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Assessing Needs, Gaps, and Barriers

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 provides a clear description of their multi-faceted approach to recruiting, engaging, and soliciting input from PLWH and those at risk. They also provide a nice narrative and visual description of the "Double Helix" continuum that outlines the different and related services needs for those at risk and PLWH. Finally, the jurisdiction breaks down needs and gaps in several ways: by three subgroups of PLWH (individuals 'unaware' of their HIV status, aware of their HIV status but 'not in care,' and 'in care'; needs and gaps of the Norfolk TGA versus the state as a whole as well as the different regions of the state; and population specific needs and gaps (e.g. MSM, IDU, sex workers, active military, rural population, etc.).

SELECTION CRITERIA: ASSESSING NEEDS, GAPS, AND BARRIERS

Exemplary Assessing Needs, Gaps, and Barriers sections met the following criteria (based on the Integrated HIV Prevention and Care Plan Guidance):

- ☑ Includes description of the process used to identify HIV prevention and service needs of those at risk and PLWH
- ☑ Demonstrates engagement of those at risk and PLWH in planning
- ☑ Clear and robust description of service needs
- ☑ Clear and robust description of service gaps
- ☑ Clear and robust description of barriers (social, policy, health department, program, service provider, and client barriers).

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

information, the new Virginia Case Management Standards, Virginia Data to Care initiatives, insurance management, and how to sharing existing resources. DDP will continue assess retention ongoing and offer this training as needed in future years.

DDP is planning to expand access to pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) for high-risk individuals, particularly MSM, over the next five years. However, because Virginia is not a Medicaid expansion state and not everyone qualifies for subsidies under the ACA, low-income individuals may not have access to PrEP outside of Gilead Sciences, Inc.'s Truvada for PrEP Medication Assistance Program. DDP has purchased medications for both PrEP and nPEP with state funding. DDP is working with both health districts and other medical providers across the state to increase access to PrEP and nPEP for individuals at risk for HIV. In addition, DDP has received funds through CDC to promote PrEP and nPEP in the Virginia Beach-Norfolk-Newport News MSA. These activities include conducting provider education, recruiting providers to become PrEP and nPEP prescribers, patient navigation services for PrEP and social marketing to promote PrEP awareness with a focus on reaching MSM, transgender persons (especially among communities of color) as well as others at risk for HIV including partners of people living with HIV.

D. Assessing Needs, Gaps, and Barriers

a. Process used to identify HIV prevention and care service needs of people at higher risk for HIV and PLWH (diagnosed and undiagnosed).

<u>Overview of Process</u>

- **Commonwealth of Virginia**

VDH utilized a mixed methods approach to assess the need for HIV prevention and care services within the Commonwealth. This included the review and analysis of the data already presented in the Epidemiology Overview section of this plan (e.g., HIV surveillance data, HIV Care Continuum data, demographic and socio-economic data from the 2014 five-year American Community Survey [ACS], etc.). The 2014 ACS data included: demographic profile of the general population (i.e., total population by sex, race/ethnicity, and age group), population living below 100% of the federal poverty level (FPL), educational attainment, per capita income, employment status, foreign-born population, language spoken at home, English spoken less than "very well," gross rent as a percentage of household income, and health insurance status. This data was compiled for Virginia's five health regions using the Federal Information Processing Standard (FIPS) codes, for the counties and independent cities in each region. FIPS codes are used to uniquely identify counties and county equivalents in the U.S. Additional data that were reviewed included Ryan White program data, HIV testing data, specific HIV surveillance reports (e.g., late testing, deaths, HIV incidence surveillance), sexually transmitted disease information, and the 2015 End of Year Report for Comprehensive HIV Prevention Programs for Health Departments. Lastly, many journal articles were also reviewed to inform this process.

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

qualitative data was gathered at: (1) a two-day consumers training on quality management of HIV/AIDS, which targets PLWH; (2) the cross-parts collaborative Quality Management Advisory Committee (QMAC) meeting, a committee which comprises of VDH staff, contracted providers and consumers; and (3) the Quarterly Contractors Meeting which comprised of contracted providers. In addition, a provider survey was disseminated via Survey Monkey, which assesses needs and challenges faced by providers in providing care to consumers and people at risk for HIV.

In addition to this data analysis, VDH conducted additional needs assessment data collection with targeted groups. These included:

- 2016 consumer survey distributed during two consumer meetings (88 responses)
- 2016 19 semi-structured consumer interviews
- 2016 targeted consumer focus groups/town halls targeting both PLWH and persons at risk for HIV (4 focus groups/town halls completed with 120 participants)
- 2016 provider survey (123 respondents)
- 2016 focus groups with provers (52 participants)
- Survey among People Who Inject Drugs
- Medical Monitoring Project data

- **Norfolk TGA**

To assess the needs specific to the Norfolk TGA, VDH relied heavily on a review of their local documents. These included the following:

- Norfolk TGA Comprehensive in Care, Newly Diagnosed & Out of Care PLWH/A: 2013 Report of Findings
- Fiscal Year (FY) 2016 Ryan White Part A Grant Application – sections specific to the Early Identification of Individuals with HIV/AIDS (EIIHA) and unmet need analysis
- FY 2014 Client Demographics
- 2017 Prioritized Service Categories for Ryan White Part A Services
- 2017 Resource Allocation by Service Category
- 2016 financial resources inventory
- 2016 assessment of clinical (i.e., HIV physicians) workforce challenges

In addition, VDH reviewed 2015 HIV surveillance data for the TGA, HIV Care Continuum data, and 2014 five-year ACS demographic and socio-economic data described above.

Strategies for Targeting, Recruiting, Retaining and Participants in Process

The following describes the process used for targeting, recruiting, and retaining participants in the needs assessment process for targeted activities.

- **Participation from PLWH and Persons at Risk for HIV**

As part of its mixed methods design, VDH used three tools to gather additional needs assessment data from PLWH and persons at high risk for HIV (i.e., survey, semi-structured interviews, and focus groups/town halls). VDH conducted recruitment and implementation of these tools during May and June of 2016. Due to time limitations, VDH leveraged pre-scheduled meetings to

recruit participants for the semi-structured interviews, focus groups, and distribute the consumer survey. A limitation of this approach was that there were more PLWH than persons at-risk for HIV or PLHW not engaged in care in attendance. As a result, the qualitative and survey data gathered is more representative of PLWH than of persons at-risk for HIV or lost-to-care. The consumer survey specifically targeted PLWH; 108 questionnaires were distributed to PLWH and 88 returned for a 73.3% response rate.
Recruitment for the PLWH focus groups/town halls, semi-structured interviews, and consumer survey were completed at pre-scheduled meetings and training events that brought together PLWH and persons at-risk for HIV. These events included the cross-parts collaborative Quality Management Advisory Committee (QMAC) and the consumers training on quality management. The focus groups/town halls, interviews, and surveys predominantly reached African American males and VDH partnered with providers and community-based organization (CBO) with a large Latino client base to recruit participation from more Latinos living with and at risk for HIV. NovaSalud, a CBO serving the Latino population in the Northern region, assisted in organizing a 12- person, Spanish-language focus group with Latinos from myriad of countries of origin, who were living with or at-risk for HIV.

- **Participant Description**

  The majority of participants in the consumer focus group and survey assessments were African-American males who self-identified as gay. Latino gay men comprised the second largest group of participants. Ages of participants ranged from younger than 25 years to over 70 years. Sixty-two percent of survey respondents were male; 36.4 % were female; and 1.6% transgender. All consumer focus groups were comprised of more male participants than female. Ninety-eight percent of the consumer survey respondents reported currently being in care. About 98% of consumer interview and focus group respondents also reported being in care.

- **Provider Surveys and Focus Groups**

In addition to investigating the needs of clients from their perspective, DDP also assessed service needs from the provider's perspective. DDP conducted four provider focus groups and administered a provider survey via Survey Monkey. One hundred and twenty three (N=123) providers across the state responded to the survey and fifty-two participated in the focus groups. Except for the online provider survey, pre-scheduled meetings and training events were used to recruit participants for the provider focus group. The two meetings included the cross-parts collaborative Quality Management Advisory Committee (QMAC), the Virginia Ryan White Part B Quarterly Contractors Meeting (QCM). One hundred and twenty three providers responded to the online survey.

