VIRGINIA INTEGRATED HIV PREVENTION AND CARE SERVICES PLAN

2027-2031

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VDH VIRGINIA DEPARTMENT OF HEALTH

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Virginia Integrated HIV Prevention and Care Plan 2027 – 2031

Prepared by:

Virginia Department of Health Division of Disease Prevention and the Norfolk, Norfolk Ryan White HIV/AIDS Program Part A Transitional Grant Area.

Special thanks to the Virginia Community HIV Planning Group.

Acknowledgements

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The Norfolk TGA Ryan White Part A program team would like to thank all the stakeholders who have contributed to development of the Virginia HIV Integrated Prevention and Care Plan. The timely support of our VDH colleagues has been instrumental in guiding the production of the document to ensure alignment with the State of Virginia's HIV Strategy. We could not inform this document without the insight of our consumers whose needs we aim to address through a sustainable strategy. Finally, we must thank the Norfolk TGA Planning council and the office recipient staff for the tireless hours spent creating this inspiring document.

I. Introduction

The Virginia Department of Health (VDH) Division of Disease Prevention (DDP) developed a new Integrated HIV Prevention and Care Services Plan (Integrated Plan) for the five-year period spanning 2027 to 2031. The Integrated Plan will serve as the guiding framework for integrating and coordinating HIV prevention and care services in Virginia. VDH is the Part B implementer which covers statewide prevention and care services, while the Norfolk Transitional Grant Area (TGA) is serving as the Part A partner and will focus on care services for the Eastern Region of Virginia. This document serves as the joint jurisdictional plan for Virginia between the Ryan White HIV/AIDS Program (RWHAP) Part B recipient and the Norfolk, Virginia RWHAP Part A Transitional Grant Area (TGA) recipient.

The District of Columbia (D.C.) RWHAP Part A Eligible Metropolitan Area (EMA) is submitting a separate plan, which includes 17 counties in Northern and Northwestern Virginia, overlapping service areas of Virginia. Virginia received a letter of concurrence from the D.C. RWHAP Part A EMA in support of this Integrated Plan (see Appendix 1.B, page 77) and provided a letter of concurrence for the D.C. RWHAP Part A Integrated HIV Prevention and Care Plan.

The Integrated Plan articulates the vision of VDH—Become the healthiest state in the nation. The Integrated Plan will do this through presenting a roadmap for integrated HIV services over the next five years; identifying specific goals, objectives, and activities to reduce HIV transmission in Virginia and improve health outcomes of all Virginians with HIV; and ultimately end Virginia's HIV epidemic. Virginia's HIV Continuum of Care, which includes four HIV outcome measures (linkage to care, evidence of care, retention in care, and viral suppression) is a cornerstone for planning and provides a useful tool for measuring Virginia's progress and success in achieving EHE goals.

VDH collaborated with the Norfolk TGA to develop the Virginia HIV Integrated Prevention and Care Plan 2027-2031 that aims to serve all people with HIV (PWH) in Virgina. The new collaborative approach allows for expanded input from the Norfolk TGA specifically to impact the Eastern Planning Region of Virginia as there are idiosyncrasies and emerging needs that are unique for the region given the dynamic social demographic changes and the federal landscape. The Integrated Plan aims to address those specific needs in this area as there is prioritized federal funding specific to this area. The Integrated Plan is a living document that is expected to be reviewed every year.

This Integrated Plan is organized into six sections and is inclusive of required elements for the Statewide Coordinated Statement of Need (SCSN):

I. **Introduction:** This section provides a description of the Integrated Plan.

II. **Community Engagement and Planning Process:** This section describes how Virginia approached the planning process and describes the collaboration of key stakeholders including PWH in the planning process.

III. **Contributing Data Sets and Assessments**: This section provides an epidemiologic overview of Virginia's HIV epidemic statewide, for each of the five-health planning regions (i.e. Central, Eastern, Northern, Northwestern, and Southwest) and the Norfolk TGA. The section also includes a financial and human resources inventory for HIV prevention and care services delivered within Virginia; and an assessment of needs, barriers, and gaps of people with and those most at-risk for HIV. This section also includes descriptions of the current and planned uses of data access, sources, and systems to improve services.

IV. **Situational Analysis**: This section provides an overview of strengths, challenges, and identified needs for HIV prevention and care services. This summarizes information provided in sections II and III.

V. **Goals and Objectives for 2027-2031**: This section describes Virginia's goals, objectives, strategies, and core activities to reduce HIV transmission in Virginia and improve the health and well-being of all Virginians with HIV. The Integrated Plan's goals and objectives closely align with the vision and goals articulated in the Ending the HIV Epidemic (EHE).

VI. **Integrated Planning Implementation, Monitoring, and Jurisdictional Follow-Up**: This section outlines a specific method for monitoring progress of measurable objectives, as well as how Virginia will use this information to improve Virginia's HIV services.

Changes since the last Integrated Plan include continued increased focus on Pre-Exposure Prophylaxis (PrEP), opioid risk reduction, and status neutral service navigation for HIV prevention and care. Additional priorities for DDP include services for aging PWH and greater collaboration with partner agencies to strengthen access to housing, mental health, and substance use disorder treatment.

Virginia's Integrated Plan is a living document. DDP will review and update the Integrated Plan annually in collaboration with our partners.

Virginia will utilize and build upon its experience implementing the 2022 to 2026 Integrated HIV Prevention and Care Services Plan and its partner base to strengthen the implementation of the current Integrated Plan. The 2027 to 2031 Integrated Plan will aim to continue focusing on specific goals, objectives and strategies that continue to demonstrate opportunities for progress.

II. Community Engagement and Planning Process

Jurisdictional Planning Process:

During the development of this Integrated Plan, DDP worked closely with multiple partners to ensure the Integrated Plan reflects community needs. Key collaborators included the Community HIV Planning Group (CHPG), Ryan White Parts A through F providers across Virginia—including the Norfolk TGA and D.C. RWHAP Part A EMA, and organizations that serve people and communities at-risk for HIV as well as PWH. In addition to these partnerships, DDP hosted a public town hall to gather broader community input on the Integrated Plan. The following examples outline how feedback has been collected and incorporated at each stage of the planning process since the previous Integrated HIV Services Plan.

Entities involved in the process:

Virginia Community HIV Planning Group: The CHPG is the HIV Prevention and Care Services planning group in Virginia. DDP aims to maintain an integrated planning approach that reflects guidelines established by CDC and HRSA's 2021 Planning Guidance, emphasizing representation and meaningful involvement of populations most impacted by HIV. To achieve this goal, approximately 30% of CHPG members are PWH. The CHPG convenes six times per year and is comprised of members from increased risk populations, as well as representatives from organizations that provide HIV-related services.

Throughout the planning process, CHPG members contributed to key components of the Integrated Plan. The CHPG reviewed and provided feedback on the epidemiological snapshot data, planned for community engagement sessions, served on several workgroups related to various sections of the Integrated Plan, and helped develop the goals, strategies, and activities in the Integrated Plan.

VDH Contracted HIV and Care Organizations: DDP engaged HIV prevention providers and RWHAP Part B contractors by presenting updates and requesting feedback during established meetings. These included the Quarterly Prevention and Care Services Contractor meetings, the Quality Management Advisory Committee (QMAC) meetings, and the HIV and Hepatitis Prevention Summit. Input gathered from these groups helped inform multiple aspects of the Integrated Plan.

Public Hearings: DDP conducts public hearings annually to solicit input on improving care and prevention strategies and activities statewide. In recent years, the annual hearings have been held virtually. This change made it much easier for PWH and other community members to attend and have their voices heard. Public hearings help to inform DDP on various barriers and needs that exist for PWH in the Commonwealth. Information gathered from public hearings is incorporated into the needs assessment section of this planning document.

Ryan White Part A Organizations: There are two Part A jurisdictions that serve PWH in Virginia: (1) Norfolk TGA and (2) D.C. RWHAP Part A EMA. The Norfolk TGA area covers Virginia's Eastern Region and includes one county in North Carolina. The D.C. RWHAP Part A EMA includes Virginia's Northern Health Planning Region in addition to several counties in the Northwest Region. These two jurisdictions have the greatest number of PWH in the state. These jurisdictions have planning councils that govern activities within the service area. DDP has voting members from both HIV and Hepatitis Prevention and HIV Care Services that sit on these Part A Planning Councils to provide updates on the planning process and updates on Virginia's HIV service delivery system. The D.C. RWHAP Part A EMA developed their own plan.

Collaboration with RWHAP C, D, and F Parts: Stakeholders received information and provided feedback in various statewide meetings throughout 2025 and 2026. Each meeting provided an update, as well as opportunities to gather feedback from stakeholders. The audiences varied throughout the year and different DDP units facilitated the meetings. VDH provided updates on the Integrated Plan at bi-monthly CHPG meetings. The CHPG also actively engages in the planning process and developing the new Integrated Plan.

VDH holds Virginia RWHAP Cross-Parts QMAC meetings, which include representation from all Ryan White Cross-Parts (including Part A, Part C, Part D, and Part F). In 2026, VDH presented Integrated Plan updates, accomplishments, and Integrated Plan implementation challenges, and solicited input for future activities and planning.

In 2026, DDP conducted a virtual town hall to provide information/updates and get feedback on the Integrated Plan. As a part of the public hearing, VDH led discussions to gather input on the Integrated Plan based on the four EHE pillars: Diagnose, Treat, Prevent, and Respond, as well as service needs/improvements and barriers to accessing HIV prevention and treatment services. The information gathered from the town hall has been incorporated into the needs assessment section of this planning document and has helped inform the goals and objectives.

Engagement of PWH: As described above, 30% of CHPG members are PWH. Feedback and engagement were encouraged through presentations, discussions, and group activities.

In 2026, DDP also engaged PWH during the Living Beyond Our Status event for PWH 50 years of age and older and those living with HIV for 15 years or more. Participants provided input and feedback on the Integrated Plan and HIV prevention and care services through a group activity.

Priorities:

The following priorities reflect key themes identified through the community engagement and broader planning process. The Goals and Objectives section provides additional details on these priorities.

- → Reducing misinformation to improve engagement in HIV prevention and care.
- → Strengthening linkage to care, retention, and re-engagement efforts for individuals who have fallen out of care.
- → Expanding access to HIV prevention and testing services, including PrEP, non-occupational post-exposure prophylaxis (nPEP), opioid risk reduction, and at-home testing.
- → Ensuring continued mental health services and substance use disorder treatment services.
- → Expanding and coordinating partnerships across healthcare providers, community organizations, and non-traditional partners to fill service gaps (focusing on rural areas).
- → Focusing on support services such as housing, food, and transportation for those at risk by HIV and PWH.
- → Addressing the needs for individuals aged 50 or older across the HIV continuum.
- → Exploring opportunities to strengthen integration and coordination with programs that impact HIV such as Hepatitis and STIs.

Norfolk TGA Jurisdictional Planning Process:

The Norfolk TGA in collaboration with VDH engages in ongoing, coordinated planning processes to support a comprehensive system of HIV prevention and care. While this effort is conducted in partnership with statewide stakeholders, the Norfolk TGA maintains responsibility for identifying jurisdiction-specific priorities, strategies, and planning approaches that reflect the unique needs of the local HIV epidemic.

Greater Hampton Roads HIV Services Planning Council: The Greater Hampton Roads HIV Health Services Planning Council, in partnership with the Part A Recipient's Office, leads the local planning process. The Planning Council utilizes a structured, data-driven framework to guide decision-making across all stages of planning. Central to this process is the Strategic Planning and Assessment (SPA) Committee, which is responsible for overseeing data collection, analysis, and interpretation. This includes the development and implementation of comprehensive needs assessment targeting PWH and individuals at increased risk for HIV acquisition.

Data sources reviewed as part of the planning process include epidemiologic data, service utilization data, annual reports, and needs assessment findings. These data are systematically reviewed by the Planning Council and its committees to identify service gaps, unmet need, and disparities among disproportionately impacted populations. Findings from these data reviews directly inform priority setting and resource allocation decisions through the Planning Council's annual Priority Setting and Resource Allocation (PSRA) process.

Collaboration with RWHAP B, C, D, and F Parts: Norfolk TGA collaborates with RWHAP Part B and other Ryan White-funded entities to support a coordinated system of care across the region. This

collaboration includes sharing of data, alignment of planning activities, and ongoing communication to ensure that prevention and care services are integrated and responsive to identified needs.

Engagement of PWH: PWH are meaningfully engaged throughout the planning process. The Planning Council currently includes 24 members, of whom approximately 30 percent are unaligned consumers, ensuring representation of individuals with lived experience.

In addition to formal membership, consumer engagement is facilitated through the Community Access Committee (CAC), which serves as the primary venue for gathering input from PWH. The CAC provides an accessible forum for consumers to review planning activities, provide feedback on identified needs and priorities, and inform the development of planning strategies.

To further strengthen community engagement, the Norfolk TGA utilizes a structured feedback approach that includes presentations and facilitated discussions at the CAC, Strategic Planning and Assessment Committee, and full Planning Council meetings. This approach ensures that input from PWH and other stakeholders is incorporated at multiple stages of the planning process and directly informs planning decisions.

Service Priorities:

Service priorities within the Norfolk TGA were established through the Planning Council's annual Priority Setting and Resource Allocation (PSRA) process. During this process, multiple data sources were reviewed and scored using a weighted ranking methodology to determine relative priority across service categories.

The resulting priorities reflect the Planning Council's assessment of community needs, service gaps, and disparities, and guide the allocation of Part A resources within the jurisdiction. They are ranked based on service offerings as follows:

1. Medical Case Management
2. Oral Health Care
3. Referral for Health Care and Supportive Services
4. Medical Transportation
5. Health Insurance Premium & Cost Sharing Assistance
6. Mental Health Services
7. Food Bank/Home Delivered Meals
8. Housing Services
9. Case Management Non-Medical
10. Outpatient Ambulatory Health Services
11. Early Intervention Services (including Minority AIDS Initiative)
12. Emergency Financial Assistance

These priorities are reviewed annually by the Planning Council.

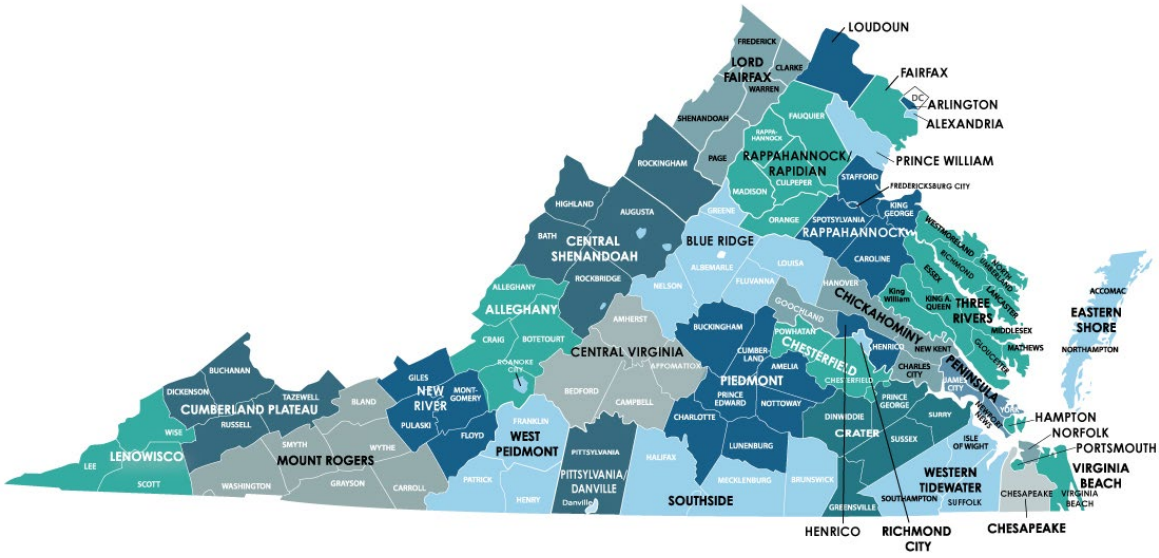
III Contributing Data Sets and Assessments

Epidemiologic Overview: People Diagnosed and At-Risk for HIV

Geographic Overview:

The Commonwealth of Virginia is a medium-size South Atlantic state, consisting of 95 counties and 38 independent cities. Virginia shares a border with five states (Maryland, West Virginia, Kentucky, North Carolina, and Tennessee) and the D.C. VDH divides the state into five Health Regions: Central, Eastern, Northern, Northwest, and Southwest, which are comprised of the 35 Health Districts (Figure 1). In addition, two large metropolitan regions within the Commonwealth receive dedicated federal HIV funding for services: Northern Virginia, which is part of the D.C. RWHAP Part A EMA, and the Norfolk TGA, which is part of the Eastern Region.

Figure 1: Virginia Health Regions, Health Districts, and Localities (Counties and Independent Cities)



This report uses 2023 population estimates and calculations that were conducted using 2023 population data sets as that was available during analysis. According to the U.S. Census Bureau, Virginia's 2023 population was 8,734,685, accounting for 2.6% of the national population (estimated 336.4 million).

Over the last decade, Virginia's population increased by approximately 610,000 residents, for a growth rate of about 7.5%, slightly above the national growth rate of about 6.0% over the same period.

Table 1 presents Virginia's total population (2023), 2024 total persons with HIV (PWH), including AIDS, and 2024 newly diagnosed PWH by Health Region.

Table 1: Virginia Population Estimates (2023) and Persons with HIV in Virginia (2024)

	2023 General Population[1]		2024 PWH[2]		2024 New Diagnoses[2]	
	Number	Percent	Number	Percent	Number	Percent
Total	8,734,685	100.0%	28,277	100.0%	851	100.0%
Known Residence	8,734,685	100.0%	28,119	99%	851	100.0%
Central	1,518,590	17.4%	6,572	23.2%	227	26.7%
Eastern	1,899,104	21.7%	8,557	30.3%	276	32.4%
Northern	2,566,637	29.4%	7,817	27.6%	204	24.0%
Northwest	1,421,002	16.3%	2,661	9.4%	73	8.6%
Southwest	1,329,352	15.2%	2,512	8.9%	71	8.3%
Unknown Residence			158	0.6%	0	0.0%
Norfolk TGA	1,728,742	19.8%	8,044	28.4%	254	29.8%

Sources: [1]2023 Virginia population by county, [2]Virginia Enhanced HIV/AIDS Reporting System (eHARS) August 2025 frozen dataset

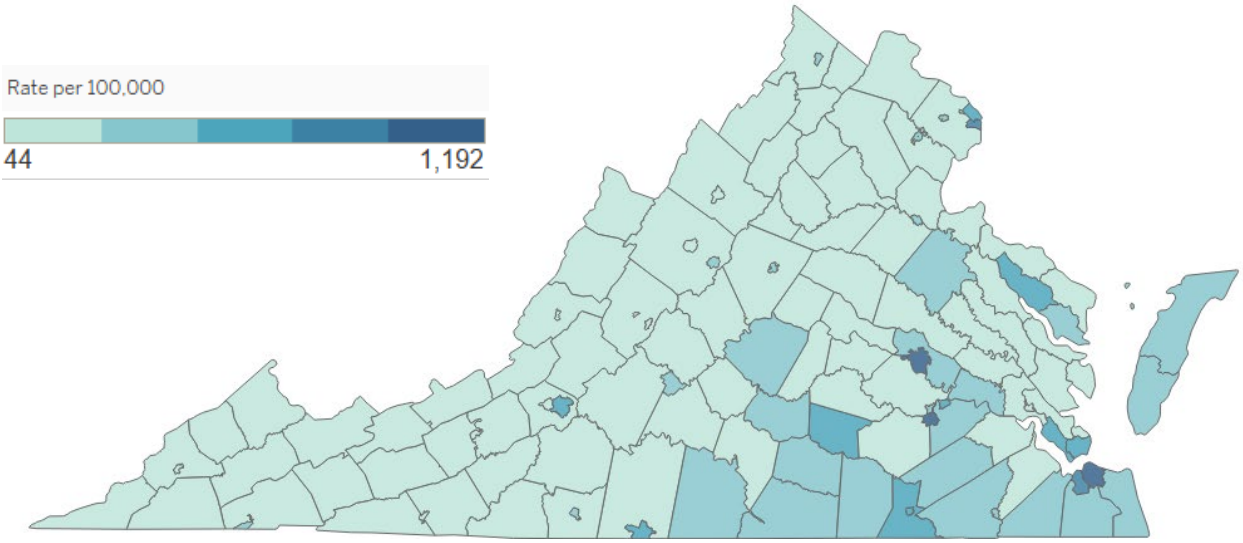
The Northern Region continues to have the largest share of Virginia's population, representing 29.4% of residents, yet it accounts for a smaller percentage of PWH (27.6%) and new diagnoses (24.0%). In contrast, the Eastern Region, which includes the Norfolk TGA, represents 21.7% of the state's total population but contains the largest percentage of PWH (30.3%) and new diagnoses (32.4%).

The Central Region, which includes Richmond City, ranks third in population size (17.4%) and has the third highest percentage of PWH (23.2%), but the second highest percentage of new diagnoses in 2024 (26.7%). Prior to 2020, the Northern Region typically reported the second highest percentage (behind Eastern) for new diagnoses annually. Since 2020, the Central Region reported the second highest percentage of new diagnoses. The Northwest and Southwest Regions together make up nearly one-third of Virginia's population (31.5%) but collectively account for less than one-fifth of PWH and new diagnoses (18.3% and 16.9%, respectively).

Within the Eastern Region, the Norfolk TGA represents 19.8% of Virginia's total population, yet it contains 28.4% of all PWH and 29.8% of all new HIV diagnoses. This demonstrates the continued concentration of Virginia's HIV epidemic in the Eastern Region, particularly within the Norfolk TGA.

Figure 2 depicts the geographic distribution of PWH across Virginia's counties and independent cities at a rate per 100,000 population. Examining HIV data using rates allows for comparison of localities with smaller populations to those with larger populations. The darkest shaded areas on the map represent counties and independent cities most impacted by HIV. Higher rates are predominantly located in the Eastern Region/Norfolk TGA and Central Region (Figure 2).

Figure 2: Persons with HIV Disease, as of December 31, 2024, Across Virginia's Counties and Independent Cities (Rates per 100,000)



Sociodemographic Characteristics:

Table 2 presents demographic characteristics of Virginia's 2023 general population, PWH as of December 31, 2024, and persons newly diagnosed with HIV in 2024. Demographics include sex at birth, age, race or ethnicity, and HIV transmission category.

