, Dental, Early Intervention Services, Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Interpretation/Translation, Outpatient Health Facilities, Outreach, Reproductive Health, and STD Screening/Treatment
Buckingham County Health Department	P.O. Box 198	Buckingham	VA	23921	(434) 969-4244	Health Education/Risk Reduction, Immunizations, Reproductive Health, and STD Screening/Treatment
Buena Vista City Health Department	2270 Magnolia Avenue	Buena Vista	VA	24416	(540) 261-2149	Dental, Health Education/Risk Reduction, Immunizations, Reproductive Health, and STD Screening/Treatment

Campbell County Health Department	P.O. Box 160	Rustburg	VA	24588	(434) 592-9550	Early Intervention Services, Health Education/Risk Reduction, Immunizations, Outreach, Reproductive Health, and STD Screening/Treatment
Carilion Hospice Services of Franklin County	180 Floyd Avenue	Rocky Mount	VA	24151	(540) 489-6503	Case Management, Counseling, Emergency Financial Assistance, Home Health, Home Nursing, Home/Community Based Services, Hospice, Medical Transportation, Nutrition Therapy, Outpatient Health Facilities/Services, Outreach, Rehabilitation/Habilitation Services, and Respite Care
Caroline County Health Department	P.O. Box 6	Bowling Green	VA	22427	(804) 633-5465	Dental, Health Education/Risk Reduction, HIV Testing, Home/Community Based Services, Immunizations, Reproductive Health, and STD Screening/Treatment
Caroline Family Practice	P.O. Box 1596	Bowling Green	VA	22427	(804) 632-1030	Case Management, Early Intervention Services, Health Education/Risk Reduction, Health Insurance Premium Assistance, Interpretation/Translation, Mental Health, Outpatient Health Facilities, Reproductive Health, STD Screening/Treatment, and Treatment Adherence
Carroll County Health Department	605-15 Pine Street	Hillsville	VA	24343	(276) 728-2166	Dental, Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Carroll County Health Department	605-15 Pine Street	Hillsville	VA	24343	(276) 728-2166	Hepatitis
Center for Comprehensive Care of Immune Deficiency	825 Fairfax Avenue, Suite 205	Norfolk	VA	23508	(757) 446-8999	Outpatient Health Services
Centra Health: SHOW Virginia Grant	2010 Atherholt Road	Lynchburg	VA	24501	(434) 200-5001	Case Management, Dental, Early Intervention Services, Health Education/Risk Reduction, Health Insurance Premium Assistance, HIV Testing, Home Health, Home Nursing, Home/Community Based Services, Hospice, Medical Transportation, Nutrition Therapy, Outpatient Health Facilities, Reproductive Health, STD Screening/Treatment, Substance Abuse, and Treatment Adherence
Central Virginia Community Health Center	25892 N. James Madison Hwy	New Canton	VA	23123	(434) 581-3271	Dental, Early Intervention Services, HIV Testing, Outpatient Health Facilities/Services, STD Screening/Treatment, and Substance Abuse

Central Virginia Community Services Board	620 Court Street	Lynchburg	VA	24501	(434) 847-8035	Case Management, Early Intervention Services, Health Education/Risk Reduction, Interpretation/Translation, Mental Health, Rehabilitation/Habilitation Services, and Substance Abuse
Central Virginia Legal Aid Society	101 W. Broad Street, Suite 101	Richmond	VA	23220	1-866-534-5243	Counseling
Central Virginia Legal Aid Society-Charlottesville	1000 Preston Avenue, Suite B	Charlottesville	VA	22903	(804) 862-1100	Counseling
Central Virginia Legal Aid Society-Petersburg	2006 Wakefield Street	Petersburg	VA	23805	(804) 862-1100	Counseling
Charles City County Health Department	7501 Adkins Road	Charles City	VA	23030	(804) 829-2490	Health Education/Risk Reduction, HIV Testing, Immunizations, Interpretation/Translation, Reproductive Health, and STD Screening/Treatment
Charlotte County Health Department	P.O. Box 670	Charlotte Court House	VA	23923	(434) 542-5251	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Charlottesville/Albemarle Health Department	P.O. Box 7546	Charlottesville	VA	22906	(434) 972-6289	Health Education/Risk Reduction, HIV Testing, Immunizations, Outpatient Health Facilities, Outreach, Reproductive Health, and STD Screening/Treatment
Chesapeake Care Free Clinic	2145 Military Highway South	Chesapeake	VA	23320	(757) 545-5700	Case Management, Counseling, Dental, Health Insurance Premium Assistance, Mental Health, and Substance Abuse
Chesapeake Community Services Board	224 Great Bridge	Chesapeake	VA	23320	(757) 547-9334	Counseling, Early Intervention Services, Mental Health, and Substance Abuse
Chesapeake Health Department	748 Battlefield Boulevard North	Chesapeake	VA	23320	(757) 382-8600	Health Education/Risk Reduction, HIV Testing, Immunizations, and STD Screening/Treatment
Chesterfield Community Services Board	P.O. Box 92	Chesterfield	VA	23832	(804) 745-1227	Case Management
Chesterfield County Health Department	P.O. Box 100	Chesterfield	VA	23832	(804) 748-1691	Dental, Health Education/Risk Reduction, Immunizations, Reproductive Health, and STD Screening/Treatment
Chincoteague Island Community Health Center	4049 Main Street	Chincoteague Island	VA	23336	(757) 336-3682	Health Education/Risk Reduction, HIV Testing, and STD Screening/Treatment

City of Chesapeake, Department of Human Services/Social Services	P.O. Box 15098	Chesapeake	VA	23328	(757) 382-2000	Emergency Financial Assistance, Food Pantry, Home Health, Home Nursing, and Home/Community Based Services
City of Virginia Beach, Department of Housing & Neighborhood Preservation	2424 Courthouse Drive	Virginia Beach	VA	23456	(757) 385-5754	HOPWA
Clarke County Health Department	100 North Buckmarsh Street	Berryville	VA	22611	(540) 955-1033	Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Home/Community Based Services, Immunizations, Outpatient Health Facilities/Services, Reproductive Health, and STD Screening/Treatment
Clifton Forge Health Department	P.O. Box 15	Clifton Forge	VA	24422	(540) 862-4131	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Clinch River Health Services, Inc.	17633 Veterans Memorial Highway	Dungannon	VA	24245	(276) 467-2201	HIV Testing, Mental Health, Outpatient Health Facilities, STD Screening, and Substance Abuse
Coinfection Clinic-Gastroenterology Hepatology Section	P.O. Box 980341	Richmond	VA	23298	(804) 828-4060	Outpatient Health Facilities/Services
Colonial Community Services Board	921 Capitol Landing Road	Williamsburg	VA	23185	(757) 253-4061	Case Management, Counseling, Mental Health, and Substance Abuse
Colonial Heights Health Department	P.O. Box 3401	Colonial Heights	VA	23834	(804) 520-9380	Dental, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Commonwealth Catholic Charities	P.O. Box 6565	Richmond	VA	23220	(804) 285-9130	Case Management, Emergency Financial Assistance, Food Pantry, Home/Community Based Services, Interpretation/Translation, Respite Care, and Treatment Adherence
Community Dental Services	1033 28th Street	Newport News	VA	23607	(757) 928-3810	Dental and Interpretation/Translation
Community Health Center of the Rappahannock Region	2217 Princess Anne Street, Suite 110	Fredericksburg	VA	22401	(540) 735-0567	Dental, Health Education/Risk Reduction, HIV Testing, Mental Health, Nutrition Therapy, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Community Psychological Resources	249 W. York Street	Norfolk	VA	23510	(757) 662-6794	Mental Health and Substance Abuse
Comprehensive Counseling Services	115 First Street, SW	Roanoke	VA	24016	(540) 343-0004	Mental Health and Substance Abuse

Council of Community Services	1502 Williamson Road, Suite B	Roanoke	VA	24012	(540) 266-7554	HOPWA
Craig County Health Center	226 Market Street	New Castle	VA	24127	(540) 864-6390	Early Intervention Services, HIV Testing, Mental Health, Nutrition Therapy, Outreach, STD Screening, and Substance Abuse
Craig County Health Department	P.O. Box 6	New Castle	VA	24127	(540) 864-5136	Case Management, Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Treatment
Crater Community Hospice, Inc	3916 S. Crater Road	Petersburg	VA	23805	(804) 526-4300	Home Health and Home/Community Based Services
Cross Over Ministry	108 Cowardin Avenue	Richmond	VA	23224	(804) 233-5016	Case Management, Counseling, Dental, Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Mental Health, Nutrition Therapy, Outpatient Health Facilities/Services, Prescription Medication Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Crossroads Community Services Board	P.O. Drawer 248	Farmville	VA	23901	(434) 392-7049	Case Management, Counseling, Health Education/Risk Reduction, Mental Health, and Substance Abuse
Culpeper County Health Department	640 Laurel Street	Culpeper	VA	22701	(540) 829-7350	Case Management, Health Education/Risk Reduction, HIV Testing, Immunization, Reproductive Health, STD Treatment, and Treatment Adherence
Cumberland County Health Department	P.O. Box 107	Cumberland	VA	23040	(804) 492-4661	Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Cumberland Mountain Community Services Board	P.O. Box 810	Cedar Bluff	VA	24609	(276) 964-6702	Case Management, Counseling, Mental Health, and Substance Abuse
Daily Planet, Inc.	517 West Grace Street	Richmond	VA	23220	(804) 237-7690	Dental, Mental Health, Respite Care, and Substance Abuse
Danville City Health Department	326 Taylor Drive	Danville	VA	24541	(434) 799-5190	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Treatment
Danville-Pittsylvania Community Services Board	245 Hairston Street	Danville	VA	24540	(434) 799-0456	Case Management, Counseling, Mental Health, and Substance Abuse