- **Engagement of Other Stakeholders, Including PLWH**

VDH planning staff presented the consumer and provider needs assessment findings to Virginia's Community HIV Planning Group (CHPG), the Norfolk TGA's Greater Hampton Roads HIV Services Planning Council, PrEP planning group, 1506/1509 planning team, Drug User Health Workgroup, Racial Disparities Among MSM workgroup, and the VDH Integrated Plan workgroup, which was comprised of the Surveillance Unit, HIV Prevention Unit, HIV Care Unit, STD Surveillance, and Operations and Data Administration (SODA) 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, which is comprised of representatives from Ryan White Parts A, B, C and D, CBOs, Department of Behavioral Health, the Department of Corrections, homeless service institutions, , HIV prevention and care providers, labor industries, academic institutions, psychosocial support and treatment service providers, officials supporting efforts against transmission of HIV, tuberculosis, hepatitis and STDs, local and state health departments, and other stakeholders. The working sessions led to agreement of what objectives, strategies and, activities to include in the work plan, as well as target population prioritization. Participants at the CHPG meeting were asked to review initial strategies and activities, and to provide feedback. Amendments were made and incorporated into the final work plan (Appendix B).

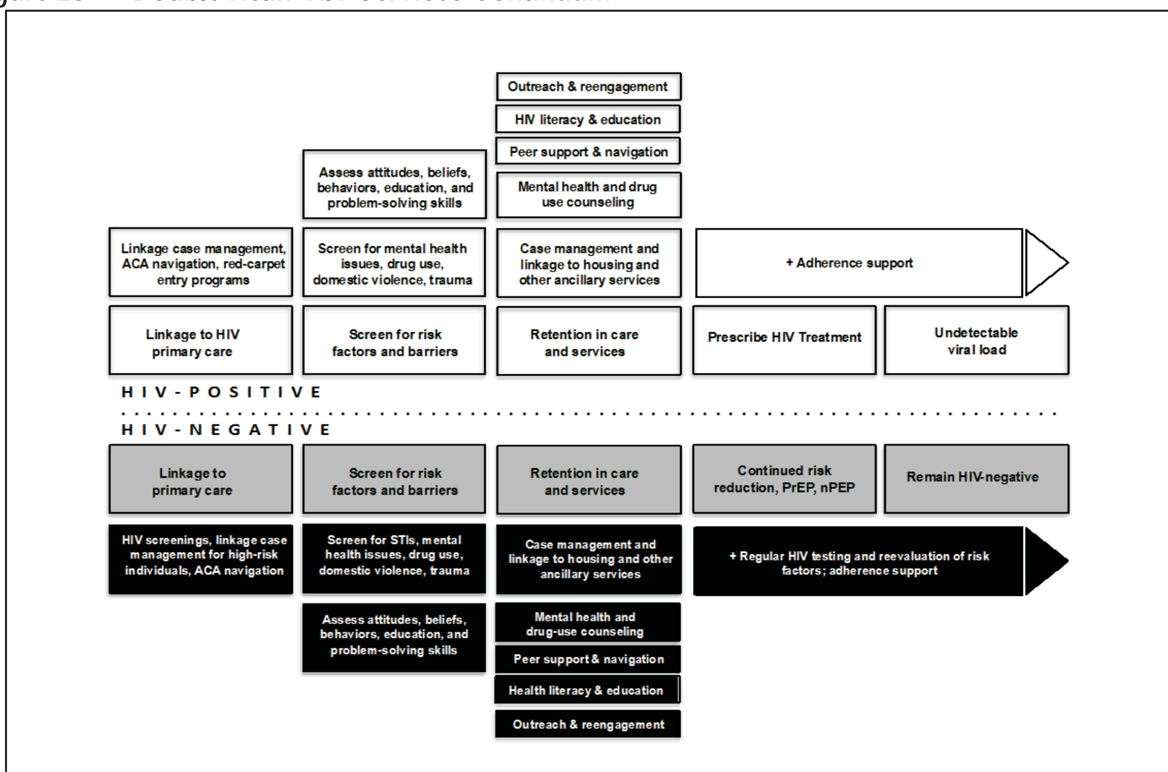
b. & c. HIV prevention and care *service needs and gaps*.

Overview

The tremendous advances in science, including the understanding of not only how to treat HIV, but also to prevent HIV has resulted in the need for more integration between HIV prevention and care. Science has demonstrated that there is reduced transmission when PLWH are virally suppressed.[cxiii] As a result, "treatment as prevention" has become one of the foremost strategies to end the HIV epidemic. Nine of the CDC's 14 required interventions that are part of its current *High-Impact HIV Prevention* strategy target HIV positive individuals and include efforts to improve linkage to care, retention in care, and treatment adherence.

Thus, to understand service needs, gaps, and barriers, one must identify the populations that will need these services as well as the specific services themselves. The two broad categories of people needing these services include those who are HIV positive (i.e., PLWH) as well as those who are HIV negative whose behaviors put them at high risk for HIV (i.e., high-risk negative persons, abbreviated as HRN). Although the HIV Care Continuum provides an invaluable tool for discussing needs of PLWH, it is less useful for HRN. VDH plans to develop an integrated HIV prevention and care continuum. However, until this model is complete, the Treatment Action Group's "Double Helix" continuum (Figure 23) offers a starting point for discussing service needs.[cxiv]

Figure 23. 'Double Helix' HIV Services Continuum



Source: Treatment Action Group, Toward Comprehensive HIV Prevention Service Delivery in the United States, June 2015.

The double helix in the figure above provides a "mirrored" services continuum, focusing on PLWH (i.e., HIV positive) on the top and High Risk Negative persons (HRN) on the bottom. The service needs within each continuum are similar with only slight differences specific to HIV status. The first layer of services for PLWH closely aligns with the HIV Care Continuum, and begins with "linkage to care" and works towards having an "undetectable viral load." The upper layers of the HIV-positive half of the double helix address a variety of other medical and support service needs of PLWH that help ensure they become fully engaged and retained in HIV medical care and adherent to treatment. Screening for personal risk factors and barriers is an essential part of the individual's needs assessment and care planning process as these factors can be major barriers to engagement and retention in care.

The HIV-negative side of the double helix depicts a similar path for HRN and begins with linkage to care. Now that full implementation of the ACA is well underway, ensuring that HRN individuals also accesses regular primary care services may well serve as a protective factor against acquiring HIV. Having a medical home may also facilitate access to pre-exposure prophylaxis (PrEP) for those at highest risk of acquiring HIV. The goal of this continuum is that the person remains HIV-negative over time.

However, within these broad population groups there are specific subpopulations with different needs. For example, there are three broad subpopulations of PLWH (i.e., persons in care, persons not in care, and persons who remain undiagnosed). Other subpopulations (e.g., racial/ethnic, gender identity, age group, those grouped by transmission risks) may also have unique service needs, as well as barriers to accessing them). Not all populations have equitable

access to services. There are many social, structural, and personal barriers that prevent PLWH and HRN from engaging and utilizing HIV services available to them.

<u>Shared Service Needs and Gaps - All Populations</u>

There are some needs that are shared by all persons, regardless of their HIV status, and regardless of their age, race, ethnicity, sex, gender identity, or sexual orientation. Addressing them, will improve the quality of services and health outcomes and remove systemic barriers that prevent the full and equitable participation of all Virginians in the portfolio of HIV services available to them. Table 16 summarizes at least three common service needs with their associated gap(s).