As of 2024, most PWH in Virginia were male (75.6%), between 45 and 64 years of age (45.5%), and non-Hispanic, Black/African American (56.0%). Among those with a reported transmission risk, the most common risk factor was male-to-male sexual contact (MMSC, 50.6%), followed by heterosexual contact[1] (17.7%). About one-fifth (21.3%) of PWH had no identified or reported risk factor.

Demographic patterns among new diagnoses in 2024 were similar to those for all PWH, with notable differences in age and race or ethnicity. Newly diagnosed individuals were primarily male (81.7%) and non-Hispanic, Black/African American (50.2%) but included a higher proportion of Hispanic/Latino persons (20.5%) compared to all PWH (11.8%). Among those with a reported risk, most new diagnoses were attributed to MMSC transmission (53.1%), while 36.3% had no risk factor reported or identified. Newly diagnosed individuals were younger overall, with 57.5% under age 35, highlighting continued HIV transmission among younger adults in Virginia.

[1] heterosexual contact refers to heterosexual contact with: person who injected drugs; bisexual male; person with hemophilia or coagulation disorder with documented HIV infection; transfusion or transplant recipient with documented HIV infection; person with documented HIV infection

Table 2: Comparison of Demographic Characteristics of Virginia's 2023 General Population with PWH and New Diagnoses as of December 31, 2024

	2023 Virginia's General Population[1]		2024 PWH in Virginia[2]		2024 New Diagnoses in Virginia[2]	
	Number	Percent	Number	Percent	Number	Percent
Total	8,734,685	100.0%	28,277	100.0%	851	100.0%
Sex at Birth						
Male	4,314,363	49.4%	21,377	75.6%	695	81.7%
Female	4,420,322	50.6%	6,900	24.4%	156	18.3%
Age (years)						
<10	1,010,540	11.6%	16	0.1%	0	0.0%
10 - 14	534,556	6.1%	21	0.1%	0	0.0%
15 - 19	569,576	6.5%	72	0.3%	41	4.8%
20 – 24	574,474	6.6%	574	2.0%	141	16.6%
25 – 29	571,677	6.5%	1,469	5.2%	150	17.6%
30 – 34	605,539	6.9%	2,787	9.9%	157	18.5%
35 – 39	601,361	6.9%	3,002	10.6%	120	14.1%
40 – 44	588,579	6.7%	2,631	9.3%	80	9.4%
45 – 49	526,512	6.0%	2,639	9.3%	52	6.1%
50 – 54	550,428	6.3%	2,936	10.4%	46	5.4%
55 - 59	549,470	6.3%	3,578	12.7%	32	3.8%
60 – 64	553,074	6.3%	3,694	13.1%	22	2.6%
65+	1,498,899	17.2%	4,858	17.2%	10	1.2%
Race / Ethnicity						
Black/African American, non-Hispanic	1,666,274	19.1%	15,844	56.0%	427	50.2%
White, non-Hispanic	5,150,160	59.0%	7,375	26.1%	208	24.4%
Hispanic/Latino (all races)	985,384	11.3%	3,325	11.8%	174	20.5%
Asian/ Hawaiian/ Pacific Islander	644,802	7.4%	494	1.8%	19	2.2%
Amer. Indian/ Alaska Native	23,253	0.3%	18	0.1%	1	0.1%
Multi-race/ Unknown	264,812	3.0%	1,221	4.3%	22	2.6%
Transmission Category						
Male-to-male sexual contact (MMSC)			14,294	50.6%	452	53.1%
Injection drug use (IDU)			1,629	5.8%	19	2.2%

MMSC & IDU			920	3.3%	13	1.5%
Heterosexual contact			5,012	17.7%	58	6.8%
Pediatric			350	1.2%	0	0.0%
Blood recipient			53	0.2%	0	0.0%
No risk factor reported or identified			6,019	21.3%	309	36.3%

Sources: [1]2023 Virginia population by county, [2]Virginia Enhanced HIV/AIDS Reporting System (eHARS) August 2025 frozen dataset.

Virginia has an aging population of PWH. A greater number of people live longer with HIV due to advances in medical treatment and care. Figure 3, which depicts the age distribution of all PWH and newly diagnosed PWH, shows that most PWH are over 45 years, with the largest age group between 55 and 64 years. In contrast, more than half of persons newly diagnosed with HIV are under 35 years.

Figure 3: Percentage by Age Group of All Persons with HIV as of December 31, 2024, and 2024 Newly Diagnosed Persons

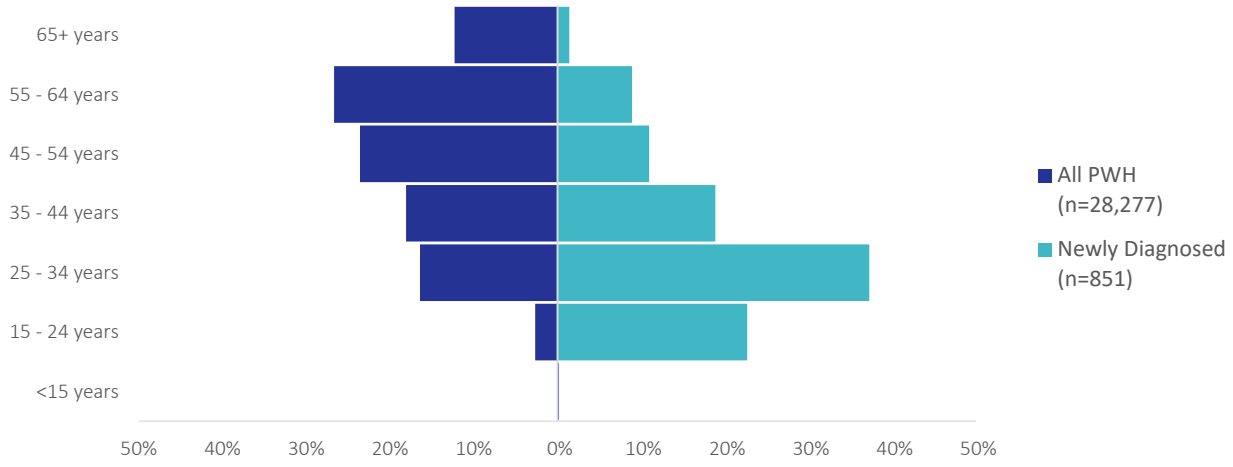


Table 3: Socioeconomic Characteristics of Virginia and Five Health Regions' General Population, 2023

	Virginia	Central	Eastern	Northern	Northwest	Southwest
Below 100% Federal Poverty Level	10.2%	11.8%	11.3%	5.9%	9.7%	16.1%
Per capita income[1]	$45,585	$33,420	$38,210	$65,430	$37,850	$30,120
Educational attainment (population ≥25 years)						
≤8th grade	3%	4%	3%	3%	3%	5%
9th to 12th grade (no diploma)	5%	6%	6%	4%	6%	9%

High school of equivalency	23%	26%	25%	13%	27%	31%
Some college	19%	20%	23%	14%	20%	21%
Associate's Degree	8%	7%	9%	6%	7%	9%
Bachelor's Degree	23%	21%	19%	32%	20%	14%
Master's Degree or higher	19%	14%	12%	29%	14%	8%
Unemployment rate[2]	3.0%	3.2%	3.2%	2.3%	2.4%	2.8%
Uninsured[3]	7.4%	8.2%	7.3%	7.9%	6.8%	6.6%
Foreign born	13.0%	9.4%	7.7%	28.5%	8.1%	5.1%
Not a U.S. Citizen[4]	47.1%	55.8%	41.2%	44.8%	54.9%	51.7%

Source: U.S. Census Bureau, American Community Survey 5-year
[1]Per capita income is calculated as an average of the average income for each locality by region. The average of averages is not a reliable calculation.
[2]Statewide rate is seasonally adjusted as of December 2023. Regional rates are not seasonally adjusted and are as of November 2023. All unemployment data are from the U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics.
[3]Uninsurance data are based on 2023 American Community Survey estimates
[4]Percent not a U.S. citizen are reported as a percent of the foreign-born population

Behavioral and Clinical Characteristics

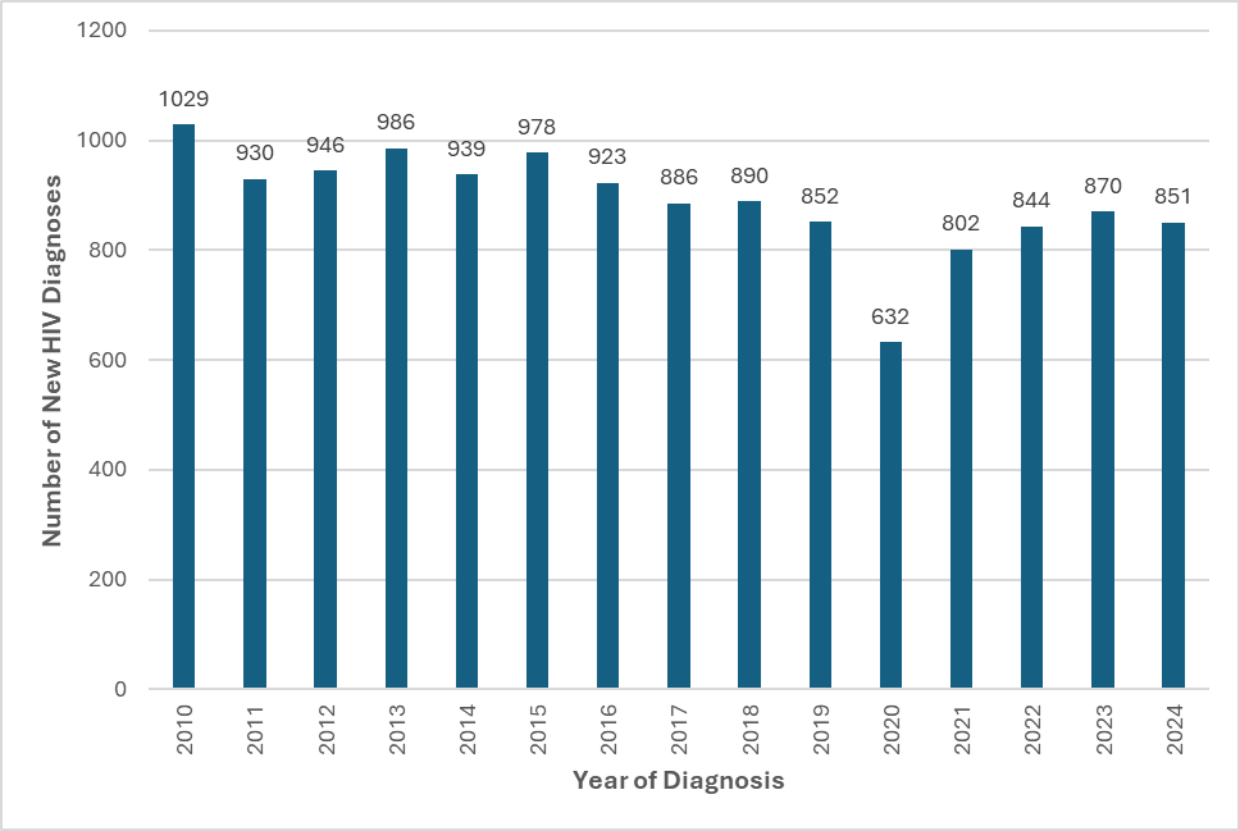
Five-Year Patterns:

Over the past five years, Virginia's new HIV diagnoses have shown long-term declines and short-term fluctuations (Figure 4). HIV diagnoses in Virginia increased from 632 in 2020 to 851 in 2024. The COVID-19 pandemic resulted in a marked decline in reported diagnoses in 2020, which departed substantially from the pattern observed in prior years. This anomaly limits the interpretation of short-term (e.g., five-year) patterns. Before the pandemic, annual HIV diagnoses in Virginia had gradually declined.

In 2024, 37,515 total HIV tests were conducted in Virginia. Of those tests conducted, 4,276 were not provided, or unable to be provided to the client, meaning these clients may be unaware of their HIV status.

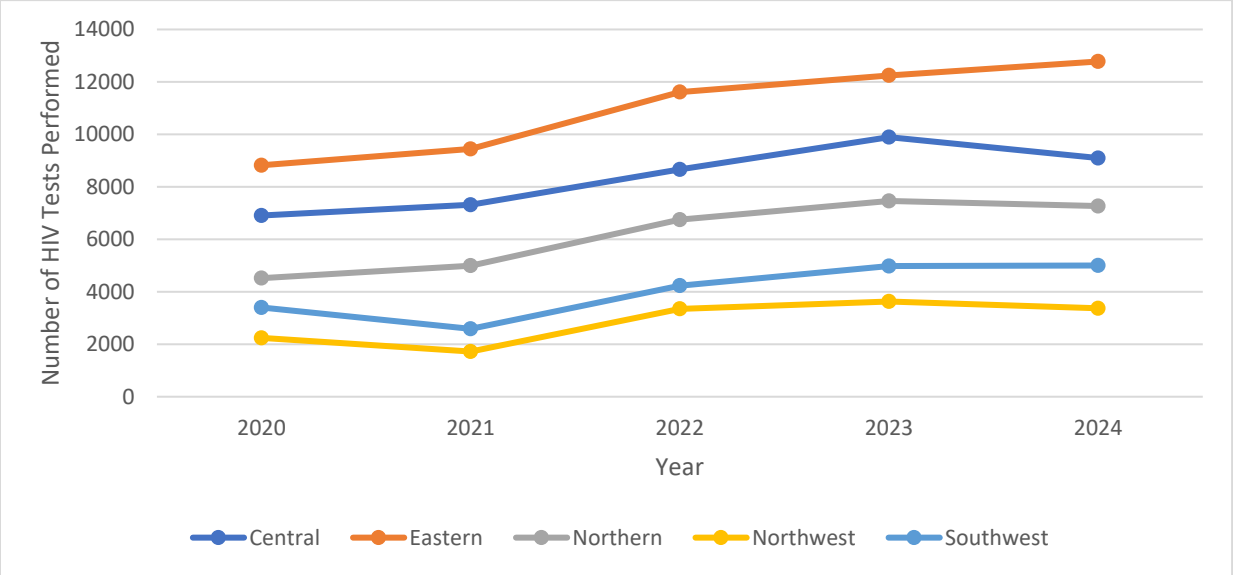
The national data provided by CDC helps explain these patterns. CDC reported a 17% decrease in new HIV diagnoses in 2020 compared to 2019 due to reduced testing and reporting during the pandemic, not a true decline in incidence[7]. Diagnoses partially rebounded in 2021, increasing 18% nationally, and rose an additional 5% in 2022[7]. CDC noted that the effects of the pandemic on HIV testing, and surveillance persisted into 2021–2022 and should be considered when interpreting trends from those years.

Figure 4: New HIV Diagnoses in Virginia 2010-2024



In 2024, a total of 37,515 HIV tests were conducted in Virginia (Figure 5). Of those tests conducted, 4,276 were not provided, or were unable to be provided to the client, meaning these clients may be unaware of their HIV status.

Figure 5: HIV Tests by Health Region from 2020-2024



Figures 6-10 present Virginia's five-year patterns in the number of new HIV diagnoses by key demographics: sex at birth, race/ethnicity, age at diagnosis, transmission risk, and Health Region.

Figure 6: New HIV Diagnoses from 2020-2024 by Sex at Birth

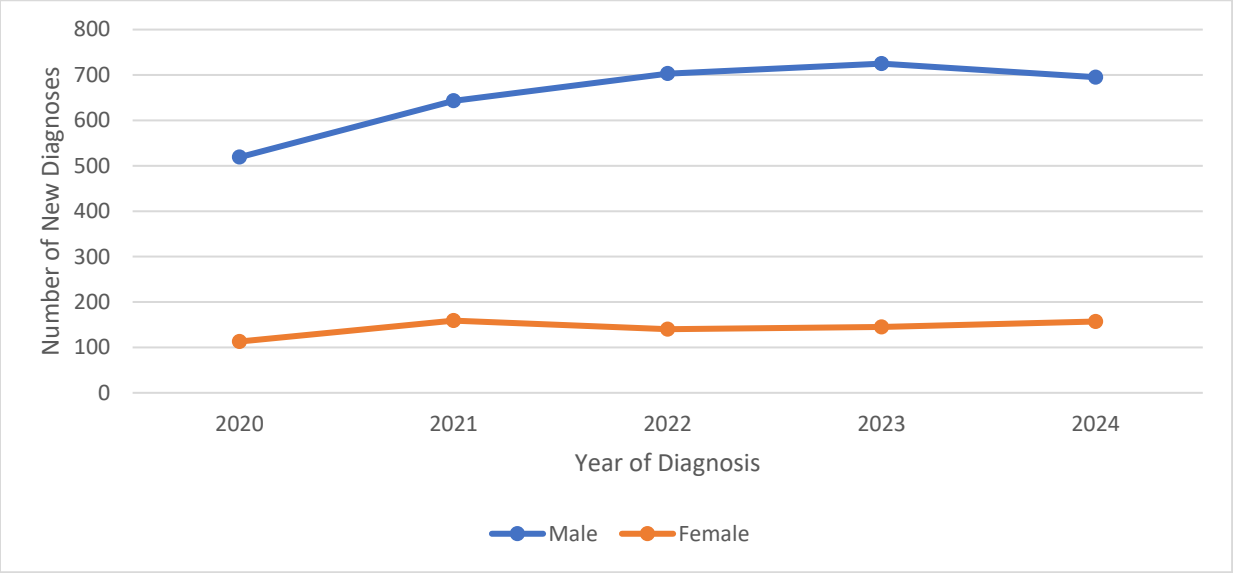
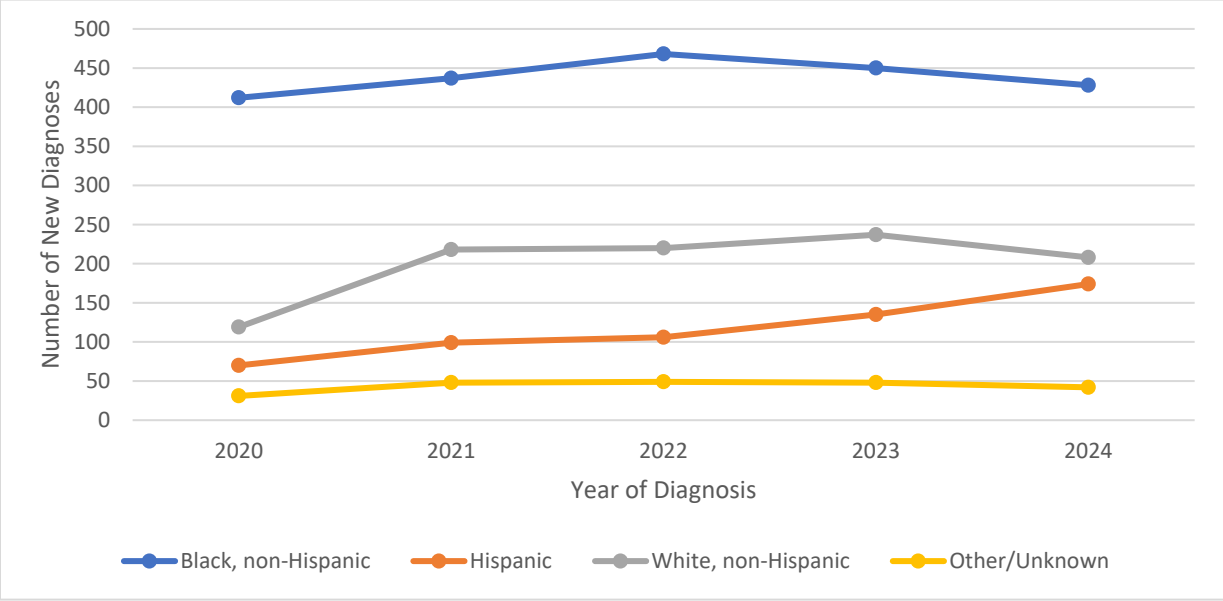


Figure 7: New HIV Diagnoses from 2020-2024 by Race/Ethnicity



*Other includes: Asian, Hawaiian/Pacific Islander, American Indian/Alaska Native, multi-race, and unknown

