2022-2026
WEST VIRGINIA
HIV and HEPATITIS C
ELIMINATION PLAN

WEST VIRGINIA
Department of
Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Office of Epidemiology and Prevention Services
350 Capitol Street, Room 125, Charleston, West Virginia 25301

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2022-2026
West Virginia
HIV and Hepatitis C Elimination Plan

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Acknowledgments

The West Virginia 2022-2026 HIV and Hepatitis C Elimination Plan is a collaborative effort of many dedicated individuals working together to improve the quality of prevention, treatment, and care services for people at risk for or living with HIV and/or HCV in the state of West Virginia. We would like to acknowledge the following people who gave their time and expertise to support development of the Plan:

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Table i: Version History

Version	Delivered Date	Version Notes
1.0	12/09/2022	Final version submitted by the West Virginia Department of Health and Human Resources, Bureau for Public Health to Centers for Disease Control and HRSA
1.1	12/20/2022	Revised final version for the West Virginia Department of Health and Human Resources, Bureau for Public Health
1.2	DATE	Final version published on West Virginia Department of Health and Human Resources, Bureau for Public Health website

Section I: Executive Summary of Integrated Plan and Statewide Coordinated Statement of Need

The 2022–2026 West Virginia HIV and Hepatitis C Elimination Plan (Plan) was developed in accordance with the guidance provided by the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) to ensure alignment with the National HIV/AIDS Strategy (NHAS). The Plan and Statewide Coordinated Statement of Need (SCSN) will provide West Virginia with a blueprint on how to address the four national HIV goals: prevent new HIV infections, improve HIV-related health outcomes for people with HIV, reduce HIV-related disparities and health inequities, and achieve integrated, coordinated efforts that address the HIV epidemic among all partners and stakeholders. The Plan is divided into five sections: Executive Summary, Community Engagement and Planning Process, Contributing Data Sets and Assessments, Situational Analysis, 2022-2026 Goals and Objectives, and 2022-2026 Integrated Planning, Implementation, Monitoring and Jurisdictional Follow-up. The Plan aims to reduce the burden of HIV and hepatitis C (HCV) in West Virginia and serves as a commitment to collaboration, best practices, and innovation among stakeholders and key partners, while also responding to the needs of people living with HIV and/or HCV as well as those at risk.

The West Virginia Department of Health and Human Resources (DHHR) Bureau for Public Health (BPH), in collaboration with partners, developed a completely new Plan using a syndemic approach. The planning and development of the Plan was guided by the Steering Committee and subcommittees which encompassed diverse partners and stakeholders. The Steering Committee served as the senior advisory body for the Plan and consisted of state and local leaders who provided strategic direction to the subcommittees and monitored overall progress on Plan development. Four subcommittees were established around the four NHAS pillars (prevent, diagnose, treat, respond), and the Health Equity and People With Lived Experience Advisory (HEPLEA) Group provided guidance and insight to the subcommittees as well ensured cultural sensitivity and responsiveness throughout the planning process. Subcommittee members supported the assessment and situational analysis phases as well as the planning stage by developing goals, objectives, strategies, activities, and process measures.

BPH, in collaboration with the Steering Committee, subcommittees, and Ryan White partners, conducted a mixed methods assessment utilizing a variety of tools to inform the planning process. Partners utilized the following methods to inform planning and development: mind mapping, epidemiological data, provider surveys, needs assessment survey engaging people with lived experience (PWLE), focus groups with PWLE and infection preventionists, and resource inventories. A situational analysis identified strengths, weaknesses, opportunities, and threats for each pillar based on the mind maps created as a result of the facilitated stakeholder discussions and key findings from the surveys, focus groups, and epidemiologic data.

The Plan was developed utilizing key findings from the assessment process as a guide. The Plan addresses the four pillars—prevent, diagnose, treat, and respond—which align with the NHAS, with each pillar having three goals. Each goal has at least one objective that reflects the desired results to be achieved. Each objective has at least one strategy or approach through which the objectives will be achieved. Specific activities are detailed for each strategy and provide action steps for the Subcommittee Task Forces and partners to accomplish the objectives.

BPH will assume primary responsibility for monitoring and evaluating the Plan’s implementation and will work closely with the Subcommittee Task Forces to track and report progress associated with goals, objectives, strategies, and activities. BPH will ensure progress and engagement are monitored throughout all phases of implementation, monitoring, evaluation, and improvement.

Section II: Community Engagement and Planning Process

Who was involved?

- The process involved several agencies including the state's BPH, Ryan White Part Programs (e.g., A, B, C, D), other federally funded HIV and HCV programs, key partners, and PWLE.

What did the process look like?

- The five-year planning period was initiated in January 2022.
- The process started with an updated epidemiologic profile to examine the current landscape of the HIV and HCV epidemics in the state.
- BPH served as the convening body for community and stakeholder engagement.
- Stakeholders identified needs, gaps, barriers, strengths, and opportunities through a needs assessment process and situational analysis.
- Subcommittees organized around four pillars—prevent, diagnose, treat, and respond—and developed goals, objectives, strategies, activities, and process measures.

What are the next steps?

- In 2023, the subcommittees, in collaboration with the HEPLEA Group, will form task forces and will begin Plan monitoring and implementation under the guidance of the planning/advisory bodies.
- A continuous improvement approach will be utilized to assess progress on a quarterly basis and update and improve the Plan annually during implementation.

The West Virginia HIV Advisory and Planning Group and the Hepatitis Elimination Technical Advisory Group are comprised of consumers and providers of HIV and/or HCV services, including PWLE. The members of these planning/advisory bodies reflect the community they serve to help ensure the decisions made by the planning/advisory bodies are in the best interest of individuals receiving HIV and/or HCV prevention and care services in West Virginia. Under the leadership of the DHHR's BPH, the 2022 – 2026 planning activities for both planning/advisory bodies were combined for a collective impact approach to the elimination of HIV and HCV across the state. This approach allows for both groups to organize and commit to a common agenda as well as leverage resources and opportunities when appropriate and possible. To operationalize this approach, BPH created a shared governance structure that actively engaged members from both planning/advisory bodies as well as other key partners and PWLE to guide the combined planning efforts. Moving forward, task forces will be established for each pillar to conduct implementation and monitoring efforts under the guidance of the planning/advisory bodies.

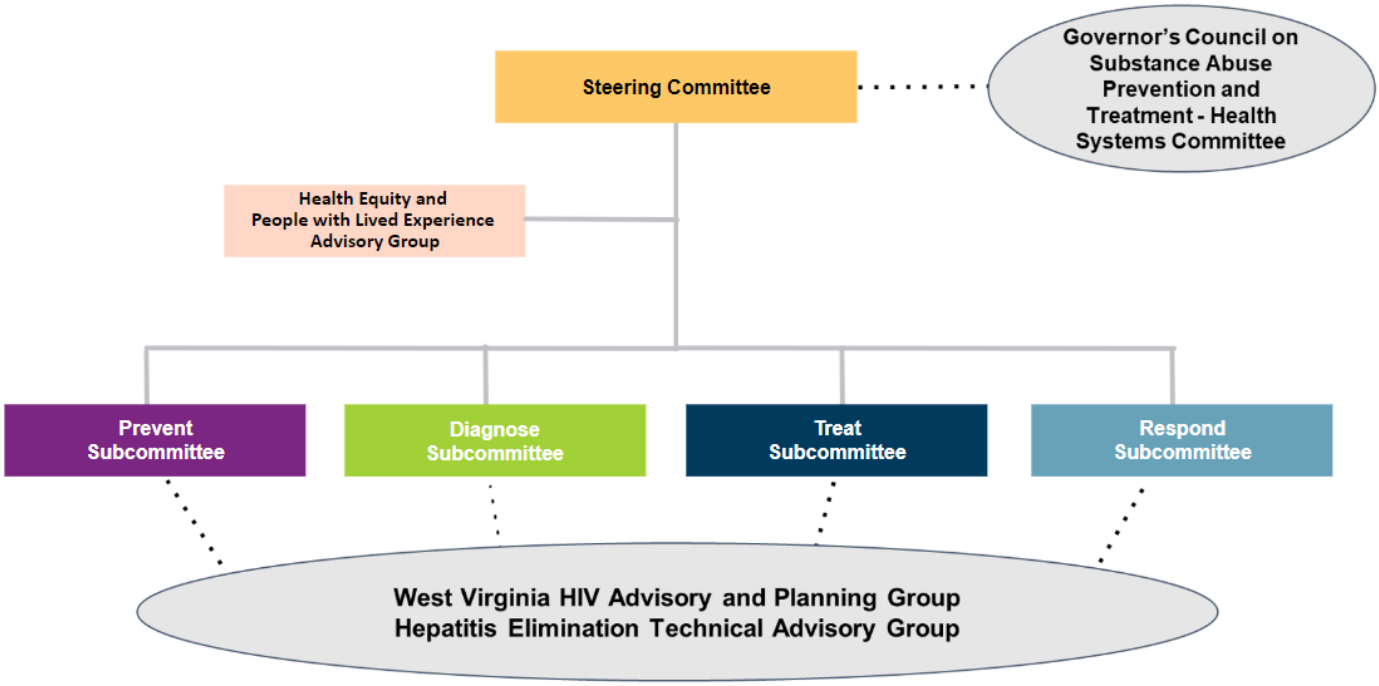
Jurisdictional Planning Process

Figure 1. State Planning Process

The five-year planning period for West Virginia kicked off in January 2022. The process started with an updated epidemiologic profile to examine the current landscape of the HIV and HCV epidemics in the state, followed by community and stakeholder engagement and the identification of needs, gaps, barriers, strengths, and opportunities through a needs assessment process. A situational analysis was conducted in collaboration with stakeholders to determine the current factors and conditions that affect the state's HIV and HCV service system. These steps informed the development of the Plan, in which BPH engaged diverse stakeholders from the state, community, and organizational levels to set goals, objectives, strategies, and process measures. Throughout the process, the partners were encouraged to design an HIV and HCV service delivery system that best reflects the local vision, values, and needs. During conversations with stakeholders, the impact of substance use disorders on HIV and HCV transmission rates and the ability of individuals to be successfully engaged and retained in care became apparent. In acknowledgment of this issue, BPH made the decision to apply a syndemic lens to the planning process. According to the CDC, a syndemic is a set of linked health problems involving two or more afflictions or epidemics interacting

simultaneously and synergistically and contributing to excess burden of disease in a population (Figure 1). In spring 2022, BPH created a charter to set a governance structure for the state planning process as part of a project management framework. This structure outlined the rules, procedures, roles, and responsibilities to support the decision-making process and allowed state planning to be organized and effective. The structure included a steering committee that coordinated with the Governor's Council on Substance Abuse Prevention and Treatment – Health Systems Committee, four subcommittees, an advisory group focused on health equity and lived experience, and the required planning/advisory bodies (Figure 2).