Table 16. Shared Service Needs and Gaps of All Populations

Needs	Gaps
• To address social determinants of health, especially poverty, educational attainment, housing, etc. that are associated with increased risk for acquiring/transmitting HIV	• No coordinated effort across health, education, social service, and employment sectors to address social determinants of health as a strategy to improve health outcomes of PLWH and persons at risk for HIV
• Improved access to and use of health care services	• An estimated 12.1% of Virginians are uninsured • Approximately 27% of FY 2016 ADAP clients are uninsured
• A trauma-informed approach to service delivery	• HIV service providers lack training on trauma-informed care to understand the impact of different types of trauma (emotional abuse, neglect, physical abuse, other forms of violence including intimate partner violence, family dysfunction) on people's lives, behavior, and their health outcomes, as well as how long-lasting effects of trauma may be a barrier to accessing the full portfolio of HIV services in Virginia

<u>Service Needs and Gaps of PLWH</u>

The service needs and gaps of PLWH must be examined through multiple lenses, using mixed methods data collection and analysis. As noted earlier, there are three subgroups of PLWH, including those who are: (1) 'unaware' of their HIV status, (2) aware of their HIV status but 'not in care,' and (3) are 'in care.'

- **Persons Living with HIV who are Unaware of their HIV status**

Persons who have undiagnosed HIV infection need to be (1) found, (2) tested for HIV to learn their HIV status, and (3) linked to care once newly-diagnosed. Table 17 examines the associated gaps to these activities.

Table 17. Service Needs and Gaps of Persons Living with HIV who are *Unaware* of Their Status

Needs	Gaps
• To identify high risk individuals through effective, innovative	• CDC estimates that 12.7% of all PLWH in Virginia are undiagnosed; this estimate is even higher (14.8%) for males

outreach (e.g., social network models, high risk venues, social media approaches, etc.) and other approaches (e.g., partner services)	13 years and older attributed to male-to-male sexual contact; applying this 2012 estimate to Virginia's 2015 HIV diagnosed cases yields an estimate of 3,576 undiagnosed persons, of whom an estimated 2,009 are MSM*
• Increase accessibility and provide *HIV testing* to high risk individuals	• Based on a 1%-4% HIV seropositivity test rate, Virginia will need to conduct between 89,400 to 357,600 HIV tests to identify the estimated 3,576 persons (this excludes any new infections that occur to increase HIV prevalence) • CDC estimates higher new HIV diagnoses in geographic areas impacted by social determinants of health (SDH). Except for VDH's pharmacy based testing program, there are few programs that geographically target testing using SDH combined with HIV prevalence data.
• Provide *linkage to care* for newly-diagnosed HIV positive individuals	• Linkage to care is not a billable service under any health insurance plan. Thus, resources to support this service must be identified through other potential sources (e.g., CDC, Ryan White, state/local discretionary funds, etc.)

*This likely underestimates total MSM as it excludes persons with dual risk of MSM/IDU and also excludes the large proportion of cases that have no identified risk, many of which may be MSM.

- **Persons Living with HIV who are Aware of their HIV status but Not in Care**

Similar to unaware PLWH, PLWH who already know their status share two needs: (1) to be found, and (2) linked to care for the first time if they have never been in care or re-engaged into care if they were once in care but dropped out. Once they are re-engaged into care, they share all of the needs of PLWH who are in care. Table 18 presents a brief description of these two needs of this population and associated gaps in Virginia's HIV services continuum.

Table 18. Service Needs and Gaps of Persons Living with HIV who are *Not in Care*

Needs	Gaps
• Effective, innovative *outreach* (e.g., social network models, data-to-care, use of social media, etc.) that identifies PLWH who are not in care	• Virginia launched its Data to Care intervention in 2014. This CDC intervention uses HIV surveillance data to identify PLWH who appear to be 'not in care'. Virginia uses a hybrid model and partners with local health departments and HIV medical clinics to assist in the follow-up. The program itself is labor intensive and requires an ongoing commitment of staff resources for success. The program needs to expand, especially in high prevalence areas with large numbers of PLWH who appear to be not in care • Innovative models need to be developed to identify PLWH who are not in care
• *Linkage to care* to engage or re-engage PLWH who are not in care into care	• Linkage to care is not a billable service under any health insurance plan. Resources to support this service must be identified through other potential sources (e.g., CDC, Ryan White, state/local discretionary funds, etc.)

- **Persons Living with HIV who are in care**

On the Double Helix continuum—"screen for risk factors and barriers"—represents the individual needs assessment of a PLWH. This is followed by "retention in care and services." Identifying the needs of PLWH and addressing them is critical as it promotes retention in care and treatment adherence. To assess the service needs of PLWH, VDH conducted a brief survey with PLWH recruited through a consumer training on quality management. VDH also conducted focus groups and semi-structured interviews with PLWH to deepen their understanding of needs, barriers, and gaps. The survey is a convenience sample of attendees of the meeting and results are not generalizable to all PLWH in Virginia. They provide a glimpse of the service needs and gaps of the survey respondents. A total of 88 PLWH completed the survey. Table 16 presents the results of service needs and gaps identified through the consumer survey. One question asked respondents to identify whether or not if they *needed* a service and if they were using the service or if they *needed but did not receive* the service (i.e., a gap). The results are listed in the order of the *service gap* versus *service need* as this approach highlights where there may be challenges in the service delivery system that require attention. At the consumer level, a service need that is filled is not a problem. It is the service need that is not filled that is the real challenge.

There were some challenges with the PLWH survey data; not everyone who took the survey completed every question. Therefore, the percentages are derived from the number of PLWH who completed the question versus the number who completed the survey. None of the questions were required, so a respondent could skip that specific question. Except for oral/dental care, four of the top five service gaps are for services that are categorized by HRSA as Ryan White support services. The top five service gaps are: (1) emergency financial assistance (25.9%); (2) housing assistance (24.4%); (3) food assistance (22.6%); (4) oral/dental care (22.0%); and non-medical case management (18.2%).

As housing assistance ranked as the second-highest need in the data from the consumer survey, this was also an expressed need of in the client focus groups, along with other basic living needs. One participant stated:

> *If I do not have a place to live, my priority should be finding a place to live, not getting HIV medication. Also, if I have no money to get basic needs like food and water, do you really think my HIV medications are my priority? Medications go with food and water and if I cannot provide those, I won't be taking any medications.*

The need for oral/dental care was identified by survey respondents as the top needed service (80.5%) of survey respondents; it also ranked fourth in terms of a service gap (22%). Good oral health is especially important for PLWH 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 willing to provide services to PLWH in Virginia. 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 PLWH. The need for an increase in mental health and substance use treatment providers were needs also cited by focus group participants. Shortage of mental health and substance use treatment counselors in Virginia was

identified as a major barrier to access these services. Respondents from the Southwest are excited about the telemedicine mental health service now available in the area and hope that this will be replicated for other services, as the Southwest region experiences a shortage in healthcare providers compared to other areas of the state. The shortage of mental health and substance use providers can result in poorer health outcomes for PLWH needing these services.

Norfolk TGA: As a Ryan White Part A jurisdiction, the Norfolk TGA regularly conducts a needs assessment with PLWH who are in care, not in care, and are newly-diagnosed to determine needed services, gaps in services, and barriers to care. Table 19 presents the top ranked service needs and service gaps of newly-diagnosed PLWH and PLWH who are in care who are living in the Norfolk TGA. Also included are top five ranked services with experienced barriers.

The results of the Norfolk TGA needs assessment are slightly different than the brief survey conducted by VDH. It is important to note that the Norfolk TGA needs assessment took place in 2013, which was prior to the full implementation of the ACA. Although Virginia is not a Medicaid expansion state, Virginians living at or below 200% of the FPL are eligible for government subsidies, making health insurance more affordable. The top five service gaps for PLWH who are in care are: (1) housing assistance, (2) insurance, (3) emergency financial assistance, (4) transportation, and (5) nutrition assistance. The top five services for newly-diagnosed persons are: (1) housing assistance, (2) health insurance premium cost sharing assistance, (3) insurance, (4) transportation, and (5) medication co-pay assistance. Thus, the needs of PLWH who are in care are largely support services needs, while the needs of PLWH who are newly-diagnosed center on getting and maintaining access to medical care and medications. The Norfolk TGA is planning their 2017 needs assessment and it will be important to see any changes in these gaps, especially post ACA implementation.