Figure 8: New HIV Diagnoses from 2020-2024 by Age Group

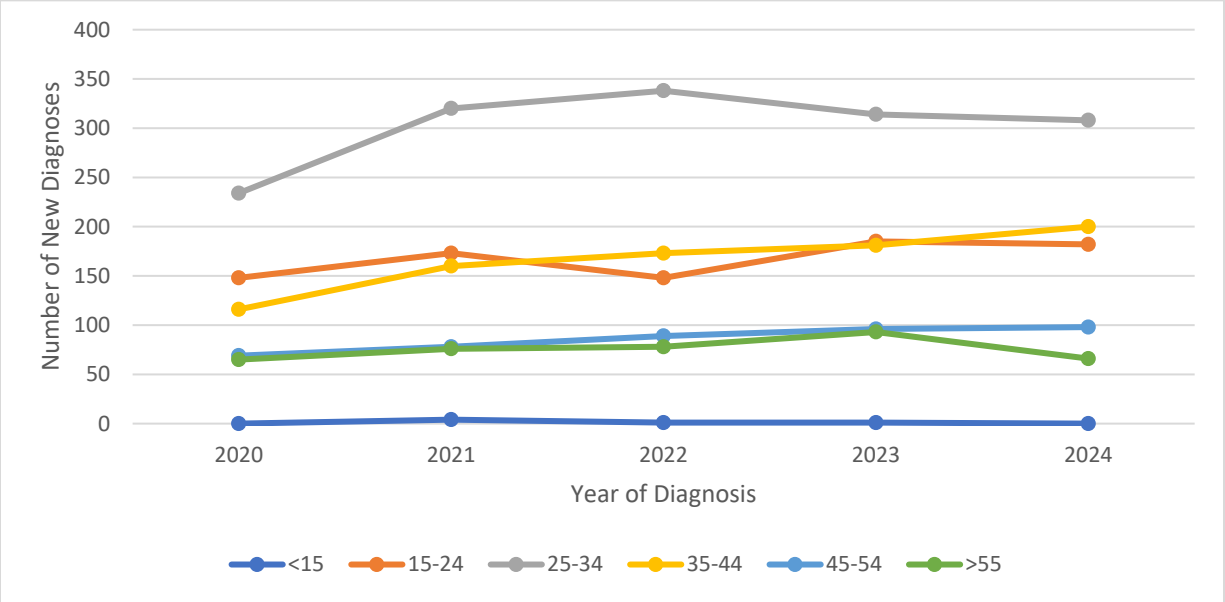


Figure 9: New HIV Diagnoses from 2020-2024 by Transmission Risk

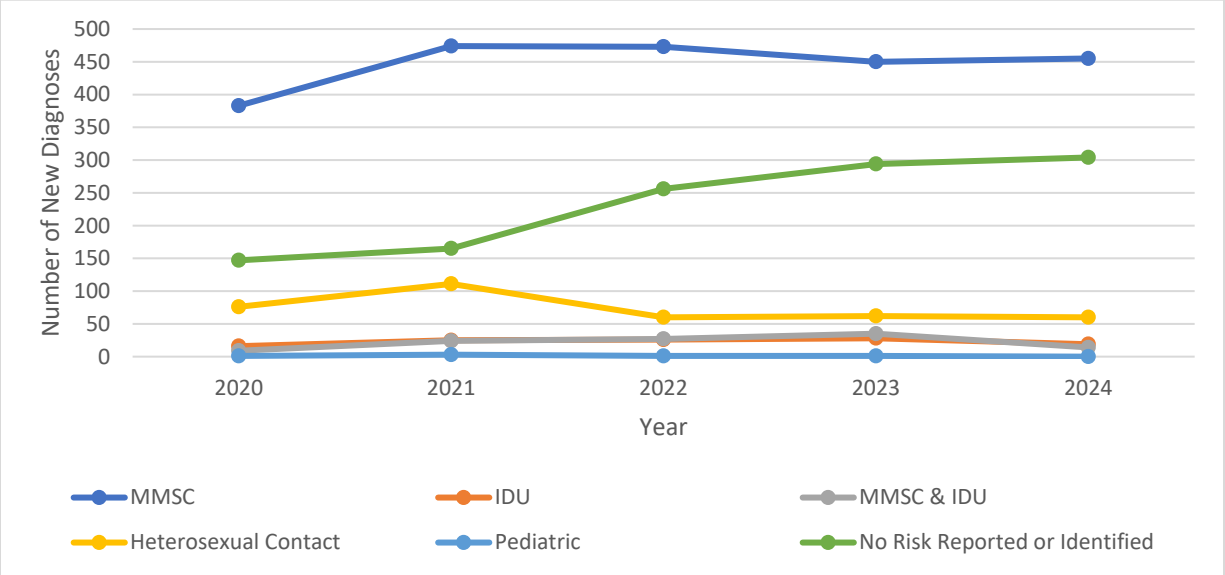
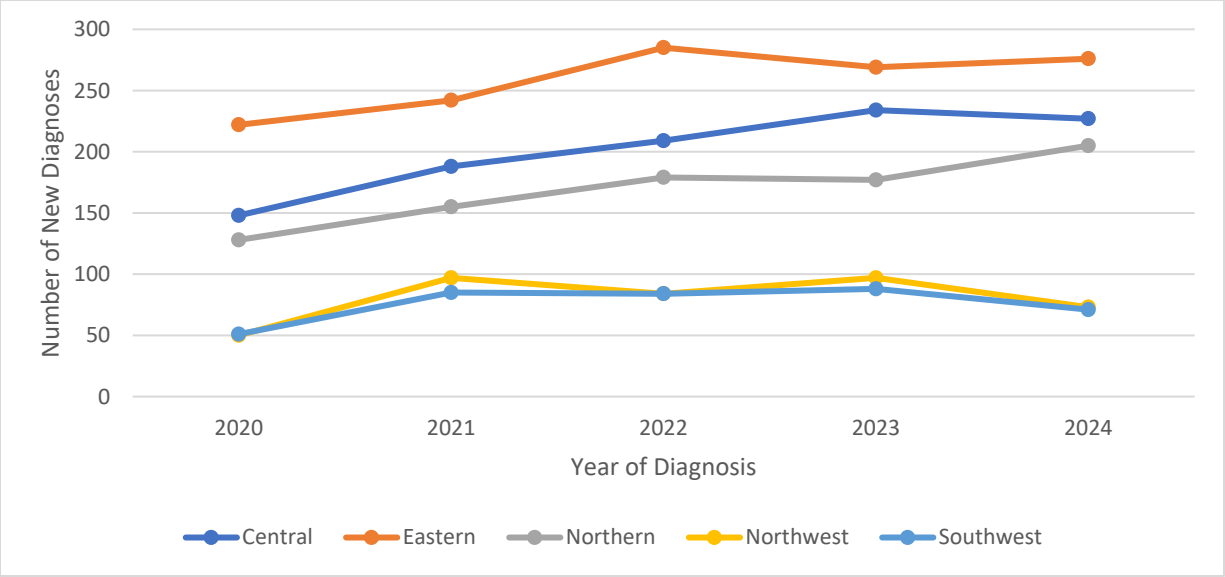


Figure 10: New HIV Diagnoses from 2020-2024 by Health Region



Late Diagnoses:

Timely diagnoses are an important component of managing the HIV epidemic. Late diagnoses refer to persons who are diagnosed with AIDS at their initial diagnosis or within one year of their HIV diagnosis. Late diagnoses data lag by one year because the determination requires a full year of follow-up.

Table 4 shows the percentage of late diagnoses from 2020-2024 by Region. Statewide, the percentage of late diagnoses remained relatively stable from 2020 to 2024, (26.3% to 24.2%, respectively). Since 2020, the Eastern and Northern Regions reported the lowest percentages of late diagnoses, while the Southwest and Central Regions reported the highest.

Table 4: Percentage of New Diagnoses that are Late Diagnoses by Region, 2020-2024

	Virginia	Central	Eastern	Northern	Northwest	Southwest
2020	**26.3%**	33.6%	25.8%	20.6%	21.6%	27.4%
2021	**23.1%**	18.7%	20.8%	28.7%	21.4%	31.5%
2022	**23.7%**	18.3%	20.7%	28.7%	35.7%	25.0%
2023	**24.4%**	22.1%	20.4%	25.8%	28.6%	34.8%
2024	**24.2%**	21.6%	28.3%	18.6%	28.8%	28.2%

The Norfolk Transitional Ryan White Part A Grant Area (TGA):

Figure 11 shows the coverage area of the Norfolk TGA. The combined population of the municipalities for 2024 was estimated at 1,764,539 compared to the general population of Virginia at 8,811,195 (from 2024 Census data), resulting in an estimated State coverage of about 19.8% overall, excluding Currituck County.

Table 5 presents demographic data for the Norfolk TGA's general population (2023), and population of PWH (2024), and newly diagnosed persons (2024).

Among all PWH in 2024, those in the Norfolk TGA were younger (20.2% under age 35 vs. 17.6% statewide), more likely to be non-Hispanic, Black/African American (66.5% vs. 56.0%), and more likely to have no transmission risk factor reported (22.5% vs. 21.3%). Norfolk TGA PWH were less likely to be non-Hispanic, White (21.2% vs. 26.1%) or Hispanic/Latino (6.8% vs. 11.8%) and were also less likely to report heterosexual contact as their primary transmission category (16.9% vs. 17.7%).

Demographic patterns among PWH and individuals newly diagnosed in the Norfolk TGA continue to differ substantially from the Eastern Region's total population. While 49.0% of the Norfolk TGA general population is male at birth, a much larger proportion of PWH (74.7%) and new diagnoses (80.7%) in the Norfolk TGA are male. Racial disparities also persist; although non-Hispanic, Black/African American residents represent 30.7% of the Norfolk TGA population, they account for 66.5% of all PWH and 66.9% of new diagnoses.

Some key differences remain between the Norfolk TGA and Virginia statewide. In 2024, persons newly diagnosed in the Norfolk TGA were slightly older, with only 53.6% under the age of 35 compared to the 57.5% statewide. Newly diagnosed individuals in the Norfolk TGA were more likely to be non-Hispanic, Black/African American (66.9% vs. 50.2% statewide) and less likely to be Hispanic/Latino (8.7% vs. 20.5% statewide). The proportion of newly diagnosed individuals with no reported or identified transmission risk was similar in the Norfolk TGA (34.7%) and statewide (36.3%). Compared to the statewide patterns, newly diagnosed individuals in the Norfolk TGA were slightly more likely to report heterosexual contact as their transmission factor (8.7% vs. 6.8% statewide).

The sociodemographic profile of the Norfolk TGA provides concrete information on the key social determinants of health that affect the general population, including PWH. When comparing the profile with that of the Commonwealth of Virginia, there are interesting findings on age, education, housing, employment, income, health insurance and poverty level. First and foremost, the Norfolk TGA has an average age of 39.9 which is slightly higher than the statewide average.

Table 5: Comparison of Demographic Characteristics of the Norfolk TGA's 2023 General Population with PWH in the Norfolk TGA and New Diagnoses in 2024 in the Norfolk TGA, as of December 31, 2024

	2023 Norfolk TGA General Population[1]		2024 PWH in Norfolk TGA[2]		2024 New Diagnoses in Norfolk TGA[2]	
	Number	Percent	Number	Percent	Number	Percent
Total	1,728,742	100.0%	8,044	100.0%	254	100.0%
Sex at Birth						
Male	846,969	49.0%	6,006	74.7%	205	80.7%
Female	881,773	51.0%	2,038	25.3%	49	19.3%
Age (years)						
<10	208,012	12.0%	6	0.1%	0	0.0%
10 - 14	105,543	6.1%	6	0.1%	0	0.0%
15 - 19	109,530	6.3%	17	0.2%	13	5.1%
20 – 24	123,715	7.2%	195	2.4%	36	14.2%
25 – 29	123,507	7.1%	503	6.3%	38	15.0%
30 – 34	130,697	7.6%	894	11.1%	49	19.3%
35 – 39	125,192	7.2%	968	12.0%	37	14.6%
40 – 44	113,446	6.6%	805	10.0%	30	11.8%
45 – 49	93,653	5.4%	703	8.7%	19	7.5%
50 – 54	96,577	5.6%	742	9.2%	16	6.3%
55 - 59	102,283	5.9%	969	12.1%	8	3.2%
60 – 64	110,343	6.4%	998	12.4%	7	2.8%
65+	286,244	16.6%	1,238	15.4%	1	0.4%
Race / Ethnicity						
Black/African American, non-Hispanic	530,759	30.7%	5,348	66.5%	170	66.9%
White, non-Hispanic	906,122	52.4%	1,702	21.2%	53	20.9%
Hispanic/Latino (all races)	145,362	8.4%	544	6.8%	22	8.7%
Asian/ Hawaiian/Pacific Islander	78,570	4.5%	70	0.18%	4	1.6%
Amer. Indian/Alaska Native	5,822	0.3%	4	0.1%	1	0.4%
Multi-race/ Unknown	62,107	3.6%	376	4.7%	4	1.6%

Transmission Category						
Male-to-male sexual contact (MMSC)			4,041	50.2%	136	53.5%
Injection drug use (IDU)			483	6.0%	4	1.6%
MMCS & IDU			251	3.1%	4	1.6%
Heterosexual contact			1,358	16.9%	22	8.7%
Pediatric			88	1.1%	0	0.0%
Blood recipient			11	0.1%	0	0.0%
No risk factor reported or identified			1,812	22.5%	88	34.7%

Sources: [1]2023 Virginia population by county, [2]Virginia Enhanced HIV/AIDS Reporting System (eHARS) August 2025 frozen dataset

Socioeconomic Data:

Table 5 presents selected socioeconomic data for Virginia and the five Health Regions. Income, education, employment, and insurance status have direct health implications for people with and at-risk for HIV. These factors determine access to healthcare, housing, and essential services.

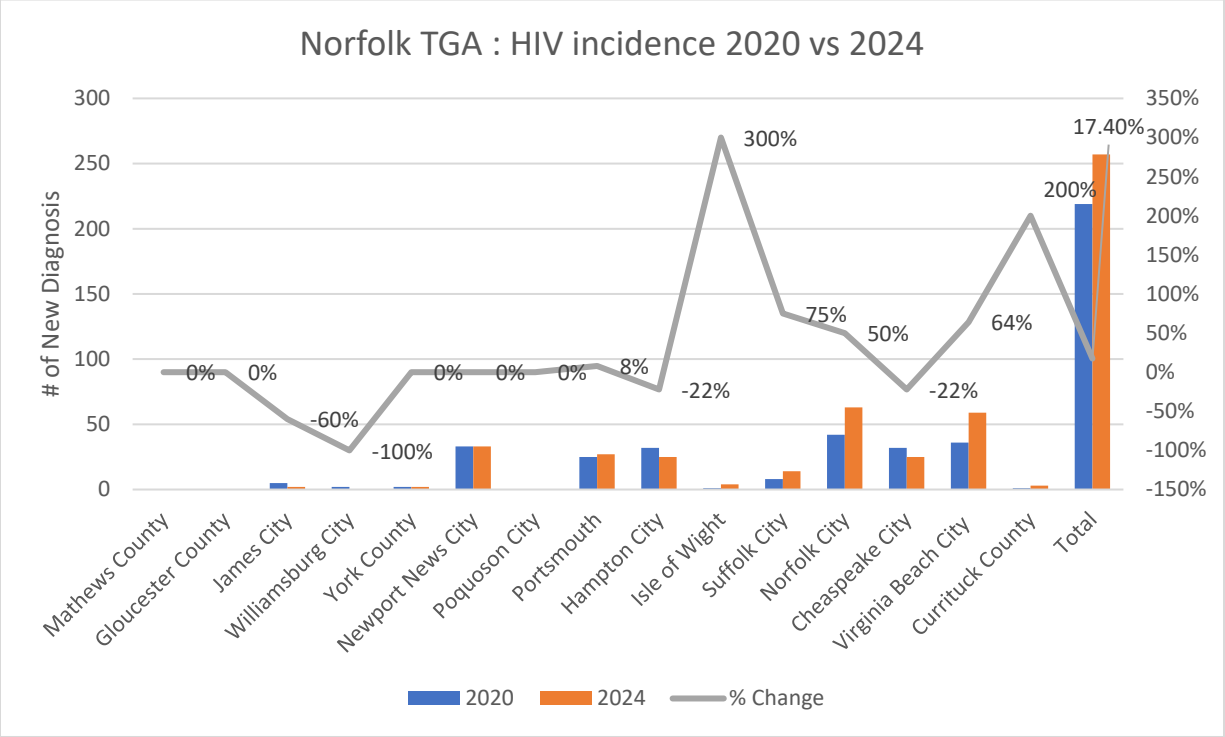
In 2023, approximately 10.2% of Virginians lived at or below 100% of the federal poverty level (FPL). This ranged from 5.9% in the Northern Region to 16.1% in the Southwest Region. Per capita income also varied substantially by Health Region, from $30,120 per capita in the Southwest Region to $65,430 in the Northern Region.

As with income, educational attainment was highest in the Northern Region, where 61% of the population aged 25 years and older had a bachelor's degree or higher, and lowest in the Southwest Region, where only 22% held a bachelor's degree or higher. Unemployment remained relatively low statewide at 3.0%, with the lowest rates in the Northern Region (2.3%) and Northwest Region (2.4%), while the highest rate was observed in the Central and Eastern regions (3.2%).

Following Virginia's Medicaid expansion in 2019, insurance coverage increased. The 2023 American Community Survey (ACS) estimates indicate that 7.4% of Virginians were uninsured, with higher uninsured rates in the Central (8.2%) and Northern (7.9%) Regions, and lower rates in the Northwest (6.8%) and Southwest (6.6%) Regions.

From 2020 to 2024, the HIV incidence for the Norfolk TGA increased by 17.4 % from 219 to 257 newly diagnosed persons. The average number of new diagnoses was 250 per year. There was significant variability between independent cities in total new diagnoses between 2020 to 2024, ranging from 0 to 311 new HIV diagnoses. The city with the highest number of new diagnoses was Norfolk, followed by Virginia Beach and Newport News. These independent cities also have some of the highest populations. Mathews County did not record any new diagnoses over the corresponding period. Currituck County in North Carolina had a total of only 6 new diagnoses from 2020 to 2024 (Figure 12). In terms of the growth of HIV diagnoses there were some municipalities that recorded an increase in new diagnoses when comparing 2020 to 2024. These included, in descending order, the Isle of Wight, Currituck County, Suffolk City, Virginia Beach, Norfolk City, and Portsmouth. Many of these independent cities are adjacent to each other with relative ease of population migration.

Figure 12: Norfolk TGA HIV incidence



Upon further analysis by population burden, there is significant variability among municipalities in terms of HIV incidence. The HIV incidence rate per 100,000 population for the Norfolk TGA ranges from 0 to 28, with an average of 10 per 100,000 overall. (Fig 4) The cities with the highest burden are Portsmouth, followed by Norfolk and Newport News, and the lowest being Poquoson City, and Williamsburg. Interestingly, 66.7% or two thirds of all cities had average or above average incidence rates of 10 per 100,000 population, including Currituck County in North Carolina. There was also geographic variability since many of the high burden and low burden cities are located near each other, further indicating spillover effects from one region to another.

People At-Risk for HIV:

In the United States, HIV continues to disproportionately impact certain populations, which are typically defined by individual attributes such as race/ethnicity, sex, and behavioral risk. CDC defines populations at greatest risk as the following[1]:

- Gay and bisexual men of all races and ethnicities
- Black/African Americans
- Hispanic/Latinos
- People who inject drugs (PWID)

These factors and the association with new HIV diagnoses in Virginia are described in the "Five Year Patterns" section of the Epidemiologic Snapshot. Other factors that increase one's risk of becoming infected or transmitting HIV include viral load, other sexually transmitted diseases, and alcohol and drug use[2]. It is important to note that 2020 new diagnoses rates should be interpreted with caution as screening and testing were negatively impacted by the COVID-19 pandemic.

Considerations of nonmedical factors that impact health enable a better understanding of populations at-risk for and disproportionately impacted by HIV. This includes the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks[4]. Healthy People 2030, describes five domains:

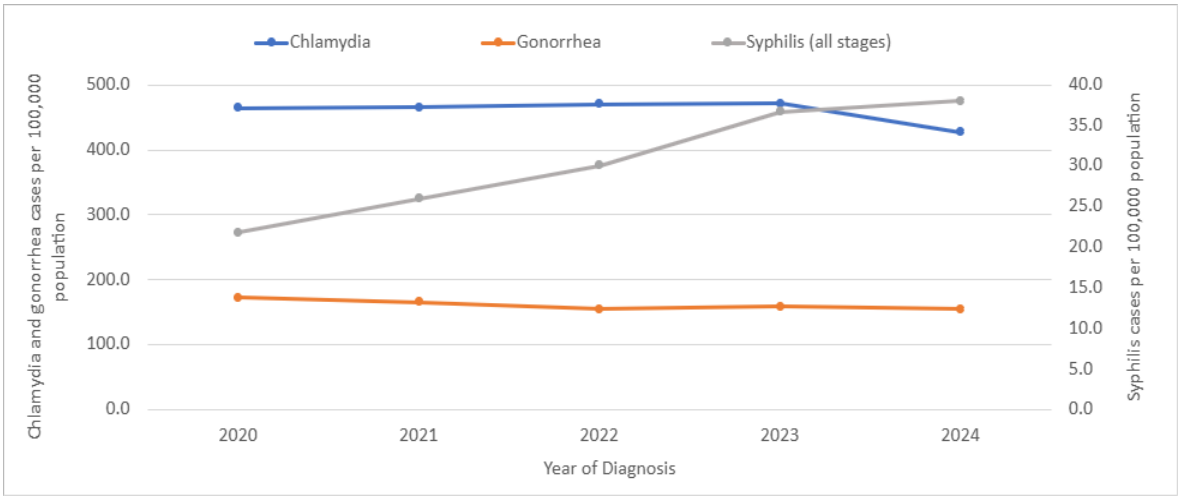
- Economic stability
- Education Access and quality
- Health care access and quality
- Neighborhood and built environment
- Social and community context

For the Norfolk TGA, the key at-risk populations have not changed considerably from 2022-2025. Comparative data indicates that the Norfolk TGA tends to have a younger population 48% vs 45.2% ages 25-34, more males diagnosed 83.7% vs 81.8% and they tend to be Black or African American 71% versus 66.1% statewide. When factoring IDU, more clients from the Norfolk TGA tend to have a higher prevalence of drug use 5.4% versus 2.4% statewide. These factors suggests that young Black/African American male PWID are an emerging high-risk group. CDC data from 2019 indicated that in Virginia, 39.1% and 26.8% of young people between the ages of 13-24 and 25-35, respectively were not aware of their status. This finding indicates the need for enhanced HIV testing and prevention among the ages 13-35. Taking all of this into account, the priority populations for the Norfolk TGA has not changed significantly and remains as follows:

- Young Black/African American Males 25-44
- Black/African American Female 25-44
- Other at-risk populations such as the aging population
- Young males and females that are unemployed

As shown in Figure 13, rates of syphilis diagnoses increased 74% from 2020-2024 while rate of chlamydia and gonorrhea diagnoses decreased (8% and 11% decrease, respectively). It is important to note that 2020 rates should be interpreted with caution as screening and testing encounters were negatively impacted during the COVID-19 pandemic.

Figure 13: Rates of Chlamydia, Gonorrhea, and Early Syphilis Diagnoses, 2020 - 2024



Overview of Network Detection and Response, 2016 – 2021:

Network Detection and Response (NDR), formerly known as Cluster Detection and Response, is a core HIV surveillance program that identifies groups of related HIV infections to stop the spread of HIV. Virginia's NDR program began in 2016. Each month, the program receives HIV genotypes (genotype is the genetic make-up of the virus) of PWH who have had a genotypic resistance test. HIV genotypes are imported into a VDH HIV surveillance database and analyzed to assess similarities. Genetically linked genotypes are at least 99.5% similar, and indicate that transmission occurred between those individuals, either directly or through a common source. The NDR program uses HIV genotypes to identify priority networks, defined as a network of at least five individuals diagnosed in the previous 12 months who have genetically linked HIV genotypes. The HIV transmission rate in priority networks is more than ten times higher when compared to the rate of HIV transmission in the entire PWH population. Once VDH identifies priority networks, staff focus treatment and prevention efforts on these areas of high HIV transmission. Between 2021 and 2025, Virginia's NDR program identified 12 priority networks, summarized in Table 6. Please note several limitations for this data. First, network detection work cannot infer directionality of transmission. In other words, it is not possible to say that person A gave HIV to person B. Second, genotypic resistance tests are recommended, not required, meaning VDH does not receive them on 100% of PWH. There could be PWH genetically linked to the molecular network that we have not been able to identify because they are yet to be diagnosed, or they are diagnosed but have not had an HIV genotype test. Third, please note the difference between a molecular network, a transmission network, and a risk network. A molecular network refers to genetically linked individuals. The transmission network includes individuals in the molecular network, and all named partners with diagnosed HIV of individuals in the molecular network. The risk network includes individuals in the transmission network and any named partners who tested negative for HIV or who have an unknown HIV status. These networks include named partners to help describe and identify characteristics of a larger picture of the networks and help focus treatment and prevention efforts. Finally, CDC conducts national network analysis quarterly on genotypes from all jurisdictions, allowing identification of cross-jurisdictional molecular networks. National analysis identified network names begin with "CDC". Virginia's local molecular analyses identified network names begin with "VA".