Figure 2. West Virginia Plan Governance



Steering Committee

The charter established the HIV and Hepatitis C Elimination Plan Steering Committee (Steering Committee) to provide guidance and oversight related to the development and implementation of the Plan. The Steering Committee served as the senior advisory body for the Plan and consisted of state and local leaders who provided strategic direction to the subcommittees and monitored overall Plan progress.

The goals of the Steering Committee were to:

- Strategize, coordinate, and inform planning efforts to efficiently and effectively develop, launch, and monitor the Plan
- Document and understand HIV and HCV trends, needs, and opportunities
- Coordinate cross-cutting activities during the planning process (e.g., surveys)

The Steering Committee served as the Plan advisory body and guided activities related to planning and monitoring. The primary responsibilities of the Steering Committee were to:

- Articulate the vision related to current and future HIV and HCV initiatives
- Identify stakeholders and advise on engagement
- Define, prioritize, and articulate the high-level goals of the Plan
- Review goals, objectives, performance measures, and activities developed by the subcommittees
- Foster relationships and communication with high-level stakeholders, including the Governor's Council on Substance Abuse Prevention and Treatment
- Guide and review assessment efforts, such as survey tools
- Monitor progress of the planning process
- Provide direction to the subcommittees through membership recommendations and project coordination

The Steering Committee consisted of 24 voting members comprised of BPH and external stakeholders, including Plan sponsors and the chair of the HEPLEA Group. The director of BPH's Division of STD, HIV, Hepatitis, and Tuberculosis (DSHHT) served as the chair of the Steering Committee. Meeting notes were

prepared by the hepatitis prevention coordinator and summarized the meeting discussion as well as identified action items to be carried out by Steering Committee members, the subcommittees, BPH, and/or stakeholders. The Steering Committee met in June, September, and November 2022 to support the development of the Plan.

Decisions and recommendations by the Steering Committee were made within the following parameters:

- Consistent with West Virginia laws and regulations
- Consistent with applicable federal laws and regulations
- Consistent with applicable federal funding guidelines and requirements
- Consistent with the *Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022-2026* developed by CDC and HRSA
- Within the purview of BPH to act
- Using existing and available resources

Decisions were determined by a simple majority vote. If there was not a majority decision, a tie-breaking vote could be cast by the director of the BPH DSHHT to establish a majority.

BPH launched the Steering Committee with members from BPH, the Ryan White Part B Program, Ryan White Part C and D Programs, DHHR's Office of Drug Control Policy (ODCP), DHHR's Bureau for Medical Services (Medicaid), DHHR's Bureau for Behavioral Health, West Virginia Association of Local Health Departments, West Virginia Primary Care Association, West Virginia Perinatal Partnership, West Virginia Behavioral Healthcare Providers Association, Fairness West Virginia (LGBTQ organization), West Virginia Hepatitis Academic Mentorship Partnership (WVHAMP), Community Education Group, and a person with lived experience (Appendix B).

Subcommittees

The charter also formally authorized subcommittees organized around the four pillars (prevent, diagnose, treat, and respond) to plan, coordinate, and monitor activities under the direction of the Steering Committee. The four pillars align with the four goals within the *National HIV/AIDS Strategy for the United States 2022-2025*, which sets the bold target to reduce new HIV infections by 75% by 2025, and by at least 90% by 2030.

Participating subcommittee members represented BPH and stakeholders from organizations with a vested interest in the elimination of HIV and HCV in the state of West Virginia.

The goals of the subcommittees were to:

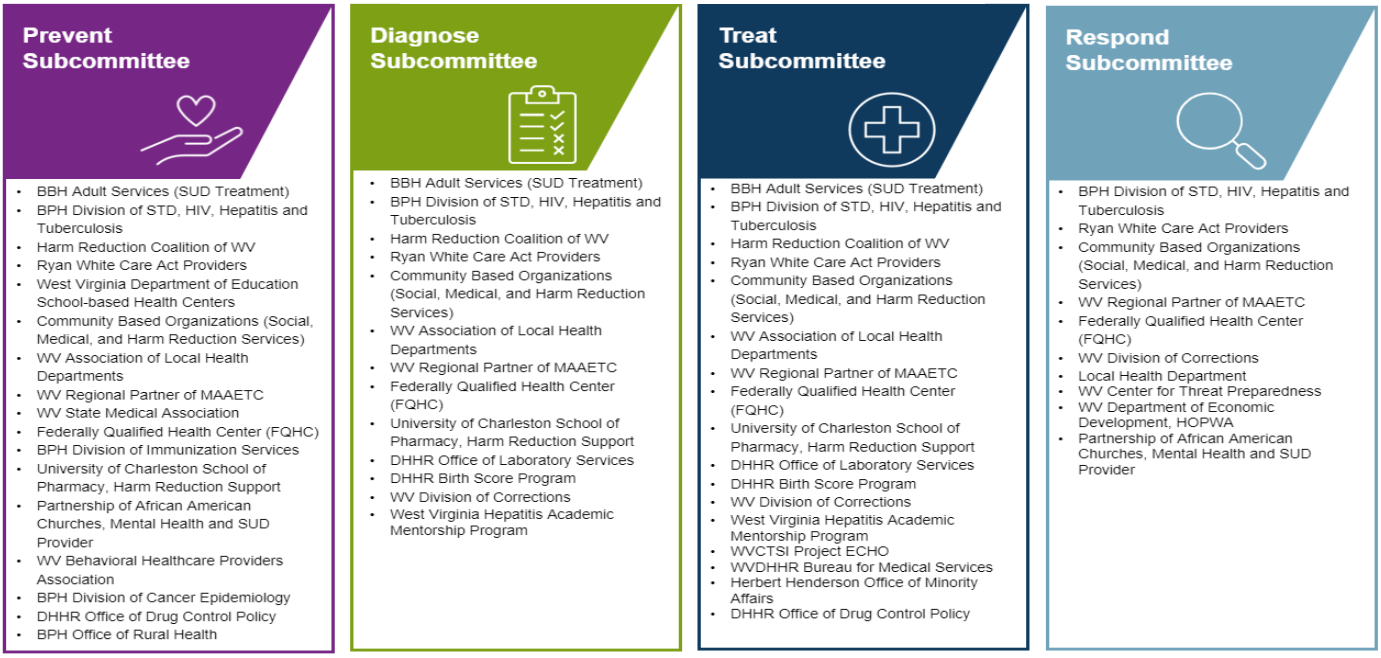
- Set 2022 – 2026 goals and objectives for each pillar
- Develop and coordinate activities to achieve goals and objectives
- Monitor and report progress
- Mobilize and engage state and local partners

The subcommittees reported to the Steering Committee and had the following primary responsibilities as well as any added responsibilities as determined by the Steering Committee:

- Define, prioritize, and articulate the goals of each pillar for the Plan
- Define and articulate objectives, performance measures, and activities for each goal
- Foster relationships and communication among stakeholders with a vested interest in the pillars
- Develop, coordinate, administer, and analyze assessment efforts, such as survey tools
- Coordinate statewide activities
- Develop a monitoring plan for each pillar's activities, objectives, and goals
- Monitor implementation of each pillar's activities, objectives, and goals and track performance measures
- Submit monthly progress reports to the Steering Committee
- Build a communication plan for each pillar to help ensure stakeholders and the public are aware of HIV and HCV efforts
- Identify solutions to address barriers to each pillar's activities, objectives, and goals

The subcommittees consisted of members from BPH and stakeholders from the following programs and organizations:

Figure 3. Subcommittee Membership



A member roster for each subcommittee is provided in Appendix C. The subcommittees had chairpersons who reported the subcommittees' activities to the Steering Committee. The subcommittees met weekly, and additional meetings were scheduled as needed. To gather stakeholder feedback on needs, gaps, barriers, strengths, and opportunities, as well as to collaborate on the development of the Plan, the subcommittees each met eight to nine times from August through October 2022.

