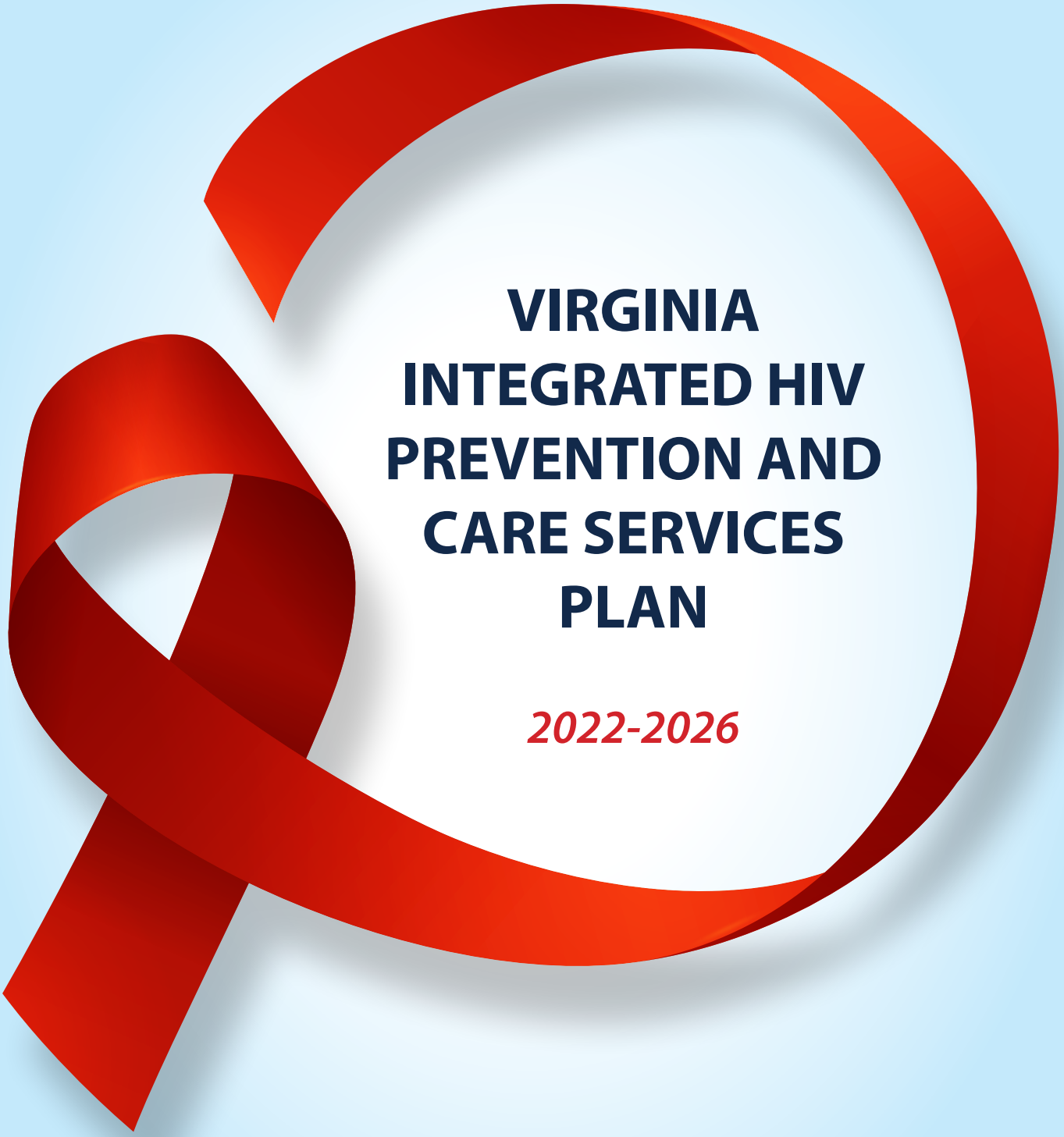

VIRGINIA INTEGRATED HIV PREVENTION AND CARE SERVICES PLAN

2022-2026

VIRGINIA INTEGRATED HIV SERVICES PLAN
https://bit.ly/3tnb6Xu

VDH VIRGINIA DEPARTMENT OF HEALTH

Virginia Integrated HIV Prevention and Care Plan 2022-2026

Prepared by:

Virginia Department of Health Division of Disease Prevention

in collaboration with the

Virginia Community HIV Planning Group and

Norfolk, Virginia Ryan White HIV/AIDS Program Part A Transitional Grant Area

Acknowledgements

Many thanks to all of the people with and affected by HIV, public health officials, researchers, staff, and volunteers of many organizations that participated in the development of this plan. This plan, which lays a concrete foundation for reaching the goals of the National HIV Strategy and ending the HIV epidemic in Virginia, would not be possible without your contributions.

VDH VIRGINIA DEPARTMENT OF HEALTH

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HOW-TO-USE

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I. Executive Summary

Introduction

The Virginia Department of Health (VDH) Division of Disease Prevention (DDP) presents this new HIV Integrated Prevention and Care Plan (Plan), in response to the integrated planning guidance issued by the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) in June 2021. This document serves as the joint jurisdictional plan for Virginia, which is a Ryan White HIV/AIDS Program (RWHAP) Part B recipient, and for the Norfolk, Virginia RWHAP Part A Transitional Grant Area (TGA). The District of Columbia RWHAP Part A Eligible Metropolitan Area (EMA) is submitting a separate plan for that jurisdiction, which includes 17 counties in Northern and Northwestern Virginia, overlapping service areas of Virginia.

The HIV National Strategic Plan: 2021-2025 outlines the national vision and action plan for curtailing the Human Immunodeficiency Virus (HIV) epidemic, improving health outcomes of all people with HIV (PWH), including Acquired Immunodeficiency Syndrome (AIDS) in the United States, and achieving a more coordinated response to the epidemic. Virginia's plan embraces this vision:

The United States will be a place where new HIV infections are prevented, every person knows their status, and every person with HIV has high-quality care and treatment and lives free from stigma and discrimination. This vision includes all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstance. (HIV National Strategic Plan, January 2021)

The Ending the HIV Epidemic in the U.S. (EHE) is a bold plan announced in 2019 that aims to end the HIV epidemic in the United States by 2030. Agencies across the U.S. Department of Health and Human Services (HHS) developed an operational plan to pursue that goal accompanied by a request for additional annual funding.

Virginia's plan articulates this vision locally and presents 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 both the HIV National Strategic Plan and EHE goals.

This plan is organized into six sections:

1. Executive Summary of the Plan and Statewide Coordinated Statement of Need (SCSN): This section provides a description of the plan, including the SCSN.

2. 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.

3. Contributing Data Sets and Assessments: This section provides an overview of Virginia's HIV epidemic statewide, for each of the five health planning (i.e. Central, Eastern, Northern, Northwestern, and Southwestern) and the Norfolk TGA. The section also describes social determinants of health (SDOH) and their impact on PWH; financial resources for services delivered within Virginia; and the needs, barriers, and gaps of persons with and those who experience risk for HIV infection. The descriptions of the current and planned use of data to improve services are also in the SCSN (section 1).

4. 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 2 and 3. This section also identifies Virginia's populations prioritized for services.

5. Goals and Objectives for 2022-2026: 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 Plan's goals and objectives closely align with the vision and goals articulated in the National HIV/AIDS Strategy (NHAS) and EHE.

6. 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 increased focus on Pre-Exposure Prophylaxis (PrEP), comprehensive harm reduction (CHR), and status neutral service navigation for HIV prevention and care. Additional priorities for HIV Care Services include expansion of Rapid Start programs, services for aging PWH, and greater collaboration with partner agencies to strengthen housing, mental health, and substance use disorder treatment.

Finally, Virginia will work to recover from the impact of the COVID-19 pandemic; including returning HIV, STI, and viral hepatitis testing to pre-pandemic levels and regaining successes previously achieved in timely linkage to care, retention in care and viral suppression.

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

II. Jurisdictional Planning Process

In the formulation of this plan, the DDP collaborated with a variety of stakeholders, including the Virginia Community HIV Planning Group (CHPG); Ryan White Parts A/B/C/D providers in Virginia, including the Norfolk TGA and Washington D.C. EMA; community-based organizations, medical providers and other agencies serving PWH and persons who experience risk for HIV infection. Each work unit (HIV Care Services, HIV and Hepatitis Prevention, STD Prevention and Surveillance, and HIV and Hepatitis Surveillance) actively participated in work groups and planning meetings to ensure inclusion of STIs, viral hepatitis, and other relevant activities into the process. The following examples Virginia's steps to solicit input in each step of the planning process since the development of the last Comprehensive HIV Services Plan and Statewide Coordinated Statement of Need.

Entities involved in the process

Virginia Community HIV Planning Group: The CHPG is the Virginia HIV Prevention and Care services planning group. DDP seeks to implement an integrated planning process that reflects guidelines established by CDC and HRSA's 2021 Planning Guidance and supports their recommendation of parity and inclusion of those most affected by HIV.

Virginia CHPG membership is reflective of Virginia's HIV epidemic by race, ethnicity, sexual orientation and gender identify. More than 40% of members are PWH. The CHPG consists of representatives

from priority populations and from stakeholders that provide and/or support HIV prevention, care, and treatment services for its Virginia's residents. CHPG membership includes representatives from local health districts, HIV medical providers, HIV prevention providers, behavioral health agencies, housing agencies, intimate partner violence programs. Clinicians, pharmacists, case managers, patient navigators, and HIV testing and outreach staff serve on the CHPG. Membership includes social sciences disciplines, business and labor industries, community health centers (CHCs), correction/detention center staff, faith communities, academic institutions, psychosocial support and treatment providers, other state agencies. The voices of people with lived experience around substance use disorder, incarceration, homelessness, mental illness and poverty who serve on the CHPG add additional layers of richness to the recommendations and decisions for this Plan. The CHPG provided input on prioritizing populations, identifying needs and constructing the strategies and activities for meeting the goals in the Plan.

VDH Contracted HIV Prevention and Care Organizations: DDP solicited input and requested feedbacks from its from HIV prevention and care (RWHAP B) contracted agencies throughout the planning process at meetings at the Quarterly Prevention and Care Services Contractor meetings, the Quality Management Advisory Committee meetings, and the Virginia RWHAP Cross Parts Quality Management Summit.

RWHAP A Organizations: There are two RWHAP A jurisdictions in Virginia: (1) Norfolk TGA and (2) Washington, D. C. EMA. The Norfolk TGA area overlaps with Virginia's Eastern region and includes one county in North Carolina. The Washington, D.C. EMA serves the portion of Virginia that comprises the Northern health region in addition to several counties in the Northwest region. These two jurisdictions have the greatest number of PWH in the state. DDP has voting members from Prevention and Care 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 Washington, D.C. EMA is developing their own plan.

The Norfolk TGA requested to be included in the 2022-2026 Integrated Plan. They provided information and data to describe service needs, barriers, and gaps in their region. They also provided input on the proposed priorities and goals of the Integrated Plan.

Collaboration with RWHAP C, D, and F Parts: Stakeholders received information and provided feedback in several statewide meetings throughout 2021 and 2022, including two annual programmatic summits, one mentioned above, as well as a Case Management Summit. Each meeting provided an update, as well as opportunities to gather feedback. The audiences varied throughout the year and different DDP units facilitated the meetings.

Public Hearings: DDP conducts two public hearings annually to ask for input to improve care and prevention strategies and activities. Public hearings have helped the RWHAP B program unify eligibility for all RWHAP Part B services in Virginia, inform DDP on how to implement a new data system for both HIV Prevention and Care services data, and provided input into this plan and other issues that PWH face. VDH incorporated feedback gathered from public hearings into the needs assessment section of this plan.

In 2022, DDP conducted a virtual public hearing to provide information/updates and get feedback on the plan. As a part of the public hearing, VDH lead discussions to gather input on the 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. VDH used feedback provided from the public hearing to inform the planning process, including the development of the goals and objectives.

DDP also presented on the process at the VDH Agency Leadership Forum that includes local health district staff and central office administrators. Disease Intervention Specialists were engaged via webinar to learn about the NHAS and Virginia's plans.

Engagement of PWH

As described above, more than 40% of CHPG members are PWH. Feedback and engagement were encouraged through both large and small group discussions, written feedback, and surveys.

VDH also engaged with the Virginia Consumer Advisory Committee (VACAC), a RWHAP B Quality Management Advisory Committee Subcommittee, which is a consumer-led committee that provides feedback on the quality of care from the contracted RWHAP B subrecipients. VDH used the quarterly statewide consumer meetings to gather regular input from VACAC into the development of the plan. The VACAC also plays a critical role in engaging additional consumers' feedback and participation.

Priorities

Several priorities emerged from the planning and community engagement process, including those listed below. The plan Goals and Objectives section further elaborates on the list below.

- Expanding access to PrEP/Non-Occupational Post-Exposure Prophylaxis (nPEP) and CHR services throughout the state
- Reducing stigma and addressing health disparities
- Addressing needs of rural areas and those with greatest nnmet need (HIV)
- Addressing needs for persons aged 50 and older across HIV service delivery system
- Focusing care and treatment needs for pregnant persons with HIV
- Addressing and incorporating SDOH into service planning and delivery across the HIV service delivery system
- Collaborating with partners for service access for both persons who experience risk for HIV infection and those with HIV

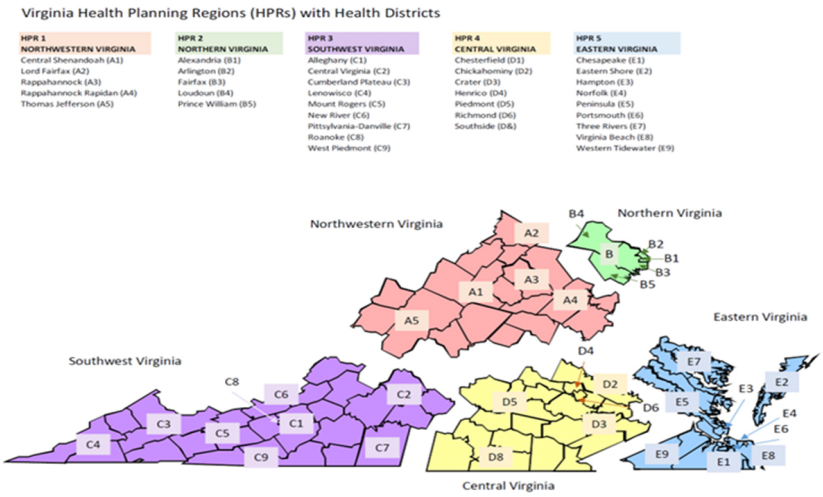
III. Contributing Data Sets and Assessments

A. Epidemiologic Overview: People Diagnosed and those that experience risk for HIV infection

Geographic Overview

Virginia is a medium-size South Atlantic state, consisting of 95 counties and 38 independent cities. Virginia shares a border with the District of Columbia (DC), Kentucky, Maryland, North Carolina, Tennessee, and West Virginia. VDH organizes the state into five health regions: Central, Eastern, Northern, Northwest, and Southwest, which are comprised of 35 health districts (Figure 1). In addition, two large metropolitan regions receive dedicated federal HIV funding for services: Northern Virginia, which is part of the DC EMA, and the Norfolk, Virginia TGA, which is part of the Eastern region.

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



Population estimates in this report are as of 2019 (utilizing 2019 data as that aligns with Virginia's most completed year for HIV epidemiological data), the most recent and complete year of the United States (U.S.) Census Bureau population estimates. According to the US Census Bureau, Virginia's 2019 population was 8,535,519, accounting for 2.6% of the national population (328,239,523). Over the last decade, Virginia's population increased by over 530,000 residents, for a growth rate of 6.7%, slightly higher than the national growth rate of 6.3%. Table 1 presents Virginia's total population data, 2020 total PWH including AIDS, and 2020 newly diagnosed PWH by health planning region.

Table 1: Virginia Population Estimates (2019) and Persons with HIV in Virginia (2020)

	2019 General Population1		2020 PWH2		2020 New Diagnoses2	
	Number	Percent	Number	Percent	Number	Percent
Total	8,535,519	100.0%	25,552	100.0%	631	100.0%
Known Residence	8,535,519	100.0%	25,252	98.8%	631	100.0%
Central	1,460,750	17.1%	6,000	23.5%	150	23.8%
Eastern	1,858,179	21.8%	7,812	30.6%	229	36.3%
Northern	2,524,874	29.6%	6,946	27.2%	140	22.2%
Northwest	1,354,019	15.9%	2,310	9.0%	53	8.4%
Southwest	1,337,697	15.7%	2,184	8.6%	59	9.4%
Unknown Residence			300	1.2%	0	0.0%
Norfolk TGA*	1,693,111	19.8%	7,404	32.5%	221	38.6%

Sources: [1]2019 Virginia population by county, [2]Virginia Enhanced HIV/AIDS Reporting System (eHARS) September 2021 frozen dataset

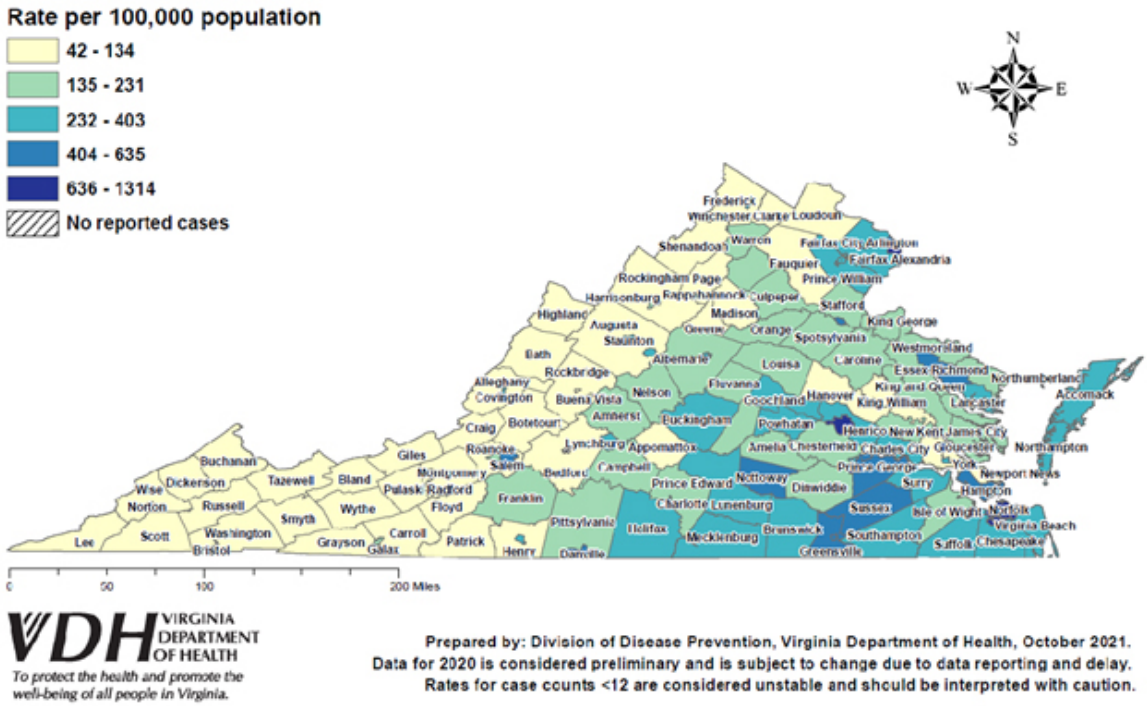
Although the 2019 Northern region population is the largest among the five health regions (29.6%), it ranks second in terms of total number of PWH (27.2%) and third in 2020 new diagnoses (22.2%). **The**

Eastern region, which includes the Norfolk TGA (which includes the following jurisdictions: Norfolk, Chesapeake, Portsmouth, Suffolk, Virginia Beach, Hampton, Newport News, Poquoson, Williamsburg, and the counties of Isle of Wight, James City, Gloucester, Mathews, and York and Currituck County North Carolina), **has both the largest number of PWH (30.6%) and the largest number of 2020 new diagnoses (36.3%).** The Central region, which is home to Virginia's capital, Richmond, ranks third in terms of total number of PWH (23.5%) and second in new 2020 diagnoses (23.8%).

The Norfolk TGA's general population represents 91.1% of the total population in the Eastern region. In terms of PWH, the Norfolk TGA contains 94.8% of the Eastern region's PWH and 96.5% of the Eastern region's 2020 newly diagnosed persons.

Figure 2 depicts the geographic distribution of PWH across Virginia's counties and independent cities as a rate per 100,000 population. Examining HIV data using rates allows for direct 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. As seen in figure 2, darker areas are predominantly located in the Eastern region/Norfolk TGA, Central region, and Northern region.

Figure 2: Persons with HIV Disease as of December 31, 2020 Across Virginia's Counties and Independent Cities as a Rate per 100,000



Sociodemographic Characteristics

The demographic characteristics of all PWH reported as of December 31, 2020, and 2020 newly diagnosed PWH compared to the demographic characteristics of Virginia's 2019 general population are in Table 2. Demographics presented in this section include sex at birth, age (age as of December 31, 2020, for PWH and age at diagnosis for 2020 new diagnoses), race/ethnicity, and HIV transmission category. VDH reports sex at birth because current gender and transgender status are incomplete in the HIV surveillance data. Additionally, VDH collaborated with the University of Virginia to conduct

an in-depth assessment of transgender and gender non-conforming (TGNC) persons with and those who experience risk for HIV infection in Virginia through a survey called This Great New Community (TGNC) Survey (www.tgncsurvey.com). The study gathers data to present a comprehensive picture of this population with the goal of better understanding and serving the healthcare needs of TGNC people in Virginia. Topics addressed include experiences of physical and sexual violence, housing status, employment status, insurance enrollment, and access to healthcare, health status with regard to conditions such as substance use, mental health, cancer, heart disease, and others, and experience of discrimination in healthcare as well as other areas such as employment and housing. It also includes an assessment of risk for HIV infection, hepatitis, and other STIs, access to treatment and care for HIV, and questions about the quality of these services available for transgender and gender non-conforming persons in Virginia.

PWH are mostly male at birth (74.8%), between the ages of 45 and 64 years (50.3%), and Black, non-Hispanic (57.8%). Among the 80% of PWH with a reported HIV transmission risk, the most common risk factor is men who have sex with men (MSM) (62.0%) followed by heterosexual contact (23.8%).

Characteristics of newly diagnosed persons follow a similar pattern to all PWH except for age distribution. As with all PWH, most new diagnoses were male at birth (81.8%) and Black, non-Hispanic (66.1%). Of those with a reported transmission risk factor, the most common transmission risk was MSM (78.7%). Newly diagnosed PWH are younger than all PWH, with the majority (54.6%) of new diagnoses between the ages of 20 and 34 years.

Transgender individuals remain a priority population for HIV prevention and care. DDP made strides to improve reporting of transgender status in the HIV surveillance database by adopting a CDC algorithm to identify persons whose current gender differs from their sex assigned at birth.