Davenport Clinic	P.O. Box 309	Davenport	VA	24239	(276) 859-0859	Health Education/Risk Reduction, HIV Testing, Mental Health, Outpatient Health Facilities/Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Dickenson County Behavioral Health Services	P.O. Box 309	Clintwood	VA	24228	(276) 926-1682	Case Management, Counseling, Mental Health, and Substance Abuse
Dickenson County Health Department	P.O. Box 768	Clintwood	VA	24228	(276) 926-4979	Case Management, Dental, Early Intervention Services, Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Interpretation/Translation, Outpatient Health Facilities, Outreach, Reproductive Health, and STD Screening/Treatment
Dinwiddie County Health Department	P.O. Box 185	Dinwiddie	VA	23841	(804) 469-3771	Health Education/Risk Reduction, HIV Testing, Immunizations, Interpretation/Translation, Prescription Medication Services, and STD Screening/Treatment
Dinwiddie Medical Center	P.O. Box 307	Dinwiddie	VA	23841	(804) 469-3731	Dental, Health Education/Risk Reduction, HIV Testing, Home/Community Based Services, Mental Health, Outpatient Health Facilities, STD Screening/Treatment, and Substance Abuse
District 19 Community Services Board	20 W. Bank Street, Suite 2	Petersburg	VA	23803	(804) 862-8054	Case Management, Counseling, Mental Health, and Substance Abuse
East End Physicians	1033 28th Street	Newport News	VA	23607	(757) 952-2160	Case Management, Counseling, Dental, Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Home/Community Based Services, Interpretation/Translation, Outreach, and STD Screening/Treatment
Eastern Shore Community Services Board	10129 Rogers Drive	Nassawadox	VA	23413	(757) 442-3636	Case Management, Medical Transportation, Mental Health, and Substance Abuse
Eastern Shore Health District	23191 Front Street	Accomack	VA	23301	(757) 787-5880	HOPWA
ECDC African Community Center	901 S. Highland Street	Arlington	VA	22204	(703) 685-0510	Counseling, Health Education/Risk Reduction, Health Insurance Premium Assistance, and Outreach
Edmarc Hospice for Children	516 London Street	Portsmouth	VA	23704	(757) 967-9251	Case Management, Counseling, Health Insurance Premium Assistance, Home Health, Hospice, Mental Health, Outreach, and Substance Abuse

Emporia Medical Center	702 N Main Street	Emporia	VA	23847	(434) 634-7725	Dental, Health Education/Risk Reduction, HIV Testing, Mental Health, Outpatient Health Facilities, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Essex County Health Department	P.O. Box 206	Tappahannock	VA	22560	(804) 443-3396	Case Management, Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Immunizations, Prescription Medication Services, Reproductive Health, and STD Screening/Treatment
Essex Village Apartments	3901 Pilots Lane	Richmond	VA	23222	(804) 329-5820	Outpatient Health Facilities
EVAN in Newport News	813 Forest Drive	Newport News	VA	23606	(757) 591-2012	Case Management, Early Intervention Services, Health Education/Risk Reduction, and Outreach
EVAN in Norfolk	9229 Granby Street, 2nd Floor	Norfolk	VA	23503	(757) 583-1317	Case Management, Emergency Financial Assistance, Food Pantry, Health Education/Risk Reduction, HIV Testing, Medical Transportation, and Treatment Adherence
EVAN in Williamsburg	479 McLaws Circle, Suite 2	Williamsburg	VA	23185	(757) 220-4606	Case Management, Emergency Financial Assistance, Health Education/Risk Reduction, and Medical Transportation
Evans-Yosief Law Firm, LLC	1517 Hardy Cash Drive	Hampton	VA	23666	(757) 827-3588	Legal Services
Fairfax County Health Department -Falls Church District Office	6245 Leesburg Pike, Suite 500	Falls Church	VA	22044-2106	(703) 534-8343	Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Interpretation/Translation, Prescription Medication Services, and STD Screening/Treatment
Fairfax County Health Department-Herndon-Reston District Office	1850 Cameron Glen Drive	Reston	VA	20190-3310	(703) 481-4242	Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Interpretation/Translation, Prescription Medication Services, and STD Screening/Treatment
Fairfax County Health Department-Mount Vernon District Office	8350 Richmond Highway	Alexandria	VA	22309-2344	(703) 704-5203	Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Interpretation/Translation, Prescription Medication Services, and STD Screening/Treatment
Fairfax County Health Department-Springfield Office District	8136 Old Keen Mill Road	Springfield	VA	22152-1850	(703) 588-1031	Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunization, Interpretation/Translation, Prescription Medication Services, and STD Screening/Treatment

Fairfax-Falls Church Community Services Board	12011 Government Center Pkwy, Suite 836	Fairfax	VA	22035	(703) 324-7000	Case Management, Mental Health, Outreach, Substance Abuse, and Treatment Adherence
Faith Community Baptist Church	P.O. Box 25538	Richmond	VA	23260	(804) 649-7225	Health Education/Risk Reduction
Family Health Clinic	3033 Wilson Blvd	Arlington	VA	22201	(703) 228-1200	Health Education/Risk Reduction, Reproductive Health, and STD Screening/Treatment
Fan Free Clinic	P.O. Box 6477	Richmond	VA	23230	(804) 358-6343	Case Management, Emergency Financial Assistance, Food Pantry, Health Education/Risk Reduction, Health Insurance Premium Assistance, HOPWA, Inmate Pre/Post Release, Mental Health, Outpatient Health Facilities, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Fauquier County Health Department	330 Hospital Drive	Warrenton	VA	20186	(540) 347-6400	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
First Church of the Brethren Clinic	2001 Carroll Ave, NW	Roanoke	VA	24017	(540) 857-6473	STD Screening
Flora Krause Casey Health Center	1200 North Howard Street	Alexandria	VA	22304	(703) 838-4400	Outpatient Health Facilities/Services, Reproductive Health, and STD Screening/Treatment
Floyd County Health Department	P.O. Box 157	Floyd	VA	24091	(540) 745-2141	Case Management, Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Prescription Medication Services, STD Screening/Treatment, and Treatment Adherence
Fluvanna County Health Department	P.O. Box 136	Palmyra	VA	22963	(434) 591-1960	Health Education/Risk Reductions, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Food and Friends	219 Riggs Road, NE	Washington	DC	20011	(202) 269-2277	Food Pantry
Food for Others	2938 Prosperity Avenue	Fairfax	VA	22031	(703) 207-9173	Food Pantry
Franklin City Health Department	P.O. Box 595	Franklin	VA	23851	(757) 562-6109	Health Education/Risk Reduction, HIV Testing, Immunizations, and STD Screening/Treatment
Franklin County Health Department	P.O. Box 249	Rocky Mount	VA	24151	(540) 484-0292	Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Franktown Community Health Center	9159 Franktown Road	Franktown	VA	23354	(757) 442-4819	Dental and STD Treatment
Franktown Dental	P.O. Box 9	Franktown	VA	23354	(757) 442-4819	Dental

Frederick/Winchester Health Department	10 Baker Street	Winchester	VA	22601	(540) 722-3470	Case Management, Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Outreach, Reproductive Health, and STD Screening/Treatment
Fredericksburg Area HIV / AIDS Support Services, Inc	415 Elm Street	Fredericksburg	VA	22401	(540) 371-7532	Case Management, Counseling, Dental, Emergency Financial Assistance, Health Education/Risk Reduction, Health Insurance Premium Assistance, HOPWA, Interpretation/Translation, Medical Transportation, Mental Health, Outpatient Health Facilities/Services, Outreach, Substance Abuse, and Treatment Adherence
Fredericksburg City Health Department	608 Jackson Street	Fredericksburg	VA	22401	(540) 899-4142	Case Management, Counseling, Health Education/Risk Reduction, HIV Testing, Immunizations, Outreach, Reproductive Health, Respite Care, and STD Screening/Treatment
Free Clinic of Danville	133 South Ridge Street	Danville	VA	24541	(434) 799-1223	Outpatient Health Facilities
Free Clinic of Central Virginia	P.O. Box 38	Lynchburg	VA	24505	(434) 847-5866	Dental, Health Education/Risk Reduction, Outpatient Health Facilities/Services, Prescription Medication Services, and Rehabilitation/Habilitation Services
Free Clinic of Franklin County	PO Box 764	Rocky Mount	VA	24151	(540) 489-7500	Case Management, Health Education/Risk Reduction, Home/Community Based Services, Mental Health, Outpatient Health Facilities, STD Screening/Treatment, and Substance Abuse
Free Clinic of Pulaski County, Inc	412 North Jefferson Avenue	Pulaski	VA	24301	(540) 980-0922	Counseling, Dental, Health Education/Risk Reduction, Medical Transportation, Mental Health, Outpatient Health Facilities/Services, Prescription Medication Services, and Substance Abuse
Free Medical Clinic of the Northern Shenandoah Valley	301 North Cameron Suite, Suite 100	Winchester	VA	22601	(540) 536-1680	Dental, HIV Testing, Mental Health, Outpatient Health Facilities, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Friendship Health and Rehab Center	327 Hershberger Road, NW	Roanoke	VA	24012	(540) 265-2100	Hospice, Rehabilitation/Habilitation Services, and Respite Care
Galax City Health Department	P.O. Box 926	Galax	VA	24333	(276) 236-6127	Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Home/Community Based Services, Immunizations, Outreach, Reproductive Health, and STD Screening/Treatment