Table 19. Service Needs and Gaps of People Living with HIV: Findings from 2016 PLWH Survey, n88

Description of Service	Total Respondents	Need	Gap	
		Percent	Number	Percent
Emergency Financial Assistance	85	45.9%	22	25.9%
Housing assistance	82	40.2%	20	24.4%
Food assistance	84	56.0%	19	22.6%
Oral/dental care	82	80.5%	18	22.0%
Non-medical case management	77	51.9%	14	18.2%
Emotional support	84	56.0%	14	16.7%
Job training	80	22.5%	12	15.0%
Mental health	82	50.0%	11	13.4%
Legal	77	19.5%	10	13.0%
Health insurance premium/ cost sharing assistance	82	69.5%	10	12.2%
Medical nutrition therapy	82	31.7%	10	12.2%
Treatment adherence counseling	75	41.3%	8	10.7%
Medical transportation	83	37.3%	8	9.6%
Medical case management	85	81.2%	7	8.2%
Outpatient HIV care	80	56.3%	6	7.5%
Outreach	80	30.0%	6	7.5%
Assistance applying for insurance, SSD benefits, Medicare, Medicaid, etc.	83	42.2%	6	7.2%
Patient assistance program through pharma	75	32.0%	5	6.7%
Health education/risk reduction	80	37.5%	5	6.3%
Assistance telling my current or future sex/needle sharing partner about my HIV status	81	9.9%	5	6.2%
AIDS Drug Assistance Program (ADAP)	80	63.8%	4	5.0%
Substance use treatment	80	12.5%	3	3.8%
Home health care	80	11.3%	3	3.8%
Translation services during medical visits	80	7.5%	3	3.8%
Child care	79	6.3%	3	3.8%
Access to free condoms	84	49.4%	2	2.5%
HIV prevention services for my sex/needle sharing partners	79	11.4%	2	2.5%
HIV medication assistance after being released from jail	82	17.1%	1	1.2%
Interpretation and translation	74	6.8%	1	1.4%
Assistance notifying my sex/needle sharing partners to get tested	81	11.1%	1	1.2%
HIV or STD testing	82	39.0%	1	1.2%
Linkage to a medical provider	84	35.7%	1	1.2%

Source: 2016 VDH Consumer Survey (convenience sample of attendees at QM training)

Table 20. 2013 Ranked Service Needs and Gaps for Newly-Diagnosed and In Care PLWH

NORFOLK TGA	
The Norfolk TGA includes the Virginia cities of Chesapeake, Hampton, Newport News, Norfolk, Poquoson, Portsmouth, Suffolk, Virginia Beach and Williamsburg; and counties of Gloucester, Isle of Wight, James City, Mathews and York within Virginia's Eastern Health Region; and Currituck County in North Carolina.	
Top ranked service needs	
'Newly Diagnosed' Persons	**'In Care' PLWH**
1. Ambulatory Outpatient Medical Care	1. Ambulatory Outpatient Medical Care
2. Support Groups	2. Medication Assistance
3. Medication Assistance	3. Housing assistance
4. Nutrition Assistance	4. Support Groups
5. Health Education / Peer Mentor	5. Transportation
6. Medical Case Manager	6. Insurance
7. Mental health	7. Nutrition Assistance
8. Housing assistance	8. Mental health
9. Transportation	9. Medical Case Manager
10. Exercise	10. Other: Employment Assistance
11. Insurance	11. Health Education / Peer Mentor
12. Emergency Financial Assistance	12. Exercise
Top ranked service gaps	
'Newly Diagnosed' Persons	**'In Care' PLWH**
1. Housing assistance	1. Housing assistance
2. Health Insurance Premium Cost Sharing Assistance	2. Insurance
3. Insurance	3. Emergency Financial Assistance
4. Transportation	4. Transportation
5. Medication Co-Pay Assistance	5. Nutrition Assistance
6. Emergency Financial Assistance	6. Other: Vision Care
7. Other: Disability Assistance	7. Health Insurance Premium Cost Sharing Assistance
	8. Other: Employment Assistance
	9. Oral Health
	10. Support Groups
	11. Medication Co-Pay Assistance
	12. Other: Disability Assistance
Top 5 ranked services with barriers	
'Newly Diagnosed' Persons	**'In Care' PLWH**
1. Housing Assistance	1. Housing Assistance
2. Health Insurance Premium Cost Sharing Assistance	2. Emergency Financial Assistance
3. Insurance	3. Other: Employment Assistance
4. Emergency Financial Assistance	4. Insurance
5. Other: More Services in Rural Areas	5. Transportation

Source: Norfolk TGA, Comprehensive 'In-Care', 'Newly Diagnosed' & 'Out of Care' PLWH/A Needs Assessment, 2013 Report of Findings. Available from: http://www.ghrplanningcouncil.org/site/2015/04/2014NorfolkTGAFinal%20Report08192014.pdf.

Service Needs for Persons at-risk for HIV

The Double Helix continuum shows the service needs of HIV-negative individuals' mirrors that of HIV-positive individuals. It begins with linkage to primary care and includes HIV screening at that first step. It progresses to include screening for risk factors and behaviors, retention in care and services, continued risk reduction and access to PrEP and nPEP as appropriate. All these stages culminate in the person remaining HIV-negative. Table 21 presents the service needs and gaps of persons at risk for HIV, including HRN.

Table 21. Service Needs and Gaps of Persons at-risk for HIV

Needs	Gaps
• Improved access to and use of health care services	• An estimated 12.1% of Virginians are uninsured
• Access to pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP)	• Limited number of providers currently prescribing PrEP (less than 25 identified by VDH as of August 2016)
• CDC high-impact prevention toolbox	• *Behavioral interventions targeting HRN* – Resources need to support effective interventions among highest risk groups.
• Syringe exchange services	• Syringe exchange services are currently illegal in Virginia. However, they play an important role in reducing risk of HIV transmission among PWID. The experience of the HIV outbreak in Scott County, Indiana put a national spotlight on HIV transmission through sharing of needles, which culminated in January 2016 of the lifting of the ban to use federal funds for syringe services. Continued efforts are needed in Virginia to make syringe services available to PWID.
• Partner Services	• The CDC's 2015 STD Treatment Guidelines recommend that partner services be provided to all persons newly-diagnosed with HIV infection. They also recommend that identified partners be provided nPEP. Currently, the capacity to conduct partner services across local health departments varies considerably. Continued resources need to support expansion of partner services for newly-diagnosed PLWH.

Population Specific Service Needs

The populations below were prioritized by the Virginia Community HIV Planning Group (CHPG) as being populations of concern in the Commonwealth. The service needs and gaps described are the result of innumerable meetings, presentations, and discussion of this group over the past three years since completion of the last Comprehensive HIV Plan and Statewide Coordinated Statement of Need in 2012 and Prevention Plan update in 2014. The needs described represent the consensus of this group.

Men who have Sex with Men, including those living with HIV

Need: Expand availability of and access to culturally-sensitive health care pertaining to health issues of gay/bisexual and other MSM.

Gap: There are gaps in the provision of culturally competent health care for MSM in different areas of the state and in different health care settings. MSM indicate that they frequently feel stigmatized for being MSM, and also for being HIV positive. This is even more frequently experienced in the rural portions of the state.

Need: Improve retention in care among all MSM, with an emphasis on young minority MSM in order to increase health outcomes and lower viral loads in the community.

Gap: Stigma, lack of access to transportation, the inability to navigate health care systems, substance use, mental health, trauma and isolation, health inequities and the nature of adolescence have all been named as contributing factors to decreased health care retention in this population.

Need: Increase the availability, acceptability, affordability, and accessibility of mental health and substance abuse services for all MSM.

Gap: There are gaps in accessing mental health care and substance abuse treatment throughout the Commonwealth, due to high demand for the services and few publically funded service providers. This gap broadens when seeking public assistance for these services for those without insurance or the underinsured. Finding mental health professionals with experience and expertise in mental health provision for MSM and MSM living with HIV further increases the gap in this service.

Need: Increase prevention efforts to reach minority MSM, particularly Black and Latino youth, and engage them in prevention and testing activities.

Gap: DDP has only one contractor located in Northern Virginia that focuses on prevention efforts specifically for Latino MSM. Prevention and testing contractors throughout the state lack the ability to engage young Latino MSM due to language barriers and lack of staff with knowledge of the population. Gaps also exist in engaging young MSM of color outside of urban areas where prevention contractors are located. Local Health Departments (LHDs) are not seen as gay or minority friendly by many young MSM.