HEPLEA Group

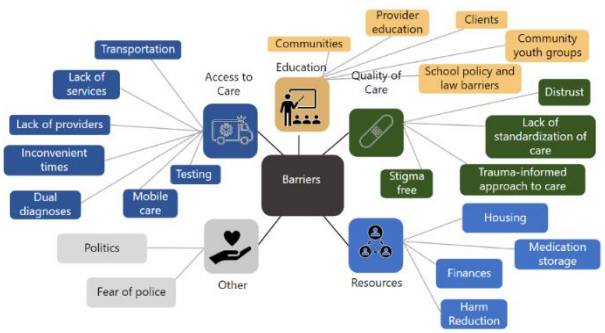
To provide guidance and insight to the subcommittees as well as help ensure cultural sensitivity and responsiveness throughout the planning process, the charter established a HEPLEA Group. The HEPLEA Group met as needed and consisted of individuals representing or serving priority populations and/or living with HIV and/or HCV. The HEPLEA Group had a designated chairperson who also served as a member of the Steering Committee. The HEPLEA Group met in September and October 2022.

In addition to the HEPLEA Group, the West Virginia HIV Advisory and Planning Group and Hepatitis Elimination Technical Advisory Group were engaged in the state planning process through members' participation on the subcommittees.

Priority Areas for State Planning Process

In August 2022, group discussions were facilitated with stakeholders organized by pillar focus and addressed the needs, gaps, barriers, strengths, and opportunities within the current West Virginia system of care. From these discussions, a thematic analysis was conducted, and similar responses were grouped. The analysis resulted in mind maps created for each pillar to display key concepts and the connections among them.

Figure 4. Prevent Subcommittee: Service Barriers

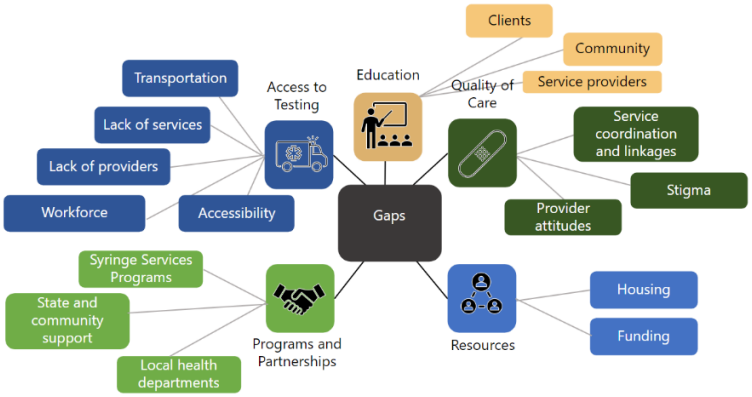


The Prevent Subcommittee identified service needs around factors such as transportation, pre-exposure prophylaxis (PrEP) education and access, testing access, support services (e.g., housing, behavioral health), trauma-informed education, stigma-free services, and provider education. Barriers included factors like lack of providers, limited services, fear, distrust, current policies, stigma, lack of standardized care, and financial considerations. Service gaps were identified around accessibility, transportation, support services (e.g., housing, behavioral health, harm

reduction), syringe services programs, prevention services and providers, and provider and client education. In addition to examining these factors, the group discussed opportunities around increasing the number of testing sites, expanding partnerships with pharmacies, utilizing social media and dating apps for education and outreach, working with communities, conducting outreach and service promotion, and offering education and mentoring to healthcare providers. Existing strengths within the West Virginia service system included mobile services, the Quick Response Team (QRT) program, Peer Recovery Support Specialists (PRSSs), the Ryan White programs, collaboration among partners, advocacy, and dedicated, passionate professionals (Figure 4).

The Diagnose Subcommittee identified service needs around factors such as transportation, universal screening, opt-out testing, integrated care, point of care testing, support services (e.g., housing, behavioral health), trauma-informed care, stigma-free services, care navigation, community health workers, syringe services programs, and education at the client, provider, and community levels. Barriers included factors like transportation, lack of providers, limited services, fear, distrust, current policies, stigma, active substance use, lack of syringe services programs, and financial considerations. Service gaps were identified around accessibility, transportation, lack of providers and services, support services (e.g., housing), syringe services programs, service coordination and linkages, provider attitudes, and education at the client, provider, and community levels.

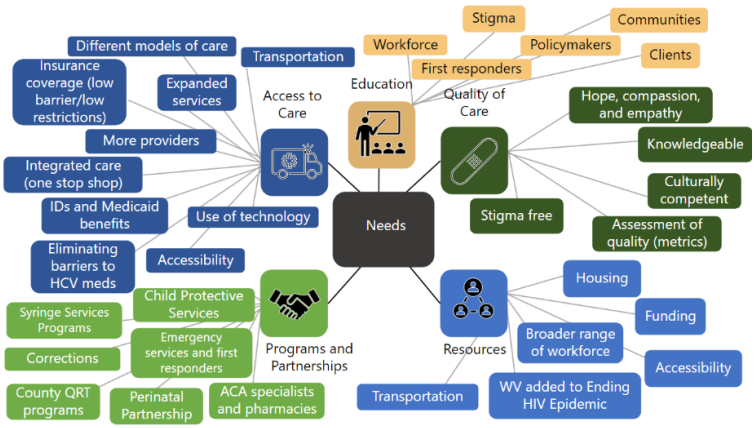
Figure 5. Diagnose Subcommittee: Service Gaps



In addition to examining these factors, the group discussed opportunities around expanding services (e.g., point of care testing, mobile services, backpack testing), increasing the number of service locations, implementing an anti-stigma campaign, conducting workforce development, messaging in the community, improving provider understanding, building relationships and community support, and utilizing syringe services programs. Existing strengths within the West Virginia service system included affordable testing, current harm reduction programs, West Virginia Clinical and Translational Science Institute (WVCTSI) Project ECHO, Medicaid expansion, testing in nontraditional settings, state lab services, the Ryan White programs, collaborations, and dedicated, passionate professionals (Figure 5).

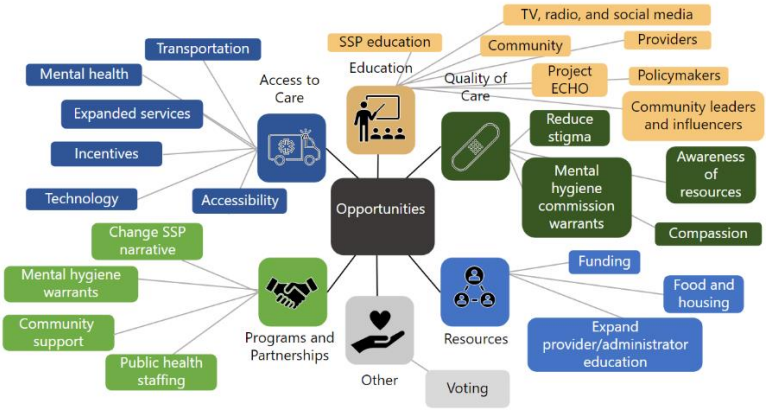
The Treat Subcommittee identified service needs around factors such as different models of care, accessibility, integrated care, eliminating barriers to HCV medications, support services (e.g., housing, transportation), partnerships (e.g., perinatal, corrections, pharmacies, child protective services, emergency services, first responders), stigma-free services, county QRT programs, syringe services programs, and education at the client, provider, policymaker, and community levels. Barriers included factors like transportation, lack of providers, limited services, healthcare administration, broadband access, lack of healthcare navigators, state regulations, current policies, stigma, substance use disorders, lack of support services, and financial considerations. Service gaps were identified around accessibility, transportation, lack of providers and services, support services (e.g., housing), syringe services programs, peer support, continuity of care, and education at the client, provider, and at-risk individual levels. In addition to examining these factors, the group discussed opportunities around expanding services (e.g., correctional settings, emergency departments, telemedicine), providing support with transportation and transitional living, increasing integrated care adoption, reducing stigma, establishing data sharing agreements, strengthening collaboration and engagement efforts, offering education at the provider and community levels, building community support, and exploring potential funding mechanisms. Existing strengths within the West Virginia service system included existing services, the Ryan White programs, use of telemedicine, collaborations, WVCTSI Project ECHO, WVHAMP, Medicaid expansion,

Figure 6. Treat Subcommittee: Service Needs



patient advocacy, resiliency, the MidAtlantic AIDS Education and Training Center (MAAETC), and dedicated professionals (Figure 6).

Figure 7. Respond Subcommittee: Service Opportunities



The Respond Subcommittee identified service needs around factors such as expanded services, mobile units, accessibility, more community health workers, access to housing and transportation, data, transparency, accountability, communication plans for outbreaks, funding, stigma-free services, syringe services programs, and education at the client, provider, and community levels. Barriers included factors like transportation, limited services, housing, funding, West Virginia geography, broadband access, lack of trauma-informed care, current policies, stigma, fear, distrust, hopelessness, previous experiences, client knowledge, lack of support, and financial considerations. Service gaps were identified around accessibility, transportation, lack of providers and services, one-stop-shop services, syringe services programs, support groups, community buy-in, state executive support, data availability, funding, connections to local resources, targeted messaging, dedicated program staff, and education at the provider, community, and school levels.