Table 2: Comparison of Demographic Characteristics of Virginia's 2019 General Population with PWH and New Diagnoses as of December 31, 2020

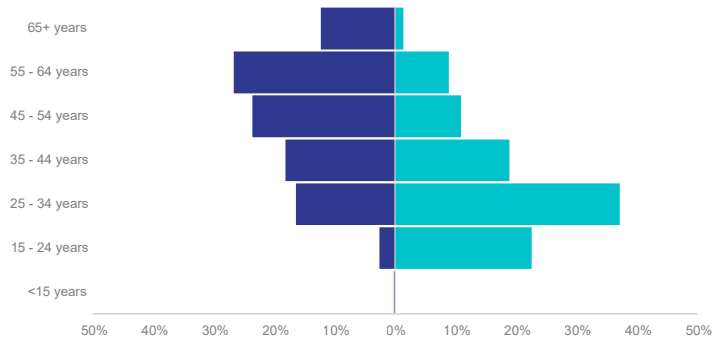
	2019 Virginia's General Population		2020 PWH in Virginia		2020 New Diagnoses in Virginia	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Total	8,535,519	100.0%	25,552	100.0%	631	100.0%
Sex at Birth						
Male	4,200,257	49.2%	19,107	74.8%	516	81.8%
Female	4,335,262	50.8%	6,445	25.2%	115	18.2%
Age (years)						
<10	1,020,363	12.0%	23	0.1%	0	0.0%
10 – 14	525,235	6.2%	24	0.1%	0	0.0%
15 – 19	541,828	6.3%	86	0.3%	33	5.2%
20 – 24	571,619	6.7%	597	2.3%	110	17.4%
25 – 29	601,926	7.1%	1,733	6.8%	132	20.9%
30 – 34	588,455	6.9%	2,463	9.6%	103	16.3%
35 – 39	581,713	6.8%	2,254	8.8%	68	10.8%
40 – 44	530,783	6.2%	2,371	9.3%	51	8.1%
45 – 49	547,506	6.4%	2,573	10.1%	36	5.7%
50 – 54	552,768	6.5%	3,458	13.5%	33	5.2%

55 – 59	584,373	6.8%	3,886	15.2%	31	4.9%
60 – 64	530,044	6.2%	2,947	11.5%	25	4.0%
65+	1,358,906	15.9%	3,132	12.3%	9	1.4%
Race/Ethnicity[1]						
Black, non-Hispanic	1,625,942	19.0%	14,766	57.8%	417	66.1%
White, non-Hispanic	5,212,705	61.1%	7,044	27.6%	127	20.1%
Hispanic/Latino (all races)	828,154	9.7%	2,463	9.6%	67	10.6%
Asian/ Hawaiian/ Pacific Islander	564,377	6.6%	413	1.6%	10	1.6%
Amer. Indian/ Alaska Native	17,497	0.2%	27	0.1%	0	0.0%
Multi-race/ Unknown	286,844	3.4%	839	3.3%	10	1.6%
Transmission Category						
Male-to-male sexual contact (MSM)			12,679	49.6%	377	59.7%
Injection drug use (IDU)			1,688	6.6%	15	2.4%
MSM & IDU			841	3.3%	8	1.3%
Heterosexual contact			4,859	19.0%	79	12.5%
Pediatric			314	1.2%	0	0.0%
Blood recipient			61	0.2%	0	0.0%
No risk factor reported or identified			5,110	20.0%	152	24.1%

Sources: [1]https://www.statista.com/statistics/588114/virginia-population-ethnicity-race/

Virginia has an aging population of PWH. A greater number of people are now living 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 and those Newly Diagnosed as of December 31, 2020



The Norfolk Transitional RWHAP A Grant Area (TGA)

Table 3 presents 2020 data from the Norfolk TGA demographics of the overall population, PWH in the TGA, and persons newly diagnosed with HIV in the TGA. Compared to Virginia's general population, Norfolk TGA residents are slightly younger; with 48.0% of residents under age 35 compared to the general population's 45.2%. Compared to Virginia's general population, Norfolk TGA residents are also more likely to be non-Hispanic Black (32.0% compared to 19.0%).

Demographics of people with and newly diagnosed with HIV in the Norfolk TGA are similar to those of the Virginia general population. Most are male at birth (73.7% of all PWH and 83.7% of newly diagnosed PWH), non-Hispanic Black (67.6% of all PWH and 71.0% of newly diagnosed PWH) and have an MSM transmission risk (48.5% of all PWH and 60.2% of newly diagnosed PWH).

Some key differences exist between PWH in the Norfolk TGA and PWH in the Virginia general population. In 2020, compared to newly diagnosed persons statewide, persons newly diagnosed in the Norfolk TGA were younger (66.6% were under age 35 compared to 59.8% in Virginia), more likely to be non-Hispanic Black (71.0% vs. 66.1%), and more likely to have an IDU transmission category (5.0% vs. 2.4%). Conversely, those newly diagnosed in the Norfolk TGA in 2020 were less likely to be Hispanic/Latino (5.4% vs. 10.6%) and to have a heterosexual contact transmission category (9.1% vs. 12.5%) compared to newly diagnosed persons statewide.

Compared to all PWH in Virginia, PWH in the Norfolk TGA are younger (23.6% under age 35 vs. 19.2% under age 35), more likely to be non-Hispanic Black (67.6% vs. 57.8%), and more likely to have no transmission risk factor reported or identified (22.9% vs. 20.0%). Compared to all PWH in Virginia, PWH in the Norfolk TGA are less likely to be non-Hispanic White (22.1% vs. 27.6%) or Hispanic/Latino (5.3% vs. 9.6%) and to have heterosexual contact as a transmission risk factor (17.7% vs. 19.0%).

Table 3: Comparison of Demographic Characteristics of the Norfolk TGA's 2019 General Population with PWH in the Norfolk TGA as of December 31, 2020 and New Diagnoses in 2020 in the Norfolk TGA

	2019 Norfolk TGA General Population		2020 PWH in Norfolk TGA		2020 New Diagnoses in Norfolk TGA	
	Number	Percent	Number	Percent	Number	Percent
Total	1,693,111	100.0%	7,404	100.0%	221	100.0%
Sex at Birth						
Male	832,287	49.2%	5,460	73.7%	185	83.7%
Female	860,824	50.8%	1,944	26.3%	36	16.3%
Age (years)						
<10	209,007	12.3%	7	0.1%	0	0.0%
10 – 14	101,420	6.0%	3	0.0%	0	0.0%
15 – 19	106,627	6.3%	27	0.4%	16	7.2%
20 – 24	132,212	7.8%	223	3.0%	45	20.4%
25 – 29	136,935	8.1%	624	8.4%	47	21.3%
30 – 34	127,043	7.5%	866	11.7%	39	17.7%
35 – 39	117,124	6.9%	744	10.0%	27	12.2%
40 – 44	96,909	5.7%	661	8.9%	15	6.8%

45 – 49	95,035	5.6%	665	9.0%	7	3.2%
50 – 54	99,085	5.9%	905	12.2%	9	4.1%
55 – 59	113,660	6.7%	1,094	14.8%	7	3.2%
60 – 64	103,236	6.1%	805	10.9%	7	3.2%
65+	254,818	15.1%	779	10.5%	2	0.9%
Race/Ethnicity						
Black, non-Hispanic	541,487	32.0%	5,005	67.6%	157	71.0%
White, non-Hispanic	940,625	55.6%	1,633	22.1%	42	19.0%
Hispanic/Latino (all races)	122,773	7.3%	396	5.3%	12	5.4%
Asian/ Hawaiian/ Pacific Islander	81,210	4.8%	68	0.9%	4	1.8%
Amer. Indian/ Alaska Native	7,016	0.4%	8	0.1%	0	0.0%
Multi-race/ Unknown			294	4.0%	6	2.7%
Transmission Category						
Male-to-male sexual contact (MSM)			3,590	48.5%	133	60.2%
Injection drug use (IDU)			491	6.6%	11	5.0%
MSM & IDU			227	3.1%	2	0.9%
Heterosexual contact			1,314	17.7%	20	9.1%
Pediatric			75	1.0%	0	0.0%
Blood recipient			14	0.2%	0	0.0%
No risk factor reported or identified			1,693	22.9%	55	24.9%

Socioeconomic Data

Table 4 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 2021, approximately 10.6% of Virginians lived at or below 100% of the federal poverty level (FPL). This varied by region from 6.2% in the Northern region to 16.6% of in the Southwest region. Per capita income varied similarly by region, with income ranging from $25,777 per capita in the Southwest region to $53,021 per capita in the Northern region.

As with income, educational attainment was highest in the Northern region, where 59% of the population 25 years and older had a bachelor's degree or higher, and was lowest in the Southwest region where 23% of those 25 years and older had a bachelor's degree or higher. Unemployment followed a slightly different pattern: the Northern and Northwest regions had the lowest unemployment rates (2.3% each), while unemployment was highest in the Eastern region (3.2%).

In January 2019, Virginia Medicaid expansion increased insurance access for individuals aged 19-64 and with income at or below 138% of the FPL. Following Medicaid expansion, uninsured rates declined statewide. The 2019 U.S. Census Bureau's American Community Survey estimates that 7.9% of Virginians were uninsured, with higher rates of uninsured in the Central (8.3%) and Northern (8.1%) regions and lower rates in the Eastern (7.4%), Northwest (7.2%), and Southwest (6.8%) regions.

Statewide, 12.7% of Virginians are foreign-born with 46.8% of them not having U.S. citizenship. The percentage of foreign-born residents varies widely by region, from a low of 5.3% in the Southwest region (and 52.1% of these not having U.S. citizenship) to a high of 28.0% of foreign-born residents in the Northern region (with 44.4% not having U.S. citizenship).

Table 4: Socioeconomic Characteristics of Virginia and Five Health Regions' General Population

	Virginia	Central	Eastern	Northern	Northwest	Southwest
Below 100% Federal Poverty Level	10.6%	12.1%	11.6%	6.2%	9.9%	16.6%
Per capita income[1]	$39,278	$28,601	$32,409	$53,021	$33,090	$25,777
Educational attainment (population ≥25 years)						
≤8th grade	4%	4%	3%	4%	4%	5%
9th to 12th grade (no diploma)	6%	7%	6%	4%	7%	9%
High school of equivalency	24%	27%	26%	14%	29%	32%
Some college	19%	20%	24%	14%	20%	21%
Associates Degree	8%	7%	10%	6%	7%	10%
Bachelor's Degree	22%	21%	19%	31%	19%	14%
Master's Degree or higher	17%	13%	12%	28%	14%	9%
Unemployment rate[2]	3.4%	3.1%	3.2%	2.3%	2.3%	2.8%
Uninsured[3]	7.9%	8.3%	7.4%	8.1%	7.2%	6.8%
Foreign born	12.7%	9.6%	7.5%	28.0%	8.3%	5.3%
Not a U.S. Citizen[4]	46.8%	56.4%	40.8%	44.4%	55.4%	52.1%

Source: U.S. Census Bureau, American Community Survey 1-year

[1]Per capita income is 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 2021. Regional rates do not adjust seasonally and are as of November 2021. All unemployment data are from the U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics.

[3]Uninsurance data are based on 2019 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

The Medical Monitoring Project (MMP) is a CDC-funded survey of adults with diagnosed HIV that assesses behavioral and clinical characteristics at a specific point in time. Data collected as part of Virginia MMP from 2015-2019 were used to report estimates of select characteristics of adults with HIV. Tables 5 and 6 present these data as unweighted frequencies and weighted percentages with 95% confidence intervals. Data with a coefficient of variance of 30% or greater are not included in this report as inferences about these data cannot be made. The MMP data are self-reported and therefore subject to response bias.

Table 5 presents behavioral characteristics of adults with HIV. An estimated 59.8% of persons with HIV reported sexual intercourse in the previous 12 months. The Northern region reported the highest percentage of sexual activity (64.1%) and the Southwest region reported the lowest (48.9%). Among participants who reported having sex in the previous 12 months, an estimated 53.9% engaged in sex without a condom in the previous 12 months, with the highest percentage in the Southwest region (63.1%) and the lowest percentage in the Northwest region (47.4%). Please note that this measurement does not consider the viral load of the person. The most reported sexual partner type was MSM, with 45.0% of persons in the Northern region indicating this type of partnership. An estimated 52.8% of persons reported alcohol use in the previous 30 days. Alcohol use was highest in the Northern region (57.8%) and lowest in the Southwest region (33.6%). Across the state, an estimated 15.6% of persons reported binge drinking in the previous 30 days. Non-injection drug use in the previous 12 months was most common in the Central region (36.5%) and least common in the Northwest region (15.5%). Across the state, an estimated 8.1% of persons reported IDU in their lifetime.

Table 5: Behavioral Characteristics, Medical Monitoring Project 2015-2019

	Virginia			Central			Eastern			Northern			Northwest			Southwest		
	N[a]	%[b]	95% CI[c]	N[a]	%[b]	95% CI[c]	N[a]	%[b]	95% CI[c]	N[a]	%[b]	95% CI[c]	N[a]	%[b]	95% CI[c]	N[a]	%[b]	95% CI[c]
Sexual intercourse, past 12 months																		
Yes	426	59.8	55.6-64.0	144	58.7	51.7-65.7	132	61.8	53.9-69.7	88	64.1	55.1-73.1	32	57.2	43.2-71.2	30	48.9	34.3-63.5
No	285	40.2	36.0-44.4	100	41.3	34.3-48.3	77	38.2	30.3-46.1	52	35.9	26.9-44.9	25	42.8	28.8-56.8	31	51.1	36.5-65.7
Engaged in condomless sex, past 12 monthse																		
Yes	225	53.9	48.5-59.4	82	58.1	49.4-66.7	65	50.5	40.6-60.4	43	52.1	40.0-64.3	16	47.4	28.2-66.6	19	63.1	43.0-83.2
No	190	46.1	40.6-51.5	59	41.9	33.3-50.6	63	49.5	39.6-59.4	41	47.9	35.7-60.0	16	52.6	33.4-71.8	11	36.9	16.8-57.0
Classification of sexual partner type[f]																		
No sex at all	284	40.1	35.9-44.3	100	41.3	34.3-48.3	76	37.9	30.0-45.8	52	35.9	26.9-44.9	25	42.8	28.8-56.8	31	51.1	36.5-65.7

Men who have sex with men (MSM)	215	32.7	28.7-36.7	70	30.1	23.7-36.5	61	29.8	22.6-37.1	55	45.0	35.4-54.5	12	21.0	9.7-32.3	17	31.4	17.5-45.3
Men who have sex with women (MSW)	65	9.1	6.8-11.4	26	11.1	6.9-15.3	24	11.0	6.5-15.6	–d	–d	–d	–d	–d	–d	–d	–d	–d
Women who have sex with men (WSM)	109	13.3	10.5-16.1	34	10.9	7.1-14.7	34	16.2	9.9-22.4	22	13.0	7.2-18.8	–d	–d	–d	–d	–d	–d
Description of sex behavior																		
No sex at all	284	40.3	36.1-44.5	100	41.5	34.5-48.5	76	38.1	30.2-46.1	52	36.2	27.2-45.3	25	42.8	28.8-56.8	31	51.1	36.5-65.7
Sex with a condom	190	26.8	23.1-30.5	59	24.2	18.4-30.1	63	29.1	21.9-36.2	41	29.7	21.1-38.4	16	30.1	16.2-44.1	–d	–d	–d
Condomless sex with only HIV-positive partners	68	9.6	7.2-12.0	22	9.8	5.5-14.1	24	11.9	7.0-16.9	–d	–d	–d	–d	–d	–d	–d	–d	–d
Condomless sex with HIV-negative partner on PrEP	23	3.9	2.1-5.7	–d	–d	–d	–d	–d	–d	–d	–d	–d	–d	–d	–d	–d	–d	–d
Condomless sex with partner of unknown HIV and PrEP status	50	6.0	4.3-7.7	20	7.6	4.2-11.0	14	5.4	2.5-8.2	–d	–d	–d	–d	–d	–d	–d	–d	–d
Condomless sex with HIV-negative partner not on PrEP or of unknown PrEP status	84	11.9	9.2-14.6	33	13.3	8.8-17.9	22	8.8	4.8-12.7	17	15.2	7.7-22.8	–d	–d	–d	–d	–d	–d
Alcohol use, past 30 days																		
Yes	367	52.8	48.6-57.0	131	56.8	50.0-63.7	113	54.6	46.5-62.6	75	57.8	48.6-67.0	24	37.7	24.3-51.1	24	33.6	20.6-46.7
No	348	47.2	43.0-51.4	113	43.2	36.3-50.0	96	45.4	37.4-53.5	67	42.2	33.0-51.4	34	62.3	48.9-75.7	38	66.4	53.3-79.4
Binge drinking, past 30 days																		
Yes	124	15.6	12.9-18.4	48	20.3	14.8-25.8	40	16.5	11.3-21.7	19	11.9	6.4-17.4	–d	–d	–d	–d	–d	–d
No	590	84.4	81.6-87.1	196	79.7	74.2-85.2	169	83.5	78.3-88.7	122	88.1	82.6-93.6	51	90.6	83.6-97.6	52	89.1	82.1-96.0
Non-injection drug use, past 12 months																		
Yes	192	26.0	22.5-29.6	83	36.5	29.8-43.3	60	25.9	19.5-32.4	25	18.6	11.4-25.8	11	15.5	6.5-24.4	13	17.3	7.4-27.2
No	524	74.0	70.4-77.5	161	63.5	56.7-70.2	150	74.1	67.6-80.5	117	81.4	74.2-88.6	47	84.5	75.6-93.5	49	82.7	72.8-92.6

History of Injection drug use																		
Yes	59	8.1	5.8-10.4	18	7.7	3.8-11.7	18	6.7	3.5-9.9	–d	–d	–d	–d	–d	–d	–d	–d	–d
No	657	91.1	89.6-94.2	226	92.3	88.3-96.2	192	93.3	90.1-96.5	132	91.8	86.1-97.5	51	88.7	80.1-97.4	56	88.8	78.7-99.0

[a]Unweighted counts; [b] Weighted percentages; [c]CIs incorporate weighted percentages

[d]Coefficient of variation (CV) is greater than 0.30; thus data are not reportable,

[e]Among participants who reported having sex in the past 12 months, [f]Classification of sexual partner type included other response options (i.e., MSMW, WSMW, MSMTG, MTG only, etc.); however, these responses were not reportable in any region and were excluded from the table

Table 6 presents clinical characteristics of adults with HIV. The majority of persons (64.9%) were diagnosed 10 or more years ago. Statewide, an estimated retention of 82.0% of persons in care in the previous 12 months. The proportion of persons retained in care in the previous 12 months was highest in the Northwest region (85.6%) and lowest in the Eastern region (74.0%). Greater than 94.0% of persons reported currently taking antiretroviral therapy (ART) in each region, with an estimated 96.5% of persons currently taking ART throughout the state. An estimated 81.6% of persons reported sustained undetectable viral loads in the previous 12 months. The Northern region reported the highest percentage of persons with sustained undetectable viral loads (90.6%) and the Eastern region reported the lowest (72.1%). CD4 cell count is used as a marker for immune system function, with lower counts indicating a weakened immune system1. An estimated 8.0% of persons reported a CD4 count below 200 in the previous 12 months across the state, while the majority of persons in each region reported all CD4 counts of 500 or more. An estimated 17.6% of persons reported an overnight hospitalization in the previous 12 months, with hospitalizations highest in the Eastern region (20.0%). An estimated 42.6% of persons reported an emergency department (ED) visit in the previous 12 months. ED visits were highest in the Eastern region (48.6%) and lowest in the Northwest region (24.5%).

Table 6: Clinical Characteristics, Medical Monitoring Project, 2015-2019

	Virginia			Central			Eastern			Northern			Northwest			Southwest		
	Na	%b	95% Clc	Na	%b	95% Clc	Na	%b	95% Clc	Na	%b	95% Clc	Na	%b	95% Clc	Na	%b	95% Clc
Time since HIV diagnosis																		
Less than 5 years	122	15.4	12.6-18.2	36	15.5	10.6-20.4	43	17.6	12.1-23.2	27	16.0	9.8-22.2	–d	–d	–d	–d	–d	–d
5-9 years	154	19.7	16.6-22.8	64	24.9	19.1-30.6	41	17.8	12.1-23.5	29	17.7	11.1-24.3	–d	–d	–d	–d	–d	–d
10 or more years	445	64.9	61.0-68.7	145	59.6	52.9-66.3	127	64.6	57.3-71.9	89	66.3	57.9-74.6	40	69.1	55.5-82.6	44	76.5	65.6-87.3
Retained in care, past 12 monthse																		
Yes	595	78.2	74.5-82.0	212	81.8	75.7-88.0	164	74.0	66.7-81.3	122	77.7	69.1-86.3	49	85.6	76.4-94.8	48	75.3	62.7-87.9
No	127	21.8	18.0-25.5	34	18.2	12.0-24.3	47	26.0	18.7-33.3	23	22.3	13.7-30.9	–d	–d	–d	14	24.7	12.1-37.3

	Virginia			Central			Eastern			Northern			Northwest			Southwest		
Time since most recent HIV care appointmente																		
0-3 months	170	55.2	48.9-61.5	74	63.2	53.7-72.6	46	59.7	47.6-71.8	22	37.9	23.1-52.8	12	62.0	40.8-83.3	16	48.6	29.7-67.5
4-6 months	91	29.6	23.9-35.2	29	23.8	15.9-31.8	26	30.2	19.3-41.2	17	31.4	17.2-45.7	–d	–d	–d	11	39.3	20.2-58.5
7 or more months	39	15.3	10.4-20.2	12	13.0	5.7-20.2	–d	–d	–d	13	30.6	15.9-45.4	–d	–d	–d	–d	–d	–d
Currently taking ART																		
Yes	690	96.5	94.8-98.2	237	97.8	95.7-99.8	199	94.7	90.7-98.8	136	95.1	90.8-99.3	56	98.3	95.0-100.0	62	100.0	100.0-100.0
No	20	3.5	1.8-5.2	–d	–d	–d	–d	–d	–d	–d	–d	–d	–d	–d	–d	0	0.0	0.0-0.0
All viral load test results undetectable (<200 copies/mL), past 12 months																		
Yes	520	81.6	78.3-85.0	182	80.6	75.1-86.0	132	72.1	64.2-80.0	113	90.6	85.7-95.4	47	89.1	81.2-97.0	46	88.9	81.1-96.6
No	125	18.4	15.0-21.7	43	19.4	14.0-24.9	52	27.9	20.0-35.8	15	9.4	4.6-14.3	–d	–d	–d	–d	–d	–d
Lowest CD4 count, past 12 months																		
0-199	56	8.0	5.9-10.2	21	8.9	5.1-12.7	16	7.3	3.7-11.0	–d	–d	–d	–d	–d	–d	–d	–d	–d
200-499	208	32.7	28.6-36.8	76	33.7	27.0-40.4	50	27.2	19.7-34.6	52	43.2	33.4-53.0	16	33.3	18.4-48.1	14	22.1	10.5-33.7
500 or more	378	59.3	55.0-63.5	130	57.4	50.4-64.3	116	65.5	57.6-73.3	68	52.5	42.7-62.4	30	54.9	39.7-70.1	34	65.5	51.7-79.4
Overnight hospitalization, past 12 months																		
Yes	130	17.6	14.5-20.8	49	19.7	4.3-25.0	39	20.0	13.4-26.7	23	14.6	8.2-21.0	–d	–d	–d	12	16.9	7.3-26.4
No	590	82.4	79.2-85.5	196	80.3	75.0-85.7	172	80.0	73.3-86.6	121	85.4	79.0-91.8	51	90.9	84.1-97.6	50	83.1	73.6-92.7
Emergency department visit, past 12 months																		
Yes	322	42.6	38.6-46.7	119	47.2	40.4-54.0	104	48.6	40.6-56.5	54	34.8	26.2-43.5	16	24.5	13.0-36.0	29	41.6	27.8-55.5
No	396	57.4	53.3-61.4	125	52.8	46.0-59.6	107	51.4	43.5-59.4	89	65.2	56.5-73.8	42	75.5	64.0-87.0	33	58.4	44.5-72.2

[a]Unweighted counts; [b] Weighted percentages; [c] CIs incorporate weighted percentages

[d]Coefficient of variance (CV) is greater than 0.30; thus data are not reportable

[e]Two elements of outpatient HIV care at least 90 days apart; of those who received outpatient care

Five-Year Trends

Over the past decade, Virginia's overall new HIV diagnoses declined. From 2010 to 2019, new HIV diagnoses decreased by 18%, from 1,026 in 2010 to 841 in 2019. This decline suggests a true decrease in new infections that attribute to increased HIV testing, uptake of PrEP, an emphasis on sustained viral suppression and faster linkage to care rates. However, the COVID-19 pandemic brought a dramatic decline in new diagnoses in 2020, much greater than the trend of the previous few years. The 2020 decline in new cases may be, in part, a reflection of decreased testing which declined by 80% in 2020 and 2021. As a result, the reader should interpret any 2020 data trends with caution.