Table 6: Priority Molecular Cluster Summary

Cluster Name	Year of Detection	Size of Transmission Cluster	Sex at Birth	Race/Ethnicity	Age	Region	Risk	Percent Virally Suppressed
VA_202107_278	2021	47	Male	Black/African American	20-29	Eastern	MMSC *	79%
VA_202202_009	2022	10	Male	Hispanic/Latino	20-29	Northern	MMSC	60%
CDC_202203_1773	2022	8	Male	White	20-29	Eastern	MMSC	75%
VA_202307_776	2023	11	Male	White	20-29	Eastern	MMSC	73%
CDC_202309_935	2023	10	Male	White	30-39	Northern	MMSC	50%
VA_202404_77	2024	14	Male	Black/African American	20-29	Eastern	MMSC	79%
VA_202407_35	2024	32	Male	Black/African American	13-29	Central	MMSC	81%
VA_202408_123	2024	7	Male	Black/African American	20-29	Eastern	MMSC	88%
CDC_202409_862	2024	6	Male	White	20-39	Central	MMSC	83%
VA_202412_980	2024	6	Male	Hispanic/Latino	20-29	Northern	MMSC	83%
VA_202501_603	2025	21	Male	Hispanic/Latino	20-39	Central	IDU**	71%
VA_202503_989	2025	7	Male	Hispanic/Latino	20-29	Northern	MMSC	100%

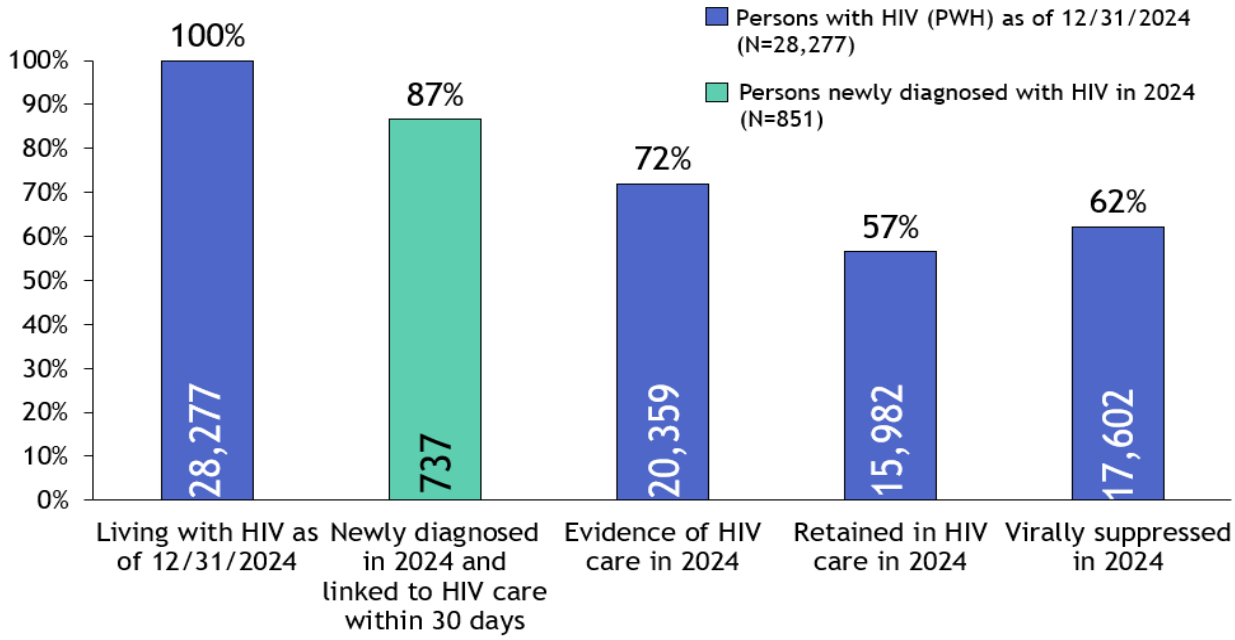
2024 HIV Care Continuum:

VDH DDP uses a diagnosis-based HIV Care Continuum (versus a prevalence-based continuum). The diagnosis-based continuum includes all PWH who are diagnosed and reported in Virginia's HIV surveillance system and excludes undiagnosed persons.

Virginia's 2024 HIV Continuum of Care (Figure 14) consists of four HIV-related measures: 1) linkage to HIV care; 2) evidence of HIV care; 3) retention in HIV care; and 4) viral suppression. The four measures are based on the presence of care markers reported to VDH and are based on the following definitions:

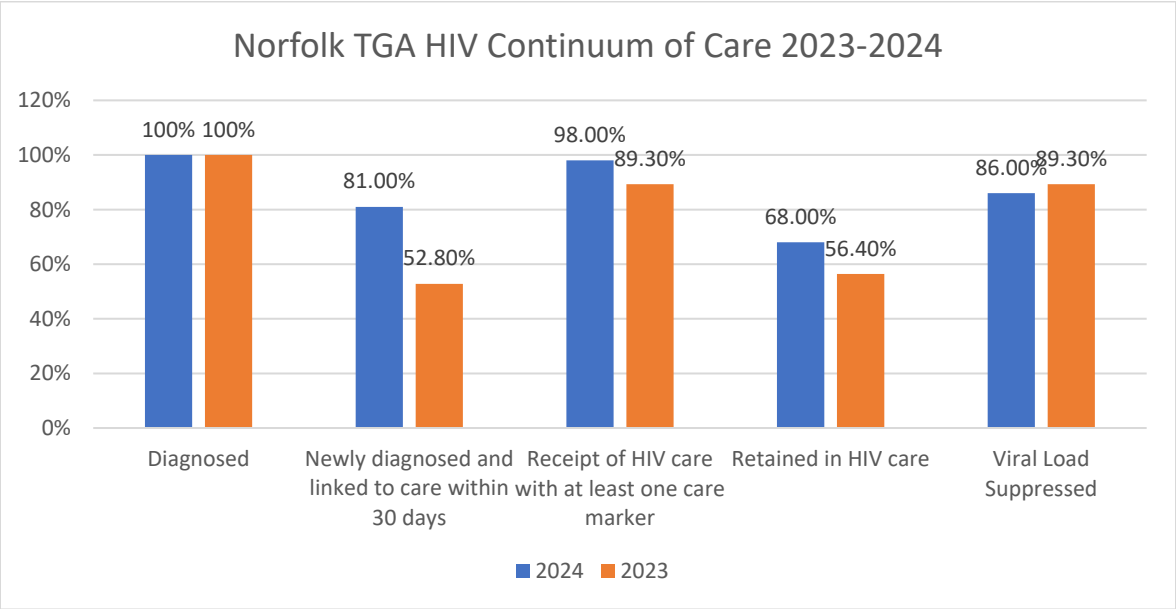
- Care marker: defined as a CD4, viral load, or genotype testing lab; an HIV medical care visit; or an antiretroviral prescription
- Persons with HIV as of December 31, 2024: the number of persons aware of their status, diagnosed, and living with HIV with a last known residence in Virginia as of 12/31/2024
- Newly diagnosed and linked to HIV care within 30 or 90 days: persons newly diagnosed in Virginia in 2024 and linked to HIV care within 30 or 90 days from initial diagnosis
- Evidence of HIV care in 2024: persons with HIV as of 12/31/2024 who had at least one care marker in calendar year (CY) 2024
- Retained in HIV care in 2024: persons with HIV as of 12/31/2024 who had at least two care markers at least three months (90 days) apart in CY 2024
- Virally suppressed in 2024: persons with HIV as of 12/31/2024 with their most recent viral load in CY 2024 measuring at <200 copies/milliliter (mL)

Figure 14: HIV Continuum of Care in Virginia, 2024



For completion of the HIV Continuum of Care, vital statistics and the National Death Index and Social Security Master Files are matched nationally to ensure that only living persons are included in calculations.

Figure 15: HIV Continuum of Care,Norfolk TGA, 2023-2024



Source: *Norfolk TGA Dashboard, Collaborative Research, 2024*

Table 7 summarizes Virginia's 2024 HIV Continuum of Care across several subpopulations of PWH, including sex at birth, race or ethnicity, transmission risk, Health Region, and age group. As shown in Table 8 and the figures that follow, disparities persist across subpopulations, with notable differences of three or more percentage points below the statewide average highlighted in bold italics and shaded grey.

In 2024, 87% of individuals were linked to care within 30 days (93% within 90 days), 72% had evidence of care, 57% were retained in care, and 62% achieved viral suppression.

By transmission risk, the largest disparities were observed among PWID. PWID demonstrated the lowest outcomes across all four measures, particularly for evidence of care (61%), retention in care (49%), and viral suppression (52%). In contrast, individuals reporting heterosexual contact showed the strongest outcomes overall, while those with male-to-male sexual contact (MMSC) achieved relatively high viral suppression (65%).

By race and ethnicity, disparities were also evident. Hispanic/Latino individuals had slightly lower evidence of care (68%) and viral suppression (60%) compared to the statewide average. Non-Hispanic, Black/African American individuals showed modestly lower retention in care (56%) and viral suppression (60%) relative to statewide levels.

By Health Region, outcomes varied across the Commonwealth. Northwest and Southwest Virginia demonstrated the most favorable outcomes, with viral suppression rates reaching 68%, while the Northern Health Region exhibited notable gaps, including lower evidence of care (64%), retention in care (49%), and viral suppression (58%).

By age group, differences were generally modest. The youngest age group (15–24 years) demonstrated strong early engagement in care (85% evidence of care), but slightly lower viral suppression (65%) compared to older age groups.

Overall, these data indicate statewide improvements across all four continuum measures since the last Integrated Plan. However, persistent disparities remain, particularly among PWID, individuals residing in the Northern Health Region, and Hispanic/Latino populations, underscoring the need for targeted interventions to improve long-term engagement and viral suppression.

Table 7: Virginia 2024 HIV Continuum of Care Data by Specific Population Groups

Population	Linked to Care within 30 days (within 90 days)	Evidence of Care	Retained in Care	Virally Suppressed
Virginia	87.0% (93.0%)	72.0%	56.5%	62.2%
Sex at birth				
Males	86.0% (92.0%)	71.0%	56.0%	62.0%
Females	90.0% (96.0%)	74.0%	59.0%	64.0%
Race/ethnicity				
Black, non-Hispanic	85.0% (93.0%)	72.0%	56.0%	60.0%
White, non-Hispanic	87.0% (92.0%)	73.0%	57.0%	65.0%
Hispanic/Latino	90.0% (94.0%)	68.0%	57.0%	60.0%
Transmission Risk				
MMSC	87.0% (93.0%)	75.0%	59.0%	65.0%
IDU	79.0% (95.0%)	61.0%	49.0%	52.0%
MMSC & IDU	100.0% (100.0%)	72.0%	57.0%	59.0%
Heterosexual Contact	93.0% (95.0%)	75.0%	60.0%	66.0%
Health Region				
Central	81.0% (90.0%)	74.0%	57.0%	64.0%
Eastern	86.0% (93.0%)	74.0%	57.0%	62.0%
Northern	90.0% (93.0%)	64.0%	49.0%	58.0%
Northwest	96.0% (99.0%)	78.0%	67.0%	68.0%
Southwest	87.0% (92.0%)	80.0%	66.0%	68.0%
Age Group* (years)				
15-24	88.0% (94.0%)	85.0%	63.0%	65.0%
25-34	87.0% (93.0%)	76.0%	58.0%	61.0%
35-44	83.0% (91.0%)	74.0%	57.0%	62.0%
45-54	88.0% (93.0%)	72.0%	57.0%	63.0%
55+	89.0% (91.0%)	69.0%	55.0%	62.0%

Table 8: Virginia's 2024 HIV Continuum of Care Data for Specific Population Groups and HIV-Related Outcome

Linked to Care within 30 days (within 90 days)		Evidence of Care		Retained in Care		Virally Suppressed	
Virginia (average)	87%	Virginia (average)	72%	Virginia (average)	57%	Virginia (average)	62%
MMSC & IDU	100%	15-24 years	85%	Northwest	67%	Northwest	68%
Northwest	96%	Southwest	80%	Southwest	66%	Southwest	68%
Heterosexual Contact	93%	Northwest	78%	15-24 years	63%	Heterosexual Contact	66%
Females	90%	25-34 years	76%	Heterosexual Contact	60%	White, non-Hispanic	65%
Hispanic / Latino	90%	MMSC	75%	Females	59%	MMSC	65%
Northern	90%	Heterosexual Contact	75%	MMSC	59%	15-24 years	65%
55+ years	89%	Females	74%	25-34 years	58%	Females	64%
15-24 years	88%	Central	74%	White, non-Hispanic	57%	Central	64%
45-54 years	88%	Eastern	74%	Hispanic / Latino	57%	45-54 years	63%
MMSC	87%	35-44 years	74%	MMSC & IDU	57%	Males	62%
25-34 years	87%	White, non-Hispanic	73%	Central	57%	Eastern	62%
White, non-Hispanic	87%	Black, non-Hispanic	72%	Eastern	57%	35-44 years	62%
Southwest	87%	MMSC & IDU	72%	35-44 years	57%	55+ years	62%
Eastern	86%	45-54 years	72%	45-54 years	57%	25-34 years	61%
Males	86%	Males	71%	Males	56%	Black, non-Hispanic	60%
Black, non-Hispanic	85%	**55+ years**	**69%**	Black, non-Hispanic	56%	Hispanic / Latino	60%
35-44 years	**83%**	**Hispanic / Latino**	**68%**	55+ years	55%	**MMSC & IDU**	**59%**
Central	**81%**	**Northern**	**64%**	**IDU**	**49%**	**Northern**	**58%**
IDU	**79%**	**IDU**	**61%**	**Northern**	**49%**	**IDU**	**52%**

*Note: **Bold** indicates populations that are at least three percentage points below Virginia average. Grey shading indicates populations that are at least five percentage points below Virginia average.*

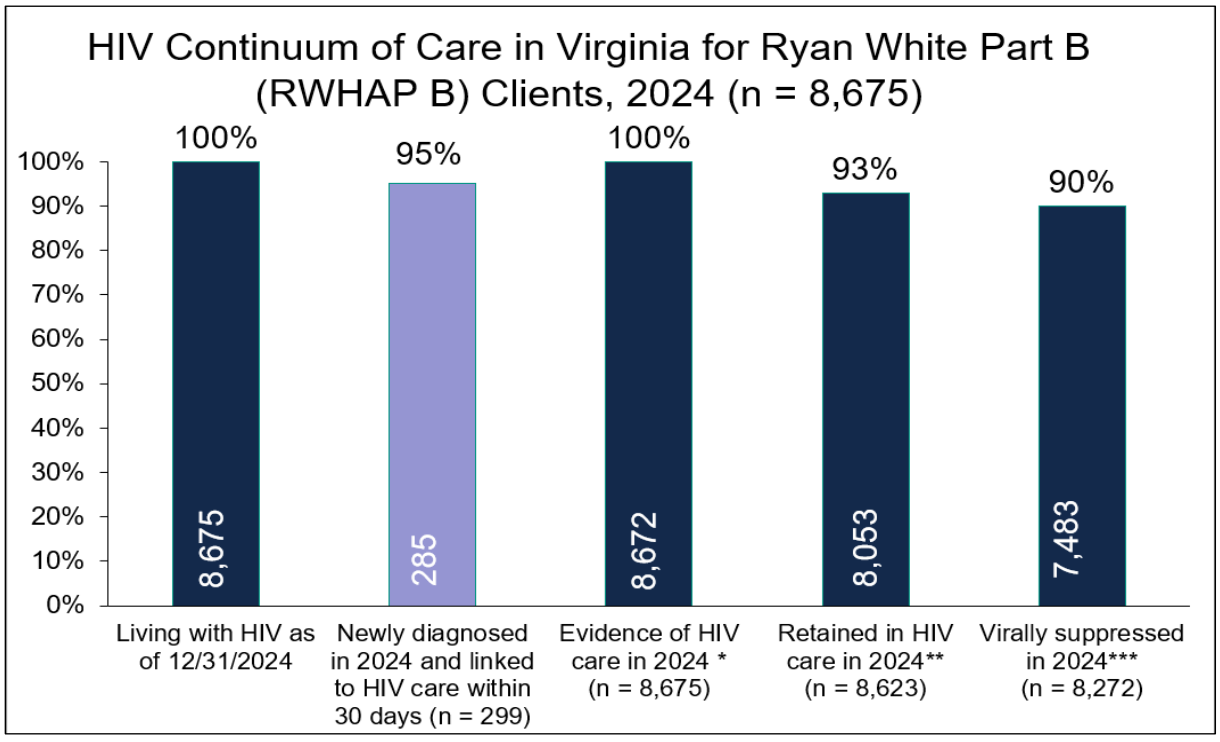
2024 Ryan White Services HIV Care Continuum:

DDP routinely reviews the HIV care continuum for clients receiving Ryan White services. Health Resources and Services Administration (HRSA) performance measures dictate the calculation of the Ryan White HIV care continuum (Figure 16); therefore, the metrics differ slightly from the statewide continuum. Whereas the statewide continuum uses the full population of PWH as the denominator for evidence of care, retention in care, and viral suppression, the Ryan White continuum contains certain exclusions. First, evidence of care is not included in the continuum, as all clients included in the continuum received Ryan White services and, consequently, have evidence of care. Secondly, HRSA calculates retention in care only among clients with a care marker in the calendar year and excludes clients who died during the year. Finally, HRSA calculates viral suppression only among those with an outpatient/ambulatory medical care visit in the calendar year.

Direct comparison between the statewide and Ryan White care continuums should be made with caution, however, a few differences are noteworthy. Linkage to care within 30 days of diagnosis is higher among Ryan White clients compared to the statewide rate (95.0% vs. 87.0%). Additionally, retention in care is very high among Ryan White clients (93.0%). Viral suppression, which is calculated only among 7,483 of the 8,272 Ryan White clients due to eligibility criteria, is higher than the statewide rate (90.0% vs. 62.0%).

These higher metrics among Ryan White clients suggest there may be factors associated with participation in the Ryan White program that contribute to better outcomes. The Ryan White program is designed to mitigate barriers to care and improve health outcomes, which may improve access to care and treatment. However, some of the improved outcomes may reflect higher data quality. Ryan White-funded providers are required to report service utilization, which leads to better reporting of health outcomes.

Figure 16: HIV Continuum of Care for Ryan White Clients in Virginia, 2024



Priority Populations for Prevention and Care:

The 2022–2025 HIV National Strategic Plan prioritizes efforts to reduce disparities and improve HIV outcomes for key populations disproportionately impacted by the epidemic. These national priority populations include:

- Gay, bisexual, and other MMSC, particularly Black/African American, Hispanic or Latino, and American Indian/Alaska Native men
- Black/African American women
- Youth aged 13–24 years
- PWID

Virginia additionally prioritizes PWH aged 65 years and older, given the growing proportion of aging PWH and their unique care engagement needs.

Tables 9 and 10 summarize the number and percent of new HIV diagnoses and total PWH in these priority populations in 2024, while Table 11 presents the 2024 HIV care continuum outcomes for each priority population.

Black/African American, Latino, and American Indian/Alaska Native MMSC (MMSC of Color):

MMSC of Color continue to represent the largest share of new diagnoses among all priority populations, accounting for 36.0%–42.0% of all new HIV diagnoses between 2021 and 2024. Among new diagnoses, Black/African American MMSC consistently represent the majority (24.0%–31.0%), while reports among Hispanic/Latino MMSC increased from 8.0% to 14.0% between 2023 and 2024.

As of 2024, MMSC of color represents 21.0–35.0% of all PWH across Health Regions, with the highest proportion in the Central and Eastern regions (35.0%) and the lowest in the Southwest (21.0%).

Compared to statewide averages, MMSC of color perform slightly better across the HIV care continuum — with 85.0% linked within 30 days, 74.0% evidence of care, and viral suppression at 63.0%, closely matching or exceeding state outcomes.

Youth and Young Adults Aged 13-24:

Youth and young adults aged 13–24 consistently account for 18.0%–22.0% of all new HIV diagnoses in Virginia — despite representing only 2–3% of all PWH statewide. The Eastern Region reports the highest proportion of young PWH.

Youth (13-24) show exceptional engagement in the early stages of the care continuum, with 88% linked to care within 30 days and 85.0% with evidence of care — both well above statewide averages. Retention (63.0%) and viral suppression (65.0%) are on par or slightly above state averages, indicating strong early care initiation and encouraging long-term adherence potential.

People who Inject Drugs:

In 2024, among all PWH, PWID demonstrated linkage to care within 30 days comparable to or exceeding the statewide average (87.0%) and viral suppression rates above the statewide average (65.0%). However, retention in care remained lower (59.0%), highlighting persistent barriers to sustained engagement in HIV care and long-term treatment stability.

PWH aged 65 and older:

PWH aged 65 and older comprise a growing share of Virginia's HIV population, representing 16.0%–18.0% dependent on region.

However, this group exhibits the lowest care engagement of all priority populations:

- lowest linkage rate statewide (80.0% vs. 87.0% overall)
- substantially lower evidence of care (66.0% vs. 72.0%)
- lowest retention in care (53.0% vs. 57.0%)
- viral suppression below state average (61.0% vs. 62.0%)

These patterns indicate a clear need for age-specific care retention and comorbidity-informed support strategies.