Gentiva Health Services- Roanoke	5320 E. Peters Creek Road	Roanoke	VA	24019	(540) 362-7578	Home Health and Home Nursing
Gentiva Health Services- Virginia Beach	230 Clearfield Avenue, Suite 106	Virginia Beach	VA	23462	(757) 499-2303	Home Health and Home Nursing
Gentiva Health Services-Christiansburg	1097 North Franklin Street	Christiansburg	VA	24073-1421	(540) 382-9311	Home Nursing
Gentiva Health Services-Lynchburg	1928 Thomson Drive	Lynchburg	VA	24501	(434) 846-5219	Home Health and Home Nursing
Gentiva Health Services-Richmond	2601 Willard Road, Suite 101	Richmond	VA	23294	(804) 675-7500	Home Health and Home Nursing
Ghent Family Practice	825 Fairfax Avenue	Norfolk	VA	23507	(757) 446-5955	Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Interpretation/Translation, Mental Health, Outpatient Health Facilities, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Giles County Health Department	120 North Main Street	Pearisburg	VA	24134	(540) 921-2891	Hepatitis Treatment, Health Education/Risk Reduction, Immunizations, and STD Screening/Treatment
Glenwood Medical Center	2711 Byron Street	Richmond	VA	23223	(804) 228-4492	Case Management, Early Intervention Services, HIV Testing, Medical Transportation, Outpatient Health Facilities/Services, Outreach, Prescription Medication Services, and STD Treatment
Gloucester County Health Department	6882 Main Street	Gloucester	VA	23061	(804) 693-2445	Case Management, Dental, Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Home/Community Based Services, Immunizations, Medical Transportation, Mental Health, Nutrition Therapy, Prescription Medication Services, STD Screening/Treatment, and Substance Abuse
Gloucester-Mathews Free Clinic	P.O. Box 943	Hayes	VA	23072	(804) 642-9515	Case Management, Dental, Hospice, and Outpatient Health Facilities/Services
Goochland County Health Department	1800 Sandy Hook Road, Suite 100	Goochland	VA	23063	(804) 556-5343	Health Education/Risk Reductions, Immunizations, and STD Screening/Treatment
Goochland Free Clinic Family Services	P.O. Box 116	Goochland	VA	23063-0116	(804) 556-6840	Case Management, Dental, Emergency Financial Assistance, Food Pantry, Health Education/Risk Reduction, Medical Transportation, and Outpatient Health Facilities/Services

Grayson County Health Department	P.O. Box 650	Independence	VA	24348	(276) 236-6127	Dental, Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Outreach, Reproductive Health, and STD Screening/Treatment
Greater Prince William Community Health Center	4379 Ridgewood Center Drive, Suite 102	Prince William	VA	22192	(703) 680-7950	Dental, Early Intervention Services, HIV Testing, Interpretation/Translation, Mental Health, Outpatient Health Facilities, Outreach, Reproductive Health, STD Treatment, and Substance Abuse
Greene County Health Department	P.O. Box 38	Stanardsville	VA	22973	(434) 985-2262	Health Education/Risk Reduction, Health Insurance Premium Assistance, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Greensville/Emporia Health Department	140 Uriah Branch Way	Emporia	VA	23847	(434) 348-4235	Health Education/Risk Reduction, HIV Testing, Immunizations, and STD Screening/Treatment
H.E.L.P. Free Clinic	P.O. Box 190	Hampton	VA	23669	(757) 850-8956	Case Management, Counseling, Dental, Emergency Financial Assistance, Food Pantry, Health Education/Risk Reduction, Mental Health, Outpatient Health Facilities, Outreach, Substance Abuse, and Treatment Adherence
Halifax County Health Department	P.O. Box 845	Halifax	VA	24558	(434) 476-4863	Health Education/Risk Reduction, HIV Testing, Immunizations, and STD Screening/Treatment
Hampton City Health District	3130 Victoria Boulevard	Hampton	VA	23661	(757) 727-1172	Health Education/Risk Reduction, HIV Testing, Reproductive Health, STD Screening/Treatment, and Treatment Adherence
Hampton Health Center	403 Yale Drive	Hampton	VA	23666	(757) 826-2079	Health Education/Risk Reduction, HIV Testing, Outpatient Health Facilities, Outreach, Reproductive Health, and STD Screening/Treatment
Hampton Roads Clinic	2712 Washington Avenue	Newport News	VA	23607	(757) 240-5223	Case Management, Counseling, Early Intervention Services, Health Education/Risk Reduction, Mental Health, Rehabilitation/Habilitation Services, and Substance Abuse
Hampton VA Medical Center	100 Emancipation Drive	Hampton	VA	23667	(757) 722-9961	Outpatient Health Services
Hampton-Newport News Community Services Board	400 Medical Drive	Hampton	VA	23666	(757) 788-0422	Substance Abuse

Hanover Community Services Board	12300 Washington Highway	Ashland	VA	23005	(804) 365-4222	Case Management, Counseling, Health Insurance Premium Assistance, Mental Health, and Substance Abuse
Hanover Health Department	12312 Washington Highway	Ashland	VA	23005	(804) 365-4313	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Harriet Zonderman, LCSW	2006 Bremo Road, Suite 204	Richmond	VA	23226	(804) 288-8925	Counseling, Mental Health, and Substance Abuse
Harrisonburg Community Health Center	563-A Neff Avenue	Harrisonburg	VA	22801	(540) 433-4913	Health Insurance Premium Assistance, Interpretation/Translation, Outpatient Health Facilities/Services, and Prescription Health Services
Harrisonburg-Rockingham Community Services Board	1241 N. Main Street	Harrisonburg	VA	22802	(540) 434-1941	Case Management, Counseling, Mental Health, and Substance Abuse
Hayes E. Willis Pharmacy	4730 North Southside Plaza	Richmond	VA	23224	(804) 230-7788	Prescription Medication Services
Haysi Clinic	P.O. Box 653	Haysi	VA	24256	(276) 865-5652	Dental, Health Education/Risk Reduction, HIV Testing, Mental Health, Outpatient Health Facilities/Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Healing Hands Health Center	210 Memorial Drive	Bristol	TN	37620	(423) 652-0260	Mental Health, Outpatient Health Facilities, and Substance Abuse
Healing Hands Health Center	210 Memorial Drive	Bristol	TN	37620	(423) 652-0260	Outpatient Health Facilities
Health and Home Support Services, Inc	3110 Chestnut Avenue	Newport News	VA	23607	(757) 247-1879	Case Management, Dental, Early Intervention Services, Health Education/Risk Reduction, and Inmate Pre/Post Release
Health and Wellness Center of Louisa	115 Jefferson Hwy	Louisa	VA	23093	(540) 967-9405	Dental, Early Intervention Services, HIV Testing, Outpatient Health Services, Reproductive Health, and STD Screening/Treatment
Health Center For Women and Families	833 Buffalo Street, Suite 200	Farmville	VA	23901	(434) 392-8177	Early Intervention Services, Health Insurance Premium Assistance, Home Health, Home Nursing, Home/Community Based Services, Hospice, Outpatient Health Facilities, Personal Care, and STD Screening

Health Center of the Piedmont - Chatham	4 S. Main Street	Chatham	VA	24531	(434) 432-4443	Case Management, Counseling, Dental, Health Education/Risk Reduction, HIV Testing, Home/Community Based Services, Interpretation/Translation, Medical Transportation, Outpatient Health Facilities/Services, Outreach, Prescription Medication Services, Reproductive Health, STD Screening/Treatment, and Treatment Adherence
Health Center of the Piedmont - Danville	705 Main Street	Danville	VA	24541	(434) 791-3630	Case Management, Counseling, Dental, Health Education/Risk Reduction, HIV Testing, Home/Community Based Services, Interpretation/Translation, Medical Transportation, Outpatient Health Facilities/Services, Outreach, Prescription Medication Services, Reproductive Health, STD Screening/Treatment, and Treatment Adherence
Health Center of the Piedmont - Martinsville	1 E. Market Street, Suite1B	Martinsville	VA	24112	(276) 632-2966	Case Management, Counseling, Dental, Health Education/Risk Reduction, HIV Testing, Home/Community Based Services, Interpretation/Translation, Medical Transportation, Outpatient Health Facilities/Services, Prescription Medication Services, Reproductive Health, STD Screening/Treatment, and Treatment Adherence
Health Wagon	119 Number Ten Street	Clinchco	VA	24226	(276) 835-9474	Outpatient Health Facilities
Healthcare for the Homeless	4714 Marshall Avenue	Newport News	VA	23607	(757) 380-8709	Case Management, Counseling, Dental, Home/Community Based Services, Outreach, Support Groups - Health Related, and Treatment Adherence
Henrico Area Mental Health and Developmental Services	10299 Woodman Road	Glen Allen	VA	23060	(804) 727-8500	Case Management, Counseling, Health Education/Risk Reduction, Outpatient Health Facilities, Substance Abuse, and Support Groups - Health Related
Henrico County Health District	P.O. Box 27032	Richmond	VA	23273	(804) 501-4522	HIV Testing, Immunizations, and STD Screening/Treatment
Henry/Martinsville Health Department	P.O. Box 1032	Martinsville	VA	24114	(276) 638-2311	Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment

Highland County Health Department	P.O. Box 558	Monterey	VA	24465	(540) 468-2270	Dental, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Highland Medical Center	P.O. Box 490	Monterey	VA	24465	(540) 468-3300	Dental, HIV Testing, Mental Health, Rehabilitation/Habilitation Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Highlands Community Services Board	610 Campus Drive, Suite 200	Abingdon	VA	24210	(276) 525-1592	Counseling, Mental Health, and Substance Abuse
Holston Family Health Center	P.O. Box 456	Damascus	VA	24236	(276) 475-5116	Dental, Health Education/Risk Reduction, HIV Testing, Mental Health, Outpatient Health Facilities/Services, Reproductive Health, STD Screening, and Substance Abuse
Home Care of Memorial Hospital	320 Hospital Drive	Martinsville	VA	24115	(276) 634-1950	Home Health and Hospice
Hopewell City Health Department	220 Appomattox Street	Hopewell	VA	23860	(804) 458-1297	Health Education/Risk Reduction, HIV Testing, Immunizations, and STD Screening/Treatment
Hospice and Palliative Care of the Eastern Shore	P.O. Box 300	Onancock	VA	23417	(757) 787-3310	Hospice
Hospice of Memorial Hospital of Martinsville & Henry Counties	P.O. Box 4788	Martinsville	VA	24115-4788	(276) 666-7469	Hospice
Hospice of the Piedmont	675 Peter Jefferson Parkway, Suite 300	Charlottesville	VA	22911	(434) 817-6900	Home/Community Based Services and Hospice
Hospice of the Rapidan	P.O. Box 715	Culpeper	VA	22701	(540) 825-4840	Case Management, Counseling, Home/Community Based Services, Hospice, Interpretation/Translation, Nutrition Therapy, and Outreach.
Human Resources, Inc	15 West Cary Street	Richmond	VA	23220	(804) 644-6439	Case Management, Counseling, Health Education/Risk Reduction, HIV Testing, Nutrition Therapy, Outpatient Health Services, Outreach, Rehabilitation/Habilitation Services, STD Screening, Substance Abuse, and Treatment Adherence
Hunter Holmes McGuire VA Medical Center	1201 Broad Rock Boulevard	Richmond	VA	23249	(804) 675-5000	Outpatient Health Services
Hurley Family Health Care	10279 Hurley Road	Hurley	VA	24620	(276) 566-7204	Dental, Health Education/Risk Reduction, HIV Testing, Mental Health, Outpatient Health Facilities/Services, STD Treatment, and Substance Abuse

Independent Living Solutions	P.O. Box 6116	Richmond	VA	23222	(804) 651-6204	Early Intervention Services, Health Education/Risk Reduction, Mental Health, and Substance Abuse
Infectious Disease Clinic	600 E Broad Street, 3rd Floor	Richmond	VA	23298	(804) 828-6163	Case Management, Counseling, Health Education/Risk Reduction, Interpretation/Translation, Mental Health, Outpatient Health Facilities/Services, STD Screening/Treatment, Substance Abuse, and Treatment Adherence
Infectious Disease Clinic of Central Virginia	2215 Landover Place	Lynchburg	VA	24501	(434) 947-3945	Case Management, Dental, Medical Transportation, Mental Health, Outpatient Health Facilities/Services, Prescription Medication Services, STD Screening/Treatment, and Substance Abuse
Infectious Diseases, Tropical Medicine and International Travel Clinic	P.O. Box 13367	Roanoke	VA	24033	(877) 827-2836	Outpatient Health Facilities/Services
Inova Juniper Program: Arlington Office	5015 Lee Highway, Suite 100	Arlington	VA	22207	(703) 522-2608	Case Management, Counseling, Dental, Medical Transportation, Mental Health, Nutrition Therapy, Outpatient Health Services, Prescription Medication Services, Substance Abuse, Support Groups - Health Related, and Treatment Adherence
Inova Juniper Program: Dumfries Office	18003 Farley Boulevard, Suite 102	Dumfries	VA	22026	(703) 321-2600	Case Management, Counseling, Dental, Medical Transportation, Mental Health, Nutrition Therapy, Outpatient Health Services, Prescription Medication Services, Substance Abuse, Support Groups - Health Related, and Treatment Adherence
Inova Juniper Program: Herndon/Reston Office	1850 Cameron Glen Drive, Suite 101	Reston	VA	20190	(703) 481-4242	Case Management, Counseling, Dental, Medical Transportation, Mental Health, Nutrition Therapy, Outpatient Health Services, Prescription Medication Services, Substance Abuse, Support Groups - Health Related, and Treatment Adherence
Inova Juniper Program: Manassas Office	8807 Sudley Road, Suite 101	Manassas	VA	20110	(703) 396-8391	Case Management, Counseling, Dental, Medical Transportation, Mental Health, Nutrition Therapy, Outpatient Health Services, Prescription Medication Services, Substance Abuse, Support Groups - Health Related, and Treatment Adherence

Inova Juniper Program: Mount Vernon Office	8350 Richmond Highway, Suite 233	Alexandria	VA	22309	(703) 704-6132	Case Management, Counseling, Dental, Medical Transportation, Mental Health, Nutrition Therapy, Outpatient Health Services, Prescription Medication Services, Substance Abuse, Support Groups - Health Related, and Treatment Adherence
Inova Juniper Program: Springfield Office	8001 Forbes Pl. Suite 200	Springfield	VA	22151	(703) 321-2600	Case Management, Counseling, Dental, Medical Transportation, Mental Health, Nutrition Therapy, Outpatient Health Services, Prescription Medication Services, Substance Abuse, Support Groups - Health Related, and Treatment Adherence
Inova VNA Home Health	5501 Backlick Road	Springfield	VA	22151	(703) 916-2800	Home Health
Interim Healthcare	3235 Virginia Avenue	Collinsville	VA	24078	(276) 647-1700	Case Management, Home Health, Home/Community Based Services, and Respite Care
Interim Healthcare of Roanoke	4395 Electric Road	Roanoke	VA	24018	(540) 774-8686	Home Health, Home/Community Based Services, Rehabilitation/Habilitation Services, and Respite Care
International Black Women's Congress	645 Church Street, Suite 200	Norfolk	VA	23510	(757) 625-0500	Case Management, Early Intervention Services, Health Education/Risk Reduction, and Outreach
Isle of Wight County Health Department	P.O. Box 309	Smithfield	VA	23430	(757) 357-4177	Dental, Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, Respite Care, and STD Screening/Treatment
Ivor Medical Center	8575 Ivor Road	Ivor	VA	23866	(757) 859-6161	Case Management, Health Education/Risk Reduction, HIV Testing, Outreach, Reproductive Health, STD Screening, and Treatment Adherence
J & B Transportation, Inc	4534 Lunenburg County Road	Keysville	VA	23947	(434) 696-9000	Medical Transportation
Jewish Family Services	6718 Patterson Avenue	Richmond	VA	23226	(804) 282-5644	Case Management, Home Health, Mental Health, and Substance Abuse
Johnson Health Center	2316 Atherholt Road, Suite 107	Lynchburg	VA	24504	(434) 947-5967	Case Management, Dental, HIV Testing, Mental Health, Outpatient Health Facilities/Services, Reproductive Health, and STD Screening/Treatment

Joseph Willard Health Center	3750 Old Lee Highway	Fairfax	VA	22030-6903	(703) 246-7100	Anonymous HIV Testing, Health Education/Risk Reduction, HIV Testing, Interpretation/Translation, Prescription Medication Services, and STD Screening/Treatment
K.I. Services, Inc	25 S. Quaker Lane Unit 4	Alexandria	VA	22314	(703) 823-4407	Counseling, Food Pantry, Health Education/Risk Reduction, Mental Health, Outreach, Substance Abuse, and Treatment Adherence
King George County Health Department	P.O. Box 92	King George	VA	22485	(540) 775-3111	Health Education/Risk Reduction, HIV Testing, Immunizations, and STD Screening/Treatment
King William County Health Department	P.O. Box 155	King William	VA	23086	(804) 769-4988	Health Education/Risk Reduction, HIV Testing, Immunizations, and STD Screening/Treatment
King William-Dawn Community Doctors	11814 Kinda William Rd.	Aylett	VA	23009	(804) 769-3022	Health Education/Risk Reduction, HIV Testing, Outpatient Health Facilities/Services, and STD Screening/Treatment
Kirkpatrick's Pharmacy	518 South Sycamore Street	Petersburg	VA	23803	(804) 733-9170	Prescription Medication Services and Treatment Adherence
Konnarock Family Health Center	20471 Azen Road	Damascus	VA	24236	(276) 388-3411	HIV Testing, Mental Health, Outpatient Health Facilities/Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
La Clinica Del Pueblo	2831 15th Street NW	Washington	DC	20009-4607	(202) 462-4788	Case Management, Counseling, Emergency Financial Assistance, Health Education/Risk Reduction, Home/Community Based Services, Interpretation/Translation, Mental Health, Nutrition Therapy, Outreach, Prescription Medication Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Lackey Free Clinic	1620 Old Williamsburg Road	Yorktown	VA	23690	(757) 886-0608	Counseling, Dental, Health Education/Risk Reduction, Mental Health, Outpatient Health Facilities/Services, and Substance Abuse
Lancaster County Health Department	P.O. Box 158	Lancaster	VA	22503	(804) 462-5197	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Lee County Behavioral Health Services	34084 Wilderness Road	Jonesville	VA	24263	(276) 346-3590	Case Management, Counseling, Early Intervention Services, Mental Health, and Substance Abuse