People Who Inject Drugs, including those living with HIV

Need: Availability of syringe exchange services.

Gap: VDH put forth a legislative proposal in 2016 to allow for sterile syringe exchange within the Commonwealth in areas with high morbidity of Hepatitis C virus (HCV) and HIV. The bill was not passed. Currently, syringe exchange as part of a comprehensive harm reduction approach is not legal in Virginia.

Need: Address the holistic health needs of PWIDs, in order to increase access to medical care by this population.

Gap: PWIDs have many health issues that could be addressed by HIV prevention and care providers. Wound care, accessing mental health and substance abuse services, enrollment in health plans, and hepatitis testing are among a few of the gaps that exist across the state.

Need: Increase the number of PWIDs that get tested for HIV each year, particularly young PWIDs.

Gap: The face of the heroin epidemic has changed. Methods that worked in the 1990s to address HIV among PWIDs are no longer relevant in a world where drugs can be ordered through the internet Methods of engaging and outreaching to the "new" opioid users are needed.

Need: Address the need for additional mental health/substance abuse treatment and detoxification (i.e., detox) centers in the state.

Gap: Virginia, like other states, doesn't have the resources to offer mental health and substance abuse treatment to all of its citizens in need. Virginia did not expand Medicaid, further creating a gap in accessing these services among those uninsured. While Opioid Treatment Facilities are expanding, there are few in the rural western part of the state where prevalence of opioid use is high, and community acceptance of these facilities is often low.

Need: Harm reduction, including PrEP and Naloxone, for active users and their families and/or friends in order to reduce HIV and HCV transmission, and fatality risk from overdose.

Gap: The utilization of PrEP to prevent HIV infections among PWIDs in Virginia is only just being explored by DDP and some LHDs. Staffing of PrEP clinics within LHDs remains an issue since CDC funding to pay for clinician's services is not allowable. Harm reduction techniques, such as bleach kits, used to prevent HIV are not always effective in the prevention of hepatitis transmission, and sterile syringe exchange is not available. Naloxone became

available without prescription at one retail pharmacy chain in Virginia in 2015. However, uptake is low and much of the population is unaware of its use and or availability. Stigma surrounding addiction and PWIDs plays a role in the lack of utilization of PrEP and Naloxone in the injection community as providers hesitate to discuss these options with patients who could benefit from their use.

High Risk Heterosexuals (HRH), including those living with HIV

Need: Increase routine sexual health assessments and STI/HIV/Hepatitis testing in primary care settings for patients under 35 years old.

Gap: HIV screening (testing) may be routinely offered to patients in all health-care settings. Virginia law allows for routine opt-out HIV testing (§32.1-37.2) and requires that, prior to 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, federally qualified health centers, emergency rooms and other clinical sites in Virginia. Many primary care providers express their lack of comfort and lack of skill in taking adequate sexual histories to ascertain the need for STD/HIV/hepatitis testing.

Need: Develop gender and age-specific education regarding PrEP and nPEP to increase awareness and access to this biomedical intervention.

Gap: Much of the promotional education surrounding PrEP and nPEP has been aimed at MSM in throughout the state. Efforts to educate young high-risk heterosexual males and females are needed. Increased efforts to inform both male and female victims of sexual assault and those engaged in high-risk behaviors regarding the use of nPEP are also needed.

Need: Increase efforts to engage heterosexual men, particularly men of color, in prevention and care interventions.

Gap: There are few effective behavioral interventions developed for heterosexual males. Stigma surrounding HIV being a "gay disease" is also prevalent and precludes heterosexual males from participating in prevention interventions. Heterosexual men living with HIV often find they are assumed to be gay or PWIDs and therefore do not engage in care interventions.

Need: Increase patient navigation for persons who are newly-diagnosed with HIV to increase engagement in care.

Gap: Patient navigation is available at most major HIV care centers in Virginia; however the expansion of these services in community health clinics and other arenas where PLWH 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.

Need: Increase HIV testing efforts among minority high-risk heterosexual (HRH) males.

Gap: Heterosexual males are among the populations least tested for HIV in Virginia, especially men of color.

Transgender Persons, including those living with HIV

Need: Create more safe havens, safe shelters, and safe job training services in order to provide a stable environment for transgender persons living with HIV.

Gap: Gaps exist in specialized services for transgender persons in the state. Collaborative efforts between prevention and care providers with community partners in housing and vocational skill attainment are needed.

Need: Increase education to transgendered persons about benefits of health insurance and help with health insurance enrollment, help navigating health systems, and help responding to questions related to current gender and gender listed on birth or ID records are needed. These can cause transgender individuals not to access health services.

Gap: Gaps exist in cultural competency to work with the transgender community in many arenas, including health plan enrollment. Capacity and educational programs to increase provider knowledge regarding barriers to health care access for this population is needed.

Need: Provide more holistic HIV prevention services that address injection drug use, commercial sex work, coping with discrimination and stigma, mental health, substance abuse, and self-esteem/self-worth issues.

Gap: Viewing HIV prevention services as a part of a holistic health care need for transgender persons is often overlooked by HIV prevention contractors, and as a new concept in the delivery of prevention services requires training and skills building initiatives.

Need: Provider more HIV care, retention, and adherence support services for transgender persons.

Gap: Transgender individuals in Virginia have low retention in HIV care.

Need: Increase the number of medical care providers with knowledge of transgender health issues.

Gap: Additional provider education and cultural capacity building sessions are needed in order to effectively provide services to transgender individuals.

Sex-Workers, including those living with HIV

Need: Create job training centers/programs and educational institutions that provide services with flexibility in order to accommodate commercial sex workers who are looking for other opportunities for employment.

Gap: Comprehensive resource directories for providers that include educational and vocational training opportunities that would benefit sex workers are lacking. Collaborative partnerships between educational/vocational organizations and providers of HIV prevention and care are also lacking in the state.

Need: Availability of affordable housing opportunities in the state, particularly for young adults in order to decrease the financial hardship that often results in engaging in sex work to remain housed.

Gap: Few HIV care and prevention providers explore housing opportunities for HIV negative individuals, and don't have the funding or expertise to do so.

Need: Increase the number of sex workers who receive PrEP.

Gap: Gaps exist in the number of HIV prevention contractors who target sex workers in their prevention efforts (currently two in Virginia). The lack of screening for sex work and the lack of capacity of providers to engage sex workers impede PrEP promotion to this community.

Need: Increase the number of mental health providers, substance abuse treatment centers, support groups, and shelters that are culturally sensitive and can address the unique needs sex workers may have.

Gap: Gaps exist in targeted services for sex workers are impeded by the illegal nature of their work. Promoting services geared toward this group could also invite intervention by police in order to arrest or identify sex workers. Collaborative efforts between law enforcement and service providers are needed in order to advance services targeted to sex workers.

Need: Increase the number of sex workers who receive at least two HIV tests per year.

Gap: Data collection on behaviors during HIV testing does not include mandatory questions regarding sex work in Virginia. Estimation of the number of sex workers in the state in order to ascertain testing habits is also difficult. Providers of HIV testing services should increase effective testing strategies, such as social networking, to increase the number of sex workers who receive at least two HIV test per year. However, capacity and funding issues targeting this population are lacking.

Rural Populations, including those living with HIV

Need: Improve transportation services that allow PLWH and high-risk individuals to more easily access health care providers.

Gap: Gaps in transportation services in rural communities are an ongoing issue. Stigma surrounding HIV often keeps rural PLWH from disclosure, preventing communities from realizing a gap exists. Lack of resources by care providers to furnish transportation services, lack of the existence of public transportation in some areas of the state, and lack of community mobilization around HIV care and prevention are also primary reasons for these gaps.

Need: Increase the number of mobile clinics (vans, buses) that provide sexual health services in rural communities.

Gap: Providing mobile clinics to address HIV and other sexual health services requires resources, including staffing and funding, which many care centers cannot afford. Collaboration with existing mobile health outreach efforts, such as mammography and prenatal care may address this issue partially, but does not engage males.