Table 9: Number and Percent of all New Diagnoses among Priority Populations, 2021-2024

Population	2021		2022		2023		2024	
	N	%	N	%	N	%	N	%
All New Diagnoses	802	100%	844	100%	870	100%	851	100%
MMSC of Color	335	42%	342	41%	316	36%	335	39%
Black MMSC	249	31%	255	30%	238	27%	202	24%
Latino MMSC	72	9%	73	9%	68	8%	118	14%
Asian/ Hawaiian / Pacific Islander MMSC	14	2%	14	2%	10	1%	14	2%
American Indian/ Alaska Native MMSC	0	0%	0	0%	0	0%	1	0.1%
Black Women	100	12%	94	11%	83	10%	102	12%
Youth 13-24 years	173	22%	148	18%	185	21%	182	21%
PWID (MMSC or MMSC & IDU)	498	62%	500	59%	486	56%	465	55%
PWH age 65+ years	91	11%	124	15%	130	15%	108	13%

Table 10: Number and Percent of all People with HIV among Priority Populations, 2024

Population	Central		Eastern		Northern		Northwest		Southwest	
	N	%	N	%	N	%	N	%	N	%
All PWH	6572	100.0%	8557	100.0%	7817	100.0%	2661	100.0%	2512	100.0%
MMSC of Color	2299	35.0%	2982	34.8%	2440	31.2%	633	23.8%	530	21.1%
Black MMSC	1987	30.2%	2659	31.1%	1285	16.4%	449	16.9%	441	17.6%
Latino MMSC	283	4.3%	278	3.2%	1008	12.9%	166	6.2%	74	2.9%

Asian/ Hawaiian / Pacific Islander MMSC	27	0.4%	43	0.5%	142	1.8%	18	0.7%	12	0.5%
American Indian/ Alaska Native MMSC	2	0.0%	2	0.0%	5	0.1%	0	0.0%	3	0.1%
Black Women	1124	17.1%	1627	19.0%	1370	17.5%	374	14.1%	366	14.6%
Youth 13-24 years	194	3.0%	218	2.5%	123	1.6%	69	2.6%	47	1.9%
PWID (IDU or MMSC & IDU)	713	10.8%	790	9.2%	446	5.7%	280	10.5%	309	12.3%
PWH age 65+ years	1163	17.7%	1362	15.9%	1419	18.2%	452	17.0%	415	16.5%

Table 11: HIV Care Continuum Outcomes among Priority Populations, 2024

Population	Linked to Care (30 days)	Evidence of Care	Retained in Care	Virally Suppressed
Virginia	87.0%	72.0%	57.0%	62.0%
MMSC of color	85.0%	74.0%	58.0%	63.0%
Black, non-Hispanic MMSC	82.0%	75.0%	58.0%	63.0%
Hispanic/Latino MMSC	90.0%	72.0%	59.0%	63.0%
Asian/Hawaiian/Alaskan Native MMSC	87.0%	71.0%	53.0%	63.0%
Black Women	92.0%	74.0%	59.0%	64.0%
Youth (13-24 years)	87.9%	85.4%	62.8%	64.7%
PWID (IDU or IDU&MMSC)	87.0%	75.0%	59.0%	65.0%
Aging PWH (65+ years)	80.0%	66.0%	53.0%	61.0%

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HIV Prevention, Care and Treatment Resource Inventory:

Funding Streams Supporting HIV Prevention, Care and Surveillance in Virginia:

Virginia receives a number of public funding sources to provide HIV prevention and care services including: Centers of Centers for Medicare & Medicaid Services, managed through the Department of Medical Assistance Services; the Centers for Disease Control and Prevention, funding supports activities for prevention and surveillance; the Health Resources and Services Administration and US Department of Housing and Urban Development (HUD) that supports low-income individuals with both primary care services and HIV care and treatment services including medication access, through the Ryan White CARES Act, the HRSA Health Center Program, and Housing Opportunities for People with AIDS (HOPWA).

CDC Prevention and Surveillance Programs:

Virginia receives CDC funds for its Integrated HIV Surveillance and Prevention Cooperative Agreement. These funds are used to support the bulk of surveillance and prevention activities, along with six core strategies and activities.

VDH funds several HIV prevention services, including HIV and Hepatitis C testing, PrEP/nPEP services, and Opioid Use Disorder Services. Additional funding supports condom distribution, social marketing and social media, hotline services, HIV home testing program, and PrEP navigation. VDH also receives funding from the Opioid Abatement Authority (OAA), Overdose Data to Action (OD2A), and the State Opioid Response (SOR) for opioid use disorder services. State funds partially support several programs including opioid use disorder services, laboratory testing, PrEP clinical time and PrEP/nPEP medication purchases. Some entities listed below receive funding for more than one program and are listed in each table for which funding is received.

Federal funding supports 31 sites that provide clinical and non-clinical testing for HIV testing and 30 sites that provide Hepatitis C testing, including mobile testing, and service navigation.

Virginia HIV and Hepatitis C (HCV) Testing Providers		
Agency Name	**City/County**	**Health Planning Region**
AIDS Response Effort	Winchester	Northwest
Arlington Health Department	Arlington	Northern
Bradley Free Clinic (HCV only)	Roanoke	Southwest
CAN Community Health	Norfolk	Eastern
Chris Atwood Foundation	Fairfax	Northern
Community Access Network	Lynchburg	Southwest
Council of Community Services	Roanoke	Southwest
Crossover Healthcare Ministry	Richmond	Central
Cumberland Plateau Health District (HCV only)	Lebanon	Southwest
Eastern Shore Rural Health	New Church	Eastern
Empowering Transgender Services, Inc.	Portsmouth	Eastern
Fairfax Health Department (HIV only)	Fairfax	Northern
Fredericksburg Area Health and Support Services	Fredericksburg	Northwest
Hampton University (HIV only)	Hampton	Eastern
Hampton/Peninsula-CHR (HCV only)	Hampton	Eastern
Health Betterment Initiative	McLean	Southwest
Health Brigade	Richmond	Central
Horizon Behavioral Health	Lynchburg	Southwest
Lenowisco Health Department	Wise	Southwest
LGBT Life Center	Norfolk	Eastern
Lighthouse Community Health (HCV only)	Lynchburg	Southwest
Loudoun Health Department	Loudon	Northern
Mary Washington Healthcare (HIV only)	Fredericksburg	Northwest
Minority AIDS Support Services	Norfolk	Eastern
Minority Health Consortium	Richmond	Central
Mount Rogers Health Department	Smyth	Southwest
Nationz Foundation	Richmond	Central
Norfolk Health Department	Norfolk	Eastern
NovaSalud	Falls Church	Northern
Peninsula Health Department (HIV only)	Newport News	Eastern
Southeastern Virginia Health System (SEVHS) (HIV only)	Newport News	Eastern
Portsmouth Health Department (HCV only)	Portsmouth	Eastern
Strength in Peers	Harrisonburg	Northwest
Virginia Beach Department of Human Services (HIV only)	Virginia Beach	Eastern
Virginia Harm Reduction Coalition	Roanoke	Southwest
Virginia Commonwealth University (HIV only)	Richmond	Central
Virginia State University (HCV only)	Petersburg	Central

Virginia also uses federal funds for eight status neutral service navigation (SNSN) sites that provide access to HIV testing, PrEP/nPEP navigation services, STI screening, and referrals for other HIV prevention and treatment services.

Virginia SNSN Providers		
Agency Name	**City/County**	**Health Planning Region**
AIDS Response Effort (ARE)	Winchester	Northwest
CAN Community Health	Norfolk	Eastern
Council of Community Services (CCS)	Roanoke	Southwest
Fredericksburg Area Health and Support Services	Fredericksburg	Northwest
LGBT Life Center	Norfolk	Eastern
Minority Aids Support Services (MASS)	Norfolk	Eastern
Minority Health Consortium (MHC)	Richmond	Central
Nationz Foundation	Richmond	Central
NovaSalud	Falls Church	Northern
Strength in Peers	Harrisonburg	Northwest

Virginia funds 16 Opioid Use Disorder service sites that provide access to hepatitis/STI/HIV testing, supportive services including emergency housing.

Virginia Opioid Use Disorder Service Providers		
Agency Name	**City/County**	**Health Planning Region**
AIDS Response Effort	Winchester	Northwest
Chris Atwood Foundation	Fairfax	Northern
Community Access Network	Lynchburg	Southwest
Council of Community Services	Roanoke	Southwest
Hampton Veterans Administration Medical Center	Hampton	Eastern
Hampton/Peninsula Health Districts	Hampton	Eastern
Health Brigade	Richmond	Central
Lenowisco Health District	Wise	Southwest
Minority AIDS Support Services	Norfolk	Eastern
Mount Rogers Health District	Symth County	Southwest
Nationz Foundation	Richmond	Central
New River Health District	Christiansburg	Southwest
Portsmouth Health District	Portsmouth	Eastern
Salem Virginia Veterans Administration Hospital	Salem	Southwest
Strength in Peers	Harrisonburg	Northwest
Virginia Harm Reduction Coalition	Roanoke	Southwest

Virginia has 40 sites that offer PrEP/nPEP services and currently funds 25 of those sites directly. Funding supports PrEP clinical services, PrEP navigation and medication access for the uninsured.

Additionally, VDH supports access to nPEP by providing medication to any Virginia resident who needs it, based on whether they are insured. The health department recently started a pilot project aimed at increasing nPEP access. It distributed starter packs (a blister pack of five doses of nPEP) to 15 LHDs across the state. This allows insured clients to work through insurance requirements without having to worry about the 72-hour dosing window.

Virginia PrEP/nPEP Providers		
Agency Name	**City/County**	**Health Planning Region**
Alexandria Health Department	Alexandria	Northern
Arlington Health Department	Arlington	Northern
Blue Ridge Health District	Charlottesville	Northwest
Community Access Network (CAN)	Lynchburg	Southwest
Chesapeake Health Department	Chesapeake	Eastern
Eastern Shore Health District	Accomac	Eastern
Fredericksburg Health Department	Fredericksburg	Northwest
Hampton Health Department	Hampton	Eastern
Inova Health Care Services (six sites)	Fairfax	Northern
Health Brigade	Richmond	Central
Lenowisco/Cumberland Plateau Health District (eight sites)	Wise	Southwest
Nationz (total of two sites)	Richmond	Central
New River Health District	Christiansburg	Southwest
Mount Rogers Health District (total of four sites)	Smyth County	Southwest
Peninsula Health Department	Newport News	Eastern
Piedmont Health District	Farmville	Central
Portsmouth Health Department	Portsmouth	Eastern
Prince William Health Department (two sites)	Manassas	Northern
Richmond Henrico Health District (two sites)	Richmond	Central
Roanoke/Alleghany Health District (two sites)	Roanoke	Southwest
Three Rivers Health District	Gloucester	Eastern

HRSA Ryan White Services:

Virginia receives HRSA Ryan White HIV/AIDS Program funding across the state. Parts A through F funds are available within the state with Part B administered through the Virginia Department of Health. HRSA Ryan White HIV/AIDS Program Minority AIDS Initiative (MAI) funding is also available through Parts A and B.

Virginia Ryan White Part A: HRSA funds Part A services through one EMA and one TGA that cover portions of Virginia.

The D.C. RWHAP Part A EMA includes eleven counties and six cities of Virginia's Northern region and a small portion of the Northwest region. The four RWHAP A providers offer a combination of Medical Case Management, Non-Medical Case Management, Early Intervention Services (EIS), Outpatient Ambulatory Health Services, Oral Health Care, Mental Health, Outpatient Substance Use Disorder Services, Medical Transportation, and Psychosocial Support Services.

D.C. RWHAP Part A EMA Ryan White Part A Providers		
Agency Name	**City/County**	**Health Planning Region**
Mary Washington Healthcare	Fredericksburg	Northwest
Neighborhood Health	Alexandria	Northern
NovaSalud	Falls Church	Northern
Virginia Health Options	Annandale	Northern

The Norfolk TGA provides Ryan White A services in the Eastern Region of the state. There are eight Ryan White Part A providers in the Eastern Region that provide a combination of services, including Medical and Non-Medical Case Management, Early Intervention Services (EIS), Health Insurance Premium Assistance, Outpatient Ambulatory Health Services, Medical Transportation, and Oral Health Care.

Norfolk TGA Ryan White Part A Providers		
Agency Name	**City/County**	**Health Planning Region**
CAN Community Health	Norfolk	Eastern
Hampton Roads Community Health Center/O.V. Medical and Dental Center (Healthy Smiles)	Portsmouth	Eastern
LGBT Life Center	Norfolk	Eastern
Minority AIDS Support Services, Inc.	Norfolk; Newport News	Eastern
Old Dominion University Research Foundation	Norfolk	Eastern
Norfolk Community Health Center	Norfolk	Eastern
Southeastern Virginia Health Systems	Portsmouth	Eastern
Urban League of Hampton Roads	Virginia Beach	Eastern

Virginia Ryan White Part B: HRSA funds Virginia for the Ryan White Part B program which is administered by the Virginia Department of Health. The Ryan White Part B grant funds HIV healthcare and treatment services for PWH. Funding supports:

- The AIDS Drug Assistance Programs (ADAP) provides funds for Food and Drug Administration (FDA)- approved medications and purchase of health care coverage for low-income PWH with limited or no health care coverage from private entities, Medicaid, or Medicare. In Virginia the name was changed to Medication Assistance Program/MAP).
- Minority AIDS Initiatives (MAI), which is funding for education and outreach to improve minority access to medication assistance programs such as ADAP, Medicaid, etc.). Funding for MAI is allocated to support services under Part B.
- Emerging Communities (EC), which is funding to support HIV services in emerging communities' cities reporting between 500 and 999 reported AIDS cases in the most recent five years. Virginia receives EC funding for the Richmond Metropolitan Statistical Area as designated by the Office of Management and Budget.
- Clinical Quality Management, which ensures access to quality care for all PWH and systematic efforts to ensure all RWHAP-funded services are delivered efficiently and effectively.

Virginia currently funds nine RWHAP B allowable services including four core medical services and six support services. Core medical services include: ADAP; Medical Case Management, including Treatment Adherence Services (MCM); Oral Health Care (emergencies only); and Outpatient/Ambulatory Health Services (OAHS). Support services funded: Non-Medical Case Management Services (NMCM); Health Education/Risk Reduction (MAI), Outreach (MAI and non-MAI) and Psychosocial Support Services.

Ryan White Part B Providers		
Agency Name	**City/County**	**Health Planning Region**
AIDS Response Effort	Winchester	Northwest
Daily Planet	Richmond	Central
Eastern Shore Health District	Accomac	Eastern
Fredericksburg Area Health and Support Services	Fredericksburg	Northwest
Health Brigade	Richmond	Central
Inova Health Care Services	Springfield	Northern
Mary Washington Healthcare	Fredericksburg	Northwest
Minority Health Consortium	Richmond	Central
Nationz Foundation	Richmond	Central
NovaSalud	Falls Church	Northern
Serenity	Petersburg	Central
Three Rivers Health District	Saluda	Eastern
University of Virginia	Charlottesville	Northwest
Virginia Health Options	Annandale	Northern

VDH also uses state funds for medication purchases, HIV testing and medications for the Department of Corrections, and early intervention services (non-RWHAP B) focusing on HIV testing and counseling in three providers.

State Funded Early Intervention Service Providers		
Agency Name	**City/County**	**Health Planning Region**
Health Brigade	Richmond	Central
VCU Arther Ashe	Richmond	Central
Central Virginia Health District	Lynchburg	Southwest

Virginia Ryan White Part C: HRSA directly funds seven providers in Virginia for Ryan White Part C Early Intervention Services (EIS). There is at least one provider in each of the five defined Virginia Health Planning Regions. Part C EIS grants fund primary health care and support services in outpatient settings for PWH.

Ryan White Part C Providers		
Agency Name	**City/County**	**Health Planning Region**
Carilion Medical Center	Roanoke	Southwest
Community Access Network	Lynchburg	Southwest
Old Dominion University Research Foundation	Norfolk	Eastern
INOVA Health Care Services	Springfield	Northern
Mary Washington Healthcare	Fredericksburg	Northwest
University of Virginia	Charlottesville	Northwest
Virginia Commonwealth University	Richmond	Central

Virginia Ryan White Part D: HRSA directly funds two providers in Virginia for Ryan White Part D services under the Women, Infants, Children, and Youth grant. One provider is in the Northern Region and one in the Northwest Region. Part D recipients provide outpatient family-centered primary and specialty medical care and support services. These services help low-income women, infants, children, and youth with HIV.

Ryan White Part D Providers		
Agency Name	**City/County**	**Health Planning Region**
INOVA Health Care Services	Springfield	Northern
University of Virginia	Charlottesville	Northwest

Virginia Ryan White Part F: HRSA directly funds two agencies in Virginia for Ryan White Part F services under the AIDS Education and Technical Centers (AETC) grant. There is one in the Northern and one in the Central Health Planning Regions. Part F recipients Provide training and technical assistance to providers treating patients with or at-risk for HIV.

Ryan White Part F Providers		
Agency Name	**City/County**	**Health Planning Region**
INOVA Health Care Services	Springfield	Northern
Virginia Commonwealth University	Richmond	Central

Medicaid: Virginia is currently a Medicaid expansion state. This greatly increases access to primary care for people with and those most at-risk for HIV, especially for those seeking HIV Pre-Exposure Prophylaxis as neither CDC nor HRSA funds may be used to pay for prescribing or purchasing PrEP medications. As of February 2026, 1,820,356 Virginians were enrolled in Medicaid, with a cumulative total of 555,141 people who were enrolled under the expansion criteria.

Federally Qualified Health Centers (FQHC): HRSA awards community-based health care providers from the HRSA Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients. In 2024, HRSA funded 26 FQHCs in Virginia to provide primary care services in underserved areas.

Virginia HRSA funded FQHC Providers		
Agency Name	**City/County**	**Health Planning Region**
Bland County Medical Clinic, Inc.	Bland	Southwest
Blue Ridge Health Center Inc.	Nelson	Northwest
Capital Area Health Network	Richmond	Central
Central Virginia Health Services, Inc.	Buckingham	Central
Clinch River Health Services Inc	Scott	Southwest
Daily Planet, Incorporated	Richmond	Central
Eastern Shore Rural Health System, Incorporated	Onancock	Eastern
Free Clinic of New River Valley Inc	Montgomery	Southwest
Greater Prince William Area Community Health Center, Inc.	Prince William County	Northern
Harrisonburg Community Health Center, Inc.	Harrisonburg	Northwest
Highland Medical Center Inc	Highland	Southwest
Horizon Health Services Inc	Southampton	Eastern
Johnson Health Center	Lynchburg	Southwest
Kuumba Community Health & Wellness Center	Roanoke	Southwest
Loudoun Community Health Center	Loudoun	Northern
Martinsville Henry County Coalition for Health and Wellness	Martinsville	Southwest
Neighborhood Health	Fairfax	Northern
Peninsula Institute for Community Health, Inc	Newport News	Eastern
Piedmont Access to Health Services, Inc.	Danville	Southwest
Portsmouth Community Health Center, Inc.	Portsmouth	Eastern
Rockbridge Area Free Clinic	Rockbridge	Northwest
Southern Dominion Health	Lunenburg	Central
Southwest Virginia Community Health	Smyth	Southwest
St. Charles Health Council, Inc.	Lee	Northern
Stony Creek Community Health Center Inc	Sussex County	Central
Tri-area Community Health	Carroll County	Southwest

HUD: As of 2024, there are four HOPWA recipient or recipient-lookalike entities in Virginia and approximately 20 direct service providers: three in Central Region, one in Eastern, five in Northern, four in Northwest, and three in Southwest. Services offered vary by Region and provider, but typically include Permanent Housing Placement (PHP), which provides security deposits and other move-in costs; Tenant-Based Rental Assistance (TBRA), which provides participants with housing voucher for use in the private rental market; Supportive Services (SS), typically housing-focused case management; and Short Term Rent, Mortgage, and Utility Assistance (STRMU), which consists of time-limited financial assistance to cover housing related expenses. All HOPWA services are based on availability of funds and are restricted to people with an HIV disease diagnosis with a household income at or below 80% of Area Median Income (AMI).

Virginia HOPWA Providers		
Agency Name	**City/County**	**Health Planning Region**
AIDS Response Effort, Inc.	Winchester	Northwest
Arlington County Department of Human Services	Arlington	Northern
City of Charlottesville	Charlottesville	Northwest
Commonwealth Catholic Charities	Richmond	Central
Council of Community Services	Roanoke	Southwest
Fredericksburg Area Health and Supportive Services	Fredericksburg	Northwest
Healthy Communities Health Centers (HCHC)	Harrisonburg	Northwest
Homestretch, Inc.	Falls Church	Northern
LGBT Life Center	Norfolk	Eastern
Lynchburg Community Action Group	Lynchburg	Southwest
Northern Virginia Family Service	Oakton	Northern
Northern Virginia Regional Commission	Fairfax	Northern
Pittsylvania County Community Action:	Chatham	Southwest
Prince William Office of Housing & Community Development	Woodbridge	Northern
Serenity, Inc.	Petersburg	Central
Virginia Supportive Housing	Richmond	Central
Wesley Housing Development Corp.	Alexandria	Northern

Integration of Services for People who Use Drugs and Alcohol: The Department of Behavioral Health and Developmental Services (DBHDS) supports forty Community Services Boards in Virginia (similar to local health departments for VDH). All community services boards provide substance use disorder treatment either directly or by referral. CSBs offer various combinations of ten core services: emergency, ancillary, consumer-run, local inpatient, outpatient, case management, day support, employment, residential, and prevention services. DBHDS promotes overdose reversal through its REVIVE training program, which educates individuals on administering naloxone to reverse opioid overdoses. In 2025, CSBs provided a variety of services to 185,027 unduplicated clients. Services included Mental Health services, Developmental Services, Substance Use Disorder services, as well as both Emergency and Ancillary services (including motivational treatment, consumer monitoring, assessment and evaluation, and early intervention services).