Lee County Health Department	P.O. Box 763	Jonesville	VA	24263	(276) 346-2011	Case Management, Dental, Early Intervention Services, Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Legal Aid Justice Center	37 Bollingbrook Street	Petersburg	VA	23803	(804) 862-2205	Counseling
Legal Aid Society of Eastern Virginia	125 St Paul's Boulevard, Suite 400	Norfolk	VA	23510	(757) 220-6837	Counseling
Legal Aid Society of Eastern Virginia: Eastern Shore Office	36314 Lankford Highway	Belle Haven	VA	23306	(757) 442-3014	Counseling
Legal Aid Society of Eastern Virginia: Norfolk Office	125 St Paul's Boulevard, Suite 400	Norfolk	VA	23510	(757) 627-5423	Counseling
Legal Aid Society of Eastern Virginia: Virginia Beach Office	291 Independence Boulevard	Virginia Beach	VA	23462	(757) 552-0026	Counseling
Legal Aid Society of Eastern Virginia: Williamsburg	199 Armistead Avenue, Suite B	Williamsburg	VA	23185	(757) 220-6837	Counseling
Legal Services of Northern Virginia	6066 Leesburg Pike, Suite 500	Falls Church	VA	22041	(703) 778-6800	Counseling
Lewis Gale Regional Health System	1900 Electric Road	Salem	VA	24153	(540) 776-4000	Outpatient Health Facilities/Services
Loudoun Community Health Center	224 Cornwall Street N.W.	Leesburg	VA	20176	(703) 443-2000	Dental, Health Education/Risk Reduction, Mental Health, Outpatient Health Facilities/Services, and Substance Abuse
Loudoun County Community Services Board	906 Trailview Blvd., Suite 300	Leesburg	VA	20175	(703) 771-5401	Case Management, Counseling, Mental Health, and Substance Abuse
Loudoun County Health Department	P.O. Box 7000, MSC #68	Leesburg	VA	20177	(703) 771-5820	Case Management, Dental, Early Intervention, Health Education/Risk Reduction, HIV Testing, Immunizations, and STD Screening/Treatment
Louisa County Health Department	P.O. Box 336	Louisa	VA	23093	(540) 967-3703	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Louisa County Resource Council	P.O. Box 52	Louisa	VA	23093	(540) 967-1510	Case Management, Food Pantry, and Outreach
Love of Jesus Health Clinic	10930 Hull Street Road	Midlothian	VA	23112	(804) 674-7499	Case Management, Counseling, Food Pantry, HIV Testing, Mental Health, Nutrition Therapy, Outpatient Health Facilities, Outreach, Reproductive Health, STD Screening/Treatment, and Substance Abuse

Lunenburg County Health Department	11387 Courthouse Road	Lunenburg	VA	23952	(434) 696-2346	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Lunenburg Medical Center	P.O. Box 70	Victoria	VA	23974	(434) 696-2165	Counseling, Dental, Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Home/Community Based Services, Interpretation/Translation, Mental Health, Outpatient Health Facilities, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Lynchburg City Health Department	P.O. Box 6036	Lynchburg	VA	24505	(434) 947-6785	Dental, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Lynchburg Community Action Group	926 Commerce Street	Lynchburg	VA	24504	(434) 846-2778	Case Management, Childcare Services, Emergency Financial Assistance, Food Pantry, HOPWA, and Outreach
Madison County Health Department	P.O. Box 67	Madison	VA	22727	(540) 948-5481	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Madison Free Clinic	PO Box 914	Madison	VA	22727	(540) 948-3667	Dental and Health Education/Risk Reduction
Main Street Medical Center	2025 East Main Street	Richmond	VA	23284	(804) 780-0840	Outpatient Health Facilities
Main Street Physicians	157 N. Main Street	Suffolk	VA	23434	(757) 925-1866	Dental and Outpatient Health Facilities
Manassas Office	9301 Lee Avenue	Manassas	VA	20110	(703) 792-6345	Hepatitis Testing, HIV Testing, and STD Screening/Treatment
Mannboro Medical Center	8631 Namozine Road	Amelia	VA	23002	(804) 561-4333	Case Management, Dental , Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Home/Community Based Services, Mental Health, Substance Abuse, Outpatient Health Facilities, STD Screening/Treatment, and Substance Abuse
Martinsville Memorial Hospital Home Health	320 Hospital Drive	Martinsville	VA	24112	(276) 634-1950	Home Health, Home Nursing, Home/Community Based Services, and Hospice

Mary Washington Hospital Infectious Disease Associates	101 Sam Perry Boulevard	Fredericksburg	VA	22401	(540) 374-3277	Case Management, Counseling, Dental, Early Intervention Services, Health Education/Risk Reduction, Interpretation/Translation, Mental Health, Nutrition Therapy, Outpatient Health Facilities/Services, Outreach, Substance Abuse, and Treatment Adherence
Mathews County Health Department	P.O. Box 26	Mathews	VA	23109	(804) 693-2445	Health Education/Risk Reduction, Immunizations, and STD Screening/Treatment
Meadowview Health Clinic	13168 Meadowview Square	Meadowview	VA	24361	(276) 496-4492	Childcare Services, Dental, Health Education/Risk Reduction, HIV Testing, Medical Transportation, Mental Health, Outpatient Health Facilities, Outreach, Reproductive Health, STD Screening/Treatment, Substance Abuse, and Treatment Adherence
Mechanicsville Free Dental Clinic	8061 Shady Grove Avenue	Mechanicsville	VA	23111	(804) 798-9797	Dental
Mecklenburg County Health Department	P.O. Drawer 370	Boydton	VA	23917	(434) 738-6545	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening
Medi Home Care	P.O. Box 1387	Coeburn	VA	24230	(276) 395-9314	Home Health, Home Nursing, Home/Community Based Services, Hospice, and Nutrition Therapy
Mendota Medical Center	P.O. Box 66	Mendota	VA	24270	(276) 645-6710	Health Education/Risk Reduction, HIV Testing, Mental Health, Outpatient Health Facilities/Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Mental Health Associates of the New River Valley, Inc	303 Church Street	Blacksburg	VA	24060	(540) 951-4990	Counseling, Mental Health, and Substance Abuse
Metro TeenAIDS	P.O. Box 15577	Washington	DC	20003-5577	(202) 543-8246	Case Management, Early Intervention Services, Emergency Financial Assistance, Health Education/Risk Reduction, Outreach, STD Screening, and Treatment Adherence
Middle Peninsula-Northern Neck Community Services Board	P.O. Box 40	Saluda	VA	23149	(804) 758-5314	Case Management, Counseling, Mental Health, Outreach, and Substance Abuse
Middlesex County Health Department	P.O. Box 415	Saluda	VA	23149	(804) 758-2381	Health Education/Risk Reduction, HIV Testing, and STD Screening
Minority Health Consortium	208 E. Clay Street, Suite B	Richmond	VA	23219	(804) 255-0820	Health Education/Risk Reduction, HIV Testing, Outreach, and Support Groups - Health Related

Mobile Van	Emancipation and Tyler Street	Hampton	VA	23666	(757) 727-5221	Outpatient Health Facilities
Montgomery County Health Department	210 South Pepper Street	Christiansburg	VA	24073	(540) 381-7100	Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, and STD Screening
Monument Pathologists, Inc	5801 Bremo Road	Richmond	VA	23226	(804) 281-8100	HIV Testing and STD Screening
Mount Rogers Community Services Board	770 W. Ridge Road	Wytheville	VA	24382	(276) 223-3200	Mental Health and Substance Abuse
Mountain Regional Hospice	P.O. Box 637	Clifton Forge	VA	24422	(540) 862-8820	Hospice
Nelson County Health Department	P.O. Box 98	Lovingston	VA	22949	(434) 263-8315	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
New Horizons Healthcare	4910 Valley View Boulevard NW, Suite 310	Roanoke	VA	24012	(540) 362-0360	Health Education/Risk Reduction, HIV Testing, Mental Health, Outpatient Health Facilities/Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
New Kent County Health Department	P.O. Box 86	New Kent	VA	23124	(804) 966-9640	Health Education/Risk Reduction, HIV Testing, Immunizations, Interpretation/Translation, Reproductive Health, and STD Screening/Treatment
New River Valley Community Services Board	700 University City Boulevard	Blacksburg	VA	24060	(540) 961-8400	Counseling, Mental Health, Substance Abuse, and Treatment Adherence
Newcomer Community Services Center	6131 Williston Dr. #8	Falls Church	VA	22044-3002	(703) 241-0300	Case Management, Counseling, and Interpretation/Translation
Nia, Inc	4247 Creighton Road	Richmond	VA	23223	(804) 643-6172	Health Education/Risk Reduction and Outreach
Norfolk City Health Department	830 Southampton Ave, Suite 200	Norfolk	VA	23510	(757) 683-2796	Dental, Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Immunizations, Outpatient Health Facilities/Services, Outreach, Reproductive Health, and STD Screening/Treatment
Norfolk Community Services Board	7460 Tidewater Drive	Norfolk	VA	23505	(757) 664-6670	Case Management, Counseling, Early Intervention Services, Substance Abuse, and Treatment Adherence
North County Health Center	11484 Washington Plaza, West #300	Reston	VA	20190	(703) 689-2180	Case Management, Mental Health, Nutrition Therapy, Outpatient Health Facilities/Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse

Northampton County Health Department	P.O. Box 248	Nassawadox	VA	23413	(757) 442-6228	Health Education/Risk Reduction, HIV Testing, and STD Screening/Treatment
Northern Virginia AIDS Ministry	803 W. Broad Street	Falls Church	VA	22046	(703) 533-5505	Health Education/Risk Reduction
Northern Virginia Regional Commission	3060 Williams Drive, Suite 510	Fairfax	VA	22031	(703) 642-0700	HOPWA
Northumberland County Health Department	P.O. Box 69	Heathsville	VA	22473	(804) 580-3731	Health Education/Risk Reduction, HIV Testing, Immunizations, Interpretation/Translation, Reproductive Health, and STD Screening/Treatment
Northwestern Community Services Board	209 W. Criser Road, Suite 300	Front Royal	VA	22630	(540) 636-4250	Case Management, Counseling, Mental Health, and Substance Abuse
Nottoway County Health Department	P.O. Box 27	Nottoway	VA	23955	(434) 645-7595	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Olde Towne Medical Center	5249 Olde Towne Road	Williamsburg	VA	23188	(757) 259-3258	Case Management, Dental, HIV Testing, Mental Health, Nutrition Therapy, Outpatient Health Facilities/Services, Prescription Medication Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Olney Community Health Center	20280 Main Street	Onancock	VA	23417	(757) 787-7374	Health Education/Risk Reduction, HIV Testing, and STD Treatment
Oral and Maxillofacial Surgery Clinic	1201 E. Marshall Street	Richmond	VA	23298	(804) 828-0805	Dental
Orange County Free Clinic	P.O. Box 441	Orange	VA	22960	(540) 672-0793	Dental and Outpatient Health Facilities
Orange County Health Department	450 N. Madison Road	Orange	VA	22960	(540) 672-1291	Dental, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Outpatient Psychiatric Services	2955 Ivy Road	Charlottesville	VA	22903	(434) 243-4646	HIV Testing, Mental Health, and Substance Abuse
Page County Health Department	75 Court Lane	Luray	VA	22835	(540) 743-6528	Case Management, Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Outreach, Reproductive Health, and STD Screening/Treatment
Partners in Recovery	400 Medical Drive, Suite A	Hampton	VA	23666	(757) 788-0422	Case Management, Mental Health, and Substance Abuse

Pathways Free Specialty Clinics	1200 W. Washington Street	Petersburg	VA	23803	(804) 862-1104	Case Management, Counseling, Health Education/Risk Reduction, Home/Community Based Services, Mental Health, Outpatient Health Facilities, Prescription Medication Services, Support Groups - Health Related, and Treatment Adherence
Patient Services Incorporated	P.O. Box 1602	Midlothian	VA	23112	(800) 366-7741	Case Management
Patrick County Health Department	P.O. Box 428	Stuart	VA	24171	(276) 694-3188	Health Education/Risk Reduction, HIV Testing, Immunizations, and STD Screening/Treatment
Peninsula Health District	416 J. Clyde Morris Boulevard	Newport News	VA	23601	(757) 594-7300	Hepatitis Testing, HIV Testing, and STD Screening/Treatment
Pennington Family Health Center	P.O. Box 70 Suite 12	Pennington Gap	VA	24277	(276) 546-3001	Health Education/Risk Reduction, HIV Testing, Mental Health, Outpatient Health Facilities/Services, Reproductive Health, STD Screening, and Substance Abuse
Petersburg City Health Department	P.O. Box 2081	Petersburg	VA	23804	(804) 863-1652	Health Education/Risk Reduction, HIV Testing, and STD Screening/Treatment
Petersburg Health Care Alliance	541 S. Sycamore Street	Petersburg	VA	23803	(804) 957-5850	Case Management and Outpatient Health Facilities/Services
Piedmont Community Services Board	24 Clay Street	Martinsville	VA	24112	(276) 631-0100	Early Intervention Services, Home/Community Based Services, HOPWA, Mental Health, and Substance Abuse
Pittsylvania Community Action Group, Inc	348 North Main Street	Chatham	VA	24531	(434) 432-8250	HOPWA
Pittsylvania County Health Department	P.O. Box 1159	Chatham	VA	24531	(434) 432-7232	Health Education/Risk Reduction, HIV Testing, and STD Screening/Treatment
Planned Parenthood of Southeastern Virginia	515 Newtown Road	Virginia Beach	VA	23462	(757) 499-7526	Health Education/Risk Reduction, HIV Testing, Outpatient Health Facilities, Outreach, Reproductive Health, and STD Screening/Treatment
Planning District One Behavioral Health Services	P.O. Box 1130	Norton	VA	24273	(276) 679-5751	Case Management, Counseling, Mental Health, and Substance Abuse

Portsmouth Community Health Center, Inc.	664 Lincoln Street	Portsmouth	VA	23704	(757) 397-0042	Case Management, Counseling, Dental, Early Intervention Services, Health Education/Risk Reduction, Home/Community Based Services, Medical Transportation, Mental Health, Outpatient Health Facilities, Outreach, Reproductive Health, STD Screening/Treatment, Substance Abuse, and Support Groups - Health Related
Portsmouth Department of Behavioral Healthcare	600 Dinwiddie Street, Suite 200	Portsmouth	VA	23704	(757) 393-8618	Case Management, Counseling, Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Medical Transportation, Mental Health, Outreach, Substance Abuse, and Treatment Adherence
Portsmouth Department of Behavioral Healthcare Mental Health Outpatient Treatment Services	505 Washington Street, Suite 200	Portsmouth	VA	23704	(757) 393-8223	Case Management, Counseling, Health Education/Risk Reduction, Mental Health, Substance Abuse, and Treatment Adherence
Portsmouth Health Department	1701 High Street	Portsmouth	VA	23704	(757) 393-8585	Health Education/Risk Reduction, HIV Testing, and STD Screening/Treatment
Powhatan County Health Department	P.O. Box 12	Powhatan	VA	23139	(804) 598-5680	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Prince Edward County Health Department	111 South Street	Farmville	VA	23901	(434) 392-8187	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Prince George County Health Department	P.O. Box 69	Prince George	VA	23875	(804) 733-2630	Health Education/Risk Reduction, HIV Testing, Immunizations, and STD Screening/Treatment
Prince William County Community Services	8033 Ashton Avenue	Manassas	VA	20109	(703) 792-7800	Case Management, Counseling, Early Intervention Services, Health Education/Risk Reduction, Mental Health, Outreach, Rehabilitation/Habilitation Services, and Substance Abuse
Prince William County Health Department	4001 Prince William Parkway, Suite 101	Woodbridge	VA	22192	(703) 792-7321	Case Management
Pulaski County Health Department	170 4th Street NW	Pulaski	VA	24301	(540) 994-5030	Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, and STD Screening/Treatment
Radford City Health Department	212 Third Avenue	Radford	VA	24141	(540) 831-5774	Hepatitis Testing, Health Education/Risk Reduction, and STD Screening/Treatment

Rainbow Tuesdays Clinic	4480 King Street	Alexandria	VA	22302	(703) 838-4400	Health Education/Risk Reduction, Immunizations, and STD Screening/Treatment
Rappahannock Area Community Services Board	600 Jackson Street	Fredericksburg	VA	22401	(540) 373-3223	Case Management, Counseling, Early Intervention Services, Home/Community Based Services, Mental Health, Outpatient Health Facilities, Outreach, Rehabilitation/Habilitation Services, Substance Abuse, and Support Groups - Health Related
Rappahannock County Health Department	P.O. Box 5	Washington	VA	22747	(540) 675-3516	Health Education/Risk Reduction, HIV Testing, and STD Screening/Treatment
Rappahannock-Rapidan Community Services Board	P.O. Box 1568	Culpeper	VA	22701	(540) 825-3100	Case Management, Counseling, Mental Health, and Substance Abuse
Region Ten Community Services Board	502 Old Lynchburg Road	Charlottesville	VA	22903	(434) 972-1800	Case Management, Counseling, Mental Health, and Substance Abuse
Resources for Independent Living, INC	4009 Fitzhugh Avenue, Suite 100	Richmond	VA	23230	(804) 353-6503	Case Management, Health Education/Risk Reduction, HIV Testing, Outreach, and STD Screening
Richard Sterling, MD	1200 E. Broad Street	Richmond	VA	23298	(804) 828-4060	Outpatient Health Facilities
Richmond Behavioral Health Authority	107 South 5th Street	Richmond	VA	23219	(804) 819-4000	Health Education/Risk Reduction, Mental Health, and Substance Abuse
Richmond City Health Department	400 East Cary Street	Richmond	VA	23219	(804) 205-3500	Dental, Health Education/Risk Reduction, HIV Testing, Immunizations, Interpretation/Translation, Outpatient Health Facilities/Services, Reproductive Health, and STD Screening/Treatment
Richmond County Health Department	P.O. Box 700	Warsaw	VA	22572	(804) 333-4043	Case Management, Dental, HIV Testing, Immunizations, Medical Transportation, Outpatient Health Facilities, Prescription Medication Services, and STD Screening/Treatment
Riverside Shore Memorial Hospital	9507 Hospital Avenue	Nassawadox	VA	23413	(757) 414-8000	Case Management, Health Education/Risk Reduction, Home Health, Home/Community Based Services, Hospice, Interpretation/Translation, Medical Transportation, Mental Health, Nutrition Therapy, Outpatient Health Facilities/Services, Prescription Medication Services, Reproductive Health, Respite Care, STD Screening/Treatment, Substance Abuse, and Support Groups - Health Related