Figure 4 shows the number of HIV tests performed by VDH over the past five years by region, which highlights the impact of COVID-19. From 2016-2019, VDH performed over 65,000 tests statewide. This number dropped considerably in 2020 to a total of slightly over 23,000 tests. While VDH testing numbers declined dramatically in 2020, requests for home test kits nearly doubled from 657 in 2019 to 1,333 in 2020.

Figure 4: Trend in HIV Tests by Health Region from 2016-2020

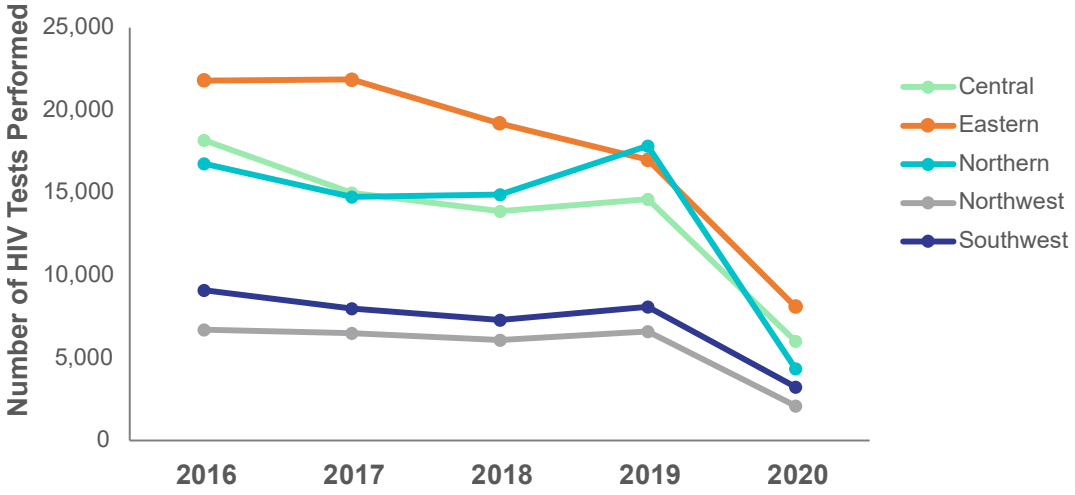
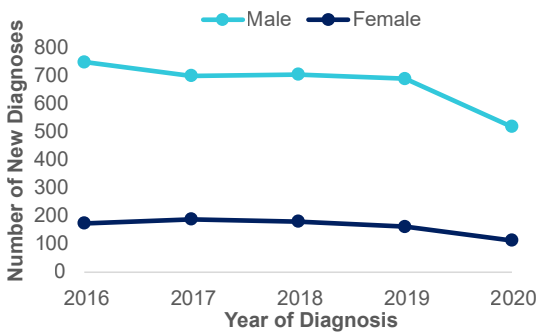
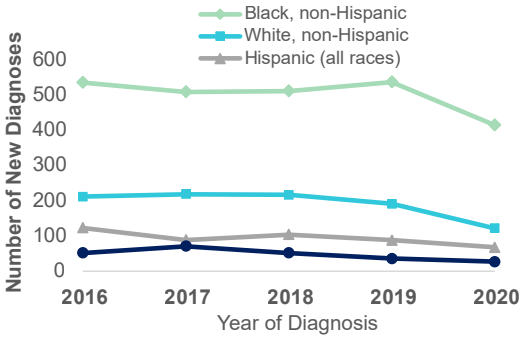


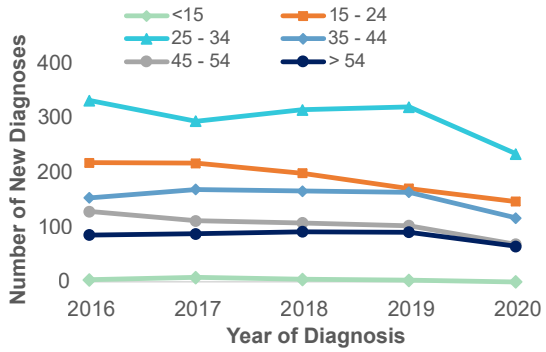
Figure 5 shows Virginia's five-year trends in the number of new HIV diagnoses by key demographics: sex at birth, race/ethnicity, and age at diagnosis, transmission risk, and health region.

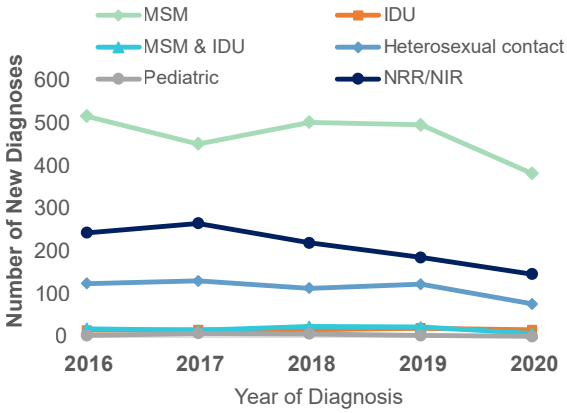
Figure 5: Trend in New HIV Diagnoses from 2016-2020 by (A) Sex at Birth; (B) Race/ Ethnicity; (C) Age Group; (D) Transmission Risk; (E) Health Region

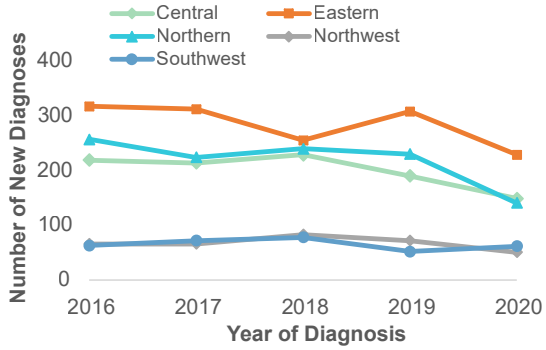




**Other includes: Asian, Hawaiian/Pacific Islander, American Indian/Alaska Native, multi-race, and unknown*







Late Diagnoses

Timely diagnoses are an important component of managing the HIV epidemic. Late diagnoses refer to persons who are classified as having AIDS at their initial diagnosis or within one year of their HIV diagnosis. Late diagnosis data lag by one year because late diagnoses require a full year of follow-up to confirm any change in disease staging.

Table 7 below shows the percentage of late diagnoses from 2015-2019 by region. Statewide, the percentage of late diagnoses remained relatively stable from 2015 to 2019, from 22.5% in 2015 to 23.2% in 2019. Over the last five years, the Eastern and Northern regions have had the lowest percentage of late diagnoses. The highest percentages were in the Southwest and Northwest.

Table 7: Percentage of New Diagnoses that are Late Diagnoses by Region, 2015-2019

	Virginia	Central	Eastern	Northern	Northwest	Southwest
2015	**22.5%**	20.5%	20.7%	24.6%	27.8%	23.5%
2016	**24.8%**	26.0%	24.3%	22.5%	26.2%	30.6%
2017	**22.6%**	23.8%	21.4%	22.3%	13.6%	33.3%
2018	**20.9%**	24.0%	21.2%	17.1%	26.5%	16.7%
2019	**23.2%**	21.6%	20.8%	22.6%	34.7%	30.8%

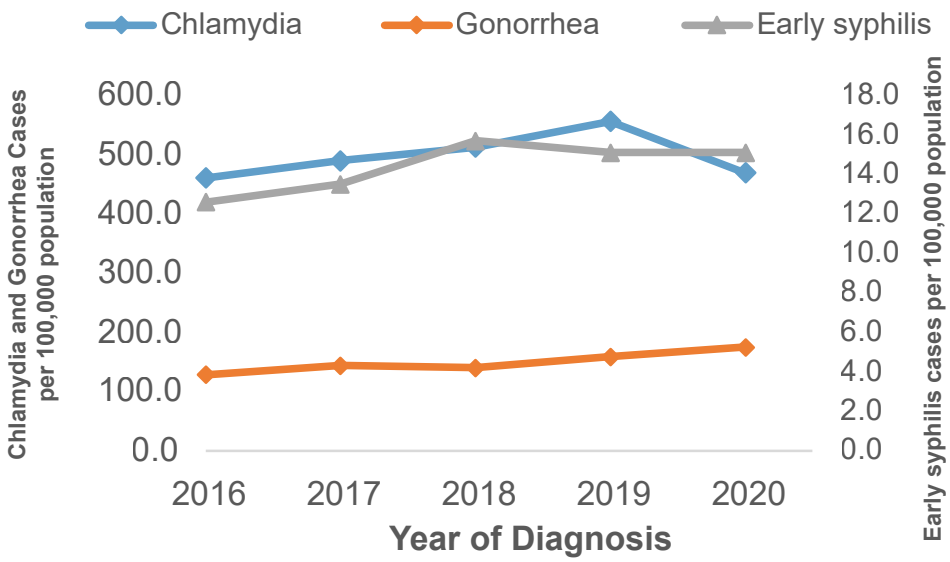
People who Experience Risk for HIV infection

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 following2:

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

The "Five Year Trends" section of the Epidemiologic Snapshot describes these factors and the association with new HIV diagnoses in Virginia (page 26). Other factors that increase one's risk of getting or transmitting HIV include viral load, other STIs, and alcohol and drug use3. As shown in Figure 6, rates of chlamydia, gonorrhea, and early syphilis increased from 2016 to 2019. Although Figure 6 depicts a decrease in chlamydia rates in 2020, interpret 2020 data with caution due to the impacts of COVID-19. Throughout the timeframe in Figure 6, rates of chlamydia increased 2%, gonorrhea increased 36%, and early syphilis increased 20%. As described by the CDC, people who have a STI may be at an increased risk of getting HIV, and in the U.S., both syphilis and HIV are highly concentrated epidemics among gay, bisexual, and other men who have sex with men4. CDC states that men who get syphilis are at a very high risk of a future HIV diagnosis. In 2015, Virginia's data mirrored that of New York City which showed that 1 in 20 MSM diagnosed with primary and secondary syphilis received an HIV diagnosis within a year and 1 in 15 MSM diagnosed with anorectal chlamydia/ gonorrhea received a HIV diagnosis within a year.

Figure 6. Rates of Chlamydia, Gonorrhea, and Early Syphilis Diagnoses, 2016 - 2020



Considerations of SDOH enable a better understanding of populations with risk factors for and disproportionately impacted by HIV. Social determinants of health (SDOH) "are 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"5. Healthy People 2030, describes five domains of SDOH:

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

According to the CDC 2020 HIV Surveillance Supplemental Report6, which accounts for individual attributes and SDOH," addressing SDOH also helps to quantify health differences between populations or geographic areas and can provide additional insight". This 2020 Supplemental Report identifies several factors using national geocoded data on persons aged 18 years and older with HIV infection diagnosed in 2018. The highest HIV diagnoses rate for both sexes in all racial/ethnic groups and all transmission categories were among those who lived in census tracts where:

- 18% or more of the residents lived below the federal poverty level
- 18% or more of the residents had less than a high school diploma
- The median household income was less than $42,000 a year
- 15% or more of the residents did not have health insurance or a health coverage plan

**NOTE:* There may be correlation between some SDOH indicators and/or selected characteristics, but we did not assess correlations of indicators and/or characteristics for this report.

The CDC Supplemental report includes additional information on health disparities and defines them "as avoidable differences in the incidence, prevalence, mortality, and cause of a disease and the related adverse health conditions that exist among specific population groups". Most health disparities are closely tied to SDOH. All factors described in this section substantially impact a person's risk for HIV infection.

People with Undiagnosed HIV

The CDC estimates that 28,400 persons were living with diagnosed or undiagnosed HIV infection in Virginia in 2019, with 3,600 (12.7%) of these persons not knowing their status. The percentage of PWH who do not know their status is estimated to vary among subpopulations. Table 8 shows the estimated percentage of PWH in Virginia who do not know their status by sex at birth, age at infection, race/ethnicity, and transmission category.

Males at birth are estimated to be living with undiagnosed HIV at a higher percentage (13.4%) than females at birth (9.6%). Data show that the percentage of PWH who do not know their status decreases with age at infection, from 39.1% of those infected at age 13-24 to 4.1% of those infected at age 55 or older. Persons of Hispanic/Latino ethnicity are estimated to have the highest percentage of undiagnosed HIV (15.0%) by race/ethnicity. PWIDs are least likely to be living with undiagnosed HIV (4.8%).

Table 8: Estimated[1] percentage of People with HIV who do not know their status

	Estimated persons living with diagnosed or undiagnosed HIV infection	Estimated persons living with undiagnosed HIV infection in Virginia	Estimated percent of People with HIV who do not know their status in Virginia
Virginia	28,400	3,600	12.7%
Sex at birth			
Male	21,600	2,900	13.4%
Female	6,800	650	9.6%
Age at infection (yrs.)			
13-24	1,100	430	39.1%
25-34	5,600	1,500	26.8%
35-44	5,300	810	15.3%
45-54	6,800	420	6.2%
>=55	9,700	400	4.1%
Race/ethnicity			
American Indian/Alaska Native	20	0	0.0%
Asian	430	50	11.6%
Black, non-Hispanic	16,400	2,100	12.8%
Hispanic/Latino[2]	2,800	420	15.0%
Native Hawaiian/Other Pacific Islander	10	0	0.0%
White, non-Hispanic	7,800	900	11.5%
Multiple races	910	130	14.3%
Transmission category[3]			
Male-to-male sexual contact	17,000	2,400	14.1%
Injection drug use	2,500	120	4.8%
--Male	1,400	70	5.0%
--Female	1,100	50	4.5%
Male-to-male sexual contact and Injection drug use	1,100	110	10.0%
Heterosexual contact[4]	7,800	890	11.4%
--Male	2,100	300	14.3%
--Female	5,700	590	10.4%

[1]Estimates derived by using HIV surveillance and CD4 data for persons aged >=13 years at diagnosis. Estimates rounded to the nearest 100 for estimates of >1,000 and to the nearest 10 for estimates of <=1,000 to reflect model uncertainty. Subgroups may not add to the column total due to rounding.

[2]Hispanics/Latinos can be of any race.

[3]Data by transmission category have been statistically adjusted to account for missing risk-factor information.

[4]Heterosexual contact is with a person known to have, or to be at high risk for, HIV infection.

Overview of Molecular Clusters Identified from 2016 – 2021

Cluster Detection and Response (CDR) is a core HIV surveillance program that identifies groups of related HIV infections in order to stop the spread of HIV. Virginia's CDR 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, HIV DNA or RNA, are imported into a VDH HIV surveillance database and analyzed to assess similarities in the genotype. Genetically linked genotypes are at least 99.5% similar, and indicate that transmission somehow occurred between those individuals, either directly or through a common source. The CDR program uses HIV genotypes to identify priority clusters, defined as a cluster of at least five individuals diagnosed in the previous 12 months who have genetically linked HIV genotypes. The HIV transmission rate in priority clusters is more than 10 times higher than the rate of HIV transmission in the entire population of PWH. Once VDH identifies priority clusters, staff focus treatment and prevention efforts on these areas of high HIV transmission to stop HIV transmission.

Since 2016, Virginia's CDR program identified 13 priority molecular clusters. Table 9 provides a summary of the priority clusters. Please note several limitations for these data. First, cluster 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, the clusters do not include every person potentially linked to the cluster. There could be PWH genetically linked to the molecular cluster that we have not been able to identify because they are yet to be diagnosed or they have been diagnosed but have not had an HIV genotype test. Third, please note the difference between a molecular cluster and a transmission cluster. A molecular cluster refers to genetically linked individuals. The transmission cluster includes individuals in the molecular cluster and all named partners of individuals with HIV in the molecular cluster. These clusters include named partners to help describe/identify characteristics of a larger picture of the clusters, and help focus treatment and prevention efforts. Finally, CDC conducts national cluster analysis quarterly on genotypes from all jurisdictions, allowing identification of cross-jurisdictional molecular clusters. Note that national analysis identified cluster names that begin with "CDC". Virginia's local molecular analyses identified cluster names beginning with "VA".

Table 9. Priority Molecular Cluster Summary

Cluster Name	Year	Size	Sex at birth	Race	Age	Region	Risk	Suppressed
CDC_201606_53	2016	58	Male	Black, White	20-39	Eastern	MSM, IDU, Heterosexual	76%
CDC_201606_153	2016	40	Male	Black	20-29	Central, Eastern	MSM	69%
CDC_201712_731	2018	37	Male	Black	20-39	Central, Northern, Eastern	MSM	72%
CDC_201803_628	2018	2*	Male	Hispanic	20-39	Northern	MSM	100%
VA_201805_075	2018	13	Male	Black	13-29	Central, Eastern	MSM	58%
CDC_201812_845	2018	10	Male	Black	20-29	Central, NW	MSM	90%
CDC_201812_3005	2018	13	Male	Black	20-29	Eastern	MSM	62%
VA_201901_090	2019	10	Male	White, Hispanic	30-39	Northern	MSM	90%
VA_201911_115	2019	9	Male	White	30-39	Eastern	MSM, MSM/IDU	67%

Cluster Name	Year	Size	Sex at birth	Race	Age	Region	Risk	Suppressed
VA_202004_617	2020	28	Male	White	20-59	NW, SW	MSM	93%
VA_202005_091	2020	14	Male	Black, White, Hispanic	20-29	Central	MSM	86%
CDC_202006_1390	2020	12	Male	Black, White	20-49	Eastern	MSM	58%
VA_202107_278	2021	29	Male	Black	20-39	Eastern	MSM	72%

*Cluster consists of 19 individuals from multiple jurisdictions; 2 of the 19 are located in Virginia

2020 HIV Care Continuum

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

Virginia's 2020 HIV Continuum of Care 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 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, 2020: the number of persons with HIV aware of their status, diagnosed, with a last known residence in Virginia as of 12/31/2020
- Newly diagnosed and linked to HIV care within 30 or 90 days: persons newly diagnosed in Virginia in 2020 and linked to HIV care within 30 or 90 days from initial diagnosis
- Evidence of HIV care in 2020: Persons with HIV as of 12/31/2020 who had at least one care marker in calendar year (CY) 2020
- Retained in HIV care in 2020: Persons with HIV as of 12/31/2020 who had at least two care markers at least three months (90 days) apart in CY 2020
- Virally suppressed in 2020: Persons with HIV as of 12/31/2020 with their most recent viral load in CY 2020 measuring at <200 copies/milliliter (mL)

Figure 6 shows the statewide measures for each of the four care continuum metrics.

Figure 6: HIV Continuum of Care in Virginia, 2020

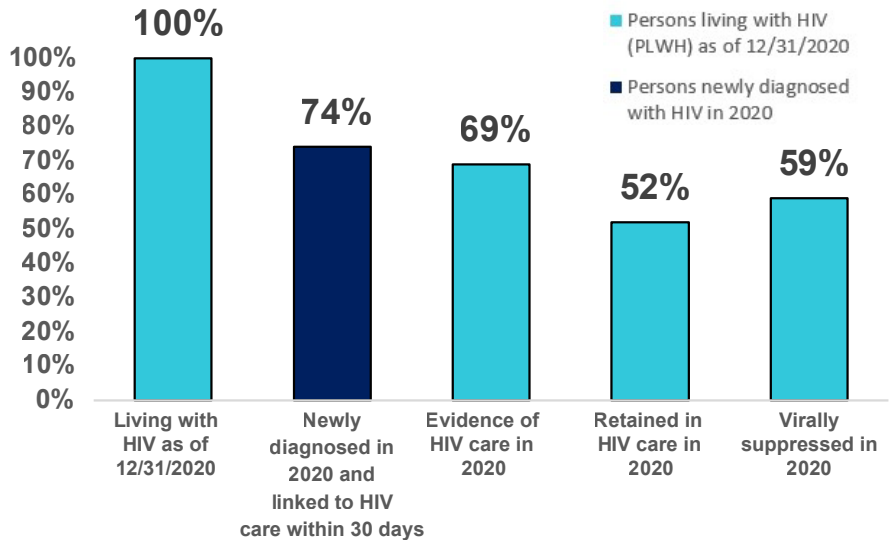


Figure 7 shows the Norfolk TGA measures for each of the four care continuum metrics.

Figure 7: HIV Continuum of Care in the Norfolk TGA, 2021

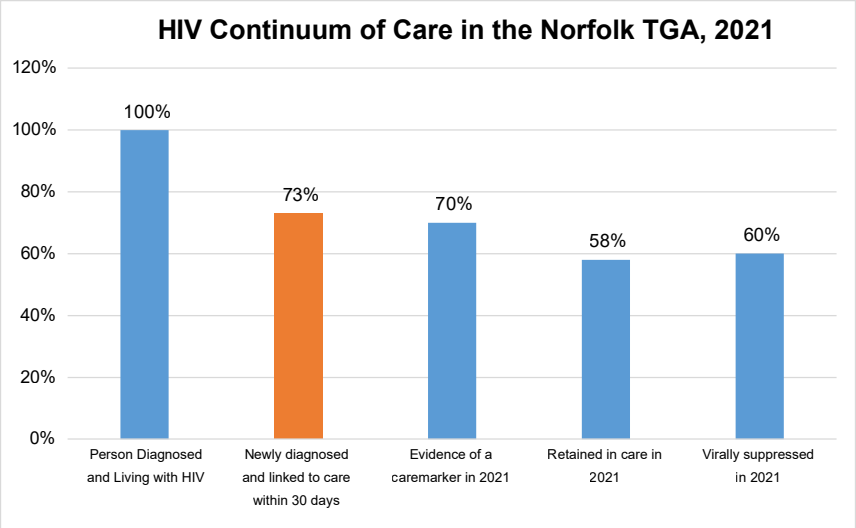


Table 10 summarizes Virginia's HIV Continuum of Care for several subpopulations of PWH including by sex at birth, current gender, race/ethnicity, transmission risk, health region, and age group. As noted in Table 10 and the figures that follow, there are some significant disparities across subpopulations. The most notable disparities, defined as three or more percentage points less than Virginia's overall percentage, are highlighted in bold italics and grey shading (Table 10).