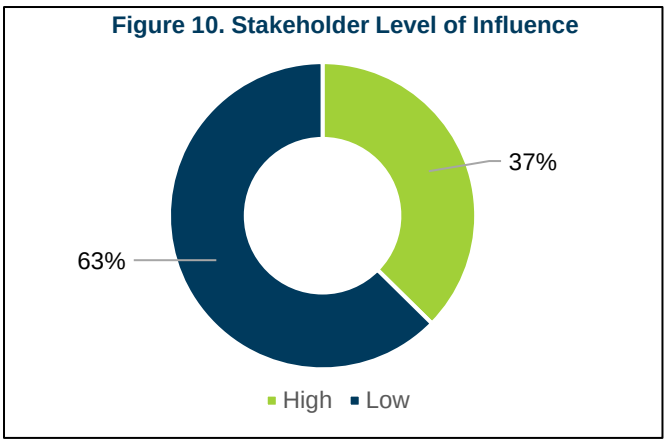
In addition to examining these factors, the group discussed opportunities around expanding services including those for mental health, providing support for basic needs (e.g., transportation, food, and housing), changing the narrative around syringe services programs, addressing mental hygiene warrants, improving community support, reducing stigma, increasing compassion and awareness, enhancing available funding, promoting participation in WVCTSI Project ECHO, and offering education at the provider, policymaker, local leader/influencer, and community levels. Existing strengths within the West Virginia service system included existing services, the Ryan White programs, use of telemedicine, collaborations, Housing Opportunities for People with AIDS (HOPWA), WVCTSI Project ECHO, WVHAMP, Medicaid expansion, MAAETC, attention to marginalized populations, and dedicated, passionate professionals. (Figure 7).

High-level priorities were identified through the mind maps, and common themes emerged across the pillars. Similar themes were determined among service providers and PWLE who were surveyed anonymously in October 2022, as well as among infection preventionists and PWLE who participated in focus group sessions. Establishing these high-level priorities allowed the subcommittees to focus on the areas deemed most important across the care continuum and better prepare for decisions during the planning process. (Figure 8).

PWLE and Community Engagement

Figure 8. West Virginia Priority Areas

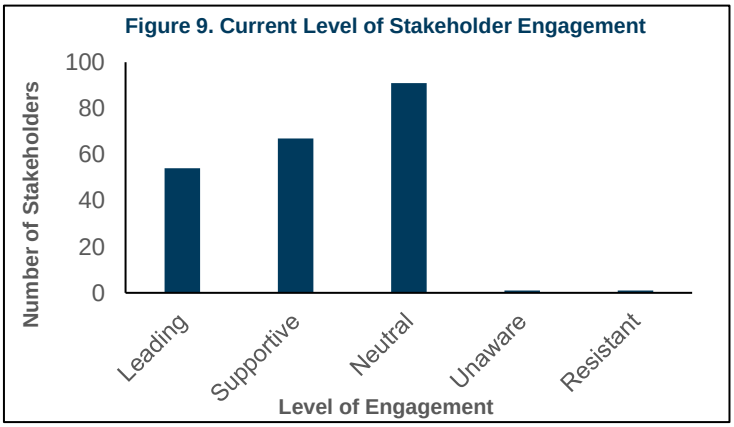
Community input is integrated into the planning process, and BPH established the HEPLEA Group to intentionally help ensure the process acknowledges and addresses the community's needs, cultures, and attributes. One key goal of the HEPLEA Group is to provide vital guidance on culturally appropriate processes, messaging, and services. An initial step in the planning process was BPH's DSHHT drafting language standards for the Plan that are based on the favored preferences of PWLE in West Virginia. These standards have three guiding principles: person-first language, the Platinum Rule, and cultural humility. Person-first language means centering the person before a particular health condition or experience, which sets the tone that one can see someone as a complex and complete person before any singular component of their life. The Platinum Rule states, "treat others as they wish to be treated." Finally, cultural humility differs from cultural competence in that it recognizes the ongoing work of creating an environment where all cultures are respected equally. These language standards were vetted and approved by the HEPLEA Group and are applied throughout the Plan.



In October 2022, BPH and stakeholders administered the *2022 Comprehensive Needs Assessment Survey for West Virginians Living with HIV and Hepatitis C* to better understand the service needs and gaps within the state and inform the priorities of the Plan. A total of 191 survey responses were received, of which 178 met inclusion criteria of living in West Virginia with HIV and/or HCV. Most respondents were between the ages of 35 and 64 years (74%), were male (65%), and reported their race as White (73%). Additionally, focus group sessions were organized and conducted by the West Virginia Ryan White Part B Program and the Ryan White Part C Program. A total of 13 focus groups with 87 participants were completed in October 2022. Participants included people living with HIV and those co-infected with hepatitis C. Six of the thirteen groups (46%) consisted of people exposed due to intravenous drug use, and two groups (15%) reported exposure through sexual activity. In the other five groups, participants either reported a mix of risk exposure including substance use and sexual activity or chose not to disclose their risk behaviors. There were three groups with specific participants: one of long-term HIV survivors, one of legal and illegal immigrants, and one of people living in rural areas of the state. Additional details and the findings from the PWLE needs assessment survey and focus groups are discussed further in Section III: Contributing Data Sets and Assessments.

Contributions of Stakeholders and Key Partners

As previously described, stakeholders and key partners served as members of the Steering Committee and subcommittees. In June 2022, BPH identified key leaders who had a strong interest in reducing HIV and HCV across the state and invited them to provide valuable guidance as well as collaborate on the development of the Plan. These individuals comprised the Steering Committee. In August 2022, the four subcommittees were convened and met over a series of 34 meetings spanning 10 weeks to support the needs assessment process and priority setting, to complete a situational analysis, to inform the SCSN, and to identify goals, objectives, strategies, activities, and process measures for the Plan. In all, 86 individual stakeholders contributed their time and expertise to develop the Plan and are committed to its implementation and monitoring.

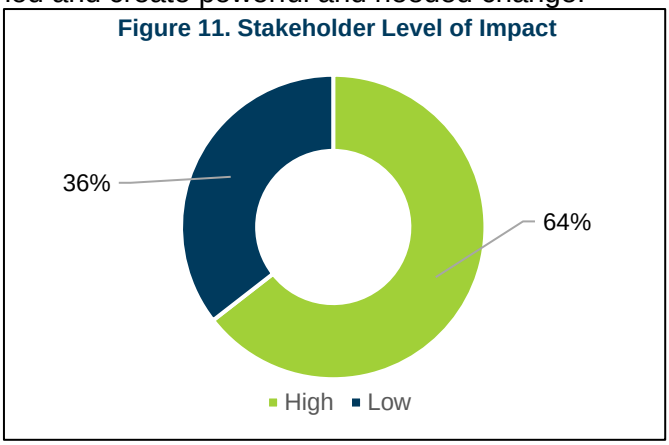


A stakeholder analysis shows a total of 214 partners were engaged in the planning process on some level from June through October 2022 with all stakeholder categories required for integrated planning represented (Appendices B and C). The level of engagement varied among stakeholders with most attending 26 – 50% of meetings and appearing neutral toward the effort and their roles; however, the total number of stakeholders with engagement levels assessed as leading (76 – 100% of meetings attended and actively contributing) and supporting (51 – 75% of meetings attended and an understanding of their role) accounted for 57% of the participating partners (Figure 9). Levels of engagement are stages that mark stakeholders' participation and commitment to the development and implementation of the Plan and their roles as team members. They relate to the stakeholders' investment in the effort and its success and can impact the processes and Plan performance. Although it may be like stakeholder satisfaction, engagement is more about a stakeholder's connection to their role and interest in the success of the Plan. Stakeholders who are fully engaged in the process may feel passionate about implementing the Plan and meeting or exceeding goals and expectations.

Stakeholders were also assessed on their potential levels of influence and impact with the Plan. Influence indicates a stakeholder's relative power or authority over and within the planning process, and impact is the ability of the stakeholder to bring about a desired change or outcome during the development and/or implementation of the Plan. Two-thirds of the stakeholders appear to have low or limited influence (Figure

10), while most have a high level of potential impact (Figure 11). These results suggest the engaged stakeholders and key partners will be able to accomplish the desired improvements in West Virginia's service delivery system during the five-year planning period and create powerful and needed change.

Figure 11. Stakeholder Level of Impact

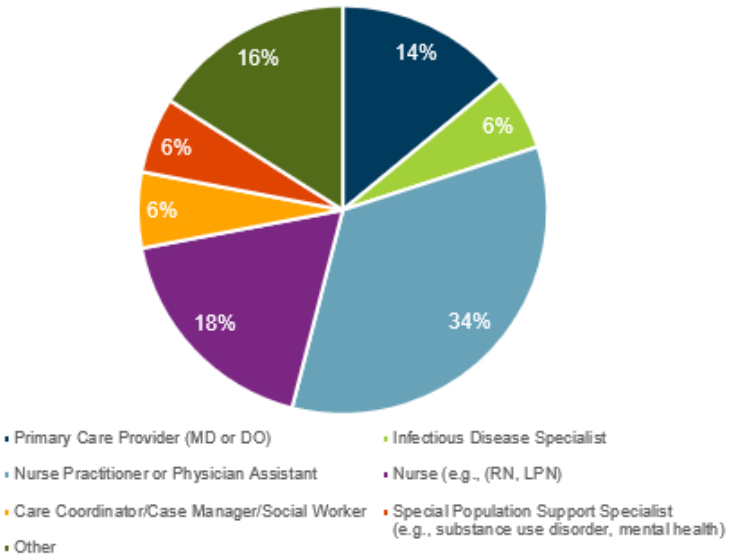


BPH, the Steering Committee, and members of the subcommittees and planning/advisory bodies worked together to design mechanisms to collect input on the needs and challenges of the community and PWLE. In October 2022, BPH and stakeholders administered the *2022 Comprehensive Needs Assessment Survey for West Virginians Living with HIV and Hepatitis C* to better understand the service needs and gaps within the state and inform the priorities of the Plan. To incentivize participation among PWLE, the West Virginia AIDS Taskforce of the Upper Ohio Valley provided $25 gift cards to each respondent who completed the entire survey. Ryan White Part A and B Programs utilized staff with established relationships in the community to reach out to PWLE and assist them in completion of the survey. Surveys were also advertised by medical and administrative staff at clinics across the state that see patients who are not part of a Ryan White program. Division staff visited one harm reduction program to administer the survey to program participants. In addition, the West Virginia Ryan White Part B Program and the Ryan White Part C Program organized and facilitated 13 focus groups with 87 participants. Participants in the focus groups were 62% male, 36% female, and 2% transgender. Participants ranged in age from 28 to 70 years old with most participants falling between 35 to 45 years of age.