Need: Design and implement community interventions to reduce stigma regarding HIV/STDs and LGBT communities, which would decrease patient fears in accessing health care.

Gap: Gaps exist in the number of prevention providers in rural areas of the state. Current prevention efforts in rural Virginia are being absorbed by the opioid epidemic, and target PWIDs. Resources for non-PWIDs are lacking.

Active Duty Military, including those living with HIV

Need: Increase collaborative efforts to link male and female enlisted personnel with sexual assault services, nPEP, and mental health and substance abuse counseling in a safe environment.

Gap: Gaps in providers to address the unique needs of military personnel seeking services off-base due to sexual assault within the military, or mental health and substance abuse counseling that the enlisted person feels may negatively impact their service status exist and are difficult to address. Conflicts with confidentiality when using military insurance programs off base, and limited access due to military services play a part in this gap.

Need: Expand outreach to veterans or enlisted men with post-traumatic stress disorder (PTSD) who engage in high-risk sexual and drug using behaviors due to their mental health disorder to encourage HIV testing and use of mental health counseling.

Gap: Community organizations providing prevention and care services and the federal entities that administer veteran's care do not or cannot in many ways form collaborations to address the needs of veterans living in Virginia. The lack of veteran's care centers in the state also impedes this process.

Need: Create transitional services for enlisted personnel living with HIV, who are leaving a managed care system and do not have health literacy skills to navigate health systems on their own.

a. Gap: Enlisted personnel living with HIV have managed health care that schedules appointments, provides transportation, and does not require insurance and health care navigation skills. Upon discharge, many veteran PLWH do not have the skills to access health care. Currently no collaborative efforts with prevention and care providers address this issue in Virginia.

Latinos, including those living with HIV

Latino focus group participants, including PLWH and persons at risk for HIV, identified the following needs:

Need: <u>*Sex and HIV education.*</u> Focus group participants identified the need for sex and HIV education in schools. One participant stated:

> *We do not see anything happening in the community regarding HIV/AIDS awareness. We need to see more community engagement efforts. You need to use the old school method to advertise services, meaning you need to preach the word at barbers shops, construction sites, churches and schools.*

Need: <u>*Community based education to foster awareness of prevention and care services in Spanish.*</u>
Over half of the Spanish-language focus group participants reported that advertisements through community outreach initiatives proved the most impactful. One participant's reflections,

> *We need to know more about the services available out there. You should come to our communities to enlighten us. Some of us cannot read and so your very wordy brochures do not help us.*

Participants identified that reaching out to predominantly Latino churches, schools, community based organizations and construction sites for such campaigns will be very beneficial. Respondents voiced that this will also help in fighting stigma and would have better health outcomes for PLWH.

Need: <u>*Culturally and linguistically appropriate services for the Latino population.*</u> Focus group participants stated that they find prevention and care services culturally-and linguistically-inappropriate, with very little information about services available in Spanish. Most said they find it hard expressing themselves to healthcare providers with a completely different culture from theirs. Most participants suggested that any promotional material targeting the Latino population be reviewed by some members of the Latino community for cultural appropriateness. Most providers also reported having insufficient cultural competency training or not being confident with the training they received.

Need: <u>*Legal assistance.*</u>
Latino focus group participants perceived intimate partner violence as prevalent in the Latino community with mostly men perpetrating violence again women. Participants stated that in a community where "*machismo*" is still very prevalent, women have no room to negotiate safer sex practices. Most of these women are unaware of how to seek help. In addition, the Latino community includes undocumented residents with no knowledge of their own basic rights in the U.S. Many undocumented Latinos fear

that an undocumented HIV patient will be deported. Consequently they do not seek care.

Need: *The need for a "one stop shop" where HIV-positive patients can also access other chronic disease services.*

Participants identified the need for holistic approaches in health assessment of PLWH especially those suffering from co-morbid conditions. Eleven percent of the PLWH survey respondents said they were diagnosed with, or treated for HCV within the last twelve months, and 6 % reported being diagnosed with or treated for hepatitis B virus (HBV). All respondents who reported being diagnosed or treated for syphilis also reported being diagnosed or treated for gonorrhea. About 33% of providers reported that they would like to increase capacity to provide HBV and HCV testing. Focus group participants stated that having a 'one stop shop' will improve health outcomes since it will address some of the barriers they already face like transportation and travel time.

Geographic-Specific Needs that Address Gaps in their Portfolio of HIV Services

Similar to the population-specific needs described above, the geographic needs discussed represent the culmination by the Virginia Community HIV Planning Group (CHPG) as being populations of concern in the Commonwealth. The service needs and gaps described are the result of innumerable meetings, presentations, and discussion of this group over the past three years since completion of the last Comprehensive HIV Plan and Statewide Coordinated Statement of Need in 2012 and Prevention Plan update in 2014. The needs described represent this group.

CENTRAL HEALTH REGION

- Expand availability of HIV prevention and testing services in eastern Piedmont area (Farmville), Crater (Colonial Heights, Greenville) and Southside areas of the health region (i.e., areas outside of Richmond, Henrico, Chesterfield, and Petersburg).
- Increase availability of HIV prevention, testing, and care services offered in Spanish, as well as translation services.
- Create new and/or improve collaborative efforts between HIV service organizations and community agencies to increase "buy-in" for those services within the community, leading to more sustainable efforts.

EASTERN HEALTH REGION

- Increase collaborative efforts between health care providers, HIV care providers, and community based organizations regarding education and referral about PrEP and nPEP.
- Mobilize CBOs and faith-based institutions to address issues surrounding HIV such as stigma, HIV testing, and adherence.
- Expand the number of health education and HIV prevention programs that specifically target young MSM in areas such as health literacy, condom negotiation, and treatment adherence.

- Provide educational programming targeting young Black MSM regarding the benefits of health coverage through the ACA, health care systems; and how to navigate those systems.
- Improve availability of and access to substance abuse and mental health treatment.

NORTHERN HEALTH REGION

- Expand availability of bilingual and/or medical translation services in HIV care centers and at HIV testing locations.
- Increase availability of transportation services for PLWH to attend medical and other care-related appointments.
- Diversify the HIV workforce, especially clinical care providers and care centers that treat PLWH.
- The need for additional community-based resources/organizations that focus on specific targeted populations in the region (i.e., youth, minorities, MSM, PWID, etc.)
- Improve the availability of support groups, either online or in person, for MSM, drug users, persons requiring disclosure assistance, etc.

NORTHWEST AND SOUTHWEST HEALTH REGIONS

- Improve access to and increase availability of transportation services for PLWH.
- Develop collaborative initiatives in rural communities to reduce stigma surrounding HIV, STDs, and lesbian, gay, bisexual, and transgender (LGBT) persons.
- Increase HIV testing in non-traditional sites (e.g., pharmacies).
- The need to increase access to care by increasing the number of providers who are trained in HIV care.
- The need for community mobilization efforts to increase the quality of life in rural communities, including better employment, educational, substance abuse and other health care opportunities.

c. *Barriers* to HIV prevention and care services.