Virginia Community Service Board Providers		
Agency Name	**City/County**	**Health Planning Region**
Alexandria Community Services Board	Alexandria	Northern
Alleghany Highlands Community Services Board	Covington	Southwest
Arlington County Community Services Board	Arlington	Northern
Blue Ridge Behavioral Healthcare	Roanoke	Southwest
Chesapeake Integrated Behavioral Healthcare	Chesapeake	Eastern

Virginia Community Service Board Providers		
Agency Name	**City/County**	**Health Planning Region**
Chesterfield Community Services Board	Chesterfield	Central
Colonial Behavioral Health	Williamsburg	Eastern
Crossroads	Farmville	Central
Cumberland Mountain Community Services Board	Cedar Bluff	Southwest
Danville-Pittsylvania Community Services Board	Danville	Southwest
Dickenson County Community Services Board	Clintwood	Southwest
Eastern Shore Community Services Board	Tasley	Eastern
Encompass Community Supports	Culpeper	Northwest
Fairfax-Falls Church Community Services Board	Fairfax	Northern
Greater Reach Community Services Board	Petersburg	Central
Goochland-Powhatan Community Services Board	Goochland	Central
Hampton-Newport News Community Services Board	Hampton	Eastern
Hanover County Community Services Board	Ashland	Central
Harrisonburg-Rockingham Community Services Board	Harrisonburg	Northwest
Henrico Area Mental Health and Developmental Services	Glen Allen	Central
Highlands Community Services Board	Abingdon	Southwest
Horizon Behavioral Health	Lynchburg	Southwest
Loudoun County Department of Mental Health, Substance Abuse and Developmental Services	Leesburg	Northern
Middle Peninsula-Northern Neck Behavioral Health	Saluda	Eastern
Mount Rogers Community Services	Wytheville	Southwest
New River Valley Community Services	Blacksburg	Southwest
Norfolk Community Services Board	Norfolk	Eastern
Northwestern Community Services Board	Front Royal	Northwest
Piedmont Community Services Board	Martinsville	Southwest
Planning District One Behavioral Health Services	Norton	Southwest
Portsmouth Behavioral Healthcare Services	Portsmouth	Eastern
Prince William County Community Services Board	Manassas	Northern
Rappahannock Area Community Services Board	Fredericksburg	Northwest
Region Ten Community Services Board	Charlottesville	Northwest
Richmond Behavioral Health Authority	Richmond	Central
Rockbridge Area Community Services Board	Lexington	Northwest
Southside Behavioral Health	Clarksville	Central
Valley Community Services Board	Staunton	Northwest
Virginia Beach Human Services	Virginia Beach	Eastern
Western Tidewater Community Services Board	Suffolk	Eastern

DDP supports services for people who use drugs through a variety of mechanisms. VDH includes five opioid use disorder treatment medications as well as an opioid reversal agent, in its HIV medication formulary.

Additionally, Virginia funds an opioid risk reduction program throughout the state that provides educational materials, referrals to drug treatment, HIV/HBV/HCV/TB/STI testing, condom distribution, counseling and an array of other health services including referrals to mental health services, health insurance enrollment, and referrals to both PrEP and PEP.

DDP, the Division of Pharmacy Services, and the DBHDS collaborated to initiate the Naloxone (Narcan) Partner Program. This program allows most businesses, both for-profit and nonprofit, to be approved to receive free naloxone (Narcan) from VDH. The goal is to distribute naloxone directly to individuals who take opioids, or to significant others to increase access to this life-saving drug. Opioid risk reduction sites must complete online or in-person training in REVIVE, a course that teaches people how to respond to an opioid overdose and administer Naloxone, and online training in harm reduction education and counseling, which provides techniques for providing education in a short, concise manner and to provide one-on-one harm reduction counseling.

DMAS also provides a spectrum of behavioral health/substance use disorder services through Medicaid, including inpatient/residential treatment, mental health rehabilitation services, intensive outpatient programs, opioid treatment programs, case management, and peer recovery support. DMAS has lifted restrictions that have made it easier for clinicians to provide medication assisted treatment for those with opioid addictions.

Integration of HIV, STI and Hepatitis Services:

VDH offers integrated services at LHDs to include HIV, STI, hepatitis B and HCV testing in STI clinics. Extragenital testing (specimens are collected from the throat and rectum) for chlamydia and gonorrhea have also been incorporated to diagnose and treat infections that would otherwise be missed, and to identify those most at-risk for HIV who are candidates for PrEP.

DDP supports rapid HIV testing at 31 provider sites (see list above). HIV testing sites also provide screening for one or more STIs and provide HCV screenings. All clients who are diagnosed with an STI are referred to treatment and partner services through an LHD. Clients who receive a positive HCV screening are linked to an LHD or another clinical setting for diagnostic testing. Clients who are diagnosed with HIV are referred to their LHD for partner services, as well as medical care through an area infectious disease or primary care clinic.

While LHDs bill insured clients for STI clinical services, the uninsured patients referred in from DIS or referred from a partner CBO can receive services without charge.

DIS services are integrated to provide partner services for both STIs and HIV and conduct data to care activities. DIS are supported by CDC-funded cooperative agreements for both HIV and STIs.

VDH receives funds to support integrated viral hepatitis surveillance and prevention programs in Virginia. This grant supports core viral hepatitis outbreak response, surveillance, and prevention activities. Priorities for this cooperative agreement are to improve surveillance for viral hepatitis in states and large cities, including outbreak detection, investigation and control; facilitate state and large city viral hepatitis elimination planning; and increase access to hepatitis B and C testing, and prevention and treatment services (e.g., vaccination and treatment services provided in high-impact settings, such as hospital emergency departments), and among high-burden populations).

Virginia prioritizes providing HIV prevention and care services to populations that are most impacted by the epidemic. These impacted populations include:

- Gay, bisexual, and other MMSC, particularly Black/African American, Hispanic or Latino, and American Indian/Alaska Native men
- Black/African American women
- Youth aged 13–24 years
- PWID
- People aged over 45 years

Virginia focuses on integrating services across both HIV prevention and care, as well as integrating STI, viral hepatitis, and opioid use disorder treatments that maximize the quality of health and support for those at-risk for and those with HIV.

Needs Assessment

Overview of Process:

Commonwealth of Virginia:

VDH utilized a mixed methods approach to assess the need for HIV prevention and care services within the Commonwealth. This included the review and analysis of the data already presented in the Epidemiology Overview section of this Integrated Plan (e.g., HIV surveillance data, HIV Care Continuum data, HIV Network Detection and Response data, etc.). Additional data that were reviewed included Ryan White program data, HIV testing data, specific HIV surveillance reports (e.g., late testing, deaths, HIV incidence surveillance), and sexually transmitted infection (STI) information.

VDH augmented this data with several qualitative data sources through surveys and assessments, listening sessions, and public forums, which focused on the identification of needs, barriers, and gaps in HIV prevention and care service provision and utilization in Virginia.
These included:

- 2022-2023 Ryan White Part B (RWHAP B) consumer survey distributed online and at a consumer event (211 responses)
- 2022 survey for consumers (84 participants) and providers (19 participants) on HIV and Aging
- 2024 Listening session with at-risk communities (54 participants)
- 2025 Organization Capacity Assessment for HIV and Hepatitis Prevention Providers (23 participants)
- 2026 Public Hearing for RWHAP B Services (53 participants)
- 2026 Town Hall focused on integrated planning (67 participants)
- 2026 HIV and Hepatitis Prevention Conference engagement session with providers (83 participants)

In addition, VDH reviewed 2024 HIV surveillance data for the Norfolk TGA.

Participation from PWH and Persons At-Risk HIV:

As part of its mixed methods design, VDH used existing tools to gather additional needs assessment data from PWH and people more at-risk for HIV (i.e., recent surveys/needs assessments, and focus groups/public hearings). VDH included a strategy to conduct additional needs assessments and listening sessions throughout the Integrated Plan timeframe to get additional feedback from communities and persons most impacted by HIV on service needs and gaps across the HIV service delivery system.

Engagement of Other Stakeholders, Including PWH:

VDH conducted regular reviews of the draft Integrated Plan components and solicited feedback from stakeholders. This included holding meetings with internal DDP Leadership, sharing progress and getting feedback at Quarterly HIV Prevention and Care Contractor's meetings, the Norfolk TGA Planning Council, and the CHPG.

VDH planning staff presented the information collected for the needs assessment section to the VDH Integrated Plan workgroup, which was comprised of the HIV and Hepatitis Surveillance, HIV and Hepatitis Prevention, HIV Care Services, and STD Prevention and Surveillance for feedback and prioritization of need. The strategies and activities outlined in the workplan are outcomes of integrated working sessions between CHPG members, which is comprised of representatives from Ryan White Parts A, B, C and D, CBOs, Department of Behavioral Health, housing service institutions, HIV prevention and care providers, local and state health departments, and other stakeholders. The working sessions led to input on the objectives, strategies and activities to include in the workplan to address needs outlined in this section.

Service Needs and Gaps of People and communities most at-risk HIV

People and communities most at-risk for HIV face significant barriers to accessing both HIV testing and other prevention services to help them remain HIV negative. Transportation is a known barrier because of either distance to services or lack of personal or public transportation. The Southwest and other rural areas of Virginia are disproportionately impacted by transportation barriers. Judgement around agencies perceived to be HIV-focused also prevents some individuals from accepting referrals. In addition, some agencies offer needed services but lack staff who are culturally competent to serve PWH or communities most impacted by HIV. There are many barriers that prevent Virginians from accessing the full spectrum of HIV services from condoms, HIV testing, and PrEP to full engagement in HIV medical care and supportive services.

HIV screening (testing) may be routinely offered to patients in all health-care settings. Virginia law allows for routine opt-out HIV testing (§32.1-37.2) and requires that, prior to testing, a medical provider inform the patient that an HIV test is planned, provide information regarding the test, and advise the patient of their right to decline the test. However, routine opt-out HIV testing has not been widely adopted by primary care providers, federally qualified health centers, emergency rooms and other clinical sites in Virginia. Barriers cited by primary care providers may include competing clinical priorities, workflow limitations, reimbursement concerns, and limited comfort or training related to conducting sexual histories; and assessing the need for STI, HIV, and viral hepatitis testing.

A major challenge to PrEP uptake is a lack of provider knowledge or buy-in. Many primary care practitioners are still unaware that PrEP exists or still believe it must be prescribed by an infectious disease specialist. Additional provider education is needed. DDP is working with a variety of partners to address this need. For example, DDP collaborated with the Virginia Rural Health Association to produce an online PrEP and PEP training that is geared for health care providers in rural areas of the state. DDP is also working to disseminate a library of PrEP educational videos that are inclusive of the populations most at-risk for HIV. Education amongst the client population is also needed to address medical mistrust.

While nPEP access continues to increase, many emergency departments (ED) and private practitioners do not prescribe nPEP consistently. Many of the people who utilized the DDP hotline reported that some ED's will help only in instances of a sexual assault. DDP is working to remedy this, through

initiatives such as leading a systems wide training for all EDs in the Inova Health System to better implement a consistent nPEP protocol. DDP will continue to look for educational opportunities to spread awareness and address barriers. Funding for PrEP clinical services is still limited. Many people who could benefit from PrEP believe they cannot afford the medication; however, medication access is no longer the largest barrier.

Virginia has made great progress in expanding opioid risk reduction since the first site was funded in 2018. VDH funds sixteen opioid risk reduction providers, with at least one in each of the five Health Regions. More sites are needed to serve individuals using drugs in the state, particularly in Northern Virginia which contains approximately 30% of the Virginia's population but only has one opioid risk reduction site. Thirteen of the current sites are funded by VDH while three have funding from other sources. Currently VDH does not have the funding available to support new sites.

In addition to preventing HIV and Hepatitis, these sites are primary distributors of naloxone and fentanyl test strips in the state. Participants have reported over 10,000 overdose reversals and statewide overdose deaths have dropped in some at-risk populations. Adulterants added to the fentanyl supply create challenges in reviving people who overdose as well as cause separate health issues. Judgement involving drug use, and certain at-risk populations make retaining opioid risk reduction participants in substance use, mental health, and medical treatment difficult.

There are additional service gaps and needs for people to be rapidly linked to HIV medical care and treatment after receiving an HIV diagnosis. A wider network of providers is needed, especially in rural areas of the state. Transportation also remains a factor. In more rural areas of the state, where providers are limited and public transportation systems are not available, people may need to travel three to four hours to access treatment.

More collaboration between HIV prevention and care sites is also needed to rapidly link clients to care. Expansion to include both prevention and clinical services within a single location would also benefit the "warm handoff" for both ART initiation and PrEP for those in need. There is also a need to make efforts to re-engage those lost to care, especially for clients who received services at agencies that were previously funded for RWHAP B services and had to find a new medical home.

The expanded use of Patient Navigation (PN) services is another service gap, as PN services can assist people receiving a new HIV diagnosis through the process of starting care and receiving emotional support. Patient navigation is available at most major HIV care centers in Virginia; however, the expansion of these services in community health clinics and other health care providers where PWH receive treatment would be beneficial. Navigation services are also needed for persons whose native language is not English, and severe gaps exist with that need around the state. The medical system can be overwhelming for people receiving a new HIV diagnosis and having someone to guide them through the process can assist in linking and keeping someone in care.

1. Barriers to HIV prevention and care services

Barriers to accessing HIV services exist due to a wide variety of reasons. Some barriers are outlined below. Many of the barriers listed below for HIV also exist for people with STIs and Hepatitis.

Lack of Health Insurance:

Lack of health insurance prevents access to a wide variety of billable health care services including primary medical care, mental health, home health care, etc. According to the 2025 Virginia Health Care Foundation's Profile of Virginia's Uninsured, there were 530,000 Virginians in 2023 under the age of 65 that went uninsured. In 2024, VDH had 1,070 clients that were enrolled in a health insurance plan from the Virginia State Marketplace funded by the VA MAP program and 2,042 clients that were enrolled in the Direct VA MAP program, which provides coverage for HIV medications for those that do not have another option to receive their HIV medication. Others have health insurance but are underinsured and therefore the insurance coverage they have does not cover the cost of health care needs. This can lead clients to have high out of pocket costs or deductibles, which for low-income clients can be barrier to care.

2. Federal, state, or local legislative/policy barriers

Funding for PrEP, and Behavioral Health:

Limited federal funding severely impacts the implementation of biomedical interventions, such as PrEP and nPEP that require a prescriber, as well as mental health and substance use treatment that cannot be supported with federal HIV prevention funds. Federal funding opportunities require the advancement of biomedical interventions, but do not allow states to allocate funding for clinical costs associated with implementing these strategies. While funds may be used for laboratory tests and patient navigation, clinical costs remain a significant barrier. To overcome constrictive out-of-pocket expenses, Virginia is funding PrEP and nPEP clinics in LHDs. Laboratory work needed for medical assessment for eligibility of PrEP is being absorbed by state funding. While this system benefits persons in need of PrEP and nPEP, it poses another burden on already burdened and underfunded health department system. The need for additional clinical staff to evaluate and prescribe PrEP is a common concern noted by LHDs considering becoming PrEP clinics. Combined with growing inflation that impacts rent, salaries, IT costs etc., funding is not sufficient to scale up PrEP to the level that will have a significant impact on ending the epidemic.

Housing, mental health services, substance use disorder treatment, food access, and transportation for people and communities most impacted by HIV are limited. Federal partners recognize the connection that mental health and substance use play in high-risk behaviors that put individuals at-risk of acquiring or transmitting HIV, and require state HIV programs to refer to these services, which often are non-existent in many areas of the state, or not culturally-competent to handle the special needs of communities most in need of these services.

Support services are generally not funded for people and communities most at-risk for HIV and there is limited availability of support services for PWH. More collaborations with community providers that provide support services to ensure people and communities most in need still have access to these services.

The Criminalization of HIV in Virginia:

Virginia Code §18.2-67.4:1 outlines the penalties of Infected Sexual Battery laws in Virginia. VDH worked with grassroots community-based organizations during the 2022 General Assembly session on Senate Bill 1138, a bill to modernize HIV criminalization laws. The bill that passed did not result in complete decriminalization, but advancements were made and the new law is an improvement over

the prior legislation. Changes to the law include the additional requirement that transmission of HIV disease must occur rather than just exposure to HIV, and the felony designation was removed. The revised law still includes that it is a Class 1 Misdemeanor to not disclose to sexual partners that they are an individual with HIV, Hepatitis B virus (HBV), or syphilis. The current legislation may still provide a barrier to individuals wanting to get tested for HIV and/or HBV for fear of having to disclose having one of these diseases. It also provides a barrier for ongoing partner services for persons with HIV, as they open themselves up to possible criminal charges for using the service.

Service provider barriers:

Engaging substance use and mental health providers in HIV prevention efforts has had moderate success. More collaborative efforts are needed to bring these services to individuals that are most at-risk for HIV, as well as PWH. Forming collaborations and community focus groups to address issues such as the opioid problem in Virginia, homelessness, and other issues are also needed and should include representation from public health, social services, criminal justice, policy makers, and the targeted populations to be effective. Community mobilization efforts are needed to engage community members in issues such as overcoming judgement surrounding HIV and other issues that impact people's willingness to access prevention and care services would also benefit efforts to advance policy within the Commonwealth.

Fear/Misinformation:

HIV misinformation remains a barrier for accessing both HIV testing and other prevention services, especially in rural areas. Individuals from more rural areas of the state are afraid of being judged and therefore do not access HIV testing and prevention services as evidence by late diagnoses in rural areas and lower rates of viral suppression. The lack of anonymity in small rural communities is perceived to decrease the likelihood of confidentiality and increase the risk for discrimination. Misinformation surrounding HIV being a "gay disease" is also prevalent and precludes heterosexual males and females from participating in prevention interventions. More education is also needed for providers to make HIV testing a routine healthcare activity to address HIV misinformation.

There is also misinformation among communities and people most impacted by HIV that can be a barrier to care. Providers need more education on these communities and how to provide services appropriately. Bad experiences with medical providers and ancillary staff can prevent someone from accessing the services that they need for fear of judgement.

Misinformation is also prevalent among persons who use/inject drugs and opioid use disorder services. There is often negative misinformation/judgement regarding persons who use drugs by healthcare professionals which can cause someone to not access the services they need. There is also misinformation around HIV and sharing needles, which can be a barrier for people who inject drugs to get tested for HIV as they would prefer not to know their HIV status.

Lack of transportation:

While lack of transportation is not as major a problem with people who live in more urban parts of the state, it is a barrier cited by those who live in rural areas where there is often a lack of public transportation and service providers. People who live in rural areas find it costly and time consuming to travel four to six hours to access care. For hourly workers, taking a day off work to access care is not a priority or a possibility. Many areas do not have ride share services or local buses to get to appointments.

Virginia's HIV Care Continuum will continue to utilize a whole person approach to providing services to people with or receiving a new HIV diagnosis. This means the many factors which may impact a person's health while seeking HIV care services such as housing instability, HIV miseducation, substance use, mental health, and other care needs will be considered while serving clients for their HIV care needs.

Norfolk TGA Needs Assessment:

The Norfolk TGA conducts a comprehensive needs assessment to identify the service needs, barriers to care, and gaps within the HIV service delivery system. The needs assessment is a core component of the Planning Council's data-driven planning process and is used to inform priority setting, resource allocation, and the development of strategies within the Integrated Plan.
The Norfolk TGA conducted a needs asessment on the aging population (people over 50 years old) to learn about their serivce needs in 2024. This was important since a growing number of PWH are aging and require more intricate care and social services. Incorporating the findings into the HIV integrated planning process is instrumental for addressing their specific needs. The survey involved 48 respondants.

Respondent profile: Male (50%), Female (50%); Race/Ethnicity: 2% Hispanic, 83% African American, 13% White, 2 % American Indian/Alaskan.

Some of the key highlights of the report include:

- Many clients prefer specialist geriatricians who are knowledgeable about HIV
- About 29% of PWH surveys have been diagnosed for at least 20 yrs
- About 85% lived in stable housing but 15% lived in unstable housing
- About 21% express concerns about having medical transportation to get to their provider
- The most used service was medical case management 57% followed by Oral Health at 36%
- The most needed service as people aged were Food Bank and Oral Health services

Service need profile for aging population of PWH:

The respondents of the survey had distinct services needs and self reported those that were most used versus those that were most needed. By far the service most used was medical case management which offers personalized treatment care and support from trained managers who help clients co-ordinate medical appointments, understand medications, access supportive services and stay engaged in care. This was then followed by Oral health services and surprisingly medical transportation which facilitates patient navigation to their social and clinical appointments. The services that clients considered to be of the utmost importance or need were Food Bank/Home Delivered Meals followed by Oral Health and Housing indicating a clear preference and distinction for social amenities (Table 2).

Table 2: Service Use Profile – Self Reported

Ranking	Most Used	Most needed
1	Medical Case Management(57%)	Food Bank / Home Delivered Meals (58%)
2	Oral Health (36%)	Oral Health/ Dental (56%)
3	Medical Transportation (32%)	Housing (54%)
4	Health Insurance Premium and Cost Sharing Assistance for low income individuals (HIPSCA)(26%)	Emergency Financial Assistance (50%)
5	Referral for Health Care services (23%)	Medical Case Management (48%)

Ranking	Most Used	Most needed
6	Food Bank/Home Delivered Meals (23%)	Medical Transportation (46%)
7	Outpatient Ambulatory Health Services (OAHS) (17%)	Mental Health (44%)
8	Non- Medical Case Management (13%)	Outreach Services (27%)
9	Mental Health Health (13%)	Referral for Health Care Services (27%)
10	Emergency Financial Assistance (9%)	HIPSCA (25%)

Source: HIV and Aging Survey 2024:

It appears that the top services needed were in line with basic necessities for survival such as food, housing and financial assitance. These results show that planning for services for the aging population must be inclusive to reflect the needs of the population so that there is minimal misalignment.

As persons with HIV age, they are afflicted with an increasing number of co-morbidities. These are often chronic and require regular care and attention in order to avoid complications, reduce morbidity, hospitalization and death. Moreover, the confluence of these aging conditions engenders polypharmacy that require regular medical education and check ups to avoid drug interactions and inadvertent usage.

Medical co-morbidities:

- The most common chronic disease condition afflicting the aging population were hypertension 33% and diabetes 25%
- Diabetes and Hypertension were most prevalent in persons between the age group of 56-60 years old followed by 51-55 years old.
- Oral health conditions such as tooth decay, loss and gingivitis was the third most prevalent co-morbidity.
- End stage renal disease a major complication from diabetes and hypertension was ranked 4th among all diagnosis.
- About 21% did not know what it meant to be virally suppressed and 40% did not know as of their last visit whether they were virally suppressed
- Approximately 29% were not aware of the Ryan White Program services that were offered in the Norfolk TGA
- Only 6% indicated that they saw a geriatrician at least one or more times a year

Source: HIV and Aging Survey 2024:

From the qualitiative analysis, there were several themes that emerged from the cohort. Stable housing was definitely an issue based on the lack of access and increasing price of rent. Many opinonied on the need for timely public transporation in order to get to see a doctor. Much attention was placed on having a good support system, improved case management and a greater awareness of other services that were available to them. Others yearned for specialized medical care that prioritized their age and the multiple health challenges that accompany aging such as co-morbid hypertension, diabetes, osteoporosis and coginitive decline. The need to manage the associated multiple medication to treat and control these conditions was also a priority so having access to a geriatrician that is knowledgeable about HIV was desired. Hence, the needs of the aging population of PWH are complex and they require greater specialized care along with soci-economic support programs.