Riverside Tangier Family Practice	P.O. Box 296	Tangier	VA	23440	(757) 891-2412	Dental, HIV Testing, Mental Health, Outpatient Health Facilities, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Roanoke County/Salem Health Department	105 E. Calhoun Street	Salem	VA	24153	(540) 387-5530	Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Roanoke County/Vinton Health Department	P.O. Box 307	Vinton	VA	24179	(540) 857-7800	HIV Testing, Home/Community Based Services, Immunizations, Reproductive Health, and STD Screening/Treatment
Rockbridge Area Community Services Board	241 Greenhouse Road	Lexington	VA	24450	(540) 463-3141	Case Management, Counseling, Mental Health, and Substance Abuse
Rockbridge/Lexington Health Department	P.O. Drawer 900	Lexington	VA	24450	(540) 463-3185	Dental, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Rockingham/Harrisonburg Health Department	P.O. Box 26	Harrisonburg	VA	22801	(540) 574-5100	Dental, Hepatitis Treatment, Health Education/Risk Reduction, HIV Testing, Immunizations, and STD Screening/Treatment
Rubicon	2000 Mecklenburg Street	Richmond	VA	23230	(804) 359-3255	Case Management, Counseling, Mental Health, Nutrition Therapy, and Substance Abuse
Russell County Health Department	P.O. Box 2347	Lebanon	VA	24266	(276) 889-7621	Case Management, Dental, Early Intervention Services, Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Interpretation/Translation, Outpatient Health Facilities, Reproductive Health, and STD Screening/Treatment
Salem VA Medical Center	1970 Roanoke Boulevard	Salem	VA	24153	(540) 982-2463	Outpatient Health Facilities/Services
Saltville Medical Center	308 West Main Street	Saltville	VA	24370	(276) 496-4433	Childcare Services, Dental, Health Education/Risk Reduction, HIV Testing, Medical Transportation, Outpatient Health Facilities, Outreach, Reproductive Health, STD Screening/Treatment, and Treatment Adherence
Scott County Behavioral Health Services	1006 US Highway 23	Weber City	VA	24290	(276) 225-0976	Case Management, Counseling, Early Intervention Services, Mental Health, and Substance Abuse

Scott County Health Department	190 Beech Street, Suite 102	Gate City	VA	24251	(276) 386-1312	Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, and STD Screening/Treatment
Self Protection Awareness	301 Tower Lane	Newport News	VA	23608	(757) 593-3531	HERR
Serenity	P.O. Box 131	Petersburg	VA	23804	(804) 861-9977	Counseling and Outreach
Shady Grove United Methodist, Cheryl Watson Memorial Medical Clinic	8209 Shady Grove Road	Mechanicsville	VA	23111	(804) 559-0486	Case Management, Dental, Mental Health, Nutrition Therapy, Outpatient Health Facilities, Outreach, Substance Abuse, and Treatment Adherence
Shenandoah County Free Clinic	PO Box 759	Woodstock	VA	22664	(540) 459-1700	Case Management, HIV Testing, Mental Health, Rehabilitation/Habilitation Services, and Substance Abuse
Shenandoah County Health Department	600 North Main Street, Suite 106	Woodstock	VA	22664	(540) 459-3733	Case Management, Health Education/Risk Reduction, HIV Testing, Immunizations, Outreach, Reproductive Health, and STD Screening/Treatment
Shiloh Baptist Eye Clinic	106 S. James Street	Ashland	VA	23005	(804) 798-8890	Case Management, Dental, Mental Health, Nutrition Therapy, Outpatient Health Facilities, Outreach, Substance Abuse, and Treatment Adherence
Smyth County Health Department	201 Francis Marion Lane	Marion	VA	24354	(276) 781-7460	Case Management, Early Intervention Services, Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunization, Prescription Medication Services, Reproductive Health, and STD Screening/Treatment
South County Center	8350 Richmond Highway, Suite 301	Alexandria	VA	22309	(703) 704-5333	Case Management, Health Education/Risk Reduction, HIV Testing, Mental Health, Nutrition Therapy, Outpatient Health Facilities/Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
South Norfolk Health Center	490 Liberty Street	Chesapeake	VA	23324	(757) 382-2600	Health Education/Risk Reduction, Reproductive Health, and STD Screening/Treatment
Southampton County Health Department	P.O. Box 9	Courtland	VA	23837	(757) 653-3040	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Southern Albemarle Family Practice	2256 Irish Road	Esmont	VA	22937	(434) 286-3602	Outpatient Health Facilities and STD Treatment

Southside Community Health Center	8380 Boydton Plank Road	Alberta	VA	23821	(434) 949-7211	Dental, Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Home Health, Home/Community Based Services, and STD Screening/Treatment
Southside Community Services Board	P.O. Box 488	South Boston	VA	24592	(434) 572-6916	Counseling, Mental Health, and Substance Abuse
Spotsylvania County Health Department	9104 Courthouse Road	Spotsylvania	VA	22553	(540) 507-7400	Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
St. Charles Community Health Center	P.O. Box Drawer S	Saint Charles	VA	24282	(276) 383-4428	Dental, Health Education/Risk Reduction, HIV Testing, Mental Health, Outpatient Health Facilities/Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
St. David's Free Health Clinic	11241 West River Road	Aylett	VA	23009	(804) 769-2996	Dental and Food Pantry
St. James the Less Free Medical/Dental Clinic	P.O. Box 117, 2nd Floor	Ashland	VA	23005	(804) 798-8890	Case Management, Dental, Nutrition Therapy, Outpatient Health Facilities, Outreach, and Treatment Adherence
St. Luke Community Clinic	316 North Royal Avenue	Front Royal	VA	22630	(540) 636-4325	Home/Community Base Services, Mental Health, and Substance Abuse
Stafford County Health Department	1300 Courthouse Road	Stafford	VA	22555	(540) 659-3101	Health Education/Risk Reduction, HIV Testing, and STD Screening/Treatment
Stone Mountain Health Services	P.O. Box 900	Pennington Gap	VA	24277-2036	(276) 762-0770	Health Education/Risk Reduction and STD Screening/Treatment
Stoneybrook Physicians	15425-H Warwick Boulevard	Newport News	VA	23608	(757) 874-8400	Outpatient Health Facilities
Stony Creek Community Health Center	P.O. Box 188	Stony Creek	VA	23882	(434) 246-6100	Case Management, Health Education/Risk Reduction, HIV Testing, Outpatient Health Facilities, Reproductive Health, and STD Screening/Treatment
Suffolk City Health Department	P.O. Box 1587	Suffolk	VA	23439	(757) 514-4700	Health Education/Risk Reduction, HIV Testing, and STD Screening/Treatment
Surry Area Free Clinic, Inc	474 Colonial Trail West	Surry	VA	23883	(757) 294-0132	Dental, Early Intervention Services, HIV Testing, Outpatient Health Facilities/Services, Prescription Medication Services, Reproductive Health, and STD Screening/Treatment

Surry County Health Department	P.O. Box 213	Surry	VA	23883	(757) 294-3185	Health Education/Risk Reduction, HIV Testing, and STD Screening/Treatment
Sussex County Health Department	P.O. Box 1345	Sussex	VA	23884	(434) 246-8611	Health Education/Risk Reduction, HIV Testing, Immunizations, Interpretation/Translation, Reproductive Health, and STD Screening/Treatment
T.K. McKee Hospital	P.O. Box 729	Saltville	VA	24370	(276) 496-4492	HIV Testing, Medical Transportation, Mental Health, Outpatient Health Facilities, Prescription Medication Services, STD Screening/Treatment, and Substance Abuse
Tazewell Community Health	583 Riverside Drive # C	North Tazewell	VA	24630	(888) 531-8354	Outpatient Health Facilities and Outreach
Tazewell County Health Department	P.O. Box 350	Tazewell	VA	24651	(276) 988-5586	Case Management, Dental, Early Intervention Services, Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Interpretation/Translation, Reproductive Health, and STD Screening/Treatment
Teen Health Center-Fleming/Ruffner	3605 Ferncliff Avenue, NW	Roanoke	VA	24017	(540) 857-7284	Health Education/Risk Reduction, HIV Testing, and STD Screening/Treatment
Teen Health Center- Hurt Park Clinic	1633 Salem Avenue, S.W.	Roanoke	VA	24016	(540) 857-7284	Counseling, Health Education/Risk Reduction, HIV Testing, Mental Health, Outpatient Health Facilities, Reproductive Health, and STD Screening/Treatment
Teen Health Center- Patrick Henry	2102 Grandin Road SW	Roanoke	VA	24017	(540) 777-2481	Health Education/Risk Reduction, HIV Testing, Outpatient Health Facilities, Reproductive Health, and STD Screening/Treatment
The Drop-In Center	P.O. Box 1381	Roanoke	VA	24004	(540) 982-2437	Health Education/Risk Reduction and Inmate Pre/Post Release
The H.E.L.P. Community Resource Center	208 E. Clay Street, Suite B	Richmond	VA	23219	(804) 255-0820	STD Screening
The Healing Place	700 Dinwiddie Avenue	Richmond	VA	23224	(804) 230-1217	Substance Abuse
The Psychotherapy Center	327 West 21st Street, Suite 205	Norfolk	VA	23517	(757) 622-9852	Counseling, Mental Health, and Substance Abuse
The Salvation Army	724 Dale Ave., SE	Roanoke	VA	24013	(540) 343-5335	Emergency Financial Assistance and Food Pantry
The Up Center	222 W. 19th Street	Norfolk	VA	23517	(757) 622-7017	Mental Health and Substance Abuse
The Way of The Cross Community Development Corp. Inc.	P.O. Box 39	Kents Store	VA	23084	(434) 589-3641	Health Education/Risk Reduction