Barriers to accessing HIV services exist due to a wide variety of reasons. They may be legal or structural in nature. In other cases, the service may be available but the travel distance and time is so great that individual choose not to access them. Some organizations may not have convenient hours of operation, which become barriers, especially for working adults. For individuals, a resource may be available but the person does not access the service due to personal reasons. 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 pre-exposure prophylaxis (PrEP) to full engagement in HIV medical care and supportive services.

i. Social and structural barriers

- **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. As noted in Table 4, about 12.1% of Virginians are uninsured with a range from 11.9% in the Northern Region to 12.5% in the Southwest Region.[cxv] In 2014, Hispanics/Latinos were the most likely to be uninsured racial or ethnic group in Virginia (27.9%), followed by non-Hispanic Asians (13.7%), non-Hispanic African Americans/ Blacks (13.6%), and non-Hispanic Whites (7.5%).[cxvi]

- **Cultural Differences, Linguistic Challenges, and Stigma as Barriers**

Virginia is a diverse state inhabited by many cultural groups. Increases in the growth of minority populations over the last few decades have posed challenges in the delivery of health care and prevention services that are acceptable to these communities. Although Virginia's Hispanic/ Latino population represents 8.4% of the general population and Asian/Native Hawaiian/Pacific Islanders represent 5.8% of the population (Table 2), few health care providers are able to provide linguistically appropriate services for these populations.[cxvii]

Various regional cultures exist within the Commonwealth. Urban areas such as Northern Virginia, Richmond, and Hampton Roads are vastly different from rural areas of the state in perceptions about health care, mental health, substance abuse, and trusting governmental systems. Western Virginia is mountainous and densely populated, which serves to add to transportation barriers in accessing health care and health information. Rural areas of the state tend to be politically conservative while urban areas politically more moderate to liberal, with some exceptions.[cxviii]

- **Stigma and Racial/Ethnic Prejudice**

Stigma and racial/ethnic prejudice in Virginia area also barriers to quality health care. Stigma surrounding HIV and STDs is particularly detrimental to the achievement of NHAS goals of identifying undiagnosed PLWH and retaining those diagnosed in care. Perceptions that HIV is a "gay disease,' a "black disease," "a disease that you deserve for being promiscuous", and a disease that "doesn't happen around here" are all pervasive attitudes that help fuel the epidemic in Virginia.[cxix] Reporting epidemiological trends in HIV may also unintentionally add to this stigma when governmental agencies focus on the epidemic data reports on one population or subset of a population.[cxx] Homophobia, transphobia, and racism are pervasive attitudes across the U.S., including Virginia. The impact of these attitudes is felt in the number of LGBT individuals and persons of color who report that they felt they did not get quality health care due to provider or care center prejudices, or misperceptions their health care providers had due to their color, gender identity, and/or sexual orientation.[cxxi] Stigma surrounding substance use and addiction as a weakness or delinquent behavior also has negative impact on engaging PWIDs into care.

- **Undocumented and Migrant Communities**

The Pew Research Center, in their November 2014 report on unauthorized immigrants in the U.S., ranks Virginia as 10th overall with approximately 275,000 undocumented individuals living in its borders.[cxxii] This accounts for approximately 3.5% of Virginia's population. Undocumented individuals are difficult to engage in health care and other social services due to

the fear of being identified and deported. PLWH or those at high-risk for acquiring HIV, who are also undocumented, pose unique challenges to health care and prevention staff and require community efforts, such as free clinics and mobile outreach units, which many communities do not have the resources to provide.

Virginia's migratory communities are inclusive of farmworkers, college students, and military personnel, as all play a significant role in the challenges of delivering prevention and health care in the state. Migrant farm workers in Virginia are most abundant in the Northwest and Eastern Health Regions. Many travel to Virginia just long enough to harvest a particular crop then move along to other states to do the same. Providing health care and prevention efforts to these populations is difficult in that they may not be in one area long enough to receive needed medical information, such as lab results, prescription renewals, and follow-up visits. Approximately 20% of Virginia's undergraduate populations in public schools in 2015 were out-of-state students.[cxxiii] Some schools have out-of-state populations that exceed 33% of the total undergraduate population. While Virginia requires students enrolled in higher education to have insurance, influx of this population increases demands in health care settings. Also, sexual activity and drug use associated with young adults may also increase transmission of undiagnosed STDs acquired in their home state to students in Virginia and vice versa.

Similar conclusions can be formed with members of the military stationed in Virginia. Virginia is the home to the largest Naval Base and Marine Base in the U.S. Over 25% of all enlisted naval personnel live in Virginia, predominantly the Norfolk/Hampton Roads area.[cxxiv] Enlisted personnel interact with residents in the area creating the opportunity for disease transmission.

With both college students and military personnel, difficulties exist when notifiable diseases occur. Access to military bases for Disease Intervention Specialists for partner services, coordinated care efforts between school and military clinics and Virginia care centers, and confidentiality concerns when billing insurance are barriers to serving these populations. Both university health care systems and military health care systems require low health literacy to navigate, since the school or military provide managed care. Graduating students and discharged service members who are PLWH and lack health literacy skills will have greatly impeded transitions into mainstream health care.

ii. Federal, state, or local legislative/policy barriers[cxxv]

- **Syringe Exchange and Drug Laws**

VDH introduced legislation in the 2016 session of the General Assembly that would decrease penalties for possession of paraphernalia and allow the State Health Commissioner to authorize syringe services programs (SSP) in times of public health emergency. The bill passed unanimously out of the Health, Education and Welfare Committee but was not reported out of the Criminal Law subcommittee of the Courts of Justice Committee. VDH and community partners who supported this proposal continue to strategize proposals to reintroduce the legislation for successful passage to add legal exchange of sterile syringes to the public health collection of harm reduction strategies to prevent HIV and other blood-borne infections.

State and Federal laws and policies that enforce punishment rather than treatment of individuals

with substance use addiction often are counterintuitive to public health methods. Treatment of substance use and drug addiction has been found to be less costly, and more beneficial than incarceration. The expansion of drug courts and social programs to address the needs of persons living with addiction and their families would greater serve the individual and the Commonwealth, than increased penalties for drug user offences.

- **Expedited Partner Therapy**

In June 2015, DDP received permission from VDH senior management to proceed with an expedited partner therapy (EPT) Legislative Proposal Request, after having postponed this activity in 2014. During a September 2015 stakeholders meeting, the Virginia College of Emergency Physicians argued that liability protections must be provided in order for physicians to prescribe EPT. The Virginia Trial Lawyers Association contended that immunity laws leave those who are harmed by negligent conduct without legal recourse for any harm done to them, and therefore should be reserved for extraordinary circumstances. As a result of these differences of opinion among stakeholders, which could not be reconciled, the proposal did not move forward.

- **Non-Medicaid Expansion State**

Virginia has not adopted Medicaid expansion, and many poor adults with incomes at or below 138% FPL with incomes below the federal poverty level fall into a coverage gap because they remain ineligible for Medicaid but earn too little to qualify for premium tax credits for Marketplace coverage. As a result, they are likely to remain uninsured. The impact of the coverage gap varies by race and ethnicity, with poor uninsured African Americans most likely to fall into the gap followed by poor uninsured Latinos. This gap in access to health care coverage will likely continue to contribute to racial and ethnic disparities in many key HIV prevention areas, such as the acquisition of PrEP and nPEP and HIV testing in clinical settings.

- **Funding for PrEP, nPEP, and Behavioral Health**

Lack of Medicaid expansion severely impacts the implementation of biomedical interventions, such and PrEP and nPEP, as well as mental health and substance use treatment. Federal funding opportunities require the advancement of biomedical interventions, but do not allow states to allocate funding for medication and clinical costs associated with implementing these strategies. While prescription assistance programs fill some of the need, the ability for high-risk individuals to access PrEP and nPEP is often hampered by medical visit costs. In order to overcome constrictive out-of-pocket expenses to pay for medical visits, Virginia is piloting PrEP and nPEP clinics in LHDs. Laboratory work need for medical assessment for eligibility of PrEP is being absorbed by the LHD or state funding. While this system benefits persons in need of PrEP and nPEP, it poses another burden on already burdened and underfunded health department system. The need for additional clinical staff to evaluate and prescribe PrEP is a common concern noted by LHDs considering becoming PrEP clinics. Federal partners recognize the connection that mental health and substance use play in high-risk behaviors that put individuals at risk of acquiring or transmitting HIV, and require state HIV programs to refer to these services, which often are non-existent in many areas of the state, or not culturally-competent to handle the special needs of PLWH, gay men, transgender 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. It is a Class 6 felony in the state to intentionally infect an individual with HIV, Hepatitis B virus (HBV), or syphilis. It is also a Class 1 Misdemeanor to not disclose to sexual partners that you are infected with any of these diseases. A workgroup formed by the CHPG in 2013 examined this issue and determined that legislation may provide a barrier to individuals wanting to get tested for HIV and/or HBV for fear of having to disclose having one these diseases. It also provides a barrier for ongoing partner services for persons with HIV, as they open themselves up to possible criminal charges for using the service. PLWH who participated in the workgroup said the law also poses the potential for vindication from partners who were disclosed to, but misrepresent that fact due to a failed relationship.

iii. Health department barriers[cxxvi]

A team of VDH staff representing DDP, LHDs, and the Health Commissioner's office met in April 2016 to discuss implementation of LHD third-party billing procedures for STI services. The focus of the initial meeting was to discuss the rationale for billing for services traditionally provided at no charge, and to review Virginia's Eligibility Guidance to assess feasibility of the process. Issues outlined included potential costs for "services" versus "goods" in the clinical setting; fee determination; potential privacy concerns regarding billing documents being sent to clients' home addresses; concerns for teens seeking STD screening and care; and considerations for fee variations among volunteer clients versus those referred for care through public health communicable disease procedures.