Table 10: Virginia 2020 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	74% (86%)	69%	52%	59%
Sex at birth				
Males	75% (86%)	68%	51%	59%
Females	77% (87%)	71%	54%	61%
Current gender				
Transgender MtF	100% (100%)	67%	48%	57%
Transgender FtM	82% (100%)	76%	53%	60%
Cisgender	74% (86%)	69%	52%	59%
Race/ethnicity				
Black, non-Hispanic	71% (85%)	70%	52%	58%
White, non-Hispanic	79% (88%)	70%	51%	63%
Hispanic/Latino	88% (93%)	62%	50%	55%
Transmission Risk				
MSM	78% (88%)	73%	54%	63%
IDU	67% (87%)	59%	46%	52%

Population	Linked to Care within 30 days (within 90 days)	Evidence of Care	Retained in Care	Virally Suppressed
MSM & IDU	100% (100%)	69%	55%	59%
Heterosexual contact	73% (86%)	73%	56%	63%
Health Region				
Central	69% (83%)	72%	53%	61%
Eastern	73% (88%)	69%	51%	58%
Northern	78% (84%)	62%	44%	55%
Northwest	85% (92%)	76%	63%	67%
Southwest	76% (88%)	78%	64%	66%
Age group* (years)				
15-24	77% (90%)	78%	53%	60%
25-34	74% (83%)	72%	51%	57%
35-44	76% (90%)	71%	52%	59%
45-54	73% (87%)	69%	51%	60%
55+	69% (81%)	66%	52%	60%

**Note: Age is assessed for PWH by current age as of December 31, 2020 and for newly diagnosed persons in 2020 (linkage to care) by age at diagnosis.*

As described in Table 10 the Eastern region, inclusive of the Norfolk TGA, reported 73% linked to care within 30 days and 88% linked to care within 90 days. Compared to Virginia statewide continuum data, the Eastern region is within one percent for linked to care data, retained in care, and virally suppressed/virally suppression categories and the same for evidence in care. Compared to the other health regions, only Central health region has a lower percentage of individuals linked to care within 30 days, and only Northern health region has lower percentages of individuals retained in care and virally suppressed.

Table 11 reorganizes the information from Table 10 and ranks from best to worst HIV-related outcome. Each column represents a component of the HCC and then lists specific populations groups (including health regions, demographics, such as age range, current gender, race/ethnicity, and transmission risk category) in order from Best to Worst HIV-related outcome. Specific population groups with the best HIV-related outcomes are closer to the top and those with the worst HIV-related outcomes are closer to the bottom.

The grey shaded boxes in Table 11 indicate that the greatest disparities are in populations that are at least five percentage points below Virginia's average. Persons who inject drugs (PWID), those in the Northern region, and the Hispanic/Latino population show the largest disparities across the four measures. The pattern of disparities remains similar to previous years, with a notable improvement among nearly all populations since the last integrated plan. Statewide, linkage to care increased from 69% to 74%, evidence of care improved from 57% to 69%, retention in care increased from 42% to 52%, and viral suppression increased from 38% to 59%.

Table 11: Virginia's 2020 HIV Continuum of Care Data for Specific Population Groups in Order from Best to Worst HIV-Related Outcome

Best ↓ Worst	Linked to Care (30 days)		Evidence of Care		Retained in Care		Virally Suppressed	
	Transgender FtM	100%	Southwest	78%	Southwest	64%	Northwest	67%
	MSM & IDU	100%	15-24 years	78%	Northwest	63%	Southwest	66%
	Hispanic/ Latino	88%	Transgender MtF	76%	Heterosexual contact	56%	White, non-Hispanic	63%
	Northwest	85%	Northwest	76%	MSM & IDU	55%	Heterosexual contact	63%
	Transgender MtF	82%	MSM	73%	Females	54%	MSM	63%
	White, non-Hispanic	79%	Heterosexual contact	73%	MSM	54%	Females	61%
	MSM	78%	Central	72%	Transgender MtF	53%	Central	61%
	Northern	78%	25-34 years	72%	Central	53%	Transgender MtF	60%
	15-24 years	77%	Females	71%	15-24 years	53%	15-24 years	60%
	35-44 years	76%	35-44 years	71%	Cisgender	52%	45-54 years	60%
	Southwest	76%	Black, non-Hispanic	70%	Black, non-Hispanic	52%	55+ years	60%
	Females	75%	White, non-Hispanic	70%	35-44 years	52%	Virginia	59%
	Virginia	74%	Virginia	69%	55+ years	52%	Males	59%
	Males	74%	Cisgender	69%	Virginia	52%	Cisgender	59%
	Cisgender	74%	MSM & IDU	69%	Males	51%	MSM & IDU	59%
	25-34 years	74%	Eastern	69%	White, non-Hispanic	51%	35-44 years	59%
	Heterosexual contact	73%	45-54 years	69%	Eastern	51%	Black, non-Hispanic	58%
	Eastern	73%	Males	68%	45-54 years	51%	Eastern	58%
	45-54 years	73%	Transgender FtM	67%	25-34 years	51%	Transgender FtM	57%
	Black, non-Hispanic	71%	55+ years	66%	Hispanic/ Latino	50%	25-34 years	57%
	55+ years	69%	Hispanic/ Latino	62%	Transgender FtM	48%	Hispanic/ Latino	55%
	Central	69%	Northern	62%	IDU	45%	Northern	55%
	IDU	67%	IDU	59%	Northern	44%	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.

Table 11 shows that the Eastern region has worse health related health outcomes than the state average, however it is not at or greater than 3% points below the Virginia average in any HCC category.

2020 Ryan White Services HIV Care Continuum

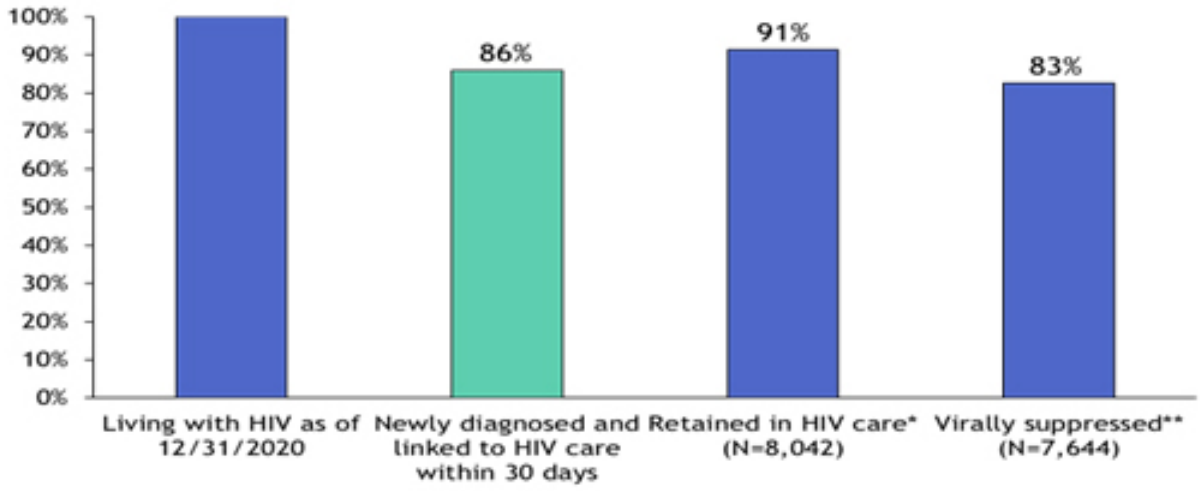
DDP routinely reviews the HIV care continuum for clients receiving Ryan White services. HRSA performance measures dictate the calculation of the Ryan White HIV care continuum; therefore, the metrics differ slightly from the statewide continuum. Whereas the statewide continuum uses the full population of persons with HIV 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.

Linkage to care within 30 days of diagnosis is higher among Ryan White clients compared to all PWH (86% vs. 75%). Additionally, retention in care is very high among Ryan White clients (91%). Viral suppression, is calculated only among 7,644 of the 8,053 Ryan White clients due to inclusion eligibility criteria by metric definition, is higher than the statewide rate (83% vs. 58%).

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 works to mitigate barriers to care and improve health outcomes, which may improve access to care and treatment. Ryan White-funded providers are also required to report service utilization, which leads to better reporting of health outcomes. Gaps exist in data availability for many PWH in Virginia.

Figure 8 below shows the 2020 HIV continuum of care among Ryan White clients.

Figure 8: HIV Continuum of Care for Ryan White clients in Virginia, 2020



Note: HIV Continuum of Care data as of May 2021

**Ineligible for retention in care calculation: Those without a care marker in the respective timeframe or those who died during the timeframe*

***Ineligible for viral suppression calculation: Those without an outpatient/ambulatory medical care visit in the respective timeframe*

Priority Populations for Prevention and Care

The 2022-2025 National HIV/AIDS Strategy (NHAS) prioritizes efforts to reduce disparities and improve HIV outcomes for priority populations. These priority populations include:

- Gay, bisexual, and other MSM, in particular Black, Latino, and American Indian/Alaska Native men
- Black women
- Transgender women
- Youth aged 13-24 years
- People who inject drugs (PWID)
- Pregnant persons with HIV

Virginia identifies an additional priority population as PWH who are age 65 and older. Tables 12 and 13 show the number of new diagnoses in Virginia among the five priority populations and aging PWH from 2016 through 2020 and the total number of PWH in each priority population by health region as of December 31, 2020. Table 14 describes the four key measures of the HIV care continuum for the priority populations.

MSM

The HNSP specifies the first priority population as gay, bisexual, and other MSM, particularly Black, Latino, and American Indian/Alaska Native men. Virginia has added Asian/Hawaiian/Pacific Islanders to this priority population. MSM of color are the largest of the priority populations, representing between 36.8% and 45.6% of all new diagnoses from 2016 to 2020, with Black, non-Hispanic MSM representing the largest share of the race/ethnicity groups (29.1% to 37.7%). Statewide, 31.2% of all PWH are Black, Latino, Asian/Hawaiian/Pacific Islander, or American Indian/Alaska Native MSM. This varies by health region, with the highest proportion in the Central region (35.0%) and the lowest proportion in the Southwest region (22.3%). The largest race/ethnic group in each region was Black, non-Hispanic MSM (18.1% to 31.6%) followed by Latino MSM (2.5% to 11.2%). Each metric of the HIV care continuum was two to four percentage points higher among this priority population than the Virginia state average.

Black Women

In Virginia, from 2016 to 2020, between 13.0% and 15.3% of new diagnoses were among Black women. As of December 31, 2020, 18.2% of all PWH statewide were Black women, with the highest proportion in the Eastern region (20.1%) and the lowest proportion in the Northwest (14.5%). Black women had similar 30-day linkage to care rates compared to the Virginia average, but better evidence of care, retention in care, and viral suppression compared to the statewide average.

Transgender Women

Transgender women make up the smallest percentage of the five priority populations. As VDH's HIV surveillance system does not always receive reports of transgender status, this data may be incomplete, resulting in an underestimate. VDH has made progress in reporting transgender status. As reported, between 1.5% and 2.6% of new diagnoses were among transgender women from 2016 to 2020. Transgender women have the highest 30-day linkage to care rate and second highest evidence of care rates of any priority population. Retention in care and viral suppression are similar among transgender women as the statewide average.

Youth aged 13-24

In Virginia, nearly one in four new diagnoses were among youth aged 13-24 between 2016 and 2020, whereas only 2.7% of all PWH fall into this age group statewide, with the highest percentage of youth in the Eastern region (3.3%) and lowest percentage in the Northern region (2.1%). In terms of new diagnoses, most occurred among youth aged 21-24 (67% on average between 2016-2020), while 28% were among youth aged 18-20 and less than 5% were among youth aged 13-17. Youth aged 13-24 have higher 30-day linkage to care and evidence of care rates than the statewide average. Viral suppression and retention in care among youth aged 13-24 is similar to the statewide average.

People who Inject Drugs

The category PWID includes individuals who reported "injection drug use" alone or both "injection drug use and MSM" as an HIV risk factor. This population comprised about 3.5%-4.9% of Virginia's new HIV diagnoses from 2016 to 2020. Statewide, 9.9% of all PWH are PWID, with the highest percentage in the Southwest region (12.8%) and the lowest percentage in the Northern region (6.6%). PWID have higher 30-day linkage to care rates than the statewide average, but lower evidence of care, retention in care, and viral suppression rates. PWID remain a priority population due to high prevalence of hepatitis c (HCV) in this population and the potential for a HCV/HIV outbreak.

PWH aged 65 and older

Over the past five years, new diagnoses among people aged 65 and older ranged from 2.6% in 2019 to 1.4% in 2020. A larger percentage of Virginians with HIV fall into this age category. The Northern region has the highest percentage of PWH aged 65 and older (13.2%) while the Eastern region had the lowest percentage (10.9%). Linkage to care rates was lowest among newly diagnosed persons aged 65 and older compared to any other priority population (56% linked within 30 days). Evidence of care was also considerably lower than the statewide rate (62% vs. 69%). Compared to Virginian's overall, retention in care and viral suppression were slightly lower among PWH aged 65 and older.

Table 12: Number and Percent of all New Diagnoses among Priority Populations, 2016-2020

	2016		2017		2018		2019		2020	
	N	%	N	%	N	%	N	%	N	%
All New Diagnoses	922	100.0%	889	100.0%	885	100.0%	852	100.0%	631	100.0%
MSM of color	379	41.1%	327	36.8%	352	39.8%	380	44.6%	288	45.6%
Black MSM	297	32.2%	259	29.1%	269	30.4%	311	36.5%	238	37.7%
Latino MSM	72	7.8%	53	6.0%	70	7.9%	59	6.9%	43	6.8%
Asian/ Hawaiian/ Pacific Islander MSM	9	1.0%	15	1.7%	11	1.2	8	0.9%	7	1.1%
American Indian/Alaska Native MSM	1	0.1%	0	0.0%	2	0.2%	2	0.2%	0	0.0%
Black women	122	13.2%	124	13.9%	135	15.3%	115	13.5%	82	13.0%
Transgender women	23	2.5%	23	2.6%	19	2.1%	13	1.5%	11	1.7%
Youth 13-24	218	23.6%	218	24.5%	200	22.6%	172	20.2%	143	22.7%
PWID	34	3.7%	31	3.5%	41	4.6%	42	4.9%	23	3.6%
PWH age 65+	22	2.4%	20	2.2%	22	2.5%	22	2.6%	9	1.4%

Note: PWID includes risk factors of "IDU" and "IDU & MSM"

Table 13: Number and Percent of all People with HIV among Priority Populations by Region

	Central		Eastern		Northern		Northwest		Southwest	
	N	%	N	%	N	%	N	%	N	%
All PWH	6,000	100.0%	7,812	100.0%	6,946	100.0%	2,310	100.0%	2,184	100.0%
MSM of color	2,102	35.0%	2,712	34.7%	2,157	31.1%	536	23.2%	486	22.3%
Black MSM	1,895	31.6%	2,470	31.6%	1,256	18.1%	429	18.6%	419	19.2%
Latino MSM	184	3.1%	195	2.5%	779	11.2%	94	4.1%	55	2.5%
Asian/ Hawaiian/ Pacific Islander MSM	21	0.4%	40	0.5%	114	1.6%	12	0.5%	10	0.5%
American Indian/Alaska Native MSM	2	0.0%	7	0.1%	8	0.1%	1	0.0%	2	0.1%
Black women	1,104	18.4%	1,573	20.1%	1,252	18.0%	335	14.5%	336	15.4%
Transgender women	78	1.3%	114	1.5%	43	0.6%	18	0.8%	9	0.4%
Youth 13-24	170	2.8%	258	3.3%	146	2.1%	57	2.5%	53	2.4%
PWID	711	11.9%	768	9.8%	459	6.6%	275	11.9%	279	12.8%
PWH age 65+	766	12.8%	852	10.9%	918	13.2%	301	13.0%	251	11.5%

Note: PWID includes risk factors of "IDU" and "IDU & MSM"

Table 14: HIV Care Continuum Outcomes among Priority Populations, 2020

	Linked to Care (30 days)	Evidence of Care	Retained in Care	Virally Suppressed
Virginia	74%	69%	52%	59%
MSM of color	78%	72%	54%	61%
Black MSM	75%	73%	55%	61%
Latino MSM	95%	67%	53%	59%
Asian/Hawaiian/ Pacific Islander	71%	74%	57%	69%
American Indian/ Alaska Native MSM	N/A	60%	45%	55%
Black women	74%	73%	54%	62%
Transgender women	81%	76%	53%	61%
Youth 13-24	77%	78%	52%	60%
PWID	78%	62%	49%	54%
Aging PWH	56%	62%	50%	57%

Notes: PWID includes risk factors of "IDU" and "IDU & MSM

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B. HIV Prevention Care, and Treatment Resource Inventory

Funding Streams Supporting HIV Prevention, Care and Surveillance in Virginia

Public funding for HIV activities is provided through a number of sources including: the Department of Medical Assistance Services, which manages Virginia Medicaid; the CDC, which supports activities for HIV prevention and surveillance; HRSA that funds both HIV care, supportive services, and medication access through the Ryan White CARE Act, and primary care services in underserved areas through the HRSA Health Center Program; and U.S. Department of Housing and Urban Development (HUD) that funds Housing Opportunities for People with AIDS (HOPWA).

Medicaid: Virginia expanded Medicaid in 2019, which increased access to primary care for people with and those that experience risk for HIV infection, especially for those seeking PrEP. No HRSA funds and limited CDC funds can be used to pay for prescribing or purchasing PrEP medications. As of April 2022, 2,013,157 Virginians enrolled in Medicaid, with a cumulative total of 651,254 people enrolled under the expansion criteria. Of those enrolled under the expansion, 45% are between the ages of 19 and 34. More than 55% of Virginia's new HIV diagnoses in 2020 were among this age group. In 2020, an estimated 7,293 PWH accessed antiretroviral (ARV) medication through Medicaid.

Medicare: Virginia has an aging PWH population. In 2020, 12% of PWH were 65 and older and Virginia anticipates 11% will become 65 or older within the next five years. In 2021, 21.9% of Virginia Medication Access Program (VA MAP) clients were between the ages of 55-64 and will likely transition to Medicare within the next 5-10 years.

Federally Qualified Health Centers (FQHC): HRSA funds 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 2021, HRSA funded 30 FQHCs in Virginia to provide primary care services in underserved areas. In 2021, those sites expended a total of $93,409,211 on all primary care services. VDH partners with a limited number of FQHCs to fund HIV, HCV, hepatitis B virus (HBV), and STI testing to uninsured patients.

CDC HIV Prevention and Surveillance: From 2018 through 2022, Virginia received $8,281,767 annually in CDC funds for its Integrated HIV Surveillance and Prevention Cooperative Agreement with $1,252,593 awarded for HIV Surveillance and $7,029,174 awarded for HIV Prevention. This is a $698,756 decrease from 2017 award levels. These funds support the majority of surveillance and prevention activities along **11 core strategies and activities.** Priority populations for VDH's prevention services include Black, White, and Latino gay, bisexual, and other MSM, PWID, Black and Latino heterosexuals and transgender persons.

Supported prevention activities include HIV testing and linkage to care, case investigations carried out by DIS, status neutral service navigation to connect people services supporting the social determinants of health, condom distribution, PrEP and nPEP, CHR, behavioral interventions, public information and social media activities. Funds used are to supplement STI, hepatitis B and C testing. There are no eligibility determinations needed to access HIV prevention services.

Virginia is not a recipient of the federal EHE funding. Federal HIV prevention funding may not be used to purchase vaccines, medications for HIV, PrEP or nPEP, clinical care for PrEP and nPEP, syringes, housing, mental health care, or substance use disorder treatment for persons with risk factors for HIV or those with HIV.

DDP receives funds for core surveillance and supplemental surveillance activities including the MMP, and the National HIV Behavioral Surveillance project (NHBS). The Virginia MMP uses medical record abstraction and patient interview to provide a snapshot of the HIV epidemic among a representative sample of PWH. VDH's MMP interviews approximately 400 PWH to obtain demographics, medical history, insurance, housing, and income status. Labs, medical visits, medication history, and other information are also collected. The NHBS is a cross-sectional survey that collects data related to HIV behavioral risk factors, HIV testing behaviors, and use of prevention services and strategies. The survey asks participants if they are willing to provide blood samples to assess HIV prevalence. NHBS has three cycles focused on the populations of men who have sex with men, PWID, and heterosexuals.

HRSA Ryan White Services

HRSA funds Part A services through one EMA and one TGA that cover portions of Virginia. The DC EMA covers six cities and 11 counties in Virginia, all of DC, five counties in Maryland, and two in West Virginia. The DC EMA received $31,479,527 in Part A funding in Grant Year (GY) 2021 (March 1, 2020 – February 28, 2021). The Norfolk TGA covers nine cities and five counties in Virginia, and one in North Carolina. The Norfolk TGA received a total of $5,755,914 in GY2021 (March 1, 2020 – February 28, 2021). Part A grants fund both core medical and support services.

VDH administers the HRSA RWHAP B grant. DDP manages the Part B program and funds HIV health care and support services for PWH. RWHAP B funding also supports the AIDS Drug Assistance Program (ADAP) renamed the Virginia Medication Assistance Program (VA MAP) in the Commonwealth. In HRSA GY 2021, (April 2020 – March 2021) VDH received a total of $96,701,460, which includes Base

funding (funding for core medical and support services), ADAP (a subset is dedicated to ADAP Flex to support medication adherence, monitoring of drug treatment, and enhanced access to services), Minority AIDS Initiative (MAI), Emerging Communities (EC), and pharmaceutical rebates MAI funding supports education and outreach to improve minority access to medication assistance programs (e.g. ADAP, Medicaid, or another HIV medication coverage program). EC funding supports all core medical and support HIV services in cities reporting between 500 and 999 reported AIDS cases in the most recent five years.

HRSA directly funds seven agencies in Virginia (at least one in each of the five defined health regions) for RWHAP Part C Early Intervention Services (EIS) for a total of $2,584,472. Part C EIS grants fund primary health care and support services in outpatient settings for people with HIV.

HRSA directly funds two agencies in Virginia (one in the Northern region and one in the Northwest region) for RWHAP Part D services under the Women, Infants, Children, and Youth grant for a total of $824,608. 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.

Pharmaceutical Rebates: VDH earns rebates on medication purchases for clients who receive medication access through health insurance coverage under VA ADAP. VDH must spend rebate allocations in accordance with the regulations and legislation governing Ryan White programs. Rebates have served as a significant source of revenue for the RWHAP B program to reinvest in the program with a priority for ADAP and to strengthen the HIV service delivery system. VDH earned varying amounts of rebates over the years, ranging from $15.6M to the highest amount of $47.1M. VA ADAP continues to provide insurance coverage for eligible clients, thus earning rebates that will be prioritized for VA ADAP or the RWHAP B program for strong and innovative service delivery.

State Funds: Through the Virginia General Assembly, DDP receives an allocation of $5,491,290 in state funds. These funds support infrastructure, administration, staffing, and awards to partner agencies for HIV, STI, and viral hepatitis programs. State funds are a vital component of DDP's response to the HIV epidemic as these funds are often used to provide services not allowable on federal funding streams. VDH uses state funds to support the State Pharmaceutical Assistance Program (SPAP) for antiretroviral medications for eligible clients. State funds also support the Comprehensive HIV/AIDS Resources and Linkages for Individuals experiencing Incarceration (CHARLII) program, the Regional HIV/AIDS Resources and Consultation Centers (VHARCC) to conduct health care provider education, clinical time and medications for HIV PrEP and nPEP, CHR including syringes, and a HCV treatment and provider education program.

HUD: In GY22 (October 1, 2021 – September 30, 2022), the Department of Housing and Community Development ((DHCD) granted approximately $1.28M in HOPWA funds to local governments and community based organizations (CBOs). The City of Virginia Beach awarded nearly $2M in GY22 (October 1, 2021 – September 30, 2022), to LGBT Life Center. The City of Richmond, allocated $1.9M to CBOs for direct services. In GY22 (October 1, 2021 – September 30, 2022), Northern Virginia Regional Commission (NVRC), allocated $2.4M to local CBOs to provide direct services.