Stakeholders were also engaged as participants in the needs assessment process through completion of the HIV Resource Inventory Compiler, focus groups, and the *2022 Provider Prevention and Care Survey for West Virginia HIV and HCV Elimination Plan*. In October 2022, DSHHT conducted two focus group sessions with a total of 10 infection preventionists from multiple locations of a large healthcare system to assess barriers to hepatitis and HIV testing and treatment and obtain information on any intervention strategies currently utilized to improve outcomes. Individual topics covered included barriers to PrEP, testing, and treatment along with ways to overcome the barriers and support that is needed.

In October 2022, BPH administered the *2022 Provider Prevention and Care Survey for West Virginia HIV and HCV Elimination Plan* to the clinical community to identify service needs and gaps and inform the priorities of the Plan. The survey was promoted through stakeholders, such as the WVCTSI Project ECHO and the West Virginia Rural Health Association. The link to the survey was also distributed at the annual Perinatal Partnership Summit. A total of 53 responses were received across a variety of healthcare provider roles (Figure 12). Most survey respondents were mid-level practitioners, which aligns with statewide healthcare workforce trends in West Virginia. Details and key findings from the provider survey and focus groups are discussed further in Section III: Contributing Data Sets and Assessments and Section IV: Situational Analysis.

Figure 12. Healthcare Provider Roles



Letters of Concurrence and Commitment

Letters of concurrence and commitment to the goals and objectives of the Plan from the chairs of the planning/advisory bodies can be found in Appendices D and E.

Section III: Contributing Data Sets and Assessments

What are West Virginia's greatest HIV and HCV needs?

- The top five unmet needs reported by PWLE who were surveyed are oral health care and emergency assistance for utilities, housing, food/groceries, and rent.
- Availability of medical care including more qualified local providers and non-traditional service provision hours and addressing stigma are substantial needs in the state.
- Due to the state's rurality, treatment and care gaps exist for people who live outside metro areas who must travel great distances to access services.
- Negative experiences related to testing were attributed to stigma, lack of confirmatory testing/treatment, lack of follow-up services and education on infection management, and confidentiality issues.
- Focus group participants identified five barriers to accessing HIV and/or HCV care: lack of education on available services; financial needs (i.e., housing, transportation, childcare, cost of services and treatment); program and/or insurance rules requiring sobriety; need for treatment approval by infectious disease specialists; inconvenient provider office hours; and stigma.

Who is affected the most by HIV and HCV in West Virginia?

- HIV currently most affects the persons who inject drugs population, with 72% of new cases in 2020 occurring in that group; however, the largest number of individuals living with diagnosed HIV remains the men who have sex with men population.
- HCV disproportionately affects males between the ages of 20-49 years who are White, non-Hispanic or Latino.

What is important to know about HIV and HCV in West Virginia?

- HIV incidence in West Virginia increased 103% between 2016 and 2020, and currently two large outbreaks affecting over 300 individuals who inject drugs are ongoing.
- West Virginia has one of the highest incidence rates of acute HCV in the nation.
- The major risk factor for acute HCV is intravenous drug use.

Data Sharing and Use

Data used for the state planning process originated from a variety of sources and include primary/secondary surveillance data, individual agency and program data, and qualitative and quantitative data from statewide needs assessments. The epidemiologic snapshot contains data from several sources including the United States Census Bureau, Kids Count Data Center, Behavioral Risk Factor Surveillance System, CDC AtlasPlus, enhanced HIV/AIDS Reporting System (eHARS), Ryan White HIV/AIDS Program (RWHAP) Compass Dashboard and Services Report, and West Virginia public health surveillance systems.

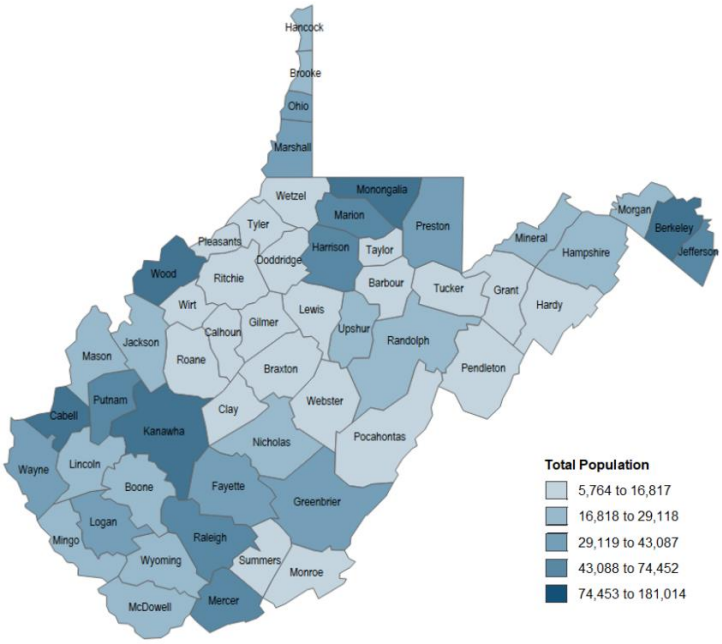
Tables and figures are based on the most recent available data, and the five most recent years' data were used when reviewing trends over time. Data for the HIV prevention, care, and treatment resource inventory were compiled by BPH in collaboration with service delivery partners. The needs assessment process involved an electronic survey and a series of focus groups engaging PWLE, both those living with HIV and/or HCV and those at risk. In addition, an online prevention and care survey was administered to providers, and focus groups were conducted with infection preventionists from a large health system. Data from these sources are presented in the following subsections and were used by BPH, the Steering Committee, and the subcommittees to develop Section IV: Situational Analysis and Section V: 2022 – 2026 Goals and Objectives.

Epidemiologic Snapshot

General Population Characteristics of West Virginia

West Virginia is the 41st largest state by area with 24,034.8 square miles of land and is often included in several geographical regions, including the Mid-Atlantic, the Upland South, and the Southeastern United States. The state is mostly rural, with 32 of the 55 counties considered rural and only 11 counties having a population of over 50,000. West Virginia is the only state entirely located within the area known as Appalachia. Compared to the United States as a whole, West Virginia has a lower median household income, lower rate for higher education attainment, and lower employment rate.

Figure 13. West Virginia Total Population by County, 2020



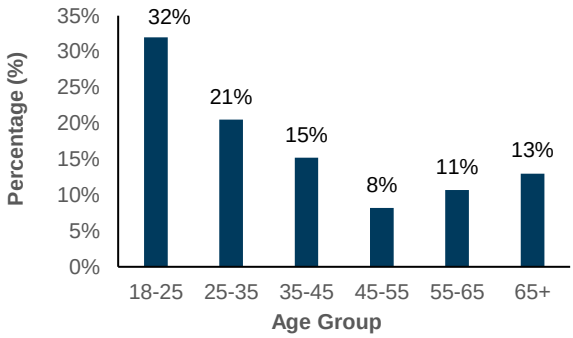
Source: U.S. Census Bureau. (2020). American Community Survey, ACS 5-Year Estimates Subject Tables, West Virginia.

The population of West Virginia is less than 1% of the United States population, with a total population of 1.79 million in 2020, making it the 12th least populous state. From 2010 to 2020, the total population of the state decreased by 3%, which was the highest rate of population decline in the United States over that period. Most of the state's population resides in the five counties of Berkeley, Cabell, Kanawha, Monongalia, and Wood (53%). Most counties within the state have a population that ranges in size from 5,764 to16,617 (Figure 13).

According to the U.S. Census Bureau, in 2020 the median age (the age at which half the population is older than and half is younger) in West Virginia was 42.7 years (compared with 38.2 years in the United States). The median age in the state has increased over the past decade and is one of the oldest median ages in the country. The largest age group in West Virginia in 2020 was 65 years and older, with over 360,000 people comprising approximately 20% of the population. The second-largest age group was 14 years and younger, with approximately 17% of the population. The two smallest age groups are 25-34 and 35-44 years, each representing approximately 12% of the state's population.

In 2020, 50.6% of the population in West Virginia was female, and 49.4% was male. Adults in West Virginia who identify as LGBTQ+ comprised 3.4% (n=61,609) of the total population, of whom 52% were men and 48% were women. Of West Virginia's LGBTQ+ population, 86.5% reported they were White, 6% reported they were Hispanic, and 2.8% reported being multiracial. The largest LGBTQ+ age group in West Virginia in 2020 was between ages 18-25 years, approximately 32% of the population (Figure 14).