DDP continues to review a proposed regulatory amendment regarding incidence surveillance, with final approval expected sometime in 2016. The request is currently undergoing the third and final stage of the review and approval process. Status of the regulatory proposal may be viewed at http://townhall.virginia.gov/L/ViewStage.cfm?stageid=7406. Once the amendment has been adopted, DDP's HIV Surveillance program will distribute the information to HIV testing laboratories in Virginia and to out-of-state reference laboratories performing HIV testing on Virginia residents.

DDP's Molecular HIV Surveillance staff also continued to monitor the progress of a state regulation amendment requiring the reporting of HIV nucleotide sequence data. The proposed regulatory amendment is currently undergoing Stage III Final Regulation and Executive Branch review; HIV Surveillance staff will continue to monitor progress of the amendment until implementation occurs.

Addressing the opioid epidemic as a public health entity is impacted in the fragmentation of services for substance abuse and substance abuse treatment in Virginia and within VDH. Prevention services are distributed between several state agencies with no one lead agency. Within VDH, the Office of Injury Prevention (OIP) and DDP provide some prevention services, but they are not comprehensive and focus on specific populations, persons driving while intoxicated (OIP) and PWIDs (DDP) as they pertain to HIV and HCV transmission.

iv. Program barriers[cxxvii]

DDP has launched a new client-level database called e2Virginia, which will allow for the analysis of HIV prevention, care, and surveillance data from one source, in order to better tract HIV Continuum of Care outcomes. Discrepancies in how data is reported, the timeliness of data reporting and the accuracy of data reporting from LHDs and prevention and care contractors may be improved with the initiation of this data system.

The lack of prevention contractors throughout the state, particularly in the Northern Health Region impedes DDP's prevention efforts. Currently, only two contractors deliver prevention services in an area that is home to one-fourth of Virginia's population. Several contractors statewide lack capacity in engaging MSM and PWID into prevention programs and HIV testing.

v. Service provider barriers[cxxviii]

Staffing issues remain a problem with many service providers. Low wages and the lack of adequate benefits make keeping qualified staff difficult. Capacity needs to address the inclusion of integration of care and prevention strategies. Biomedical interventions and behavioral interventions that address viral suppression are lacking as well.

Engaging substance use and mental health providers in HIV prevention efforts has had moderate success. More collaborative efforts are needed to bring these services to high-risk negative individuals, as well as PLWH. 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. Community mobilization efforts are needed to engage community members in issues such as overcoming stigma surround HIV, sexuality, sexual orientation, gender identity, and addiction would also benefit efforts to advance policy within the Commonwealth.

vi. Client barriers

In the 2016 consumer survey, a total of 79 respondents at-risk for HIV and PLWH answered questions related to barriers to HIV services. Table 22 shows that the majority of all respondents (60%) stated that they did not have any barriers to accessing HIV-related services. However, among those experiencing barriers, the top barrier to accessing services was *fear and/or stigma* (50% of respondents reporting barriers), followed by *lack of transportation* (26.9%), and *culturally inappropriate services* (23.1%).

Table 22. Survey respondents' top three barriers to accessing HIV prevention and services within the last twelve months (N=79)

Barrier	Number	Percent (all responses) (N=79)	Percent (Persons w/Barriers) (N=26)
Fear/stigma	13	14.7%	50.0%
Lack of transportation	7	8%	26.9%
Culturally inappropriate services	6	6.8%	23.1%
No barriers	53	60%	

Source: Virginia Department of Health, Division of Disease Prevention, 2016 Consumer Survey.

These barriers are discussed in more detail below in addition to barriers identified through the additional forums described.

Fear/stigma

Respondents identified fear and stigma as their biggest barrier. Most participants from the Northwest and Southwest regions are afraid of being stigmatized and therefore prefer to not access services. The lack of anonymity in small rural communities is perceived to decrease the likelihood of confidentiality and increase the risk for discrimination. This was highlighted by one focus group participant who said:

> *Where I live in the Southwest, everybody knows everybody. I would rather travel six hours to access care than see a clinician in my area and have everybody in the village start pointing fingers at me. But then, a six hours journey is quite a drive, which renders me incapable of attending all my medical appointments.*

Lack of transportation

While lack of transportation is not as major a problem with PLWH who live in Central and Eastern Virginia, it is a barrier cited by those who live in rural areas, especially those who reside in the Northwest Region where there is lack of public transportation. PLWH find it costly and time consuming to travel four to six hours to access care. For hourly workers, taking a day off work to access care is not a priority or a possibility. Latino respondents said that many in their communities are unable to drive because they are undocumented and do not have drivers' licenses. Their families and friends who have a driver's license are usually very busy with work and seldom in the position to assist with transportation.

Culturally inappropriate services

A common barrier cited by respondents is culturally-inappropriate services. PLWH indicated that they would like to be assigned case managers who are of similar race/ethnicity and/or sexual orientation because they believe their challenges and concerns would be better addressed by someone who understood their culture. This was a common barrier expressed by PLWH of color.

Inconvenient Times and Locations of Services

A barrier to accessing prevention and treatment services was identified as the inconvenience of scheduled time and place of services and/or events. Focus group participants and interview respondents stated that most organized events interfered with work schedules or were not

accessible due to lack of transportation due to location. One focus group participant echoed the feelings of others when he said:

> *Most events are in the afternoon. I go to work at from 9 a.m. until 6 p.m. I cannot afford to take off as I am an hourly employee and need the money. Events are not organized on weekends, unfortunately.*

This was also a major barrier echoed by the Latino focus group participants.

Shortage of providers
Shortage of providers was mostly reported by consumers who reside in the Southwestern region of Virginia. As a result, most consumers end up accessing care out of state or go without treatment. The Latino community in the Northern region expressed the need for more providers who understand the Latino culture. This was not a common response on the surveys and interviews but was a barrier identified by nearly all of the participants in the focus group conducted in the Latino community.

E. Data: Access, Sources, and Systems

VDH utilized numerous data sources to conduct the needs assessment, including development of the Virginia's HIV Continuum of Care. These included HIV surveillance, prevention, and care data that is integrated into Virginia's Care Markers Database (CMDB); surveys targeting both clients and providers; focus groups; and semi-structured interviews. A description of several of these data sources follows.

Enhanced HIV/AIDS Reporting System (eHARS)
The Enhanced HIV/AIDS Reporting System (eHARS) serves as the main data system for all PLWH within Virginia, as it collects data on all reported cases of HIV. Following a positive, confirmatory HIV test, the case is entered into eHARS from the CDC case reporting form, which contains information on patient demographics and risk, testing and treatment history, and medical history on HIV-related conditions. Updates include laboratory results on CD4 counts and viral loads that are received either electronically or on paper, as well as updates on patient history and location, received from medical sites and local health departments. The eHARS data serve as the base for Virginia's HIV Continuum of Care, as it is used to generate the number of persons living with HIV as of a given date, as well as the number of new diagnoses in a given time frame.

Medical Monitoring Project (MMP)
MMP is an ongoing supplemental HIV surveillance program that uses a patient's medical record abstraction (MRA) and a patient interview to provide a representative sample of the HIV epidemic in Virginia in order to better assess the needs of PLWH. Approximately 400 randomly selected participants from HIV medical provider sites are interviewed to obtain demographics, medical history, insurance, housing, and income status. The associated MRA is retrieved from the patient's medical provider site and information is entered into the MMP data system, including labs, medical visits, medication history and other information for a two-year period.