Directly Funded CBOs: CDC directly funds two agencies in Virginia for HIV prevention activities. Inova Health System receives a total of for $841,623 for PS21-2102 which funds "Strategic Partnerships in Northern Virginia to Increase HIV Diagnosis, Treatment, Prevention and Response among High-Risk Heterosexual Black, Latinx, and Immigrant Populations" and PS22-2203, which supports comprehensive high impact HIV Prevention Program for Young Men of Color who have sex with Men. LGBT Life Center receives a total $841,625 for the same founding opportunities. They utilize CDC PS21-2102 to serve African American and Multi-Racial MSM, inclusive of Hispanic and Non-Hispanic persons,

30 to 64 years of age with priority HIV testing, integrated STI screening, service navigation for persons at risk for HIV, condom distribution, and behavioral interventions for PWA and persons who experience risk for HIV. Though CDC PS23-2203, they serve Young, African American MSM 16 to 29 years of age with comprehensive high impact prevention interventions.

Allocation of Funds to Partners

Health Districts: DDP supports HIV, STI and hepatitis B and C testing at local health departments (LHDs) by paying the laboratory costs for uninsured STI clinic patients. DDP also supports Disease Intervention Specialists in LHDs to conduct partner services, linkage to HIV, STI and hepatitis medical care, support services and PrEP.

HIV Prevention: VDH has allocated a total of $7,029,174 towards prevention services. Federal funding allocated through contracts is $3,761,291 and supports clinical and non-clinical testing for HIV and HCV, status neutral service navigation, CHR, condom distribution, social marketing and social media, hotline services, HIV home testing program, and PrEP navigation. State funding totals $3,043,838 and partially support a number of programs including CHR, laboratory testing, PrEP clinical time, PrEP/nPEP medication purchases, and CHARII activities not funded with pharmaceutical rebates. HIV prevention funding supports approximately 42 partner agencies both directly and indirectly. The AIDS Services and Education Grants (ASE) Program was established by the General Assembly to award funds for HIV services. The CHARLII program aims to support individuals with HIV or who experience risk for HIV, nearing release, or recently released, from incarceration.

HIV Care: RWHAP B provides high-quality care and treatment for people with HIV (PWH) supported by Part B base, ADAP earmark, MAI, EC, pharmaceutical rebate funds. VDH allocated slightly more than $39M 2021 for the direct provision of Ryan White core medical and support services for PWH with RWHAP B grant dollars, state dollars, and pharmaceutical rebate funds. In 2021, the Ryan White Program served a total of 9,199 clients (Virginia 2021 Ryan White Services Report) and of those, 5,297 clients received either Direct Medication assistance or Health Insurance Premium assistance through the VA MAP (Virginia 2021 ADAP Data Report).

Virginia directly contracts with 33 subrecipients and vendors for 21 RWHAP B allowable services and indirectly with 16 contracts that we fund for allowable services to PWH. Overall, VDH supports 9 core medical services and 12 support services. They include ADAP; Early Intervention Services (EIS); Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals (HIPCSA); Medical Case Management, including Treatment Adherence Services (MCM); Medical Nutrition Therapy (MNT); Mental Health Services (MH); Oral Health Care; Outpatient/Ambulatory Health Services (OAHS); Substance Abuse Outpatient Care (including Medication Assisted Therapy for opioid disorders), Emergency Financial Assistance (EFA); Food Bank/Home Delivered Meals; Health Education/Risk Reduction (HE/RR); Housing; Legal Services; Linguistic Services; Outreach, Medical Transportation; Non-Medical Case Management Services (NMCM); Other Professional Services; Psychosocial Support Services; and Substance Abuse Services (residential).

RWHAP B contracted providers also participate in VDH's Data to Care program which identifies PWH who have not been identified as in care in the past year and utilizes Community Health or outreach workers (Patient Navigators) to review out-of-care lists created by VDH to identify those lost to care clients and re-connect them into care.

As of November 2022, VDH supports 16 sites (direct funding to 15 sites) to provide Rapid Start of Antiretroviral Therapy that includes access to initial ART medications, transportation, and Medical

and Non-Medical Case Management, including intensive case management follow-up beginning the first day following initiation of ART medication through 180 days afterwards. The goal of Rapid Start is to initiate HIV treatment within 14 days of diagnosis, improve retention in care, and to help clients achieve and maintain viral suppression.

The Care Coordination program assists PWH recently released from correctional facilities within the past six months with access to medications and linkage to medical care and support services. The program historically provided an initial 30-day supply of medications and assists clients with enrollment into an insurance plan or VA MAP. With the advent of Virginia Medicaid expansion, many people released from state correctional facilities have access to medications or Medicaid coverage. The Care Coordinators monitored access to medication and medical care for 12 months and assists clients by addressing barriers and linking them to community services. This program is under review at VDH to determine its next iteration to best serve people who are justice involved in not only state correctional facilities, but also local and regional jails.

RWHAP A

The DC EMA funds six providers with RWHAP A funds. They offer a combination of NMCM, EIS, OAHS, Oral Health Care, Mental Health, and Outpatient Substance Use Disorder Services.

The Norfolk TGA Planning Council funds nine providers with RWHAP A funds. They provide a combination of services, including MCM, NMCM, EIS, HIPCSA, OAHS, Medical Transportation, and Oral Health Care. The Norfolk TGA provided services to 2,463 clients in GY2021 (March 2021-February 2022).

RWHAP C and D

There are seven RWHAP C providers, including at least one Part C provider in four of the five defined health regions. Part C agencies provide outpatient ambulatory health services and support services in outpatient settings for people with HIV.

RWHAP C Providers		
Carilion Medical Center	Roanoke (Southwest)	VA
Community Access Network	Lynchburg (Southwest)	VA
Eastern Virginia Medical School	Norfolk (Eastern)	VA
INOVA Health Care Services	Springfield (Northern)	VA
Mary Washington Hosp./Medicorp Health System	Fredericksburg (Northwest)	VA
University of Virginia	Charlottesville (Northwest)	VA
Virginia Commonwealth University	Richmond (Central)	VA

There are two RWHAP D providers in the state: Inova Juniper located in the Northern region and the University of Virginia located in the Northwest region. Both provide outpatient family-centered primary and specialty medical care and support services. These services help low-income women, infants, children, and youth with HIV.

Housing: As of 2022, 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, which provides security deposits and other move-in costs;

Tenant-Based Rental Assistance, which provides participants with housing vouchers for use in the private rental market; Supportive Services, typically housing-focused case management; and Short Term Rent, Mortgage, and Utility Assistance, 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.

HIV Prevention and Treatment/Care Services by Health Region as of November 2022

Central Region has total of 16 contractors; nine fully funded sites, four supported sites, and three LHDs. Ten of these sites provide testing for HIV and hepatitis. There are two sites that offer PrEP; one is a health department and the other is a CBO. Five agencies provide SNSN. One contractor provides services to transgender women though the ASE program. One site funded for CHR and one that provides CHARLII services throughout the region Populations served include but are not limited to PWH, MSM, PWID, heterosexuals, trans men, trans women, and people of color. There are nine RWHAP B providers in the region that provide core medical and support services for PWH.

Eastern Region has a total of sixteen contractors; eight fully funded sites, eight supported sites, and six LHDs. Eight sites provide HIV and hepatitis testing. Two agencies provide SNSN. Three is one regional CHARLII site. The region's first CHR site will begin operations in early 2023. Populations served include but are not limited to PWH, MSM, PWID, heterosexuals, trans men, trans women, and people of color. There are five RWHAP B providers in the region that provide core medical and support services for PWH.

Northern Region has a total of nine contractors; eight fully funded sites, one supported site, and one LHD. Four sites provide HIV and hepatitis testing. One agency provides SNSN. One contractor has two agreement for ASE services: one for people who use drugs and one for Latina transgender women. CHR services are provided by one agency. One contractor provides CHARLII services. Populations served include but are not limited to PWH, MSM, PWID, heterosexuals, trans men, trans women, and people of color. There are seven sites that offer PrEP; one is a health departments and six are part of a hospital system. There are five RWHAP B providers in the region that provide core medical and support services for PWH.

Northwest Region has a total of eight contractors; five fully funded sites, three supported sites, and two LHDs. Six sites provide HIV and hepatitis testing. Two agencies provide SNSN. One agency administers CHR. One contractor provides CHARLII. Populations served include but are not limited to PWH, MSM, PWID, heterosexuals, trans men, trans women, and people of color. There is one HD site that offers PrEP. There are six RWHAP B providers in the region that provide core medical and support services for PWH.

Southwest Region has a total of ten contractors; five fully funded sites, five supported sites, and four LHDs. Three sites provide HIV and hepatitis testing. One agency provides SNSN. DDP has one contractor providing ASE. CHR is conducted by two health departments and one CBO, with an additional agency beginning services in late 2022. CHARLII is provided by one contractor. Populations served include but are not limited to PWH, MSM, PWID, heterosexuals, trans men, trans women, and people of color. Three RWHAP B providers in the region provide core medical and support services for PWH.

Integration of Services for People who Use Drugs and Alcohol

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) support forty community services boards (CSBs) in Virginia (similar to LHDs for VDH). All CSBs provide substance use disorder treatment either directly or by referral. CSBs offer various combinations of 10 core services: emergency, ancillary, consumer-run, local inpatient, outpatient, case management, day support, employment, residential, and prevention services. DBHDS promotes and supports the REVIVE training program, which educates individuals on administering naloxone to reverse opioid overdoses. In 2019, the CSBs provided services to 218,851 unduplicated clients including mental health services, developmental services, substance use disorder services, and both emergency and ancillary services (motivational treatment, consumer monitoring, assessment and evaluation, and early intervention services).

Three agencies in Virginia also receive funding directly from Substance Abuse and Mental Health Services Administration (SAMHSA) to provide services to PWH to directly address substance use disorder and mental health disorders. These agencies are located in the Northwest and Southwest regions. Total funding allocations equal $655,063 for services including case management, counseling, outreach services, peer support, and peer recovery services.

DDP supports services for people who use drugs through a variety of mechanisms. RWHAP B and CHARLII programming provide outpatient and residential substance use disorder services either directly or through referral, for PWH. In addition, VDH includes five opioid use disorder treatment medications as well as an opioid reversal agent, in its HIV medication formulary.

In 2017, the Virginia General Assembly passed CHR legislation in response to the Opioid Public Health Crisis. Virginia had eight counties considered at high risk for an HIV or HCV outbreak related to injection drug use. In 2020, Virginia revised its CHR legislation to lift restrictions on geographic eligibility, remove requirements for law enforcement approval and to give CHR participation protection from prosecution for possession of paraphernalia acquired through the program.

Virginia's CHR programs include the distribution of sterile and disposal of used hypodermic needles and syringes. The CHR program also provides access to naloxone, fentanyl test strips, educational materials, referrals to drug treatment, HIV/HBV/HCV/TB/STI testing, distributes condoms, and provides counseling and an array of other health services including referrals to mental health services, health insurance enrollment, family planning, PrEP and nPEP.

DDP's drug user health coordinator serves on several committees to help mobilize community support for CHR and to provide technical assistance to interested agencies and jurisdictions. Committees include: The Virginia Overdose Prevention Resource Collaborative, the DDP Rapid Response Committee; the SAMHSA Region 3 Harm Reduction Group, the DBHDS Opioid Crisis workgroup, and the DC Metro Harm Reduction Group

DDP, the Division of Pharmacy Services, and the DBHDS collaborated to initiate the Naloxone (Narcan) Partner Program. This program allows some agencies, to receive free naloxone (Narcan) from VDH. The goal is to distribute naloxone directly to individuals who take opioids or to their peers/partners in order to increase access to this life-saving drug. Partner sites must complete online or in-person training in REVIVE, 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. Funding is provided by DBHDS grants and funds from the General Assembly; however, demand is quickly outpacing resources. Securing additional funding will be a priority moving forward.

VDH received a State Opioid Response (SOR) Grant through the Office of Emergency Preparedness from DBHDS. The SOR grant funded local health department personnel for opioid response. The opioid response personnel providing community education, hired a number of peer recovery coaches, and purchased Naloxone. The Office of Injury Prevention receives funding from CDC for overdose prevention to purchase fentanyl test strips for CHR programs.

DMAS provides behavioral health and 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 lifted restrictions that 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 (HBV) and hepatitis C (HCV) testing, and PrEP and nPEP. Since the last integrated plan, VDH now offers extra-genital testing (specimens are collected from the throat and rectum) for chlamydia and gonorrhea to diagnose and treat infections that would otherwise be missed, and to identify those at highest risk for HIV who are candidates for PrEP.

DDP supports rapid HIV testing at 16 community-based organizations (CBO), seven of which are also able to conduct conventional HIV testing via phlebotomy and extragenital testing for chlamydia and gonorrhea. Of these 16 CBOs, seven also provide screening for one or more STIs, and 12 provide HCV screening. All clients 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 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. Many sites are partnering with HCS Rapid Start locations to ensure fastest access to ARVs.

While LHDs now bill insured clients for STI clinical services, the uninsured, and patients referred by DIS or from a partner CBO can receive follow-up HIV and STI services without charge.

DIS services are integrated to provide partner services for both STIs and HIV and conduct data to care activities. Support of DIS is a combination of pharmaceutical rebates, CDC-funded cooperative agreements for both HIV and STIs and state funds. In 2021, VDH received supplemental STI funds from CDC. Prior to receipt of this award, VDH employed 5 Regional STD Program Coordinators (RSPC) and 51 DIS. Receipt of the STI supplemental funds enabled VDH to create six additional RSPC and 30 additional DIS positions.

VDH also receives funds from the CDC for the STD Prevention and Control for Health Departments (PCHD) to implement and strengthen STD prevention and control programs. The purpose of the PCHD grant is to prevent and control three major STIs: chlamydia, gonorrhea, and syphilis. PCHD supports strategies and activities to eliminate congenital syphilis; prevent drug resistant gonorrhea; reduce primary and secondary syphilis; prevent STI-related pelvic inflammatory disease, ectopic pregnancy, and infertility; address STI-related outbreaks; and reduce STI-related health disparities.

In 2021, VDH received funds to support integrated viral hepatitis surveillance and prevention programs through cooperative agreement PS21-2103. 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 syringe services programs (SSPs), and among high-burden populations). Funding for this program is minimal and therefore HIV prevention and general funds play an integral role in funding hepatitis activities.

In September 2022, the Division of Surveillance and Investigation transferred hepatitis surveillance activities and the hepatitis B Perinatal Program to DDP to help facilitate better communication and collaboration.

C. Needs Assessment

Overview of Process

VDH utilized a mixed methods approach to assess the need for HIV prevention and care services, this included the review and analysis of the data already presented in the Epidemiology Overview section of this plan (e.g., HIV surveillance data, HCC data, 2019 MMP data, NHBS data, CDR data, etc.). Additional data reviewed included Ryan White program data, HIV testing data, HIV surveillance reports (e.g., late testing, deaths, HIV incidence surveillance), and STI information.

VDH augmented this data with a number of qualitative data sources through surveys and focus groups, which focused on the identification of needs, barriers, and gaps.

These included:

- 2019 RWHAP B consumer survey distributed (126 responses)
- 2021 RWHAP B provider and consumer survey on new injectable long acting antiretroviral (LARV) medication Cabenuva (34 provider responses; 114 responses)
- 2021 focus groups with consumers and providers about the injectable form of PrEP (23 participants)
- 2022 focus groups with CHR providers (52 participants)
- 2022 Public Hearing focused on the plan (67 participants)
- 2022 focus group with women with HIV (27 participants)
- 2022 focus group with people with HIV (focusing on people with HIV aged 50 years or greater and those with HIV for more than fifteen years)
- In addition, VDH reviewed 2020 HIV surveillance data for the TGA and HCC data.

Participation from PWH and Persons who experience risk for HIV

VDH used existing tools to gather additional needs assessment data from PWH and persons at elevated risk for. Due to time challenges, VDH leveraged existing needs assessment data to gather information to inform the needs assessment process for the plan. A limitation of this approach was that there were more PWH than persons with risks for HIV or PWH not engaged in care in attendance. VDH included a strategy to conduct additional ongoing needs assessments and focus groups throughout the plan timeframe to get additional feedback from priority populations on service needs and gaps across the HIV service delivery system.

Engagement of Other Stakeholders, including PWH

VDH conducted regular reviews of the draft plan components and solicited feedback from stakeholders. This included holding bi-weekly meetings with internal DDP Leadership, sharing progress and getting feedback at Quarterly HIV Prevention and Care Contractors' meetings, and sharing progress with the Norfolk TGA Planning Council as well. VDH disseminated information across the office and districts through the weekly agency leadership forum and with DIS on the monthly STD webinar.

VDH planning staff presented the information collected for the needs assessment section to Virginia's CHPG, and the VDH Plan Workgroup, which was comprised of the HIV Surveillance, HIV and Hepatitis Prevention, HIV Care Services, and STD Prevention and Surveillance (SPS) for feedback and prioritization of need. The strategies and activities outlined in the work plan are outcomes of an integrated working session between CHPG members. The working sessions led to agreement of what objectives, strategies and, activities to include in the work plan, as well as priority populations. Participants at the CHPG meeting were asked to review initial strategies and activities, and to provide feedback.

Service Needs and Gaps of People who experience risk for HIV

People who experience risk for HIV infection face significant barriers to accessing both HIV testing and other prevention services to help them remain HIV negative. Travel, either due to distance or lack of personal or public transportation, is a barrier. Many organizations do not offer evening or weekend services, which creates a barrier for working individuals without paid leave. Stigma around agencies perceived to be HIV or LGBT focused also prevents some individuals from accepting referrals. In addition, some agencies offer services needed but lack staff who are culturally competent to serve PWH or LGBT clients in a respectful and non-traumatizing manner. Thus, there are real and perceived barriers to HIV services that prevent the full and fair participation of all populations. It is only to the extent that people are able to access and use services that needs are met. The following narrative describes many of the barriers that prevent Virginians from accessing the full spectrum of HIV services from free condoms, HIV testing, and PrEP to full engagement in HIV medical care and supportive services.

Virginia law allows for routine opt-out HIV testing (§32.1-37.2) in health care settings and requires that, prior to HIV testing, a medical care provider shall inform the patient that the test is planned, provide information, and advise them of their right to decline the test. However, routine opt-out HIV testing has not been widely adopted by primary care providers, FQHCs, emergency rooms and other clinical sites. Many primary care providers express their lack of comfort or skill in taking adequate sexual histories to ascertain the need for STI/HIV/hepatitis testing or PrEP. Others site lack of clinician time or reimbursement challenges.

While access to PrEP and nPEP have improved since the previous integrated plan, there are still gaps in availability and stigma remains. The network of PrEP and nPEP prescribers remains limited, especially in more rural areas of the state. Additional provider education is needed. Many primary care physicians are still unaware that PrEP exists or believe an infectious disease specialist must prescribe it. Often, national PrEP campaigns, commercials and other PrEP information is marketed only to MSM, with minimal focus on other populations such as transgender persons, heterosexual women, women of color, persons who engage in sex work, etc. There is need for education to address medical mistrust as well as potential interactions with hormones as evidenced by focus groups held with transgender women as part of a CDC demonstration project. Funding for PrEP clinical services remains limited.

Many people who could benefit from PrEP believe they cannot afford the medication; however, medication access is no longer the largest barrier. A combination of generics, Medicaid billing, pharmaceutical assistance programs and medications purchased by DDP for the uninsured help reduce this barrier. While there is funding for PrEP medications and lab tests, the only public source to pay for clinician time for the uninsured is a small amount of state funding. Funding is also insufficient to support patient navigators who are key to ensuring patients keep appointments and are successful in being adherent to medication. Even persons who have insurance have challenges in accessing PrEP. Insurance does not always cover the clinical costs of PrEP such as labs and clinician time, which can also be a barrier for those that need to access PrEP.

Many emergency rooms (ERs) do not prescribe nPEP or will only do so if an individual reports they have been sexually assaulted. Some individuals do not have a primary care home for follow up which may also create a barrier to ERs being willing to prescribe. Individuals can get nPEP through some LHDs. The VDH Division of Pharmacy Services can ship medications overnight. However, as clinical sites are not open on weekends, the 72-hour window for starting nPEP can be a barrier.

Housing, mental health services, substance use disorder treatment, food access, and transportation for persons who are HIV negative are limited. There are many specialized services available for PWH, but there is a lack of funding and providers that provide similar services for those who are HIV negative.

Since funding the first CHR site in 2018, Virginia's CHR program expansion has made great progress. VDH funds eight CHR providers, with at least one in each of the five health regions. In addition to preventing HIV and viral hepatitis, these sites are the primary distributors of naloxone and fentanyl test strips. Participants have reported almost 3,000 overdose reversals; however, overdose rates are still increasing and additional CHR providers are needed to serve PWUD in need of care. Additionally, there needs to be more provider education around non-stigmatizing language and services for people who use drugs and alcohol.

Service Needs and Gaps of PWH

Several service gaps exist for PWH that act as barriers to retention in care and achieving viral load suppression. As mentioned in a previous section, transportation is a service gap for Virginia, especially in the more rural areas where public transportation systems do not exist. Availability of linguistic services and expansion of available languages is another service gap. While there are linguistic services available, not every language is available within the service, which can still cause gaps in service for those that speak languages that are not available. Availability of case managers throughout the state is a service gap. There has been significant and sustained turnover of case managers since the start of COVID-19, which led to longer intervals between client contacts and clients having multiple case managers assigned to them in a single year.

To ensure sustainability of medication access, PWH served by the VA MAP program need ongoing education and support to be enrolled in the appropriate medication access program for which they are eligible (Medicaid, ACA, ADAP, Medicare, etc.). Some clients express reluctance or may refuse to enroll in Medicaid or an ACA insurance plan because of concerns about losing their provider or having to pay out of pocket costs for co-pays. Explanation of the benefits of being fully insured (not just coverage for HIV medication) does not serve as a motivating factor as PWH report they will just use the emergency room and won't be billed for receiving indigent care.

Housing is also a large service gap for PWH in Virginia. Rental costs have increased in recent years, making it more challenging for PWH to retain housing. This also leads to clients not having money for other necessities such as food, gas, utilities, etc. Another issue is finding available and affordable

housing. Although funding may be available to support housing, many landlords refuse to participate in any public housing or voucher options. In addition, many of the public housing and federal housing assistance programs are difficult to access as there are waitlists for services that can last years. Available housing in motels or apartments is often located in neighborhoods and areas deemed to be unsafe, placing clients at risk for crime and contributing to additional mental health challenges. Lastly, some clients find it hard to find housing due to issues with previous rental history, credit scores, background checks, etc. All of these challenges with housing access can lead to someone becoming unhoused, which often leads to clients falling out of care.

PWH consistently identify the need for oral/dental care. Good oral health is especially important because having dental problems increases the likelihood of developing serious oral manifestations and oral cancers. Poor oral health can lead to inadequate food intake, which affects HIV medication absorption. There is a shortage of oral/dental health providers in Virginia. While Medicaid expanded Oral Health services for adults, there is still a shortage, as many dental providers do not accept Medicaid coverage. The need for more oral/dental health providers varies across the state: the Southwest, Northwest, and Northern regions are areas that need more dental providers to serve PWH.