Figure 14. LGBTQ+ Adults by Age Group, West Virginia, 2020 (n=61,609)

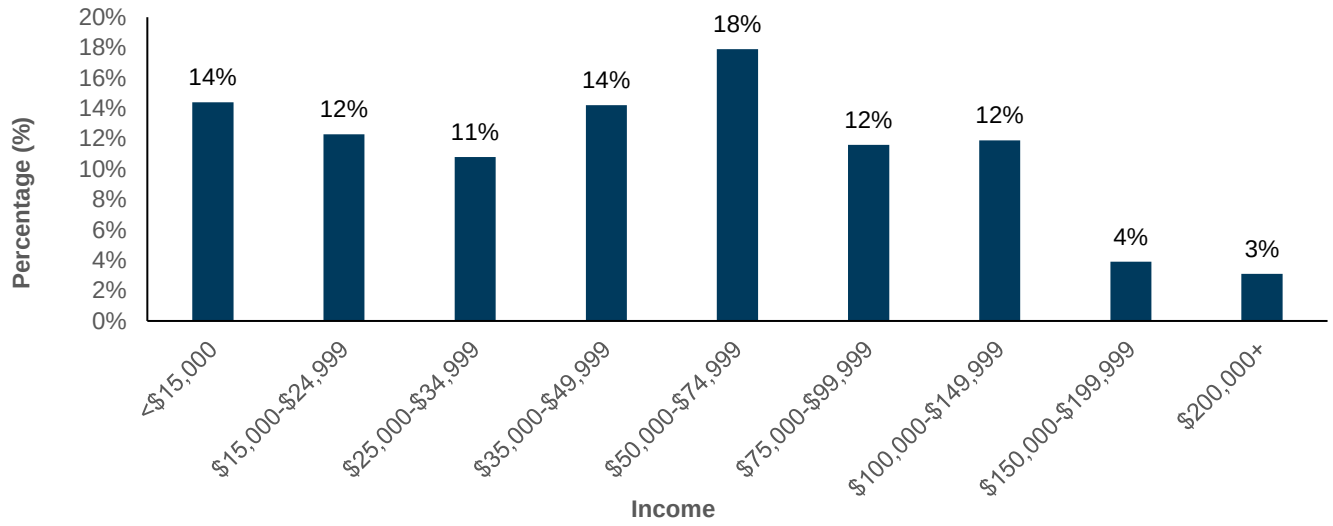


Source: U.S. Census Bureau. (2020). American Community Survey, ACS 5-Year Estimates Subject Tables, West Virginia.

According to the 2020 U.S. Census, approximately 90% of the population in West Virginia is White, whereas 70% of the U.S. population is White. The second-largest race group is Black, comprising less than 4% of the total population, and 2.9% identify as other races. In 2020 in West Virginia, 98% of the population indicated they were not Hispanic or Latino.

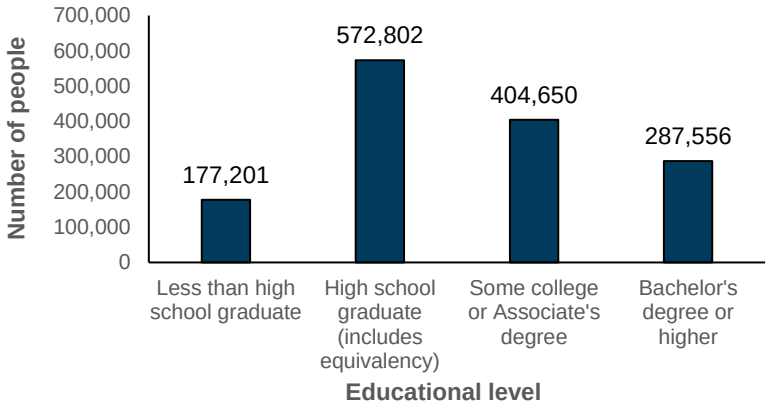
Median household income is the income amount that divides a population into two equal groups, half having an income above that amount, and half having an income below that amount. In 2020, the median household income in the United States was $64,994. In West Virginia, the median household income was $48,037, with more than 50% of the population making less than $50,000 annually (Figure 15).

Figure 15. Annual Household Income, West Virginia, 2020



Educational attainment refers to the highest level of education a person has completed. The most common level of educational attainment in West Virginia is high school graduate or the equivalency, with 40% of people 25 years and older, followed by some college or associate degree at 26% (Figure 16). Lower educational attainment can result in having a low-wage job. In 2018, the percentage of West Virginia jobs in occupations with median annual pay below 100% of the federal poverty threshold for a family of four ($25,100) was 27%, ranking the state 44th in the country for low-wage jobs.

Figure 16. Educational Attainment for Population 18 Years and Over, West Virginia, 2020

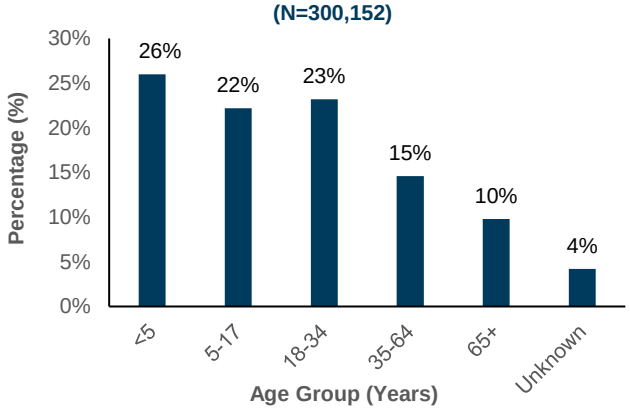


Source: U.S. Census Bureau. (2020). American Community Survey, ACS 5-Year Estimates Subject Tables, West Virginia.

Employment status has been stable in West Virginia since 2017. The percentage of unemployment in 2020 was 7% and varies by county. The highest percentage of unemployment in individuals 16 years and over is in McDowell County (15%) and the lowest in Jackson and Mason counties (<3%).

The federal poverty threshold, or poverty line, is the minimum level of resources that are adequate to meet basic needs. In 2020, over 300,000 people in West Virginia were living below the poverty line. The racial and ethnic group with the highest percentage of people living below the poverty level in West Virginia in 2020 is Black or African American (29%). The Asian population has the smallest percentage of people living below the poverty level, with 15%. The largest racial and ethnic group in West Virginia is White, with 17% or over 268,000 people living below the poverty level.

Figure 17. Percentage of Individuals Living Below Poverty Level by Age Group, West Virginia, 2020, (N=300,152)



Source: U.S. Census Bureau. (2020). American Community Survey, ACS 5-Year Estimates Subject Tables, West Virginia.

Though the smallest age group in West Virginia, individuals less than five years of age represent the highest percentage (26%) of the population living below the poverty level (Figure 17).

The age group with the smallest percentage of people living below the poverty level is those aged 65 years and older. The largest number of individuals living below the federal poverty level are between the ages of 35–64, with over 100,000 people.

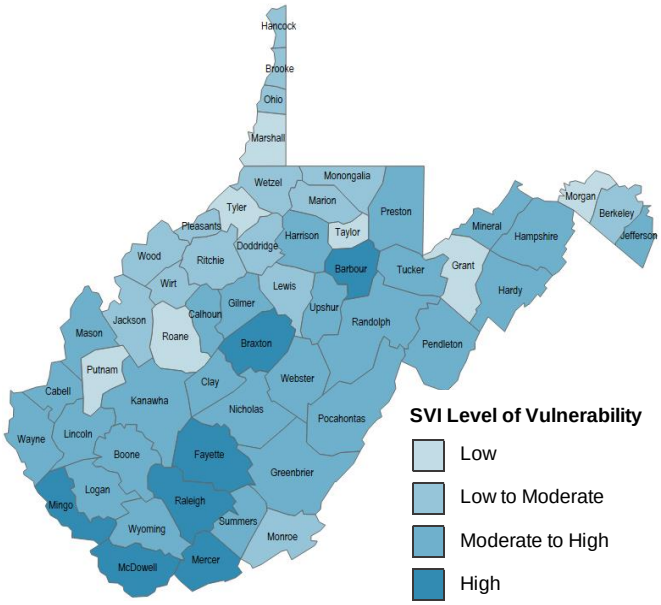
The population experiencing homelessness in West Virginia has varied in size over the past few years. In 2020, an estimated 1,341 people were experiencing homelessness in West Virginia. Of that total, 58 were family households, 104 were veterans, 112 were unaccompanied young adults (aged 18-24 years), and 174 were adults experiencing chronic homelessness. The percentage of males (61%) experiencing homelessness is greater than that of females in West Virginia. Black or African Americans are disproportionately impacted, accounting for over 13% of the population experiencing homelessness.

Many people living in West Virginia in 2020 had health insurance coverage. The two age groups with the lowest percent of health insurance coverage are individuals aged 19-25 years (88%) and 26-34 years (89%). For all other age groups, over 90% of the population has health insurance coverage. The percentage of people covered by health insurance varies by county ranging from <4% to 11%.

Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health. Various factors, such as poverty, lack of access to transportation, and crowded housing can create stress and may weaken a community's ability to prevent human suffering. Such stresses include natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss.

The CDC and the Agency for Toxic Substances and Disease Registry (ATSDR) utilize 15 U.S. Census variables to develop a CDC/ATSDR Social Vulnerability Index (SVI). The SVI in West Virginia ranges from low to high, with most counties categorized as either "moderate to high" or "high" (Figure 18).

Figure 18. Social Vulnerability Index by County, West Virginia, 2018



Source: CDC/ATSDR. (2018). Social Vulnerability Index.

Households that are unable to obtain sufficient food at times due to lack of money and/or other resources are considered food insecure. According to the United States Department of Agriculture (USDA), in 2020, West Virginia had the second-highest food insecurity ranking in the nation at 15% (or 113,099 households), which was significantly higher than the national average of 11%.