Customer Valuation Survey:

Customer satisfaction is an important component of providing quality health services for PWH. Clients deserve the best possible care and knowing what they want and need directly is an important part of the process of delivering good quality care. The Ryan White Program under took a customer valuation exercise with PWH serving as key informants to asses the quality of care and perception of the program and value of services offered. It served as a specialized focus group contribution to the needs assessment.

Based on the collective interviews there were some key themes that developed: These included the following:

- Ensuring that PWH have a trusted provider is important for the overall quality of care and their engagment in care. This says a lot about the quality of service provided to them.
- A supportive trusting environment allows clients to strengthen their resilience and advocate for other to make the world a better place.
- The safety net provided to PWH through the Ryan White program is a vital part of accessing critical health services that keep people well and healthy.
- On a programmatic level it is important that HIV program and services are efficient and financially sustainable to allow for continued essential services.
- Clients believed that prioritizing medication adherence is an important means of avoiding HIV resistance and preventing transmission to their partner.
- Current uncertainty and instability in federal grant funding are affecting the perception of clients and creating a certain level of anxiety that if not managed properly can lead to disengagement in care because of lack of trust and security.

The perception of clients reflect the realities on the ground. These perception must be carefully investigated and addressed to ensure that PWH get the right quality of services at the right time. For many, the threat of a loss of service is causing anxiety that can have a detrimental impact on their mental health leading to adherence issues and disenagement in care. Dropping out of care can lead to personal health neglect, increasd morbidity, hospitalizations, HIV transmission and mortality among PWH. Periodic customer valuation surveys should continue to be a key part of the tools used to ensure that PWH get the quality of care they deserve.

IV. Situational Analysis

The information in this section of Virginia's Integrated Plan document summarizes the material, facts and data from the preceding sections including the findings from the community engagement and planning process, the epidemiological snapshot, the resource inventory, and specifically draws upon feedback and input from PWH. The information below is presented using the Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis framework. For each EHE pillar, one complete SWOT analysis is presented.

Pillar One: Diagnose	
Strengths: • Availability of multiple methods to get an HIV test. † • Increased availability of HIV testing providers. • Availability of quality training and certification to provide rapid testing. • Increased availability of integrated testing for HIV, STIs, and Hepatitis.	**Opportunities:** • Increasing education/training about HIV transmission. † • Improving provider education on HIV to make HIV testing a normalized part of health care. • Increasing focused messaging for populations who may not perceive themselves as having a reason to test for HIV. • Increasing use of Early Intervention Services (EIS) to test those at-risk for HIV and immediately link to care those newly diagnosed.* • Expanding collaborations with community partners (e.g. universities, CBOs, EDs). † • Expanding the HIV self-test program. †
Weaknesses: • Misinformation and lack of knowledge related to HIV.† • Providers may not test persons if they do not perceive them as being at-risk. • Missed opportunities – universal testing may not be done at all primary care settings, urgent cares centers, EDs and hospitals, including labor and delivery. † • Funding restrictions inhibited some CBOs from expanding their HIV testing program to include conventional testing. • The loss of Comprehensive HIV/AIDS Resources and Linkages for Individuals Experiencing Incarceration (CHARLII) program led to a decreased capacity for rapid HIV testing in correctional facilities.	**Threats:** • Potential for decreases in federal funding for HIV prevention. • A decrease in workforce stability. • Fear of judgement and unfavorable treatment have increased hesitancy for people seeking HIV testing. †

* Norfolk TGA only items
† Norfolk TGA and VDH shared items

Pillar Two: Treat

Strengths:

- Linkage to Care among community-based organizations is high.
- Unified Eligibility for all RWHAP B processes which reduced client burden for accessing HIV treatment services.
- Availability of a long-acting injectable option for ART.
- Expanded ADAP formulary and increased access for ART medications.
- Medicaid expansion in Virginia.
- The Status Neutral Service Navigation Program, funds eight CBOs to provide linkage to medical and support services for PWH.
- Collaboration between Ryan White cross-part providers. †
- Number of providers and services funded through Ryan White Part A.*

Opportunities:

- Increasing collaboration between community resources and providers.
- Increasing education on treatment and medication coverage through insurance, Medicaid, Medicare, VA MAP, etc.
- Increasing specialized treatment, care, and support services for PWH 45+.†
- Strengthened referral systems for those newly diagnosed in the Norfolk TGA. *
- Prioritizing early start initiatives to ensure enrollment in care within one week. *
- Implementing an appointment and reminder system to ensure the early detection of missed clinical visits for stronger patient navigation. *
- Standardizing re-engagement protocols for PWH lost to care. *
- Expanding medical transportation and telehealth options for PWH. *

Weaknesses:

- Lack of availability of infectious disease providers, especially in rural areas.
- Funding changes limited the ability of CBOs to re-engage clients into care.
- Reduced funding for medical and support services for PWH.†
- Housing challenges.
- The loss of the CHARLII program led to decreased capacity for HIV treatment and support services for people recently released from incarceration.

Threats:

- The potential for a loss of expanded Medicaid. †
- Anticipated higher insurance premiums, co-pays, and out-of-pocket expenses. †
- Decreased workforce stability.
- Mistrust and fear have increased hesitancy for people seeking HIV treatment. †
- Clients dropping out of care due to decreased ability to maintain high insurance coverage. †

* Norfolk TGA only items

† Norfolk TGA and VDH shared items

Pillar Three: Prevent

Strengths:	Opportunities:
• The expansion of the opioid risk reduction program throughout the commonwealth. • The implementation of the opioid risk reduction pregnancy pilot at three sites. • PrEP/nPEP services and distribution have increased despite no dedicated funding. • The implementation of 340b funding to help sustain the PrEP program. • Consolidation of the Status Neutral Service Navigation program and the Community HIV Testing Program. • An increase in condom distribution providers and locations.	• More public and provider education on PrEP/nPEP, including the long-acting injectable PrEP. • Increasing collaborations with the VDH PrEP program through EIS. * • Increasing the availability and usage of DoxyPEP. * • Distributing more health communication materials to address HIV miseducation. †
Weaknesses:	**Threats:**
• Funding uncertainty inhibits the expansion of prevention services. • DDP condom inventory is limited due to contract negotiations stalling.	• Perceived judgement creates a barrier for opioid risk reduction participants to request services and for community buy-in to support opioid risk reduction sites.

* Norfolk TGA only items
† Norfolk TGA and VDH shared items

Pillar Four: Respond

Strengths:	Opportunities:
• Collaboration of the HIV Network Detection and Response team with neighboring jurisdictions such as Maryland, the D.C., and the Norfolk TGA. † • DDP successfully detected and responded to priority molecular networks. • The HIV Network Detection and Response Coordination Group was maintained to respond to networks quickly and effectively.	• Continue strengthening partnerships around coordination and integration. • Creating collaborations with neighboring jurisdictions • Increasing community education on HIV Network Detection and Response activities. • Ensuring that people newly diagnosed are quickly entered into CAREWare® for accurate and up-to-date data analysis and reporting. * • Strengthening communication activities for general HIV/STI testing and awareness. †
Weaknesses:	**Threats:**
• DIS and LHD staff availability for HIV surveillance activities. • Limited funding for surveillance activities and outreach. • Limited data collection for transmission risk from local and regional jail facilities.	• Youth (ages 13-19) being identified in a recent HIV networks. • The increased use of anonymous hook-up apps amongst those at-risk for HIV.

* Norfolk TGA only items
† Norfolk TGA and VDH shared items

V. Goals and Objectives for the Period 2027-2031

V. Goals and Objectives for Virginia's HIV Services Plan, 2027-2031

Note to Federal reviewers: Subsequent to submission, VDH plans to establish a workgroup to revise the work plan provided in Section V. The revised work plan will be reformatted and provide outcomes that are quantifiable, where appropriate. This work group will be cross-parts. Virginia is also the recipient of an invitation from HRSA for technical assistance related to identifying and engaging individuals with HIV who are undiagnosed or out of care. VDH will include updates related to this work in updates to the Integrated Plan when possible.

EHE PILLAR #1: DIAGNOSE ALL PEOPLE WITH HIV AS EARLY AS POSSIBLE			
Objective 1.1: By December 31, 2031, increase the number of people in Virginia who know their HIV status			
Key Partners: DDP, LHD, Clinical sites, CBOs, and FQHCs			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Expand HIV testing in both clinical and non-clinical settings, home testing, and opioid risk reduction sites, continuing the "No Wrong Door" [2]approach.	CDC, ARPA, State, OAA, SOR, OD2A	Increase in number of HIV tests over 2019 (pre-COVID-19) testing levels.	Evaluation Web, Provide®
Strategy B: Increase HIV testing among communities at increased risk for HIV.	CDC, State	Increase in HIV tests among priority populations. Reduction in the # of late diagnoses.	Evaluation Web, Provide®, CAREWare®
Strategy C: Ensure HIV testing in at least 85% of pregnant women who inject drugs.	CDC, State, OAA, SOR, OD2A	Reduction in HIV perinatal transmission; # of pregnant women who've received an HIV test;	eHARS
Strategy D: Reduce late diagnoses among people 45 and older by developing strategies to increase linkage to care.	CDC, HRSA	Increase in testing and linkage to care among people 45 and older. Decrease in the # of late diagnoses.	eHARS, Caremarkers database
Strategy E: The Norfolk TGA will partner with at least five CBOs annually to conduct targeted outreach and testing events.	HRSA	# of HIV tests conducted in the Norfolk TGA. # of outreach events conducted in the Norfolk TGA.	Evaluation Web, CAREWare®

[2] No Wrong Door - The "No Wrong Door" approach in Virginia provides accessible, often free, HIV testing through diverse channels, including community partners, local health departments and other methods to normalize testing and reach underserved populations

Objective 1.2: By December 31, 2031, increase STI and Viral Hepatitis testing among people in Virginia			
Key Partners: DDP, Ryan White Cross-Parts, CBOs, Medicaid, behavioral health and mental health service providers, housing providers and transportation services			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Increase the capacity of HIV test sites to conduct STI and hepatitis testing and to perform blood draws for conventional testing	CDC, State	Increase in number of agencies capable of performing conventional testing for STI, hepatitis and conventional HIV testing.	Labcorp reporting, Evaluation Web, contractor reports, REDCap
Strategy B: By December 31, 2028, all opioid risk reduction programs in Virginia will be trained in rapid syphilis and hepatitis C testing.	CDC, State, OAA, SOR, OD2A	Increase in number of opioid risk reduction programs capable of performing rapid testing for STI, and Hepatitis C.	Labcorp reporting, Evaluation Web, contractor reports, REDCap
Strategy C: Integrate STI and hepatitis screening for PWH to achieve optimal health outcomes.	CDC, HRSA	Increase # of agencies providing STI and hepatitis screening for PWH; increase # of PWH screened for STI and hepatitis.	Provide®

Objective 1.3: By December 31, 2031, increase knowledge of HIV, STI, and Viral Hepatitis testing among people in Virginia			
Key Partners: DDP, Ryan White Cross-Parts, CBOs, Medicaid, behavioral health and mental health service providers, housing providers and transportation services			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Conduct health communications activities that provide education about HIV, STIs, and hepatitis among the general population, as well as rural areas.	CDC	# of health communication activities conducted; Increase # of HIV, STI, and Viral Hepatitis testing.	Campaign metrics, surveys, Evaluation Web, Provide®, VEDSS
Strategy B: By December 31, 2031, conduct health communication activities that promote the HIV Self-Test Kit program	CDC	Increase in HIV self-test kit program utilization.	REDCap

EHE PILLAR #2: TREAT PEOPLE WITH HIV RAPIDLY AND EFFECTIVELY TO REACH SUSTAINED VIRAL SUPPRESSION.			
Objective 2.1: By December 31, 2031, link people to care immediately after diagnosis and provide low-barrier access to HIV treatment			
Key Partners: DDP, LHD, clinical and non-clinical test sites, Ryan White Cross-Parts, and FQHCs			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Increase the number of people with new HIV diagnoses being linked to ARV medications within 14 days	HRSA, providers program income, Medicaid	reduce # of days to ARVs; reduce # of days to viral suppression.	eHARS, Provide®, CAREWare®;
Strategy B: Reduce the incidence of syphilis among those newly diagnosed with HIV through implementation of Doxycycline for STI prevention (DoxyPEP).	CDC	# of new Syphilis diagnoses with previous HIV	eHARS, VEDSS
Strategy C: Implement DIS interviews and referrals for patients with STIs who are co-infected with HIV and are not in care.	CDC	Increase in the # of diagnosed w/ syphilis and co-infected with HIV (not in care) who are interviewed and linked to care.	eHARS, VEDSS
Strategy D: Increase clients linked to care through Status Neutral Service Navigation utilizing patient navigators to connect newly diagnosed PWH to care and support services.	CDC	Increase the % of clients linked to care within 30 days of diagnosis.	eHARS, Provide®
Strategy E: Improve linkage rates among PWH diagnosed in the private sector, community-based organizations, or LHD clinics through the collaboration with HIV Surveillance, LHDs and (DIS).	CDC	Increase the % of clients linked to care and the % linked to care within 30 days.	eHARS
Strategy F: Update and maintain the resources list of HIV clinicians through strengthening Resource Connections and 211 Virginia infrastructure.	CDC, HRSA	# of HIV clinicians identified, Increase the % of clients linked to care and the % linked to care within 30 days.	eHARS, Provide®, CAREWare®; Resource Connections, 211 Virginia

Objective 2.2: By December 31, 2031, increase the number of people with HIV in Virginia re-engaged and retained in care to achieve viral suppression.			
Key Partners: DDP, Ryan White Cross-Parts, CBOs, Medicaid, behavioral health and mental health service providers, housing providers and transportation services			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Improve the use Data to Care protocols to identify and re-engage people with HIV into care and other services.	TBD	# of PWH re-engaged in care; # of re-engaged PWH who achieve viral suppression.	eHARS, CareMarkers database, Provide®
Strategy B: Identify and assess barriers for PWH with evidence of episodic care, high viral load, or other markers for falling out of care and achieve improved health outcomes.	CDC, HRSA	# clients engaged with evidenced barriers, increase % of PWH retained in care, increase # of PWH who are virally suppressed.	eHARS, Caremarkers database, Provide®, CAREWare®
Strategy C: Provide education for PWH on the health insurance or medication access programs (i.e. Medicaid, Medicare, ACA Marketplace, direct ADAP) for which they qualify, to maximize access to health care, improve clinical outcomes, and ensure Ryan White serves as the payer of last resort.	CDC, HRSA	Increase in the # or % of PWH who are enrolled in a medication access program (i.e. Medicaid, Medicare, ACA Marketplace, and direct ADAP).	Provide®, DMAS
Strategy D: Identify and collaborate with supportive HIV service providers (e.g. housing, mental health, substance use disorder treatment, food bank/home delivered meals, medical transportation etc.) to increase retention in care and achieve optimal health outcomes including viral load suppression.	TBD	Increase # of agencies identified that provide supportive HIV services; increase # of clients accessing supportive HIV services; increase in the % of PWH retained in care and virally suppressed.	Provide®, VEDSS;

Strategy E: Increase the number of points of entry into the HIV Care System in Virginia that are aware of RWHAP services (e.g. EDs, Indian Health Services, etc.)	HRSA	Increased retention in care, increased viral suppression.	eHARs, Provide®, CAREWare®
Strategy F: Increase access to HIV services in rural areas and for those with transportation challenges by expanding collaborations.	CDC, HRSA	Increased retention in care; increased viral suppression.	eHARS, Caremarkers database, Provide®
Strategy G: Increase communication and resource sharing with community service providers (e.g., Community Services Boards, HOPWA and other housing providers, Department for Aging and Rehabilitative Services, DBHDS) to learn about service provision and potential areas of collaboration.	CDC, HRSA, state	# of organizations, # of meetings with community service providers, of resources shared between VDH and community service providers.	Meeting minutes and documents
Strategy H: The Norfolk TGA will implement standardized re-engagement protocols across 100% of Part A subrecipients.	HRSA	# of people re-engaged to care.	CAREWare®

Objective 2.3: By December 31, 2031, provide whole-person care to PWH aged 45+ and long-term survivors			
Key Partners: DDP, clinical providers ADAP Advisory Committee, VACAC, Department of Medical Assistance Services, and Department of Aging and Rehabilitative Services			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Annually work with the ADAP Advisory Committee to review the VDH RWHAP B medication formulary to meet the specific medication needs of PWH aged 45+.	HRSA	# and type of medications reviewed/recommended for the formulary, drug utilization.	VA MAP and RW formulary and utilization reports
Strategy B: Initiate a partnership with agencies that provide services to the aging population to assess and address the needs of older PWH, including the Virginia Department of Aging and Rehabilitative Services (such as aging services, housing for adults 45+, substance use treatment, and disability and other medical services).	TBD	# of collaborations with agencies that provide services to persons 50+.	Meeting minutes and documents
Strategy C: Collaborate with community advisory groups to identify and prioritize best practices to meet the psychosocial and behavioral health needs of PWH 45+ and long-term survivors including substance use disorder treatment, mental health services and programs designed to decrease social isolation.	CDC, HRSA	Development of programs designed to meet the needs of aging PWH.	VACAC, CHPG, and Living Beyond Our Status meeting minutes, evaluations, and other meeting documents
Strategy D: The Norfolk TGA will provide education on nutrition for chronic disease for at least 85% of PWH 45+.	HRSA	# of PWH 45+ receiving nutrition education.	CAREWare®

Objective 2.4: By December 31, 2031, increase collaboration with PWH or those at-risk for HIV to promote an HIV workforce that is representative and responsive to the needs of those communities.			
Key Partners: DDP, clinical sites, CBOs			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Maintain leadership opportunities for PWH and those at-risk for HIV infection through the Virginia Consumer Advisory Committee, Virginia Community HIV Planning Group, Mind, Body, Soul Advisory Committee, ADAP Advisory Committee, and Living Beyond Our Status conference planning.	CDC/HRSA	# and demographics of people who participate on in planning bodies and engagement activities.	Membership demographics, meeting attendance, individual and cohort trainings supported
Strategy B: Prepare written communication, including web content, for the public and providers in plain language at appropriate reading levels to ensure health and medication literacy and accessible materials.	CDC, HRSA	Percentage of client and provide materials written at an appropriate reading level. # of materials translated.	Website analytics for accessibility
Strategy C: Conduct needs assessments through focus groups or other engagement activities for at least two communities most at-risk for HIV.	CDC/HRSA	Identification of emerging needs to be addressed through the Integrated Plan.	Focus group notes, survey results,

EHE PILLAR #3: PREVENT NEW HIV TRANSMISSIONS BY USING PROVEN INTERVENTIONS, INCLUDING PRE-EXPOSURE PROPHYLAXIS (PrEP) AND OPIOID RISK REDUCTION.			
Objective 3.1: By December 31, 2031, improve implementation of and access to PrEP/nPEP services with priority on communities and people more at-risk for HIV.			
Key Partners: DDP, LHD, Clinical sites, CBOs, FQHCs, Emergency Departments			
Strategies	**Funding Sources**	**Outcomes**	**Data Sources**
Strategy A: Conduct public health detailing for clinicians (PrEP, nPEP) and emergency departments (nPEP).	CDC	Increase the # of clinicians that provide PrEP/ nPEP; Increase the # of EDs that provide nPEP.	Follow up with participating sites
Strategy B: Improve PrEP adherence by removing service barriers, offering long-acting injectables and providing ongoing client engagement and education through patient navigation.	CDC, State	Increase in the # of months clients are taking PrEP; increase in PrEP adherence (decrease in missed doses).	PrEP database, client and provider surveys
Strategy C: Expand access to PrEP/nPEP through LHD clinical services (STI, Family Planning).	CDC, State	Increase in the # of LHDs offering PrEP/nPEP; increase in PrEP enrollment.	MOAs, PrEP services database
Strategy D: Increase access to PrEP/nPEP through new initiatives such as nPEP starter packs, telePrEP, PrEP 2-1-1, etc.	CDC, State	Increase in # PrEP enrollments; increase in the # of nPEP starter packs provided.	Provide®
Strategy E: Increase enrollment in PrEP services among people and communities most at-risk for HIV.	CDC, State	Increase the # PrEP enrollments among people and communities most at-risk for HIV.	Provide®

Objective 3.2: By December 31, 2031, improve implementation of and access to opioid risk reduction services with priority on communities more at-risk for HIV.			
Key Partners: DDP, CBOs, other clinical partners			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Expand the opioid risk reduction program into three additional jurisdictions in Virginia.	CDC, State, SOR, OAA, OD2A	Increase in the # of cities/counties with opioid risk reduction services.	MOA, opioid risk reduction database
Strategy B: Complete a three-year pilot study on risk reduction for Virginia women who are pregnant and using drugs.	CDC, State, SOR, OAA, OD2A	# of sites for pregnancy pilot; # of pregnant women utilizing opioid risk reduction services.	MOA, opioid risk reduction database
Strategy C: Increase HIV testing, linkage, retention in care, and viral suppression among people who inject drugs through education on substance use disorder, use of appropriate person-first language, and increased engagement with opioid risk reduction and behavioral health providers.	CDC, State, SOR, OAA, OD2A	Increase in HIV testing, linkage to care, retention and viral suppression rates; # of people who receive education on substance use disorders	eHARS, Caremarkers database

Objective 3.3: By December 31, 2031, improve implementation of and access to safe, effective HIV prevention interventions with priority on communities and people more at-risk for HIV.			
Key Partners: DDP, Ryan White Cross-Parts, CBOs, other clinical partners			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Assist PWH or those who experience risk for HIV infection with obtaining health insurance to optimize health outcomes and access to HIV treatment, testing, PrEP and behavioral health services.	CDC, HRSA	Increased enrollment in health insurance.	Provide®, contractor quarterly reports, insurance enrollment vendor data and reports
Strategy B: Expand condom distribution and condom distribution sites by 25% to ensure access to those in need.	CDC, State, SOR, OAA, OD2A	# of new condom distribution sites; # of condoms distributed over the 4,000,000 baseline.	DDP condom distribution reports
Strategy C: Increase number of clients prescribed DoxyPEP through LHDs to reduce likelihood of STI-mediated HIV infection.	State	# of clients with documented DoxyPEP encounter at a LHD STI clinic.	WebVision, EHR
Strategy D: Identify and engage with key VDH offices (e.g., Community Health Services, Family Health Services, etc.) to promote information sharing and education on services provided to intersecting populations.	CDC, HRSA, state	# of meetings, # of key VDH offices engaged.	Meeting minutes
Strategy E: Coordinate referrals to HIV prevention services among community-based testing sites for people accessing STI testing or treatment.	CDC, state	# of charts with a documented referral to HIV prevention services for people accessing STI testing and treatment.	Agency charts, site visit reports
Strategy F: Coordinate referrals to HIV prevention services among community-based testing sites for people accessing hepatitis testing or treatment.	CDC, state	# of persons with a documented referral to HIV prevention services for people accessing hepatitis testing and treatment.	Hepatitis testing data