Virginia needs to expand services that address the needs of aging persons with HIV and long-term survivors. As PWH are aging and living longer, there is an increased need to ensure that the services provided are able to meet their needs as they age. There needs to be more intersection of geriatric services and HIV treatment services.

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 fewer medical providers practice, and public transportation systems are not available, newly diagnosed persons may need to travel 3-4 hours to access treatment.

To address the lack of providers and transportation issues, the continued and expanded use of telehealth is needed to rapidly link persons to care. Expansion of telehealth to lab services would help increase timely linkage to care and retention in HIV care.

There is a need for more collaboration between HIV prevention and care sites 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. Since the last integrated plan, there has been in an increase in the number of sites able to provide both prevention and care services.

The need for an expanded use of Patient Navigation (PN) services is another service gap, as PN services can assist persons who are newly diagnosed 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 locations 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 persons newly diagnosed with HIV and having someone to guide them through the process can assist in linking and keeping someone in care.

Barriers to HIV prevention and care services

Barriers to accessing HIV services exist due to a wide variety of reasons. Many of the barriers listed below for HIV also exist for people seeking STI and viral hepatitis services.

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 Virginia Health Care Foundation's Profile of Virginia's Uninsured, there are 455,000 Virginians under the age of 65 that are uninsured. In 2021, VDH had 1,541 clients enrolled in a health insurance plan from the ACA Federal Marketplace funded by the VA MAP program and 1,582 clients enrolled in the Direct VA MAP program, which provides coverage for HIV medications for those that do not have another coverage option. Many people with HIV were enrolled in Medicaid due to Medicaid Expansion. 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 a barrier to care.

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. In order to overcome restrictive out-of-pocket expenses, VDH is funding PrEP and nPEP clinics in LHD and non LHD sites. Laboratory work needed to assess for medical eligibility for PrEP is being supported through state funding. While this system benefits persons in need of PrEP and nPEP, it poses another burden on an 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 undertaking PrEP services. In addition, prospective clinical partners also routinely ask DDP to fund navigation services, but DDP does not have funds to meet those requests. Federal HIV prevention funding in the state is below 2017 awards, and federal demonstration projects that supported the launch of PrEP have ended. 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.

Federal partners recognize the connection that mental health and substance use play in high-risk behaviors that put individuals at risk of getting or transmitting HIV. Referrals are challenging as agencies may have wait lists, don't exist in many areas, or not culturally competent to handle the needs of PWH, gay men, people of color, transgender and non-binary individuals, and PWIDs.

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 Virginia's Infected Sexual Battery law. The bill that passed did not result in complete decriminalization but did make advancements 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 law removed the felony designation. The revised law still makes non- disclosure of HIV, HBV or syphilis to a sexual partner a Class 1 Misdemeanor. The current legislation may still provide a barrier to individuals wanting to test. It also provides a barrier for partner services if people fear possible criminal penalties.

Service Provider Barriers

Staffing issues remain a problem with many HIV service providers. Low wages, part-time employment, and the lack of adequate benefits make keeping qualified staff difficult at many agencies.

Engaging substance use and mental health providers in HIV prevention efforts has had moderate success. There is need for more collaborative efforts to bring these services to individuals that experience risk for HIV, as well as PWH. Forming collaborations and community focus groups to address issues such as the opioid problem in Virginia, homelessness, homophobia, and racism are also needed and should include representation from public health, social services, criminal justice, policy makers, and the targeted populations to be effective. It is crucial to pursue community mobilization efforts in order to engage community members in issues such as HIV stigma, sexuality and sexual orientation, gender identity, and addiction. These mobilization efforts would benefit efforts to advance policy within the Commonwealth.

Reporting burdens for subrecipient agencies for federal funding remains a high barrier for smaller CBOs. Capacity building efforts needs to include investments in workforce, structural and administrative enhancements, and staff training to administer larger awards of federal funds to assure their confidence in handling the programmatic, data, and fiscal requirements.

Fear/stigma

HIV stigma remains a barrier for accessing both HIV testing and other prevention services. Individuals from more rural areas of the state are afraid of being stigmatized and therefore do not access HIV testing or medical services as evidenced by late diagnoses in rural areas and lower rates of viral suppression. Individuals perceive the lack of anonymity in small rural communities to decrease the likelihood of confidentiality and increase the risk for discrimination. Stigma surrounding HIV as being a "gay disease" is also prevalent and limits heterosexual males from participating in prevention interventions. Providers also need more education to make HIV testing a routine healthcare activity to address HIV stigma. In 2020, Virginia's HIV Stigma Summary Score was 36.6 (2020 MMP Data Report), which is greater than the 2020 National average score of 27.6 (2020 MMP, United States) and indicates that stigma may be more prevalent in Virginia.

There is also stigma among transgender and non-binary populations that can be a barrier to care. Providers need more education about how to provide gender-affirming care. Bad experiences with medical providers and ancillary staff can prevent someone from accessing the services that they need for fear of discrimination.

Stigma is also prevalent among PWUD/PWID, and for individuals accessing CHR. There is often negative stigma regarding PWUD by healthcare professionals, which can make the services they need inaccessible. There is also stigma around HIV and sharing needles, which can be a barrier for PWID to seek HIV testing, as they would prefer not to know their HIV status. While law enforcement in some areas has been supportive of CHR, it varies significantly by locality. Continued engagement with and education of law enforcement is needed to gain community support for new sites and to help prevent needless arrests of program participants.

Broadband Internet Access

Lack of broadband internet access is a significant barrier to needed services. As more options for telehealth are available for services, if clients do not have access to reliable and stable broadband internet access, this can be a gap in being able to access services. In 2022, the Virginia General Assembly allocated $8 million from the American Rescue Plan Act to further increase broadband connections to VDH facilities and improves the agency's network infrastructure.

IV. Situational Analysis

This section presents a summary of the strengths, challenges, and identified needs with respect to HIV prevention and care services activities within the four EHE Pillars: Diagnose, Treat, Prevent, and Respond. The situational analysis is based on themes that emerged from the community engagement and planning process, epidemiologic snapshot, resource inventory, and needs assessments.

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

Challenges:

- Stigma/knowledge related to HIV
- Providers may not routinely screen patients for testing
- 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
- COVID-19 pandemic created increased burden on health care system
- For a significant proportion of new diagnoses, no identified risk for transmission is collected

Needs:

- Increased education/training about HIV transmission and stigma
- Provider education on HIV to make HIV testing a normalized part of health care

Pillar Two: Treat

Strengths:

- Linkage to Care among community-based organizations is high
- Resources available to fund a variety of HIV medical and support services for PWH
- Expansion of telehealth and mobile health service delivery
- Unified Eligibility for all RWHAP B processes which reduces client burden for accessing HIV treatment services
- Availability of long-acting injectable option for ART
- Medicaid Expansion in Virginia

Challenges:

- Availability of infectious disease providers
- Transportation (especially in rural areas)
- High rates of turnover for case management
- Housing
- Broadband Internet access

Needs:

- Focus on services for people aging with HIV
- Increased collaborations between Mental Health and Substance Use Disorder providers
- More education on Care and medication coverage through insurance, Medicaid, Medicare, Ryan White, VA MAP, etc.
- More education on health literacy

Pillar Three: Prevent

Strengths:

- Expansion of the CHR program in Virginia
- Relaxed legislation for syringe services
- Creation of the Status Neutral Service Navigation program
- Expansion of PrEP services despite no dedicated funded
- Condom distribution

Challenges:

- Funding for HIV Prevention especially PrEP/nPEP (including PrEP navigators)
- Limited availability of PrEP providers
- Support services for people who experience risk for HIV infection (Housing, Mental Health, Substance Use Disorder, Transportation, etc.)
- HIV and Substance Use Disorder stigma

Needs:

- More public and provider education on PrEP for both the public and providers
- More education on stigma for substance use disorders
- Funding/availability for support services

Pillar Four: Respond

Strengths:

- HIV Outbreak Rapid Response Plan
- Rapid Response Team monthly meetings to review data to identify possible outbreak/cluster
- Rapid Response meetings are integrated to include HIV, STIs and hepatitis

Challenges:

- DIS and LHD staff availability for HIV surveillance activities
- Limited funding for surveillance activities and outreach

Needs:

- Increased community education on Cluster Detection Response activities
- Increased capacity for HIV surveillance activities at local level

Prioritized Populations: Virginia identified the following priority populations for this plan:

- Young persons (between 20-34)
- Latinos
- MSM of all races and ethnicities with an emphasis on Black MSM
- Black Heterosexual Men
- Women of Color
- Transgender Women
- Non-Binary/Gender Non-Conforming persons
- Persons who use/inject drugs
- People who are 50+
- People who live in rural areas

Virginia Integrated Plan NHSP Indicators 2022-2026 (2020 and 2021 Data Not Included Due to COVID-19 Pandemic)									
Indicator Title & Number	**Definition & Source**	**Data Availability**	**Virginia By Year (Baseline Year: 2017)**			**Virginia 3 Year Average**		**2026 Virginia Target**	**National Target**
			2017	**2018**	**2019**	**Average**	**Percent**		
1. Increase knowledge of status to 95% by 2026	**Numerator:** Number of persons aged ≥13 years living with diagnosed HIV at end of a measurement year. **Denominator:** Estimated number of persons aged ≥13 years living with diagnosed or undiagnosed HIV at the end of a measurement year.[1]	Data are published annually	Num: 22,945	Num: 23,869	Num: 24,747	Num 23,886	86.11%	95.00%	By 2025, increase to knowledge of HIV status to 95%.
2. Reduce new infections in Virginia by 25% by 2026	Incidence is the estimated number of new HIV infections among persons aged ≥13 years that occurred in the measurement year and includes diagnosed and undiagnosed infections.[1]		Den: 27,100	Den: 27,600	Den: 28,400	Den 27,700			
			810	780	750	780	N/A	585	By 2025, reduce incidence by 75% from baseline. By 2030, reduce incidence by 90% from baseline.

3. Reduce new HIV diagnosis in Virginia by 25% by 2026	Number of persons ≥13 years who have received laboratory or clinical confirmation of HIV in a measurement year.[1]	Data are published annually. Preliminary data are also available quarterly.	882	881	851	871	NA	218	By 2025, reduce diagnoses by 75% from baseline. By 2030, reduce diagnoses by 90% from baseline. [A]
4. Increase timely linkage to care in Virginia to 95% by 2026	**Numerator:** Number of persons aged ≥13 years with HIV diagnosed in a measurement year and who had ≥1 viral load (VL) or CD4 test ≤1 month after HIV diagnosis. **Denominator:** Number of persons aged ≥13 years with HIV infection diagnosed during a measurement year.[1]		Num: 631 Den: 882	Num: 635 Den: 881	Num: 629 Den: 851	Num: 632 Den: 871	72.49%	95%	By 2025, increase to 95%. [B]
5. Increase viral suppression among PWA in Virginia to 80% by 2026	**Numerator:** Number of persons aged ≥13 years living with diagnosed HIV and have a viral load test result <200 copies/mL at the most recent viral load test during a measurement year. **Denominator:** Number of persons aged ≥13 years living with diagnosed HIV by the end of the year prior to the measurement year and alive at the end of the measurement year.	Data are published annually	Num 11,759 Den 21,650	Num 13,658 Den 22,579	Num 15,123 Den 23,462	Num 13,513 Den 22,564	59.89%	80%	By 2025, increase to 95%. [C]

5A. Increase viral suppression among MSM to 80% by 2026	Same as # 5	Same as #5	Num 5,966 Den 1,0656	Num 7,089 Den 11,152	Num 7,952 Den 11,673	Num 7,002 Den 11,160	62.74%	80%	Increase viral suppression among MSM diagnosed with HIV to 95% from a 2017 baseline of 62.74%.[D]
5B. Increase viral suppression among Black MSM to 80% by 2026	Same as #5	Same as #5	Num 2,803 Den 5,043	Num 3,350 Den 5,306	Num 3,776 Den 5,573	Num 3,310 Den 5,307	62.36%	80%	Increase viral suppression among Black MSM diagnosed with HIV to 95.% from a 2017 baseline of 58.4%.[E]
5C. Increase viral suppression among Latino MSM to 80% by 2026	Same as #5	Same as #5	Num 533 Den 1022	Num 640 Den 1093	Num 723 Den 1165	Num 632 Den 1,093	57.80%	80%	Increase viral suppression among Latino MSM diagnosed with HIV to 95. % from a 2017 baseline of 64.9%.[F]
5D. Increase viral suppression among Black Women to 80% by 2026	Same as # 5	Same as #5	Num 2,336 Den 4,035	Num 2,671 Den 4,164	Num 2,896 Den 4,294	Num 7,903 Den 4,164	63.26%	80%	Increase viral suppression among Black women diagnosed with HIV to 95.00% from a 2017 baseline of 59.30%.[G]

5E. Increase viral suppression among Transgender Women to 80% by 2026	Same as # 5	Same as # 5	Num 110 Den 172	Num 138 Den 192	Num 152 Den 210	Num 133 Den 192	69.44%	80%	Increase viral suppression among transgender women in HIV medical care to 95.00% from a 2017 baseline of 80.50%.[H]
5F. Increase viral suppression among PWID to 80% by 2026	Same as # 5	Same as #5	Num 748 Den 1,588	Num 831 Den 1,603	Num 884 Den 1,621	Num 821 Den 1,604	51.18%	80%	Increase viral suppression among people who inject drugs diagnosed with HIV to 95.00% from a 2017 baseline of 54.90%. [I]
5G. Increase viral suppression among Youth aged 13-24 to 80% by 2026	Same as # 5	Same as #5	Num 394 Den 842	Num 446 Den 835	Num 475 Den 780	Num 6,746 Den 13,999	53.52%	95%	Increase viral suppression among youth aged 13–24 diagnosed with HIV to 95.00% from a 2017 baseline of 57.10%.[J]
6. Decrease HIV stigma in Virginia by 25% by 2026	Definition: The median score of a 10-item stigma scale, ranging from 0 (no stigma) to 100 (high stigma), measured among persons aged >18 years living with diagnosed HIV infection living in the United States and Puerto Rico.	Data are published annually.	N/A	31.2	N/A	N/A	N/A	23.4	By 2025, decrease by 50%. Indicator: 31.2 represents the median score. [K, L]

7. Reduce homelessness among PWA in Virginia by 50% by 2026	Numerator: Number of persons aged ≥18 years living with diagnosed HIV in a measurement year and report having been homeless during the 12 months prior to interview. Homelessness is defined as living on the street, living in a shelter, living in a single-room-occupancy hotel, or living in a car. Denominator: A sample of persons aged ≥18 years living with diagnosed HIV in a measurement year, as documented in the medical record.	Data are published annually.	9.10%	NA	NA	NA	N/A	4.5%	By 2025, reduce by 50.00%.[L]
99. Quality of life measure	Pending guidance from the White House National HIV Strategic Plan on the appropriate quality of life measures.								

Indicator Notes

A. Provisional annual data (annual data with ≥12 months of reporting delay) will be used to measure progress.

B. Data are reported for jurisdictions with complete laboratory reporting of CD4 and viral load test results to CDC. The number of jurisdictions may vary each year. Provisional annual data (annual data with ≥12 months of reporting delay) will be used to measure progress.

C. Increase viral suppression among individuals diagnosed with HIV. Data are reported for jurisdictions with complete laboratory reporting of CD4 and viral load test results to CDC and with complete death ascertainment. The number of jurisdictions may vary each year.

D. Increase viral suppression among individuals diagnosed with HIV. Data are reported for jurisdictions with complete laboratory reporting of CD4 and viral load test results to CDC and with complete death ascertainment. The number of jurisdictions may vary each year.

E. Increase viral suppression among individuals diagnosed with HIV. Data are reported for jurisdictions with complete laboratory reporting of CD4 and viral load test results to CDC and with complete death ascertainment. The number of jurisdictions may vary each year.

F. Increase viral suppression among LATINO MSM diagnosed with HIV. Data are reported for jurisdictions with complete laboratory reporting of CD4 and viral load test results to CDC and with complete death ascertainment. The number of jurisdictions may vary each year.

G. Increase viral suppression among BLACK WOMEN diagnosed with HIV. Data are reported for jurisdictions with complete laboratory reporting of CD4 and viral load test results to CDC and with complete death ascertainment. The number of jurisdictions may vary each year.

H. Increase viral suppression among TRANSGENDER WOMEN diagnosed with HIV. Data are reported for jurisdictions with complete laboratory reporting of CD4 and viral load test results to CDC and with complete death ascertainment. The number of jurisdictions may vary each year.

I. Increase viral suppression among people who inject drugs diagnosed with HIV. Data are reported for jurisdictions with complete laboratory reporting of CD4 and viral load test results to CDC and with complete death ascertainment. The number of jurisdictions may vary each year.

J. Increase viral suppression YOUTH diagnosed with HIV. Data are reported for jurisdictions with complete laboratory reporting of CD4 and viral load test results to CDC and with complete death ascertainment. The number of jurisdictions may vary each year.

K. The stigma scale was revised for the 2018 data collection cycle and includes three questions with a 12-month reference period to allow participants to provide experiences in a defined and more recent period of time for one domain of stigma (personalized stigma).

L. Only one year of data were available for the reduction of stigma and the reduction of homelessness.

Data Source

1. National HIV Surveillance System (NHSS).11 NHSS is the primary source for monitoring trends in HIV in the United States. It is the data source for incidence, diagnoses, and other HIV care continuum data.

2. Medical Monitoring Project (MMP). MMP is a cross-sectional, nationally representative, complex sample survey that assesses the behavioral and clinical characteristics of adults with diagnosed HIV infection in the United States. MMP also provides information on behaviors and clinical outcomes affecting the risk of HIV transmission, morbidity, and mortality. In 2015, MMP sampling and weighting methods were revised to include all adults with diagnosed HIV infection regardless of HIV care status.

V. Goals and Objectives for Virginia's HIV Services Plan, 2022-2026

NHAS GOAL #1: PREVENT NEW HIV INFECTIONS

Objective 1.1: By December 31, 2026, increase health communications activities to prevent HIV and improve HIV-related health outcomes among priority populations.

Key Partners: DDP, LHD, Pharmacies, Clinical sites, CBOs, FQHCs

Strategies	Funding Sources	Outcomes	Data Indicators
Strategy A: Conduct health communications activities/campaigns to promote HIV testing among young people (20-34), Latinos, Black MSM, and Heterosexual males, ensuring community engagement in the development of messaging and channels. *(Diagnose, Prevent)*	TBD	Increase in use of test site locators; Increase in HIV testing among priority populations. **(NHSP Indicator#1)**	campaign metrics, DDP hotline call log, Evaluation Web, Provide
Strategy B: Conduct health communications activities/campaigns to promote PrEP among MSM of all races and ethnicities, Black Women, Transgender women and non-gender conforming (NGC) individuals, ensuring community engagement in the development of messaging and channels. *(Diagnose, Prevent)*	TBD	Measure click through rates and ad activities by location; **(NHSP Indicator#1, 2, 3, 7)**	campaign metrics, Provide
Strategy C: Conduct health communications activities/campaigns that address HIV stigma and U=U among the general population, as well as rural areas. *(Diagnose, Treat, Prevent)*	TBD	**(NHSP Indicator #7)**	campaign metrics, surveys; eHARS; Caremarkers database

Objective 1.2: By December 31, 2026, increase knowledge of HIV status among people in Virginia

Key Partners: DDP, LHD, Pharmacies, Clinical sites, CBOs, FQHCs, Correctional Facilities

Strategies	Funding Sources	Outcomes	Data Indicators
Strategy A: Expand HIV testing in both clinical and non-clinical settings, home testing, pharmacies, and comprehensive harm reduction (CHR) sites, continuing the "No Wrong Door" approach. *(Diagnose, Prevent)*	CDC, HRSA, ARPA, State	Increase in number of HIV tests over 2019 (pre-COVID-19) testing levels. **(NHSP Indicator#1, 2, 3)**	Evaluation Web/ Provide
Strategy B: By January 1, 2024, merge the Community HIV Testing (CHT) and Status Neutral Service Navigation (SNSN) grant programs to improve linkage to HIV care, PrEP and support services. *(Diagnose, Prevent, Treat)*	CDC	Reduced time for linkage to care; increased linkage for PrEP and support services. **(NHSP Indicator# 2, 3, 5, 6)**	Evaluation Web
Strategy C: Increase the capacity of HIV test sites to conduct STI and hepatitis testing and to perform blood draws for conventional testing *(Diagnose, Prevent, Treat)*	CDC, State	Increase in STI, hepatitis and conventional HIV testing. **(NHSP Indicator# 1, 2, 3)**	Labcorp reporting, Evaluation Web, contractor reports, REDCap
Strategy D: Increase HIV testing among young people (20-34), Black MSM, and PWID in the Norfolk TGA. *(Diagnose, Prevent)*	CDC/HRSA RW Part A	Increase in HIV tests among priority populations. Reduction in late diagnoses. **(NHSP Indicator# 1, 2, 3, 5, 6b, 6g, 6h)**	Evaluation Web. Provide, CAREWare
Strategy E: Ensure third trimester HIV testing in at least 85% of pregnant persons diagnosed with HIV with a baseline of 80% in 2021 and refer them to high risk OB GYN care in the RWHAP cross parts care system *(Diagnose, Prevent)*	CDC	Reduction in HIV perinatal transmission. **(NHSP Indicator#1, 2, 3, 5, 6e)**	eHARS
Strategy F: Increase viral suppression rate at third trimester in pregnant persons diagnosed with HIV to 85% with a baseline of 80% in 2021 *(Treat, Prevent)*	CDC	Reduction in HIV perinatal transmission. **(NHSP Indicator#1, 2, 3, 5, 6e)**	eHARS
Strategy G: Educate and counsel 95% of people diagnosed with syphilis about HIV risk and provide referrals to PrEP services. *(Prevent)*	CDC	# diagnosed with syphilis/ with referral to PrEP. **(NHSP Indicator#1, 2, 3, 5)**	VEDSS, Provide
Strategy H: Beginning January 1, 2024, implement DIS interviews and referrals for patients with STIs who are 1.) co-infected with HIV and are not in care or have high viral loads, and 2.) those with rectal GC. *(Diagnose, Prevent, Respond, Treat)*	CDC HIV Prevention CDC STI, HRSA	# diagnosed w/ chlamydia or gonorrhea and co-infected with HIV (not in care or detectable VL) who are interviewed and linked to care; # diagnosed w/ rectal GC who are interviewed and referred to PrEP services. **(NHSP Indicator# 2, 3, 5)**	eHARS, VEDSS

Objective 1.3: By December 31, 2026, improve implementation of and access to safe, effective HIV prevention interventions with priority on serving gay and bisexual men, Black/African-Americans, Latinos, PWID, Transgender and non-binary/gender non-conforming persons, Black Women, Youth, PWH 65 and older.