Transportation is a social determinant of health that significantly impacts rural states because it affects access to healthcare, social services, employment, and educational opportunities. In 2020, 9% of households had no vehicles available, and many of the remote communities across the state have limited public transportation options. The Medical Access Roads Program (MARP), located in all 55 counties, is part of Governor Justice's initiative to improve access to medical facilities for residents. The 2020 MARP allocated $50 million to projects that focus heavily on decreasing obstructions and increasing access to medical facilities and medical supply transportation routes.

For rural communities across West Virginia, computer access and broadband connectivity can serve as a gateway to health, social, and educational services. Telehealth presents an opportunity to address health disparities and deliver much-needed healthcare and public health services to underserved areas of the state, especially connecting local providers and residents in remote areas to specialized care. According to the Federal Communications Commission (FCC), the percentage of West Virginia residents with access to fixed broadband service is 73%, compared to the national percentage of 90%. Access in rural areas is lower, with only 57% of rural West Virginians having fixed broadband service compared to 62% nationally.

A Health Professional Shortage Area (HPSA) is a geographic area, population group, or healthcare facility that HRSA has designated as having a shortage of primary, dental, or mental healthcare providers. As of March 2022, West Virginia had 113 HPSAs for primary care covering 785,937 residents. According to HRSA, the state has an unmet need of 47% and would need an additional 137 primary care providers to remove the HPSA designation.

HIV Trends in West Virginia

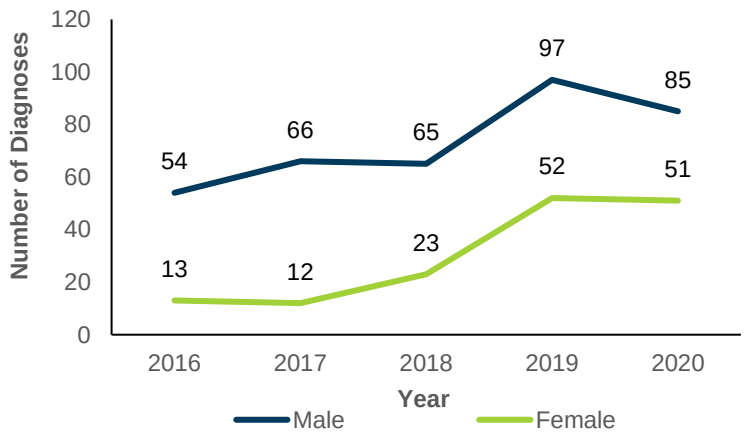
HIV data is considered provisional for ≥ 12 months, therefore, data in this report are as of the end of 2021, for HIV cases diagnosed by the end of 2020. Note that standardized HIV care metrics measure care events over 365 days, therefore 2020 care data is calculated on 2019 cases as of the end of 2020.

HIV is a virus that attacks the body's immune system and if left untreated can lead to AIDS (acquired immunodeficiency syndrome). There is currently no effective cure. Once people get HIV, they have it for life, but with proper medical care, HIV can be controlled. People with HIV who get effective HIV treatment can live long, healthy lives and protect their partners.

People Newly Diagnosed with HIV

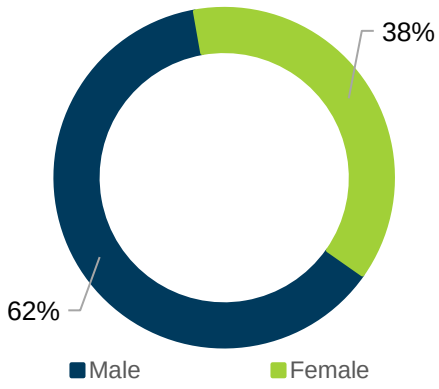
In West Virginia, there were 136 individuals newly diagnosed with HIV in 2020. Although the rate of new HIV diagnoses decreased nationally between 2018 and 2020 (13.6 to 10.9), the rate in West Virginia increased significantly during that same time from 5.6 in 2018 to 9.1 in 2020. The number of individuals diagnosed with HIV by sex at birth in West Virginia follows a similar trend to that of the United States, with males diagnosed more frequently than females. In 2020, 62% (n=85) of people diagnosed with HIV were assigned male at birth and 38% (n=51) were assigned female at birth (Figures 19 and 20). The number of people diagnosed with HIV in West Virginia increased overall between 2016-2020 by 103%, and nearly tripled for females (292%); however, the number of cases declined between 2019-2020, which could largely be the result of reduced testing in the community due to the COVID-19 pandemic.

Figure 19. Number of Reported HIV Diagnoses by Sex at Birth, West Virginia, 2016-2020



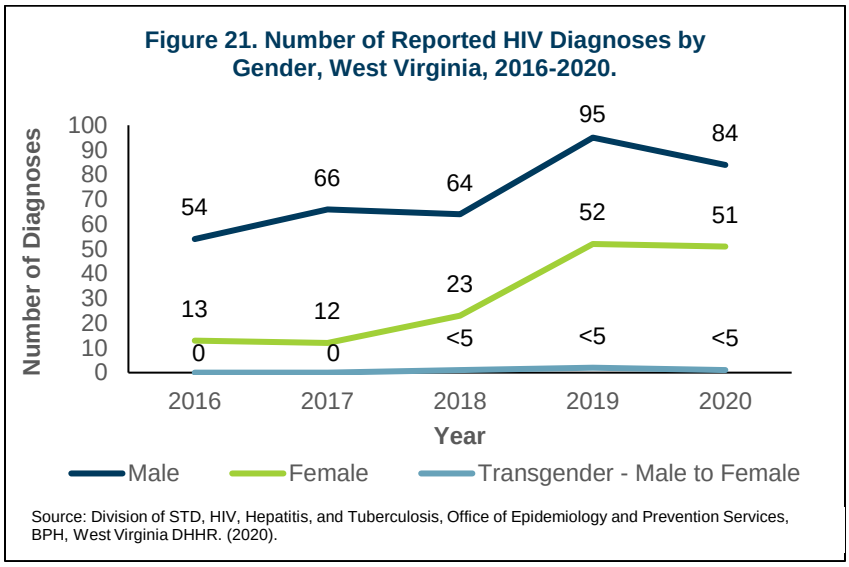
Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Figure 20. Percentage of Reported HIV Diagnoses by Sex at Birth, West Virginia, 2020 (N=136)

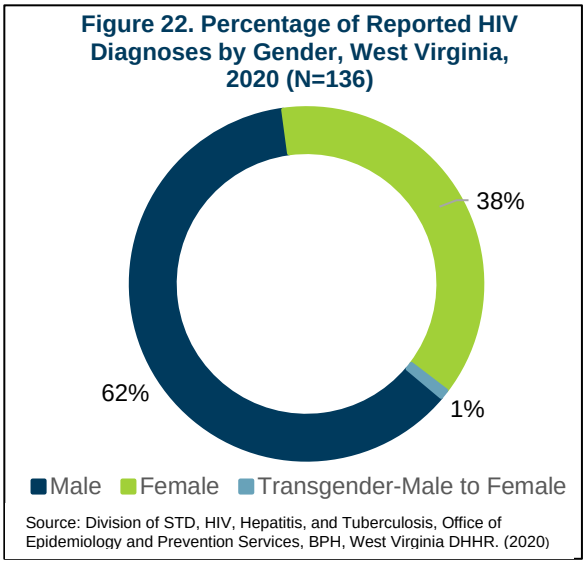


Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

In 2020, more cisgender males were diagnosed with HIV than cisgender females or transgender males to females. Of the individuals diagnosed with HIV, 62% (n=85) were male, 38% (n=51) were female, and less than 1% were transgender male to female. There were no reported cases of HIV among the transgender female to male population in 2020 (Figures 21 and 22).

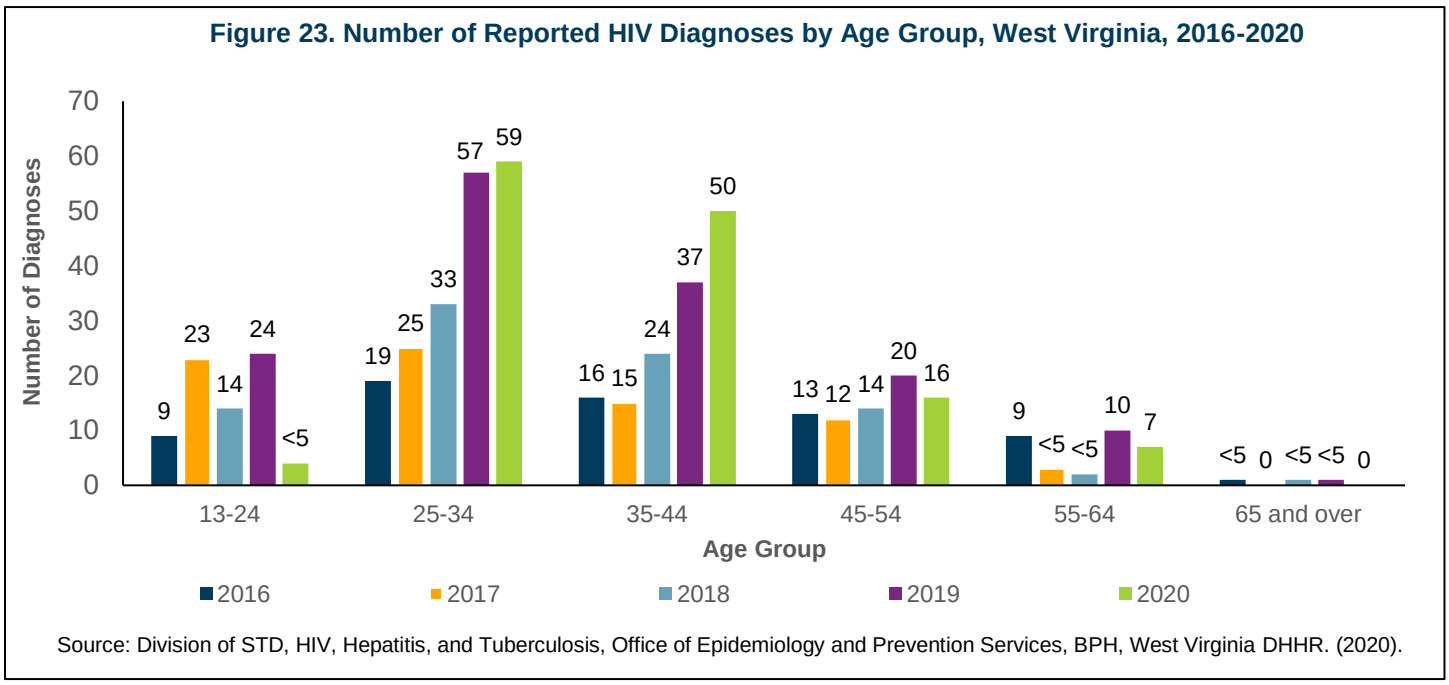


Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).