EHE PILLAR #4: RESPOND QUICKLY TO POTENTIAL HIV OUTBREAKS TO GET VITAL PREVENTION AND TREATMENT SERVICES TO PEOPLE WHO NEED THEM.			
Objective 4.1: By December 31, 2031, build an integrated HIV Prevention and Care rapid response plan			
Key Partners: DDP, LHDs, other clinical providers, free clinics, FQHCs, DBHDS, Division of Pharmacy Services			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Continue DDP monthly rapid response meetings with participation from STD Prevention and Surveillance, HIV and Hepatitis Surveillance, HIV Care Services and HIV and Hepatitis Prevention to quickly identify geographic areas or potential areas of concern and collaborate with LHDs for outbreak response.	CDC, HRSA, state	# of LHDs collaborated with, Monthly reports to identify unusual or increased case reporting. Identification of actions needed to prepare for outbreak response.	Meeting minutes
Strategy B: Develop orientation resources for all DDP staff, regardless of role, staff on reaching communities experiencing rapid transmission and people at-risk for and those with HIV.	State	# of staff who complete course work by the end of their first year of employment.	Training records and training plans
Strategy C: Provide annual updates on the HIV Network Detection and Response Program to key informants and stakeholder groups including care and prevention providers, the CHPG, the VACAC, and Part A Planning Councils.	CDC	# of presentations conducted each year.	Meeting minutes
Strategy D: The Norfolk TGA will conduct quarterly data reviews to identify trends, networks, and service gaps.	HRSA	# of trends, networks, and service gaps identified.	Meeting minutes

Objective 4.2: By December 31, 2031, increase coordination among HIV, STIs, and Viral Hepatitis to tailor services for communities experiencing rapid transmission.			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Work with community partners to identify and reduce barriers to seamless service delivery across HIV, STIs, and Viral Hepatitis services.	CDC, HRSA, State	# and types of best practices identified to streamline the HIV, STIs, and Viral Hepatitis service delivery system, # of partners engaged.	Meeting minutes and program documents
Strategy B: Coordinate services among community-based test sites to ensure a treatment referral network for people diagnosed with STIs.	CDC, HRSA, state	# of charts with a documented referral to STI treatment services for people diagnosed with STIs.	Agency charts and site visit reports
Strategy C: Coordinate services among community-based test sites to ensure a treatment referral network for people diagnosed with hepatitis.	CDC, HRSA, state	# of people diagnosed in community settings who are linked to hepatitis treatment services.	VEDSS
Strategy E: Coordinate services among clinical providers including LHDs, to ensure a treatment referral network for people diagnosed with hepatitis.	CDC, HRSA, state	# of people diagnosed in clinical settings who are linked to hepatitis treatment services.	VEDSS
Strategy F: Provide or ensure that contracted organizations provide training for staff on reaching communities experiencing rapid transmission.	CDC, HRSA	# of staff at contract agencies that complete training.	Training records and quarterly reports

Objective 4.3: By December 31, 2031, enhance the quality, accessibility, sharing, and uses of data to measure, monitor, evaluate, and use the information to identify areas of potential outbreaks.			
Key Partners: DDP, VDH, DMAS, DBHDS, Veterans Administration, DARS, VDSS			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Continue the Washington, D.C., Maryland and Virginia partnership to coordinate data exchanges and services across jurisdictions.	CDC, HRSA	# of meetings; # of data exchanges.	Meeting minutes and program documents
Strategy B: Create partnership with other border states (e.g., North Carolina, West Virginia, Kentucky, and Tennessee) to coordinate data exchanges and services across borders.	CDC, HRSA	# of meetings; # of data exchanges.	Meeting minutes and program documents
Strategy C: Contribute to maintenance of the VDH electronic health record to meet health care needs of programs serving PWH and those at-risk for HIV, STIs and viral hepatitis.	TBD	Maintenance of EHR that meets the needs of HIV, STI and viral hepatitis programs.	Program documents
Strategy D: Improving data collection, reporting, and use of VDH HIV, STI, and Viral hepatitis data to inform services for people at-risk for and those with HIV.	CDC/HRSA	# of data sources; # of data presented on HIV, STI, and Viral hepatitis	Provide®, eHARs, CAREWare®, EvaluationWeb

VI. Monitoring and Evaluation

The 2027-2031 Virginia Integrated HIV Prevention and Care Services Plan is supported by VDH central office and Norfolk TGA program staff and leadership who believe in the vision and purpose of the Integrated Plan. To effectively achieve the Integrated Plan's goals and objectives, a structured, and data-driven coordination process will be utilized to engage a diverse network of partners. Utilizing this approach will ensure alignment across prevention and care systems and leverage available resources. With respect to data, the Integrated Plan is informed by robust data systems, including the Virginia Electronic Disease Surveillance System (VEDSS), the Enhanced HIV/AIDS Reporting System (EHARS), Provide®, and a completed Epidemiological Snapshot to show the burden of HIV and other STIs in Virginia.

Virginia is entering the 2027-2031 integrated planning process learning from the two prior successful plans developed and implemented. Key infrastructure which will support the Integrated Plan include existing planning bodies (e.g., CHPG, Norfolk Planning Council/Planning Body) and an Integrated Plan Steering Committee, to guide the implementation and monitoring of the Integrated Plan. Additionally, regular meetings and communication with partners where data is shared will ensure the Integrated Plan is transparent and collaborative. Lastly, formal agreements, where applicable, define roles and responsibilities, and expectations across agencies and funding streams.

Implementation: VDH will utilize its network of existing partnerships including the CHPG, the VACAC and both prevention and care services providers to inform the planning process. Additionally, stakeholders, including PWH were invited to participate in a townhall discussion in March of 2026 to help inform the creation of the Integrated Plan. As a part of the development of the Integrated Plan, VDH developed work groups with representation across HIV and Hepatitis Prevention, HIV Care Services, HIV Surveillance, STD Prevention and Surveillance, and community members that will continue to be utilized throughout the life of the Integrated Plan.

Monitoring: A REDCap survey tool will be developed to track the progress of implementing the strategies that Virginia will use to achieve our goals and objectives. The tool will be used to obtain regular updates (e.g., semi-annual) on the progress of implementing the Integrated Plan's strategies from internal and external implementing partners. Additionally, Virginia has developed a Microsoft Excel data management tool to continually monitor and track performance of Virginia's strategy and indicator data and targets. This tool will be organized by Virginia's goals and objectives. The Integrated Plan Core Team and key stakeholders will meet regularly to assess monitoring and evaluation progress. The status of goals, objectives, indicators, and targets will be shared with DDP leadership, CHPG, and the Norfolk TGA team quarterly. VDH will also share updates with additional stakeholders, including HIV prevention and care providers during community meetings and events (e.g. the DDP Joint Quarterly Contractors Meetings and the HIV and Hepatitis Prevention Summit). Integrated Plan stakeholders will be present at each meeting and will provide recommendations on how to ensure momentum is made in addressing gaps toward implementation and progress. Coordination with these stakeholders has already begun and will continue throughout the monitoring process.

Specific to Part A, the Norfolk TGA will monitor the goals through Sub recipient quarterly reports. Sub recipients shall align their workplan with the Norfolk TGA goals and objectives. These goals and objectives will be monitored through quarterly reports and will be monitored by the RWHAP Part A

recipient's office. Progress shall be reported to the stakeholders through various forums including the Norfolk TGA's Planning Council that represents the community of PWH.

Norfolk TGA Clinical Quality Management (CQM) will select the Performance Measures (PM) from the goals in the 4 pillars (Diagnosis, Treat, Prevent, and Respond). These goals and objectives will be monitored by the CQM committee. The committee will meet quarterly to evaluate performance measures progress on goals and objectives

Evaluation: The Integrated Plan monitoring and evaluation will use performance measures that are aligned with the six Ending the HIV Epidemic data indicators (i.e., incidence, knowledge of status, diagnoses, linkage to HIV medical care, viral suppression, PrEP coverage) to continually track the progress of implementing the Integrated Plan. The REDCap survey data derived from internal and external partners will be used to provide updates on the implementation progress. Additionally, Virginia specific data systems including VEDSS, EHARS, Provide® will be sources of data for HIV, STI, and viral hepatitis prevention and care service metrics that will be used to inform progress on the Integrated Plan. Additional data will be derived from program documents and other assessments where feasible (e.g., surveys, focus groups). The EHE goals and indicator data will be obtained from the AHEAD [3]dashboard and will be used as a benchmark for measuring against Virginia specific data for each of the EHE indicators. Progress will be measured on an annual basis. Progress will be measured against measures of success for each one of the strategy indicators in the Integrated Plan. A dashboard using a red light, yellow light, green light system will be used to highlight data and findings, including areas where Virginia is doing well, areas of caution, and areas needing improvement. The data will be used to drive impactful services needed for the community. Reviewing performance will be conducted quarterly. Findings will be shared with all Integrated Plan stakeholders on a regular basis (e.g., semi-annual).

Improvement: Revisions to the Virginia Integrated Plan will be made at least annually or as needed throughout the year based on evaluation findings and any recommendations for driving continual improvement. Revisions will be inclusive of the community's voice (i.e., CHPG, VACAC, Norfolk TGA, and HIV prevention and care providers). Virginia Integrated Plan stakeholders will review recommendations to improve the Integrated Plan and provide input on whether to adopt recommendations.

Reporting and Dissemination: Semi-annually, PWH, VDH Staff, and implementation partners (i.e., CHPG and the Norfolk TGA) will receive updates on the Integrated Plan's implementation, evaluation findings, and improvements made to the Integrated Plan. Updates and findings will be shared during the various stakeholder meetings.

Updates to Other Strategic Plans Used to Meet Requirements: Not applicable.

[3] AHEAD: America's HIV Epidemic Analysis Dashboard, which supports EHE indicator data.

Appendices

Appendix 1.A – Letters of Concurrence

June 1, 2026

Darryl Richards
Public Health Advisor/Project Officer
Program Development and
Implementation Branch Division of HIV
Prevention
Centers for Disease Control
and Prevention 1600 Clifton
Road, NE, Mailstop USB-3
Atlanta, GA 30333

Kim Fitzpatrick Brown, MHA, MSW Project
Officer Health Resources and Services
Administration HIV/AIDS Bureau
Division of State HIV/AIDS Programs 5600 Fishers Lane, MS-09SWH03
Rockville, MD 20857

Dear Mr. Richards and Ms. Brown:

The Virginia HIV Community Planning Group (CHPG) concurs with the submission by the Virginia Department of Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar years 2027-2031. The CHPG has reviewed the Integrated HIV Prevention and Care Plan to verify that it describes the allocation of programmatic activities and resources for the populations most at-risk for HIV and geographical areas with high rates of HIV. The planning body concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The CHPG worked closely with VDH over the past 12 months on the plan development. Each section of the plan was presented to and reviewed by the CHPG throughout year with opportunity for member input for each. A final opportunity to provide input for the plan was conducted via remote meeting on May 14, 2026. The signatures below confirm the concurrence of the planning body with the 2027-2031 Integrated HIV Prevention and Care Plan.

Sincerely,

Jerome Cuffee

Jerome Cuffee Community
Co-Chair

Olivia Allison
Olivia Allison (Jun 1, 2026 14:39:16 EDT)

Olivia Allison
Health Department Co-Chair

Virginia Community HIV Planning Group, 109 Governor Street, 3rd floor,

Appendix 1.B - Letters of Concurrence

Washington, DC Regional PLANNING COMMISSION on HEALTH and HIV

*The **Washington, D.C. Regional Planning Commission on Health and HIV** (COHAH) will invigorate planning for HIV prevention and care programs that will demonstrate effectiveness, innovation, accountability, and responsiveness to our community.*

June 15, 2026

Attention:
José E. Au Lay, HRSA Project Officer
Shuenae Smith, CDC Project Officer

Dear Mr. Au Lay and Ms. Smith:

The Washington DC Regional Planning Commission on Health and HIV (COHAH) concurs with the following submission by the Virginia Department of Health (VDH)in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of the Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2027- 2031.

The COHAH has reviewed the Integrated HIV Prevention and Care Plan submission to CDC and HRSA. The plan describes the programmatic activities, coordination of the HIV planning process and resources allocated to the most disproportionately affected populations, including those that are within the DC EMA. The COHAH concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The signatures below confirms the concurrence of the planning body with the Integrated HIV Prevention and Care Plan.

Regards,

Lamont Clark
Washington DC Regional Planning Commission on Health and HIV (COHAH) Government Co-Chair
Lamont.Clark@dc.gov

Melvin Cauthen
Washington DC Regional Planning Commission on Health and HIV (COHAH) Community Co-Chair
Betelhem123@gmail.com

Murray Penner
Washington DC Regional Planning Commission on Health and HIV (COHAH) Community Vice Chair
Murray_penner@yahoo.com

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

899 N. CAPITOL ST., NE; 4TH FL.
WASHINGTON, DC 20002-4263
WWW.DCHEALTH.DC.GOV/COHAH

➢ Table of Contents

GREATER HAMPTON ROADS
HIV HEALTH SERVICES
PLANNING
COUNCIL

June 4, 2026

Virginia Department of Health
Office of Epidemiology
Division of Disease Prevention

Dear Virginia Department of Health,

The Norfolk Transitional Grant Area Ryan White Part A (TGA) Planning Council concurs with the following submission by the Virginia Department of Health (VDH) in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV Prevention (DHP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2027-2031.

The Norfolk TGA Planning Council has reviewed the Integrated HIV Prevention anc Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected people and communities and geographical areas with high rates of HIV. The Norfolk TGA Planning Council concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The Norfolk Transitional Grant Area (TGA) will utilize the Virginia Integrated HIV Prevention and Care Plan as a guiding framework to coordinate and strengthen its local HIV planning process. By aligning local priorities, service delivery strategies, and performance measures with the goals and objectives outlined in the State Integrated Plan, the Norfolk TGA will promote a coordinated and data-driven approach to addressing the HIV epidemic across the region. Key components of the State Integrated Plan, including linkage to care, retention in care, viral suppression, health equity, and disparities reduction, will be incorporated into planning council discussions, resource allocation decisions, quality management activities, and program evaluation efforts. Information, updates, anc relevant performance expectations derived from the State Integrated Plan will be regularly communicated to ensure consistent implementation across funded programs.

The signatures below confirm the concurrence of the Norfolk TGA Planning Council with the Integrated HIV Prevention and Care Plan.

Respectfully,

Jonathan Spain
Norfolk TGA/Greater Hampton Roads HIV Planning Council Co-Chair

830 Southampton Avenue, Suite 2074 • Norfolk, Virginia 23509
https://www.ghrplanningcouncil.org

Appendix 2: Acronyms

ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CHARLI	Comprehensive HIV/AIDS Resources and Linkages for Individuals experiencing Incarceration
CHPG	Community HIV Planning Group
CHT	Community HIV Testing
CHW	Community Health Worker
CMDB	Care Markers Database
COHAH	Commission on Health and HIV
CY	Calendar Year
DBHDS	Department of Behavioral Health and Developmental Services
DC	District of Columbia (Washington, DC)
DDP	Division of Disease Prevention
DIS	Disease Intervention Specialist
DJJ	Department of Juvenile Justice
DM	Data Manager
DMAS	Department of Medical Assistance Services
DMV	DC, Maryland, Virginia
DOC	Department of Corrections
DOE	Department of Education
DoxyPEP	Doxycycline for post-exposure prophylaxis
DSA	Data Sharing Agreement
DSI	Division of Surveillance and Investigation
DSS	Department of Social Services
DtC	Data to Care
ED	Emergency Department
eHARS	Enhanced HIV/AIDS Reporting System
EIS	Early Intervention Services
EMA	Eligible Metropolitan Area
FQHC	Federally Qualified Health Centers
HAV	Hepatitis A Virus
HBV	Hepatitis B Virus
HCC	HIV Continuum of Care
HCS	HIV Care Services (VDH)
HCV	Hepatitis C Virus
HD	Health Department
HHP	HIV and Hepatitis Prevention
HHP	HIV and Hepatitis Surveillance
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for People with AIDS
HRSA	Health Resources and Services Administration
IDU	Injection Drug Use
LtC	Linkage to Care
LHD	Local Health Department

MAI	Minority AIDS Initiative
MD	Maryland
MMP	Medical Monitoring Project
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MSA	Metropolitan Statistical Area
MMSC	Male to male sexual contact
NC	North Carolina
NDR	Network Detection and Response
NHSS	National HIV Surveillance System
NIH	National Institutes of Health
NIR/NRR	No Identified Risk/No Reported Risk
NOA	Notice of Award
nPEP	Non-Occupational Post-Exposure Prophylaxis
OAA	Opioid Abatement Authority
OD2A	Overdose Data to Action
OEpi	Office of Epidemiology
OFHS	Office of Family Health Services (VDH)
OUD	Opioid Use Disorder
PEP	Post exposure prophylaxis
PHER	Perinatal HIV Exposure Reporting
PWH	Persons with HIV
PN	Patient Navigator or Patient Navigation
PrEP	Pre-Exposure Prophylaxis
PWID	Persons who inject drugs
QMAC	Quality Management Advisory Committee
REDCap	Research Electronic Data Capture
RFA	Request for Applications
RFP	Request for Proposals
RRP	Rapid Response Plan
RRRC	Rapid Response Review Committee
RW	Ryan White
RWHAP	Ryan White HIV/AIDS Program
S&C	Security and Confidentiality
SAMHSA	Substance Abuse and Mental Health Services Administration
SNSN	Status Neutral Service Navigation Program
SOR	State Opioid Response
SPS	STD Prevention and Surveillance
STI	Sexually Transmitted Infection
SUD	Substance Use Disorder
TA	Technical Assistance
TGA	Transitional Grant Area
VA	Virginia
VACAC	Virginia Quality of Care Consumer Advisory Committee
VA MAP m	Virginia Medication Assistance Program (replaces former ADAP at VDH)
VA	Veterans Administration
VDH	Virginia Department of Health
VHARCC	Virginia HIV/AIDS Resource and Consultation Center
VL	Viral Load

Appendix 3: Completed Integrated Plan Checklist

CY 2027 – 2031 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

Requirement	New Material and/or Existing Material	Title/File Name of Materials	Page(s) for this Section
Section I: Introduction of Integrated Plan and SCSN			
1. Introduction	New Material	Jurisdiction created new material	Pg. 4 - 5
a. Approach	New Material	Jurisdiction created new material	Pg. 4
b. Documents submitted to meet requirements	New Material	Jurisdiction created new material	Pg. 4-5
Section II: Community Engagement and Planning Process			
1. Jurisdiction Planning Process	New Material	Jurisdiction created new material	Pg. 5-9
a. Entities involved in the process	New Material	Jurisdiction created new material	Pg. 6
b. Role of the RWHAP Part A Planning Council/Planning Body (not required for state only plans)	New Material	Jurisdiction created new material	Pg. 6-8
c. Role of Planning Bodies and other entities	New Material	Jurisdiction created new material	Pg. 6
d. Collaboration with RWHAP Parts – SCSN requirement	New Material	Jurisdiction created new material	Pg. 7
e. Engagement of People with HIV – SCSN requirement	New Material	Jurisdiction created new material	Pg. 7
f. Priorities	New Material	Jurisdiction created new material	Pg. 7-8
g. Updates to other strategic plans used to meet requirements	N/A		N/A

Section III: Contributing Data Sets and Assessments			
1. Data Sharing and Use	New Material	Jurisdiction created new material	Pg. 10
2. Epidemiologic Snapshot	New Material	Jurisdiction created new material	Pg. 10-18
3. HIV Prevention Care and Treatment Resource Inventory	New Material	Jurisdiction created new material	Pg. 19-32
a. Strengths and gaps	New Material	Jurisdiction created new material	Pg. 43
b. Approaches and partnerships	New Material	Jurisdiction created new material	Pg. 23;26-33
4. Needs Assessment	New Material	Jurisdiction created new material	Pg. 33-43
a. Priorities	New Material	Jurisdiction created new material	Pg. 34-36
b. Actions taken	New Material	Jurisdiction created new material	Pg. 33

Section IV: Situational Analysis			
1. Situational Analysis	New Material	Jurisdiction created new material	Pg. 43-47
a. People and communities disproportionately impacted by HIV	New Material	Jurisdiction created new material	Pg. 34-36
Section V: 2027-2031 Goals and Objectives			
1. Goals and Objectives Description	New Material	Jurisdiction created new material	Pg. 48-63
a. Updates to other strategic plans used to meet requirements	N/A		N/A

Section VI: 2027-2031 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow-Up			
1. 2027-2031 Integrated Planning Implementation Approach	New Material	Jurisdiction created new material	Pg. 64-66
a. Implementation	New Material	Jurisdiction created new material	Pg. 64
b. Monitoring	New Material	Jurisdiction created new material	Pg. 64-65
c. Evaluation	New Material	Jurisdiction created new material	Pg. 65
d. Improvement	New Material	Jurisdiction created new material	Pg. 65
e. Reporting and dissemination	New Material	Jurisdiction created new material	Pg. 65-66
f. Updates to other strategic plans used to meet requirements	N/A		N/A

Section VII: Letters of Concurrence			
1. CDC Prevention Program Planning Body Chair(s) or Representative(s)	**Virginia Community HIV Planning Group** Jerome Cuffee Community Co-Chair Olivia Allison, Health Department Co-Chair	Jurisdiction created new material	Pg. 75
2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)	**Norfolk TGA Part Planning Council** Jonthan Spain, Community Co-Chair **District of Columbia EMA Part A Planning Council** Melvin Cauthen, Community Co-Chair Murray Penner, Community Vice-Chair Lamont Clark, Government Co-Chair	Jurisdiction created new material	Pg. 77-78
3. RWHAP Part B Planning Body Chair or Representative			N/A
4. Integrated Planning Body			N/A
5. EHE Planning Body			N/A

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