Key Partners: DDP, LHD, Pharmacies, Clinical sites, CBOs, FQHCs, Emergency Departments

Strategies	Funding Sources	Outcomes	Data Sources
Strategy A: By December 31, 2024, conduct public health detailing for 40 pharmacies (PrEP, nPEP) and emergency departments (nPEP). *(Diagnose, Prevent)*	CDC	Increase the # of pharmacies that provide PrEP/ nPEP; Increase the # of EDs that provide nPEP. **(NHSP Indicator# 2, 3)**	Follow up with participating sites
Strategy B: By December 31, 2025, increase access to PrEP through new initiatives such as pharmacy-provided PrEP, telePrEP, PrEP 2-1-1, etc. *(Diagnose, Prevent)*	CDC, state	Increase in PrEP enrollment. **(NHSP Indicator# 1, 2, 3)**	Provide
Strategy C: Improve PrEP adherence by removing service barriers, offering long-acting injectables and providing ongoing client engagement and education through patient navigation. *(Prevent)*	CDC, state	Increase in the # of months clients are taking PrEP; increase in PrEP adherence (decrease in missed doses). **(NHSP Indicator# 1, 2, 3, 7)**	Pharmacy data, PrEP database, client and provider surveys
Strategy D: Expand access to PrEP/nPEP through LHD clinical services (STI, Family Planning). *(Diagnose, Prevent)*	CDC, state	Increase in the # of LHDs offering PrEP/nPEP; increase in PrEP enrollment. **(NHSP Indicator# 1, 2, 3, 7)**	MOAs, PrEP services database
Strategy E: Establish comprehensive harm reduction (CHR) services in the Norfolk TGA (Eastern Region), by Dec. 31, 2022. *(Diagnose, Prevent)*	CDC, ARPA, state	Authorization of one or more CHR sites in the Norfolk TGA. **(NHSP Indicator# 1, 2, 3, 6g)**	MOAs; CHR database
Strategy F: Expand CHR services to ensure more equitable access across Virginia. *(Diagnose, Prevent)*	CDC, state, ARPA	Increase in the # of cities/ counties with CHR services. **(NHSP Indicator# 1, 2, 3, 6g, 7)**	MOA; CHR database
Strategy G: By December 31, 2025, expand condom distribution by 25% to ensure equitable access to those in need. *(Prevent)*	CDC	# of new condom distribution sites; # of condoms distributed over 4,000,000 baseline. **(NHSP Indicator# 2, 3)**	DDP condom distribution reports

NHAS GOAL #2: INCREASING ACCESS TO CARE AND IMPROVING HEALTH OUTCOMES FOR PEOPLE WITH HIV

Objective 2.1: By December 31, 2026, 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, FQHCs, Department of Corrections. local and regional jails

Strategies	Funding Sources	Outcomes	Data Indicators
Strategy A: Increase the number of HIV service providers that participate in Rapid Start. *(Diagnose, Treat, Prevent)*	HRSA, HRSA cross-parts funding, providers program income, Medicaid	increase # of clients served through Rapid Start; # **of clients enrolled in RS program after 6 months of a new contracted site reduce # of days to ARVs; reduce # of days to viral suppression. (NHSP Indicator# 2, 3, 5)**	eHARS, Provide, CareWare; VDH contracts
Strategy B: Continue implementation of Status Neutral Service Navigation utilizing patient navigators to connect newly diagnosed PWH to care and support services within two weeks. *(Diagnose, Treat, Prevent)*	CDC	Increase the % of clients linked to care within 30 days of diagnosis. **(NHSP Indicator# 1, 2, 3, 5, 6a-h, 7, 8)**	eHARS, Provide
Strategy C: Continue working with HIV Surveillance, LHDs and disease intervention specialists (DIS) to improve linkage rates among PWH diagnosed in the private sector, community-based, or LHD clinics. *(Diagnose, Treat, Prevent)*	CDC	Increase the % of clients linked to care and the % linked to care within 30 days. **(NHSP Indicator# 2, 3, 5)**	eHARS
Strategy D: Continue implementation (and evaluation) of Unified Eligibility for RWHAP B program to reduce client and staff burden and help promote uninterrupted access to care. *(Treat, Prevent)*	HRSA	Increased retention in care, increased viral suppression. **(NHSP Indicator# 2, 3, 5)**	eHARs, Provide, CareWare

Objective 2.2: By December 31, 2026, increase re-engagement and retention in care and adherence to HIV treatment 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, Department of Corrections, local and regional jails

Strategies	Funding Sources	Outcomes	Data Indicators
Strategy A: Continue to improve use Data to Care protocols to identify and re-engage people with HIV into care and other services. *(Treat, Prevent)*	CDC, HRSA	# of PWH re-engaged in care; # of re-engaged PWH who achieve viral suppression; **(NHSP Indicator# 2, 3, 5)**	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. *(Treat, Prevent)*	HRSA	# clients engaged with evidenced barriers, increase % of PWH retained in care, increase # of PWH who are virally suppressed. **(NHSP Indicator# 2, 3, 5, 6a-h, 7, 8)**	eHARS, Caremarkers database, Provide, CareWare
Strategy C: Provide education for PWH in 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. *(Treat)*	HRSA	Increase in the # or % of PWH who are enrolled in a medication access program (i.e. Medicaid, Medicare, ACA Marketplace, and direct ADAP). **(NHSP Indicator# 2, 3, 5, 6a-h, 7, 8)**	Provide/ DMAS
Strategy D: Expand access and integrate supportive HIV services (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. *(Treat)*	HRSA	Increase # of agencies providing supportive HIV services; increase # of clients accessing supportive HIV services; increase in the % of PWH retained in care and virally suppressed. **(NHSP Indicator# 2, 3, 5, 6a-h, 7, 8)**	Provide; VEDSS;
Strategy E: Integrate STI and hepatitis screening for PWH to achieve optimal health outcomes. *(Treat)*	HRSA	increase # of agencies providing STI and hepatitis screening for PWH; increase # of PWH screened for STI and hepatitis **(NHSP Indicator# 5, Quality of Life)**	Provide; VEDSS;

Objective 2.3: By December 31, 2026, expand capacity to provide whole-person care to PWH aged 50+ and long-term survivors

Key Partners: DDP, clinical providers ADAP Advisory Committee, VACAC, Division of Pharmacy Services , Department of Medical Assistance Services, Department of Aging and Rehabilitative Services, consultants to VDH RWHAP B

Strategies	Funding Sources	Outcomes	Data Indicators
Strategy A: Annually work with the ADAP Advisory Committee to review RWHAP B medication formularies to meet the specific medication needs of PWH aged 50+. *(Treat)*	HRSA	# and type of medications added to the formularies, drug utilization. **(NHSP Indicator# 2, 3, Quality of Life Measure)**	VA MAP and RW formularies 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 50+, substance use treatment, and disability and other medical services). *(Treat)*	HRSA	# of services created/expanded that meet the needs of PWH 50+, # of meetings/ communications with agencies, # of collaborations with agencies that provide services to persons 50+. **(NHSP Indicator# 2, 3, Quality of Life Measure)**	Meeting minutes and documents
Strategy C: Collaborate with community advisory groups and program consultants to identify and prioritize best practices to meet the psychosocial and behavioral health needs of older PWH and long-term survivors including substance use disorder treatment, mental health services and programs designed to decrease social isolation. *(Treat)*	HRSA	Development of programs and services designed to meet the needs of aging PWH. **(NHSP Indicator# 2, 3, 5, 6g, Quality of Life Measure)**	VACAC and CHPG meeting minutes and documents

NHAS GOAL #3: Reduce HIV-Related Disparities and Health Inequities

Objective 3.1: By December 31, 2026, reduce disparities in new HIV infections, in knowledge of status, and along the HIV care continuum

Key Partners: DDP, LHD, Pharmacies, Clinical sites, CBOs, FQHCs

Strategies	Funding Sources	Outcomes	Data Indicators
Strategy A: Increase enrollment in PrEP services among Black and Hispanic MSM, Black women, and transgender women and GNC individuals through stigma reduction *(Diagnose, Prevent)*	CDC, state	Increase the # and proportion of PrEP enrollments among Black and Hispanic MSM, Black women, transgender women and NCG individuals. **(NHSP Indicator# 1, 2, 3, 6a-h, 7)**	Provide
Strategy B: Prepare written communication, including web content, for the public and providers in plain language at appropriate reading levels to help ensure health and medication literacy. Provide culturally and linguistically appropriate trans creation of materials. *(Diagnose, Treat, Prevent)*	CDC, HRSA	Percentage of client and provider materials written at an appropriate reading level. # of materials translated. **(NHSP Indicator# 2, 3, 7)**	DDP materials checklist
Strategy C: Increase linkage, retention in care, and viral suppression among people with HIV who inject drugs through provider education on substance use disorder-related stigma, use of appropriate person-first language, and increased engagement with CHR and behavioral health providers. *(Treat, Prevent)*	CDC, HRSA	Increase retention and viral suppression rates; # of agencies and staff who receive training in non-stigmatizing service delivery for PWID. **(NHSP Indicator# 2, 3, 5, 6g, 7)**	eHARS, Caremarkers database
Strategy D: Reduce late diagnoses among, and develop strategies to increase linkage to care, for people 55 and older who are diagnosed with HIV. *(Diagnose, Treat, Prevent)*	CDC/HRSA	Increase in testing, increase in linkage to care, decrease in late diagnoses. **(NHSP Indicator# 2, 3, 5, Quality of Life Measure)**	eHARS, Caremarkers database
Strategy E: Expand equitable access to HIV treatment through use of telehealth mobile health strategies, in-home care, or other mechanisms in rural areas and for those with transportation challenges. *(Treat, Prevent)*	HRSA	Increased retention in care; increased viral suppression. **(NHSP Indicator# 2, 3, 5)**	eHARS, Caremarkers database, Provide
Strategy F: Conduct needs assessments through focus groups or other engagement activities for at least two priority populations annually. *(Diagnose, Treat, Prevent, Respond)*	CDC/HRSA	Identification of emerging needs to be addressed through the integrated plan. **(NHSP Indicator# 1, 2, 3, 5)**	focus group notes, survey results,

Objective 3.2: By December 31, 2026, provide public leadership opportunities for people with or who experience risk for HIV infection as well as promote a diverse HIV workforce that is representative of and responsive to the needs of the populations served.

Key Partners: DDP, clinical sites, CBOs

Strategies	Funding Sources	Outcomes	Data Indicators
Strategy A: Maintain leadership opportunities for PWH and those who experience risk for HIV infection such as Ryland Roane Fellowship Program, Virginia Consumer Advisory Committee, Virginia Community HIV Planning Group, Mind, Body, Soul Advisory Committee, ADAP Advisory Committee, BLOC training, sub-recipient community advisory boards and Part A Planning Councils. *(Diagnose, Treat, Prevent, Respond)*	CDC/HRSA	# and demographics of people who participate on planning bodies and in engagement activities. **(NHSP Indicator# 7, Quality of Life Measure)**	Membership demographics, meeting attendance, individual and cohort trainings supported
Strategy B: Continue participation on the VDH Office of Epidemiology Equity, Inclusion and Action Council and collaborate with the Office of Epidemiology's Health Equity Coordinator to support a diverse workforce. Identify and promote opportunities to reduce health disparities and to improve understanding of race, sexual orientation, gender identity, culture, immigration status, mental health and substance use on public health policies and programs. *(Diagnose, Treat, Prevent, Respond)*	State	# of learning opportunities; # of participants: # of policies developed and implemented to promote health equity and support a diverse workforce. **(NHSP Indicator# 7)**	Meeting minutes, training records, new policies
Strategy C: Develop orientation resources for all DDP staff, regardless of role, that address racism, sexual orientation and gender identity, violence, trauma informed approaches, medical mistrust, and person-first language. *(Diagnose, Treat, Prevent, Respond)*	State	# of staff who complete course work by the end of their first year of employment. **(NHSP Indicator# 7)**	Training records, training plans
Strategy D: Provide or ensure that contracted organizations provide training for staff on racism, sexual orientation and gender identity, violence, trauma informed approaches, medical mistrust, and person-first language. *(Diagnose, Treat, Prevent, Respond)*	CDC, HRSA	# of staff at contract agencies that complete training. **(NHSP Indicator# 7)**	Training records, quarterly reports
Strategy E: By December 31, 2023, implement part of VDH's Trauma Informed Care strategic plan by providing a training series in trauma informed approaches that will be implemented for external HIV service providers to help eliminate institutional barriers and implement policies that will contribute to beneficial client experiences and improved health outcomes for both people with risk factors for HIV and people with HIV. *(Treat, Prevent)*	CDC, HRSA	# of agencies and staff that complete training; number of agencies that make structural or policy changes to support improved health outcomes. **(NHSP Indicator# 1, 2, 3, 7)**	Training documents, sub-recipient reports, eHARS, CareMarkers database, Provide

Objective 3.3: By December 31, 2026, address social and structural determinants of health and co-occurring conditions that impede access to HIV services and exacerbate HIV-related disparities

Key Partners: DDP, Ryan White Cross-Parts, CBOs, other clinical partners

Strategies	Funding Sources	Outcomes	Data Indicators
Strategy A: Collaborate with RWHAP cross parts jurisdictions, and other entities to reduce administrative burdens for clients to access quality HIV care and treatment. *(Treat, Prevent)*	HRSA,	Increased retention in care, increased viral suppression. **(NHSP Indicator# 2, 3, 5)**	eHARs, Provide, CareWare
Strategy B: 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. (Diagnose, Treat, Prevent)	CDC/HRSA	Increased enrollment in health insurance. **(NHSP Indicator# 1, 2, 3, 5, Quality of Life Measure)**	Provide, contractor quarterly reports, insurance enrollment vendor data and reports
Strategy C: Improving data collection, reporting, and use of VDH HIV, STI, and Viral hepatitis data to inform services for Transgender and non-binary/gender non-conforming persons. *(Treat, Prevent, Diagnose)*	CDC/HRSA	# of data sources that include data collection categories for transgender and non-binary/ gender non-conforming persons; # of data presented on HIV, STI, and Viral hepatitis that include transgender and non-binary/gender non-conforming persons. **(NHSP Indicator# 6a, b, c, f)**	Provide, eHARs, CAREWare, EvaluationWeb

NHAS GOAL #4: Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties

Objective 4.1: By December 31, 2026, coordinate with public and private partners, community-based organizations and academic partners, to address the syndemic of HIV, STIs, viral hepatitis, and substance use and mental health disorders.

Key Partners: DDP, LHDs, other clinical providers, free clinics, FQHCs, DBHDS, Division of Pharmacy Services

Strategies	Funding Sources	Outcomes	Data Indicators
Strategy A: Strengthen relationships with community service providers (e.g., Community Services Boards, HOPWA and other housing providers, Department for Aging and Rehabilitative Services, DBDHS) to learn about service provision and areas of collaboration. *(Treat, Prevent)*	CDC, HRSA, state	# of organizations, # of areas of collaboration identified, # of meetings with community service providers. **(NHSP Indicator# 5, 8)**	Meeting minutes and documents
Strategy B: Secure additional funding to expand the Naloxone Partners program to ensure access to opioid reversal drugs by people who use opioids. *(Treat, Prevent)*	state, ARPA, DBHDS	# Naloxone kits dispensed # reported overdose reversals. **(NHSP Indicator# 6g)**	DPS prescription data; REDCap
Strategy C: Coordinate services among community based test sites to ensure a strong treatment referral network for people diagnosed with STIs *(Diagnose, Treat, Prevent)*	CDC, HRSA, state	# of people diagnosed in community settings who are linked to STI treatment services. **(NHSP Indicator# 1, 2, 3, 5)**	eHARS
Strategy D: Coordinate services among community based test sites to ensure a strong treatment referral network for people diagnosed with hepatitis C *(Diagnose, Treat, Prevent)*	CDC, HRSA, state	# of people diagnosed in community settings who are linked to hepatitis treatment services. **(NHSP Indicator# 1, 2, 3, 5)**	VEDSS
Strategy E: Coordinate services among clinical providers including LHD, to ensure a strong treatment referral network for people diagnosed with STIs *(Diagnose, Treat, Prevent)*	CDC, HRSA, state	# of people diagnosed in clinical settings who are linked to STI treatment services. **(NHSP Indicator# 1, 2, 3, 5)**	eHARS
Strategy F: Coordinate services among clinical providers including LHDs, to ensure a strong treatment referral network for people diagnosed with hepatitis *(Diagnose, Treat, Prevent)*	CDC, HRSA, state	# of people diagnosed in clinical settings who are linked to hepatitis treatment services**.(NHSP Indicator# 1, 2, 3, 5)**	VEDSS
Strategy G: By December 31, 2024, initiate pilot sites for implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT). *(Treat, Prevent)*	CDC, state, DBHDS?	# of sites funded, # clients screened, # of referrals. **(NHSP Indicator# 1, 2, 3, 5)**	Meeting minutes and documents

Objective 4.2: By December 31, 2026, increase coordination of HIV programs across governmental agencies and with public and private health care payers, community-based organizations, and academic partners

Strategies	Funding Sources	Outcomes	Data Indicators
Strategy A: Work with federal partners (e.g., HRSA, SAMHSA, CDC, HUD) to identify and reduce duplicative reporting, administrative burden, and barriers to seamless service delivery across the care continuum. Identify and implement best practices for working across federal funding streams to ensure optimal outcomes for PWH and those who experience risk for HIV infection. *(Treat, Prevent, Diagnose)*	CDC, HRSA, State	# and types of best practices identified to streamline the HIV service delivery system, # of federal partners engaged. **(NHSP Indicator# 5, Quality of Life Measure)**	Meeting minutes and program documents
Strategy B: Continue the Washington, D.C., Maryland and Virginia partnership to coordinate data exchanges and services across jurisdictions. *(Treat, Prevent, Diagnose)*	CDC, HRSA	# of meetings; # of data exchanges. **(NHSP Indicator# 2, 3, 5)**	Meeting minutes and program documents
Strategy C: Create partnership with other border states (e.g., North Carolina, West Virginia, Kentucky, and Tennessee) to coordinate data exchanges and services across borders. *(Treat, Prevent, Diagnose)*	CDC, HRSA	# of meetings; # of data exchanges. **(NHSP Indicator# 2, 3, 5)**	Meeting minutes and program documents

Objective 4.3: By December 31, 2026, enhance the quality, accessibility, sharing, and uses of data, including HIV prevention and care to measure, monitor, evaluate, and use the information to report progress and course correct as needed in order to achieve the goals of the integrated plan.

Key Partners: DDP, VDH, DMAS, DBHDS, Veterans Administration, VDOC, VDSS

Strategies	Funding Sources	Outcomes	Data Indicators
Strategy A: Continue DDP monthly rapid response meetings with participation from STD Prevention and Surveillance, HIV Surveillance, HIV Care Services and HIV and hepatitis Prevention to quickly identify geographic areas or potential areas of concern and intervene in potential outbreaks. *(Respond)*	CDC, HRSA, state	Monthly reports to identify unusual or increased case reporting. Identification of actions needed to prepare for or intervene in potential outbreaks. **(NHSP Indicator# 1, 2, 3, 5)**	Meeting minutes
Strategy B: Identify and engage with key VDH offices (e.g., Health Equity, Community Health Services, Family Health Services, etc.) to promote information sharing and education on services provided to intersecting populations. *(Treat, Prevent, Diagnose)*	CDC, HRSA, state	# of meetings, # of key VDH offices engaged. **(NHSP Indicator 2, 3, 5)**	Meeting minutes
Strategy C: Contribute to development of the VDH electronic medical record to meet health care needs of programs serving PWH and those with risk factors for HIV, STIs and viral hepatitis. *(Treat, Prevent, Diagnose)*	ARPA	Establishment of EMR that meets the needs of HIV, STI and viral hepatitis programs. **(NHSP Indicator# 1, 2, 3, 5)**	Program Documents
Strategy D: Provide annual updates on the Cluster Detection and Response Program to key informants and stakeholder groups including care and prevention providers, the CHPG, and the VACAC. *(Respond)*	CDC	# of presentations conducted each year. **(NHSP Indicator# 2, 3)**	Meeting minutes

VI. Monitoring and Evaluation

The 2022-2026 Virginia Integrated HIV Prevention and Care Services Plan is supported by VDH program staff and strong leadership who believe in the vision and purpose of the plan. With respect to data, the plan is informed by robust data systems, including Virginia Electronic Disease Surveillance System (VEDSS), and the Enhanced HIV/AIDS Reporting System (EHARS), a completed Epidemiological Snapshot of the burden of HIV and other STIs in Virginia, and multiple state and local needs assessments, inclusive of voices of PWH. Work groups were established with representation across HIV and hepatitis Prevention, HIV Care Services, HIV Surveillance and STD Prevention and Surveillance. The VDH Provide Enterprise database is a new data source for drawing HIV prevention and care services data, which were used to inform the plan progress.

VDH will utilize its network of existing partnership including the CHPG, the VACAC, and both HIV prevention and care services providers to inform the process. Additionally, stakeholders, including those with HIV have to participate in focus groups and needs assessments to inform the creation of the plan document. Public hearings have been conducted and preliminary plan information will be shared with health departments and other state agencies. Focus for the new plan will include engagement with the Department of Medical Assistance Services, the Department of Aging and Rehabilitative Services and housing partners. DDP's management team holds monthly expenditure meetings to track funding across grants and work units to adjust spending plans.

Virginia has developed a Microsoft Excel tracking tool to continually monitor and track performance of plan indicators, and targets. A similar tool will be developed to track the progress meeting the goals and objectives. Core Virginia plan stakeholders will meet at least quarterly and more frequently if needed to assess plan progress. The status of goals, objectives, indicators, and targets will be reviewed by DDP leadership quarterly, and shared semi-annually at CHPG meetings, the Norfolk RWHAP A TGA and during Quarterly HIV Prevention and Care Contractors' meetings. Plan stakeholders will be present at each meeting and make recommendation on how to make positive momentum on areas of gaps or deficiencies. In 2022, VDH's coordination with these stakeholders began, and will continue throughout the plan cycle.

The Plan Monitoring and Evaluation plan will use performance measurement to continually track the progress meeting pre-established goals, objectives, and indicators and targets. Virginia will collect data to inform progress implementing the plan by reviewing program documents, conducting surveys and focus groups, and potentially conducting environmental scans. Specific National HIV Strategic Plan (NHSP) indicators were included in the plan. Virginia data for these specific indicators was obtained and will be updated annually to inform progress. Measurement of progress will be by comparing against pre-established measures of success for each one of the indicators described in Virginia's logic model. Many of the indicators track the number and types of outputs resulting from specific plan activities. A dashboard using a red light, yellow light, green light system will be used to highlight data and findings. Areas where Virginia is doing well, areas of caution, and areas needing improvement will be highlighted. Reviewing performance will be conducted monthly, and the findings shared with Virginia plan stakeholders on a quarterly basis via the CHPG meetings. Recommendations will be developed if needed, for driving improvements based on the findings shared.

Revisions to the plan will be made at least once per year. More frequent plan updates will made throughout the year depending on the findings and recommendations stemming from quarterly performance measurement meetings, which will be inclusive of the community's voice. Virginia plan stakeholders will review the recommendations derived from the performance measurement process, and decide whether to implement them, and if so, at which level they will be implemented.

Semi-annually, PWH, VDH Staff, and implementation partners (CHPG members) will be updated on the progress of implementing the plan, evaluation findings, and improvements made to the plan during the CHPG meetings. Data and findings will be managed and analyzed using various tools, including Microsoft Excel, Power BI, and dashboards in development to highlight findings. Additionally, Virginia plan findings will be posted to a plan specific webpage on the VDH website. Progress will be shared at contractor meetings, public hearings, and with other community advisory groups.