Thompson Family Health Center	P.O. Box 1149	Vansant	VA	24656	(276) 597-7081	Health Education/Risk Reduction, HIV Testing, Mental Health, Outpatient Health Facilities/Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Town Center Physicians	10980 Buckley Hall Road	Mathews	VA	23109	(804) 725-9191	Health Education/Risk Reduction, HIV Testing, Mental Health, Outpatient Health Facilities/Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Transformation Retreats, Inc.	800 S. Cathedral Place	Richmond	VA	23220	(804) 353-0060	Counseling and Health Education/Risk Reduction
Tri-Area Community Health Center at Ferrum	40 Wiley Drive	Ferrum	VA	24088	(540) 365-4469	HIV Testing, Outpatient Health Facilities, Reproductive Health, and STD Screening/Treatment
Tri-Area Community Health Center at Floyd	P.O. Box 835	Floyd	VA	24091	(540) 745-9290	HIV Testing, Outpatient Health Facilities, Reproductive Health, and STD Screening/Treatment
Tri-Area Community Health Center at Laurel Fork	P.O. Box 9	Laurel Fork	VA	24352	(276) 398-3331	Case Management, HIV Testing, Interpretation/Translation, Outpatient Health Facilities, Outreach, Reproductive Health, STD Screening/Treatment, and Treatment Adherence
Tri-County Health Clinic	PO Box 202	Richlands	VA	24641	(276) 963-8505	Dental and Outpatient Health Facilities
Troutdale Medical Center	67 High Country Lane	Troutdale	VA	24378	(276) 677-4187	Counseling, Dental, HIV Testing, Home/Community Based Services, Medical Transportation, Mental Health, Outpatient Health Facilities, Outreach, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Twin City Medical Center	2195 Euclid Avenue, Suite 6	Bristol	VA	24201	(276) 669-5179	Childcare Services, Dental, HIV Testing, Medical Transportation, Outpatient Health Facilities, Outreach, Reproductive Health, STD Screening/Treatment, and Treatment Adherence
Urban League of Hampton Roads	3225 High Street	Portsmouth	VA	23707	(757) 627-0864	Case Management and Health Education/Risk Reduction
Valley AIDS Network	MSC 9018 JMU	Harrisonburg	VA	22807	(540) 568-8833	Case Management, Counseling, Emergency Financial Assistance, Food Pantry, Health Education/Risk Reduction, HOPWA, Medical Transportation, and Support Groups - Health Related

Valley Community Services Board	85 Sanger's Lane	Staunton	VA	24401	(540) 887-3200	Case Management, Counseling, Interpretation/Translation, Medical Transportation, Mental Health, Outpatient Health Facilities/Services, Substance Abuse, and Treatment Adherence
Vernon J. Harris Medical Center	719 N 25th Street	Richmond	VA	23223	(804) 828-8813	Counseling, Emergency Financial Assistance, Food Pantry, Health Education/Risk Reduction, HIV Testing, Home/Community Based Services, Medical Transportation, Mental Health, Outpatient Health Facilities, Prescription Medication Services, STD Screening, Substance Abuse, and Treatment Adherence
Veterans Affairs Medical Center	1970 Roanoke Boulevard	Salem	VA	24153	(540) 982-2463	Case Management, Dental, Health Education/Risk Reduction, HIV Testing, Home Health, Home/Community Based Services, Hospice, Medical Transportation, Mental Health, Rehabilitation/Habilitation Services, Reproductive Health, Respite Care, STD Screening/Treatment, and Substance Abuse
Virginia Beach Department of Public Health	4452 Corporation Lane	Virginia Beach	VA	23462	(757) 518-2670	Case Management, Dental, Health Education/Risk Reduction, HIV Testing, Outpatient Health Facilities/Services, Reproductive Health, STD Screening/Treatment, and Treatment Adherence
Virginia Beach Family Medical Center	940 General Booth Boulevard	Virginia Beach	VA	23451	(757) 425-3610	Case Management, Counseling, Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Mental Health, Nutrition Therapy, Outreach, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Virginia Beach Human Services-HIV Unit	289 Independence Boulevard, Pembrooke 3, Suite 109	Virginia Beach	VA	23462	(757) 385-0811	Early Intervention Services, Health Education/Risk Reduction, Mental Health, and Substance Abuse
Virginia Farm Workers Programs	1000 Preston Avenue, Suite B	Charlottesville	VA	22903	(434) 327-1442	Case Management, Legal Services, and Outreach
Virginia Legal Aid Society-Danville	519 Main Street	Danville	VA	24541	(866) 534-5243	Counseling
Virginia Legal Aid Society-Emporia	412 S. Main Street	Emporia	VA	23847	(434) 634-5172	Counseling

Virginia Legal Aid Society-Farmville	104 High Street	Farmville	VA	23901	(434) 392-8108	Counseling
Virginia Legal Aid Society-Lynchburg	P.O. Box 6200	Lynchburg	VA	24505	(434) 528-4722	Counseling
Virginia Legal Aid Society-Suffolk	155 E. Washington Street	Suffolk	VA	23434	1-866-534-5243	Counseling
Virginia Supportive Housing	PO Box 8585	Richmond	VA	23226	(804) 836-1050	HOPWA
Walnut Hill Pharmacy	1950 South Sycamore Street	Petersburg	VA	23805	(804) 733-7711	Prescription Medication Services
Warren County Health Department	134 Peyton Street	Front Royal	VA	22630	(540) 635-3159	Case Management, Health Education/Risk Reduction, HIV Testing, Immunizations, Outreach, Reproductive Health, and STD Screening/Treatment
Washington County Health Department	15068 Lee Highway	Bristol	VA	24202	(276) 676-5604	Dental, Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Waverly Medical Center	344 W. Main Street	Waverly	VA	23890	(804) 834-8871	Case Management, HIV Testing, Nutrition Therapy, Outreach, Reproductive Health, STD Screening/Treatment, and Treatment Adherence
Waynesboro City Health Department	211 West - 12th Street	Waynesboro	VA	22980	(540) 949-0137	Dental, Hepatitis Testing, Health Education/Risk Reduction, Immunizations, Reproductive Health, and STD Screening/Treatment
West Piedmont AIDS Task Force	P.O. Box 3413	Martinsville	VA	24115	(540) 666-2437	Case Management, Food Pantry, Health Education/Risk Reduction, Medical Transportation, Mental Health, Outpatient Health Services, Prescription Medication Services, and Substance Abuse
Western Lee County Health Clinic	P.O. Box 159	Ewing	VA	24248	(276) 445-4827	Dental, Health Education/Risk Reduction, HIV Testing, Mental Health, Outpatient Health Facilities/Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Western Tidewater Community Services Board	5268 Godwin Boulevard	Suffolk	VA	23434	(757) 255-7100	Case Management, Counseling, Early Intervention Services, Health Education/Risk Reduction, Mental Health, Outreach, Rehabilitation/Habilitation Services, Substance Abuse, and Support Groups - Health Related

Western Tidewater Free Clinic	2019 Meade Parkway	Suffolk	VA	23434	(757) 923-1060	Counseling, Dental, Health Education/Risk Reduction, Medical Transportation, Mental Health, Nutrition Therapy, Prescription Medication Services, and Substance Abuse
Westmoreland County Health Department	P.O. Box 303	Montross	VA	22520	(804) 493-1124	Health Education/Risk Reduction, HIV Testing, and STD Screening/Treatment
Whitetop Community Health	16309 Highlands Parkway	Whitetop	VA	24292	(276) 388-3067	Childcare Services, Dental, Health Education/Risk Reduction, HIV Testing, Outpatient Health Facilities, Outreach, Reproductive Health, STD Screening/Treatment, and Treatment Adherence
Whitman Walker Clinic-Elizabeth Taylor Medical Center	1701 14th Street, NW	Washington	DC	20009	(202) 745-7000	Case Management, Counseling, Dental, Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Mental Health, Nutrition Therapy, Outpatient Health Facilities/Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Whitman Walker Clinic-Max Robinson Center	2301 Martin Luther King, Jr. Avenue, SE	Washington	DC	20020	(202) 745-7000	Case Management, Counseling, Dental, Early Intervention Services, Health Education/Risk Reduction, HIV Testing, Mental Health, Nutrition Therapy, Outpatient Health Facilities/Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
Wholistic Family Agape Ministries	2423 Mount Vernon Avenue	Alexandria	VA	22301	(703) 519-9100	Case Management, Counseling, Food Pantry, Health Education/Risk Reduction, and Outreach
William A. Davis Clinic	P.O. Box 900	Saint Paul	VA	24283	(276) 762-0770	Health Education/Risk Reduction, HIV Testing, Mental Health, Outpatient Health Facilities/Services, Reproductive Health, STD Screening/Treatment, and Substance Abuse
William Byrd Community House	224 South Cherry Street	Richmond	VA	23220	(804) 643-2717	Childcare Services, Case Management, Emergency Financial Assistance, Food Pantry, and HOPWA
Winchester Family Health Center	525 Amherst Street, Suite 104	Winchester	VA	22601	(540) 722-2369	Interpretation/Translation, Outpatient Health Facilities/Services, and STD Screening/Treatment
Wise County Behavioral Health Services	3169 Second Avenue West	Big Stone Gap	VA	24219	(276) 523-8300	Case Management, Counseling, Early Intervention Services, Mental Health, and Substance Abuse

Wise/Norton Health Department	134 Roberts Avenue SW	Wise	VA	24293	(276) 328-8000	Case Management, Dental, Early Intervention Services, Hepatitis Testing, Health Education/Risk Reduction, Immunizations, and STD Screening/Treatment
Woodbridge Office	4001 Prince William Parkway, Suite 101	Woodbridge	VA	22192	(703) 792-7321	Case Management, Dental, Hepatitis Testing, Mental Health, Outpatient Health Facilities, Outreach, and Substance Abuse
Wythe County Community Hospital	600 W. Ridge Rd.	Wytheville	VA	24382	(276) 288-0200	HIV Testing, Home Health, Home Nursing, Home/Community Based Services, Hospice, Nutrition Therapy, Rehabilitation/Habilitation Services, Reproductive Health, Respite Care, and STD Screening/Treatment
Wythe County Health Department	750 West Ridge Road	Wytheville	VA	24382	(276) 228-5507	Dental, Hepatitis Testing, Health Education/Risk Reduction, HIV Testing, Immunizations, Reproductive Health, and STD Screening/Treatment
Yellow Cab	3203 Williamsburg Road	Richmond	VA	23231	(804) 222-7300	Medical Transportation
Youth Challenge of Hampton Roads	332 34th Street	Newport News	VA	23607	(757) 244-1234	Substance Abuse