INTEGRATED HIV/AIDS PLANNING IHAP TA CENTER

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Integrated HIV Prevention and Care Plan

Virginia Integrated HIV Services Plan 2017-2021

REGION	South
PLAN TYPE	Integrated state/city/county prevention and care plan
JURISDICTIONS	State of Virginia and Norfolk County TGA
HIV PREVALENCE	High

Virginia's Integrated HIV Prevention and Care Plan, which includes the Norfolk County TGA, includes SMART objectives that are specific, measurable, and timed, and align with each of the four NHAS goals. It includes baseline data for each objective to measure progress towards the target and also includes a column in the Integrated Plan chart on "Gap" to indicate whether the activities are intended to fill gaps along the Virginia HIV Care Continuum. It also includes an additional chart that outlines the yearly targets for each SMART objective and includes a description of how the strategies/activities were developed.

SELECTION CRITERIA: INTEGRATED HIV PREVENTION AND CARE PLAN

Exemplary Integrated HIV Prevention and Care Plan sections met the following criteria (based on the Integrated HIV Prevention and Care Plan Guidance):

- ☑ Comprised of SMART objectives, strategies to correspond to each objective, activities, targeted population, timeframe, resources needed, who is responsible for each task, covers time period 2017-2021
- ☑ Specific metrics to monitor activities
- ☑ Objectives and activities aimed at addressing gaps along the HIV Care Continuum.
- ☑ Objectives that align with the National HIV/AIDS Strategy (NHAS)
- ☑ Description of how the Integrated Plan was developed

Additional exemplary plan sections are available online:
www.targetHIV.org/exemplary-integrated-plans

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

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

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

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

Section II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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