Inputs	Activities (Aligned with HIV National Strategic Plan)	Outputs	Outcomes
Staff & Resources VDH Staff and Leadership People at Risk for /or Impacted by HIV VA HIV Prevent/ Care Partners Funding Stakeholders and allies. Other Comm. Assessments **Integrated Plan Activities** Data and Evaluation Community Needs Assessment **HIV/STI/Hepatitis National Strategic**	1. Recruit individuals with critical skill sets and fill hard to fill positions. 2. Develop systems of care which coordinate and address inequities in HIV prevention and care services. 3. Coordinate communities to provide equitable access to all available tools to end the HIV epidemic. 4. Address local inequities at the jurisdictional level and develop goals and objectives that align public and private sectors. 5. Assess HIV prevention & care resources & service delivery gaps and needs regardless of source, and allocate resources based on data. 6. Use data to prioritize populations where there is high morbidity and lower viral suppression rates. 7. Promote Status Neutral approach to reduce HIV transmission and improve viral load suppression rates. 8. Address requirements for planning, community engagement, coordination (i.e., RWHAP, CDC, HRSA). 9. Promote equitable delivery of services and engage people with lived experience in service delivery and system design. Transform law and policy to facilitate effective public health intervention 10. Implement activities to reduce impact of STI, Hepatitis, and SUD among at-risk and PWH. 11. Improve access to CHR, PrEP, & PEP.	**O1.** Individuals with critical skill sets recruited and hard to fill positions staffed **O2.** # and types of systems of care developed which address inequities in HIV prevention and care services. **O3.** # and types of tools shared with communities in Virginia. **O4.** # and types of local inequities identified and addressed, and # and type of goals and objectives developed with local jurisdictions **O5.** # and types of prevention and care resources and needs identified with resources allocated to address gaps. **O6.** # and types of data sources used to identify IP priority populations for HIV prevention, care, and reducing disparities. **O7.** # and types of ways SN approach used to reduce HIV transmission and to improve viral suppression rates. **O8.** Requirements for planning addressed. **O9.** # and types of ways that racial justice and health equity addressed. **O10.** # and types of ways law and policy transformed to benefit public health interventions. **O11.** # and type of comorbidity reducing interventions implemented **O12.** Geographic distribution of CHR, PrEP/nPEP points of access & participants.	**Earlier Outcomes** • New HIV infections prevented. • Earlier diagnosis and access to treatment • HIV-related outcomes for people with HIV improved. • HIV-related disparities and health inequities reduced. • Increased # of individuals enrolled in prevention and care services. • Efforts that address the HIV epidemic among all partners and stakeholders are integrated and **Long Term Outcomes** Reduce new HIV Infections by 75% by 2025 Reduce new HIV Infections by 90% by 2030

<<----------Assumptions & External Factors----------

Appendix 1: Completed Integrated Plan Checklist

2022-2026 Integrated Plan Checklist

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
Section I: Executive Summary of Integrated Plan and SCSN	**Purpose:** To provide a description of the Integrated Plan, including the SCSN and the approach the jurisdiction used to prepare and package requirements for submission **Tips for meeting this requirement** 1. Be sure to write the summary with enough detail to ensure the reader understands how you have met Integrated Plan requirements. 2. If you are using a combination of new and existing materials, be sure to describe how submitted materials relate to each other.		
1. Executive Summary of Integrated Plan and SCSN	Provide an overall description of the Integrated Plan, including the SCSN, and the extent to which previous/other plans/SCSNs inform this plan/SCSN, or provide an overall description of an existing plan/SCSN that meets all requirements and includes the information below.	***New material required***	
a. Approach	Describe approach to preparing the Integrated Plan submission (e.g., updated previously submitted plan, integrated sections of existing plans or other documents, developed an entirely new plan, etc.).	***New material required***	
b. Documents submitted to meet requirements	List and describe all documents used to meet submission requirements, including existing materials and newly developed materials used for each requirement.	New material required	N/A

Section II: Community Engagement and Planning Process	**Purpose:** To describe how the jurisdiction approached the planning process, engaged community members and stakeholders, and fulfilled legislative and programmatic requirements including: 1. SCSN 2. RWHAP Part A and B planning requirements including those requiring feedback from key stakeholders and people with HIV 3. CDC planning requirements **Tips for meeting this requirement** 1. Review of the HIV National Strategic Plan and the updated HIV strategy, when released. 2. This requirement may include submission of portions of other submitted plans including the EHE plan submitted as a deliverable for PS19-1906. 3. Be sure to provide adequate detail to confirm compliance with legislative and programmatic planning requirements. 4. The community engagement process should reflect the local demographics. 5. The planning process should include key stakeholders and broad-based communities that include but are not limited to: people with HIV, funded-service providers, and stakeholders, especially new stakeholders, from disproportionately affected communities. See Appendix 3 for required and suggested examples of stakeholders to be included. 6. Explain how the jurisdiction will build collaborations among systems of prevention and care relevant to HIV in the jurisdictions (e.g., behavioral health and housing services). 7. Include community engagement related to "Respond" and support of cluster detection activities.		

1. Jurisdiction Planning Process	Describe how your jurisdiction approached the planning process. Include in your description the steps used in the planning process, the groups involved in implementing the needs assessment and/or developing planning goals and how the jurisdiction incorporated data sources in the process. Describe how planning included representation from the priority populations. This may include sections from other plans such as the EHE plan. Please be sure to address the items below in your description	Jurisdiction created new material.	Pg. 6
a. Entities involved in process	List and describe the types of entities involved in the planning process. Be sure to include CDC and HRSA-funded programs, new stakeholders (e.g., new partner organizations, people with HIV), as well as other entities such as HOPWA-funded housing service providers or the state Medicaid agency that met as part of the process. See Appendix 3 for list of required and suggested stakeholders	Jurisdiction created new material.	Pg. 6
b. Role of the RWHAP Part A Planning Council/Planning Body (not required for state-only plans)	Describe the role of the RWHAP Part A Planning Council(s)/Planning Body(s) in developing the Integrated Plan.	Jurisdiction created new material.	Pg. 6
c. Role of Planning Bodies and Other Entities	Describe the role of CDC Prevention Program and RWHAP Part B planning bodies, HIV prevention and care integrated planning body, and any other community members or entities who contributed to developing the Integrated Plan. If the state/territory or jurisdiction has separate prevention and care planning bodies, describe how these planning bodies collaborated to develop the Integrated Plan. Describe how the jurisdiction collaborated with EHE planning bodies. Provide documentation of the type of engagement occurred. EHE planning may be submitted as long as it includes updates that describe ongoing activities.	Jurisdiction created new material.	Pg.6
d. Collaboration with RWHAP Parts – SCSN requirement	Describe how the jurisdiction incorporated RWHAP Parts A-D providers and Part F recipients across the jurisdiction into the planning process. In the case of a RWHAP Part A or Part B only plan, indicate how the planning body incorporated or aligned with other Integrated Plans in the jurisdiction to avoid duplication and gaps in the service delivery system.	Jurisdiction created new material.	Pg. 7

e. Engagement of people with HIV – SCSN requirement	Describe how the jurisdiction engaged people with HIV in all stages of the process, including needs assessment, priority setting, and development of goals/objectives. Describe how people with HIV will be included in the implementation, monitoring, evaluation, and improvement process of the Integrated Plan.	Jurisdiction created new material.	Pg. 7
f. Priorities	List key priorities that arose out of the planning and community engagement process.	Jurisdiction created new material.	Pg. 8
g. Updates to Other Strategic Plans Used to Meet Requirements	If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe: 1. How the jurisdiction uses annual needs assessment data to adjust priorities. 2. How the jurisdiction incorporates the ongoing feedback of people with HIV and stakeholders. 3. Any changes to the plan as a result of updates assessments and community input. 4. Any changes made to the planning process as a result of evaluating the planning process.	N/A	N/A

Section III: Contributing Data Sets and Assessments	**Purpose:** To analyze the qualitative and quantitative data used by the jurisdiction to describe how HIV impacts the jurisdiction; to determine the services needed by clients to access and maintain HIV prevention, care and treatment services; to identify barriers for clients accessing those services; and to assess gaps in the service delivery system. This section fulfills several legislative requirements including: 1. SCSN 2. RWHAP Part A and B planning requirements including those requiring feedback from key stakeholders and people with HIV 3. CDC planning requirements **Tips for meeting this requirement** 1. This requirement may include submission of portions of other submitted plans including the EHE plan submitted as a deliverable for PS19-1906. Please ensure that if using a previously developed plan that the data included describes the entire jurisdiction and not just a subsection of the jurisdiction such as an EHE priority county. 2. Be sure to provide adequate detail to confirm compliance with legislative and programmatic planning requirements. 3. Include both narrative and graphic depictions of the HIV-related health disparities in the area including information about HIV outbreaks and clusters. 4. The data used in this section should inform both the situational analysis and the goals established by the jurisdiction. 5. Appendix 4 includes suggested data resources to assist with this submission including the Epidemiologic Snapshot.		
1. Data Sharing and Use	Provide an overview of data available to the jurisdiction and how data were used to support planning. Identify with whom the jurisdiction has data sharing agreements and for what purpose.	Jurisdiction created new material	Pg. 8

2. Epidemiologic Snapshot	Provide a snapshot summary of the most current epidemiologic profile for the jurisdiction which uses the most current available data (trends for most recent 5 years). The snapshot should highlight key descriptors of people diagnosed with HIV and at-risk for exposure to HIV in the jurisdiction using both narrative and graphic depictions. Provide specifics related to the number of individuals with HIV who do not know their HIV status, as well as the demographic, geographic, socioeconomic, behavioral, and clinical characteristics of persons with newly diagnosed HIV, all people with diagnosed HIV, and persons at-risk for exposure to HIV. This snapshot should also describe any HIV clusters identified and outline key characteristics of clusters and cases linked to these clusters. Priority populations for prevention and care should be highlighted and align with those of the HIV National Strategic Plan. Be sure to use the HIV care continuum in your graphic depiction showing burden of HIV in the jurisdiction.	Jurisdiction created new material	Pg. 8
3. HIV Prevention, Care and Treatment Resource Inventory	Create an HIV Prevention, Care and Treatment Resource Inventory. The Inventory may include a table and/or narrative but must address **all** of the following information in order to be responsive: ➜ Organizations and agencies providing HIV care and prevention services in the jurisdiction. ➜ HRSA (must include all RWHAP parts) and CDC funding sources. ➜ Leveraged public and private funding sources, such as those through HRSAs Community Health Center Program, HUDs HOPWA program, Indian Health Service (IHS) HIV/AIDS Program, Substance Abuse and Mental Health Services Administration programs, and foundation funding. ➜ Describe the jurisdictions strategy for coordinating the provision of substance use prevention and treatment services (including programs that provide these services) with HIV prevention and care services. ➜ Services and activities provided by these organizations in the jurisdiction and if applicable, which priority population the agency serves. ➜ Describe how services will maximize the quality of health and support services available to people at-risk for or with HIV.	Jurisdiction created new material	Pg. 46

a. Strengths and Gaps	Please describe strengths and gaps in the HIV prevention, care and treatment inventory for the jurisdictions. This analysis should include areas where the jurisdiction may need to build capacity for service delivery based on health equity, geographic disparities, occurrences of HIV clusters or outbreaks, underuse of new HIV prevention tools such as injectable antiretrovirals, and other environmental impacts.	Jurisdiction created new material	Pg. 62
b. Approaches and partnerships	Please describe the approaches the jurisdiction used to complete the HIV prevention, care and treatment inventory. Be sure to include partners, especially new partners, used to assess service capacity in the area.	Jurisdiction created new material	Pg. 46
4. Needs Assessment	Identify and describe all needs assessment activities or other activities/data/information used to inform goals and objectives in this submission. Include a summary of needs assessment data including: 1. Services people need to access HIV testing, as well as the following status neutral services needed after testing: b. Services people at-risk for HIV need to stay HIV negative (e.g., PrEP, Syringe Services Programs) – Needs c. Services people need to rapidly link to HIV medical care and treatment after receiving an HIV positive diagnosis - Needs 2. Services that people with HIV need to stay in HIV care and treatment and achieve viral suppression –Needs 3. Barriers to accessing existing HIV testing, including State laws and regulations, HIV prevention services, and HIV care and treatment service – Accessibility	Jurisdiction created new material	Pg. 55
a. Priorities	List the key priorities arising from the needs assessment process.	Jurisdiction created new material	Pg. 58
b. Actions Taken	List any key activities undertaken by the jurisdiction to address needs and barriers identified during the needs assessment process.	Jurisdiction created new material	Pg. 55
c. Approach	Please describe the approach the jurisdiction used to complete the needs assessment. Be sure to include how the jurisdiction incorporated people with HIV in the process and how the jurisdiction included entities listed in Appendix 3.	Jurisdiction created new material	Pg. 55

Section IV: Situational Analysis	**Purpose:** To provide an overview of strengths, challenges, and identified needs with respect to several key aspects of HIV prevention and care activities. This snapshot should synthesize information from the Community Engagement and Planning Process in Section II and the Contributing Data sets and Assessments detailed in Section III. **Tips** 1. New or existing material may be used; however, existing material will need to be updated if used. 2. This section not only provides a snapshot of the data and environment for goal-setting but meets the RWHAP legislative requirement for the SCSN. 3. Jurisdictions may submit the Situational Analysis submitted as part of their EHE Plan to fulfill this requirement. *However, it must include information for the entire HIV prevention and care system and not just the EHE priority area or service system. If using EHE plans to fulfill this*		
1. Situational Analysis	Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III, provide a short overview of strengths, challenges, and identified needs with respect to HIV prevention and care. Include any analysis of structural and systemic issues impacting populations disproportionately affected by HIV and resulting in health disparities. The content of the analysis should lay the groundwork for proposed strategies submitted in the Integrated Plan's goals and objective sections. The situational analysis should include an analysis in each of the following areas: a. Diagnose all people with HIV as early as possible b. Treat people with HIV rapidly and effectively to reach sustained viral suppression c. Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs) d. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them *Please note jurisdictions may submit other plans to satisfy this requirement, if applicable to the entire HIV prevention and care service system across the jurisdiction.*	Jurisdiction created new material	Pg. 62

a. Priority Populations	Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III, describe how the goals and objectives address the needs of priority populations for the jurisdiction.	Jurisdiction created new material	Pg. 64
Section V: 2022-2026 Goals and Objectives	**Purpose:** To detail goals and objectives for the next 5 years. Goals and objectives should reflect strategies that ensure a unified, coordinated approach for all HIV prevention and care funding. **Tips for meeting this requirement:** 1. Recipients may submit plans (e.g., EHE, Getting to Zero, Cluster and Outbreak Detection and Response plan) for this requirement as long as it sets goals for the entire HIV prevention and care delivery system and geographic area. 2. Goals and objectives should be in SMART format and structured to include strategies that accomplish the following: a. Diagnose all people with HIV as early as possible b. Treat people with HIV rapidly and effectively to reach sustained viral suppression c. Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP) and syringe services programs (SSPs) d. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them. 3. The plan should include goals that address both HIV prevention and care needs and health equity.		
1. Goals and Objectives Description	List and describe goals and objectives for how the jurisdiction will diagnose, treat, prevent and respond to HIV. Be sure the goals address any barriers or needs identified during the planning process. There should be at least 3 goals and objectives for each of these four areas. See Appendix 2 for suggested format for Goals and Objectives. *Please note jurisdictions may submit other plans to satisfy this requirement as long as they include goals that cover the entire HIV prevention and care service delivery system and geographic area.*	Jurisdiction created new material	Pg. 77
a. Updates to Other Strategic Plans Used to Meet Requirements	If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe any changes made as a result of analysis of data.		N/A

Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up	**Purpose:** To describe the infrastructure, procedures, systems, and/or tools that will be used to support the key phases of integrated planning. In this section jurisdictions will detail how best to ensure the success of Integrated Plan goals and objectives through the following 5 key phases: 1. Implementation 2. Monitoring 3. Evaluation 4. Improvement 5. Reporting and Dissemination **Tips for meeting this requirement** 1. This requirement may require the recipient to create some new material or expand upon existing materials. 2. Include sufficient descriptive detail for each of the 5 key phases to ensure that all entities understand their roles and responsibilities, and concur with the process. 3. If you are submitting portions of a different jurisdictional plan to meet this requirement, you should include updates that describe steps the jurisdiction has taken to accomplish each of the 5 phases.		
1. 2022-2026 Integrated Planning Implementation Approach	1. Describe the infrastructure, procedures, systems or tools that will be used to support the 5 key phases of integrated planning to ensure goals and objectives are met	Jurisdiction created new material	Pg. 91
a. Implementation	2. Describe the process for coordinating partners, including new partners, people with HIV, people at high risk for exposure to HIV, and providers and administrators from different funding streams, to meet the jurisdictions Integrated Plan goals and objectives. Include information about how the plan will influence the way the jurisdiction leverages and coordinates funding streams including but not limited to HIV/AIDS Bureau (HAB) and CDC funding.	Jurisdiction created new material	Pg. 91

b. Monitoring	3. Describe the process to be used for monitoring progress on the Integrated Plan goals and objectives. This should include information about how the jurisdiction will coordinate different stakeholders and different funding streams to implement plan goals. If multiple plans exist in the state (e.g., city-only Integrated Plans, state-only Integrated Plans), include information about how the jurisdiction will collaborate and coordinate monitoring of the different plans within the state to avoid duplication of effort and potential gaps in service provision. Be sure to include details such as specific coordination activities and timelines for coordination. Note: Recipients will be asked to provide updates to both CDC and HRSA as part of routine monitoring of all awards.	Jurisdiction created new material	Pg. 91
c. Evaluation	4. Describe the performance measures and methodology the jurisdiction will use to evaluate progress on goals and objectives. Include information about how often the jurisdiction conducts analysis of the performance measures and presents data to the planning group.	Jurisdiction created new material	Pg. 91
d. Improvement	5. Describe how the jurisdiction will continue to use data and community input to make revisions and improvements to the plan. Be sure to include how often the jurisdiction will make revisions and how those decisions will be made.	Jurisdiction created new material	Pg. 91
e. Reporting and Dissemination	6. Describe the process for informing stakeholders, including people with HIV, about progress on implementation, monitoring, evaluation and improvements made to the plan.	Jurisdiction created new material	Pg. 91
f. Updates to Other Strategic Plans Used to Meet Requirements	If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe: 1. Steps the jurisdiction has already taken to implement, monitor, evaluate, improve, and report/disseminate plan activities. 2. Achievements and challenges in implementing the plan. Include how the jurisdiction plans to resolve challenges and replicate successes. 3. Revisions made based on work completed.	NA	NA

Section VII: Letters of Concurrence	Provide letters of concurrence or concurrence with reservation. Each letter should specify how the planning body was involved in the Integrated Plan development. Include a letter of concurrence for each planning body in the state/territory or jurisdiction. See Appendix 6 for a sample Letter of Concurrence.		120
1. CDC Prevention Program Planning Body Chair(s) or Representative(s)	**Virginia Community HIV Planning Group** Bryan Price, Community Co-Chair Elaine Martin, Health Department Co-Chair	Included	120
2. RWHAP Part A Planning Council/ Planning Body(s) Chair(s) or Representative(s)	Norfolk TGA Jerome Cuffee, Planning Council Co-Chair Ashley Brown, Planning Council Co-Chair	Included	121
3. RWHAP Part B Planning Body Chair or Representative			
4. Integrated Planning Body	If submitting an EHE plan, please ensure that the EHE planning body concurs.	N/A	N/A
5. EHE Planning Body	If submitting an EHE plan, please ensure that the EHE planning body concurs	N/A	N/A

Appendix 2: Acronyms

ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
ASO	AIDS Service Organization
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CDR	Cluster Detection and Response
CHARLI	Comprehensive HIV/AIDS Resources and Linkages for Individuals experiencing Incarceration
CHPG	Community HIV Planning Group
CHR	Comprehensive Harm Reduction
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
DOJ	Department of Justice

DSA	Data Sharing Agreement
DSI	Division of Surveillance and Investigation
DSS	Department of Social Services
DtC	Data to Care
eHARS	Enhanced HIV/AIDS Reporting System
EIS	Early Intervention Services
ELR	Electronic Lab Reporting
EMA	Eligible Metropolitan Area
HAB	HIV/AIDS Bureau
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 (replaces former HPS at VDH)
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
IDU	Injection Drug Use
IHSP	Integrated HIV Services Plan
LGBT	Lesbian, Gay, Bisexual, Transgender
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning
LHD	Local Health Department
MAI	Minority AIDS Initiative
MAVEN	Name of current STI database used; not an acronym
MD	Maryland
MMP	Medical Monitoring Project
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding

MSA	Metropolitan Statistical Area
MSM	Men Who Have Sex with Men/Male-to-male sexual contact
NC	North Carolina
NHAS	National HIV/AIDS Strategy
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
OEpi	Office of Epidemiology
OFHS	Office of Family Health Services (VDH)
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
S&C	Security and Confidentiality
SAMHSA	Substance Abuse and Mental Health Services Administration
SFTP	Secure File Transfer Protocol
SODA	Surveillance, Operations and Data Administration (DDP)-former name of current SPS
SNSN	Status Neutral Service Navigation Program

SPS	STD Prevention and Surveillance (new name for former SODA)
SSP	Syringe Services Program
STI	Sexually Transmitted Infection
STD*MIS	Sexually Transmitted Disease Management Information System
SUD	Substance Use Disorder
TA	Technical Assistance
TGA	Transitional Grant Area
VA	Virginia
VACAC	Virginia Quality of Care Consumer Advisory Committee
VA MAP	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 III: Letters of Concurrence:

1. CHPG Letter of Concurrence:

December 7, 2022

Sarah S. Yacoub
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 Ms. Johnson 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 2022-2026. 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 most disproportionately affected populations 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 18 months on the plan development. The plan was the primary focus of the CHPG's retreat in October, and a final opportunity to provide input for the plan was conducted via remote meeting on November 18, 2022. The signatures below confirm the concurrence of the planning body with the 2022-2026 Integrated HIV Prevention and Care Plan.

Sincerely,

DocuSigned by:
Bryan Price
C197BEA8166A41F...

Bryan Price
Community Co-Chair

DocuSigned by:
Elaine Martin
987DC44A3282467...

Elaine Martin Health
Department Co-Chair

Virginia Community HIV Planning Group, 109 Governor Street, 3rd floor, Richmond, VA 23219

2. Norfolk TGA Letter of Concurrence:

Monday, December 5, 2022

Virginia Department of Health Services

Division of Disease Integration Services

Integrated Planning Team

The Norfolk Transitional Grant Area Ryan White Part A 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/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 year (CY) 2022-2026.

The Norfolk Transitional Grant Area Ryan White Part A Planning Council has reviewed the Virginia HIV/STI/Hep C 2022-2026 Integrated Plan submission to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The Norfolk Transitional Grant Area Ryan White Part A Planning Council concurs that the Integrated Virginia HIV/STI/Hep C 2022-2026 Integrated 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.

VDH, in conjunction with Norfolk Transitional Grant Area Ryan White Part A Planning Council and community members conducted an extensive planning process throughout 2021-2022 to develop the Integrated Plan. Activities included Triennial needs assessments surveys for HIV Care and HIV Prevention Services, subject matter expert workgroups and a systems-level Oversight Committee; and sharing and listening sessions held during planning bodies meetings. These activities included persons with HIV and hepatitis C, community advocates, community based organizations providing care and prevention services, medical providers, and other community groups affected by HIV/STIs/Hep C who had not previously been engaged in planning processes.

The signatures below confirms the concurrence of the Norfolk Transitional Grant Area Ryan White Part A Planning Council with the Virginia HIV/STI/Hep C 2022-2026 Integrated Plan submission.

Respectfully,

Jerome Cuffee (Dec 5, 2022 11:20 EST)

Jerome Cuffee
Planning Council Co-Chair

Ashley Brown (Dec 5, 2022 14:22 EST)

Ashley Brown
Planning Council Co-Chair