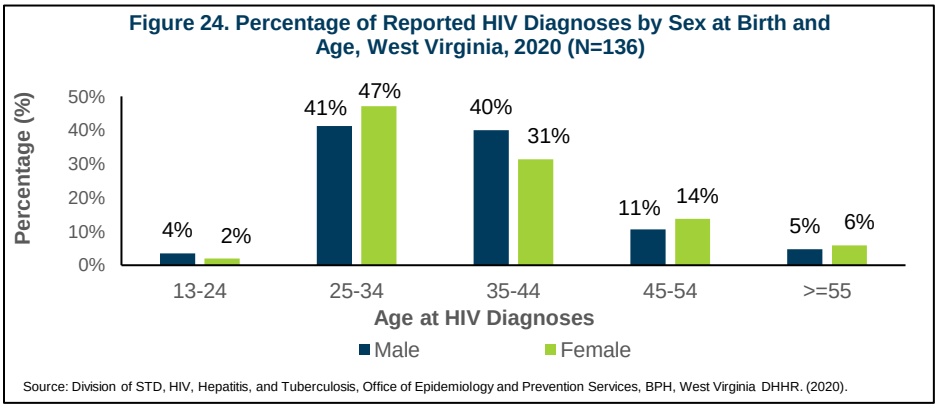
Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020)

In 2020, 80% of newly diagnosed individuals were between the ages of 25 to 44 years. Between 2016-2020 there was a 211% increase in HIV diagnoses within the 25 to 44 years age group. The age group with the lowest number of HIV diagnoses was among the 65 years and older age group (Figure 23).



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

In 2020, among the 25 to 34 years, 45 to 54 years, and the 55 years and older age groups, new HIV diagnoses were reported more among females than males. The largest number of diagnoses for both males and females occurred in the 25 to 44 years age group (Figure 24).



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

In 2020, the racial distribution of new HIV cases was similar to the distribution of West Virginia's population. The highest number of new diagnoses occurred in the White non-Hispanic population (84%). The highest number of new diagnoses occurred in the White non-Hispanic population (84%) (Table 1). Although Black/African Americans only represent 4% of the state's population, they represented 7% of the HIV diagnoses in 2020. In West Virginia from 2016 to 2020, the White, non-Hispanic group accounted for the largest number of people diagnosed with HIV (78%). Between 2016 to 2020, there was a 128% increase in diagnoses among White, non-Hispanics from 50 in 2016 to 114 in 2020. Black/African Americans accounted for 14% of all diagnoses between 2016-2020. Between 2019-2020 there were declines in HIV diagnoses among all racial and ethnic groups except for the Hispanic/Latino and Asian groups (Table 1). The decrease in HIV diagnoses might be attributable to decreases in HIV testing during the COVID-19 pandemic.

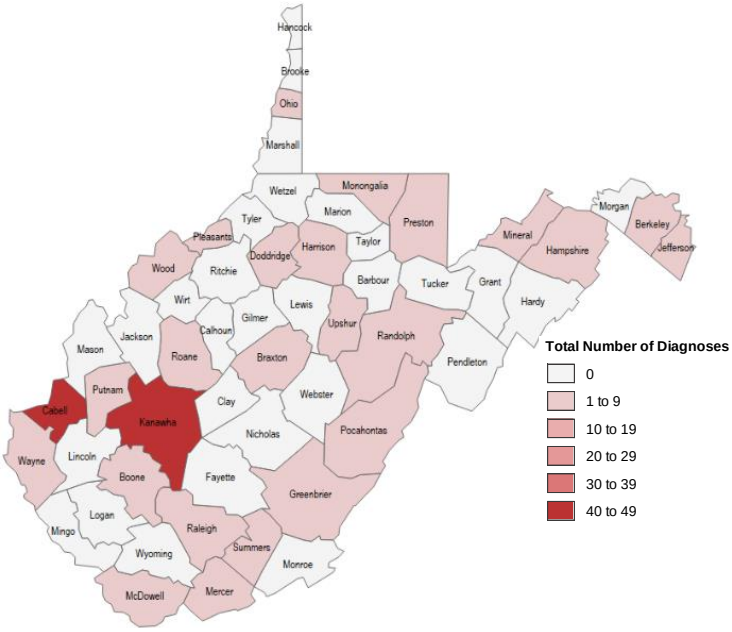
Table 1. Number of Persons Diagnosed with HIV in West Virginia by Race and Ethnicity, 2016-2020

Race/Ethnicity	Year of Diagnosis				
	2016	2017	2018	2019	2020
Hispanic, All races	0	<5	<5	<5	5
American Indian/Alaska Native, Non-Hispanic	0	0	0	0	0
Asian, Non-Hispanic	0	<5	<5	0	<5
Black, Non-Hispanic	11	19	15	16	10
Native Hawaiian/Other Pacific Islander, Non-Hispanic	0	0	0	0	0
White, Non-Hispanic	50	51	66	122	114
Multiple Race, Non-Hispanic	6	5	<5	8	6
Unknown	0	0	0	0	0

Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

A total of 29 counties in West Virginia had no reported HIV diagnoses in 2020. Cabell and Kanawha counties had the highest number of reported HIV diagnoses, comprising 33% (n=45) and 32% (n=44) of all cases in West Virginia in 2020, respectively. The remaining 24 counties that reported HIV diagnoses in 2020 had between one and six diagnoses (Figure 25).

Figure 25. Number of HIV Diagnoses by County, West Virginia, 2020

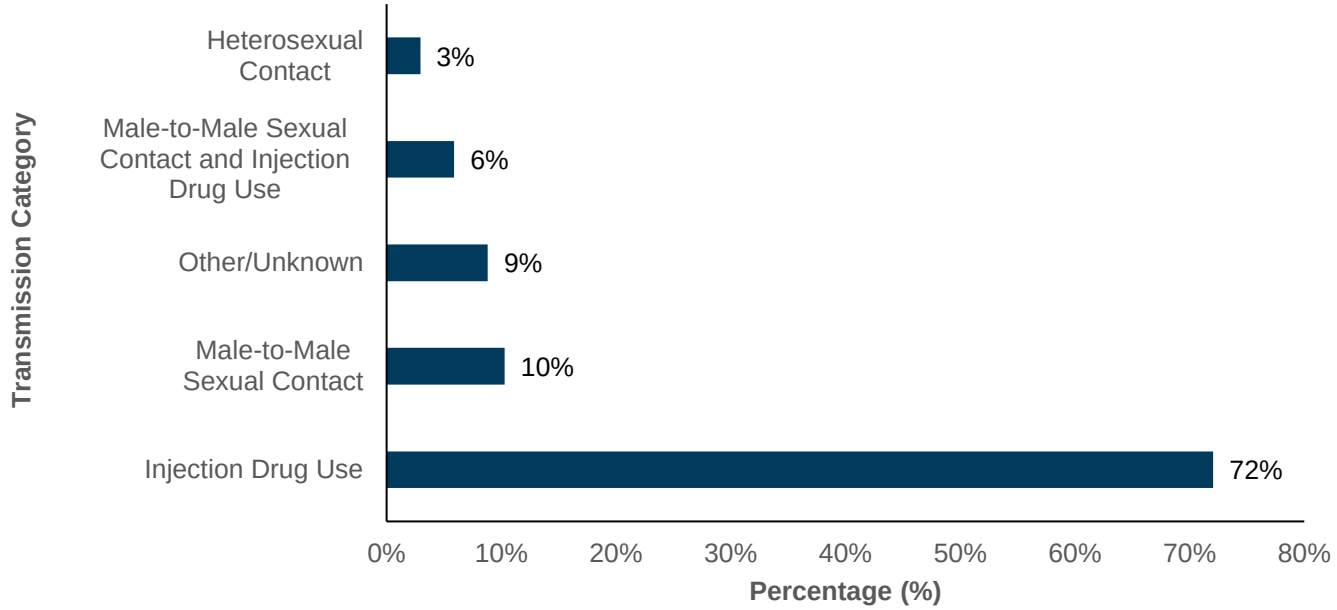


Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

HIV is most often transmitted through anal sex, vaginal sex, or sharing needles, syringes, or other drug injection equipment. In West Virginia, the most prevalent HIV transmission category was injection drug use (IDU) (72%). The transmission of HIV is greater for male-to-male sexual contact (10%) than other categories of sexual contact (Figure 26).

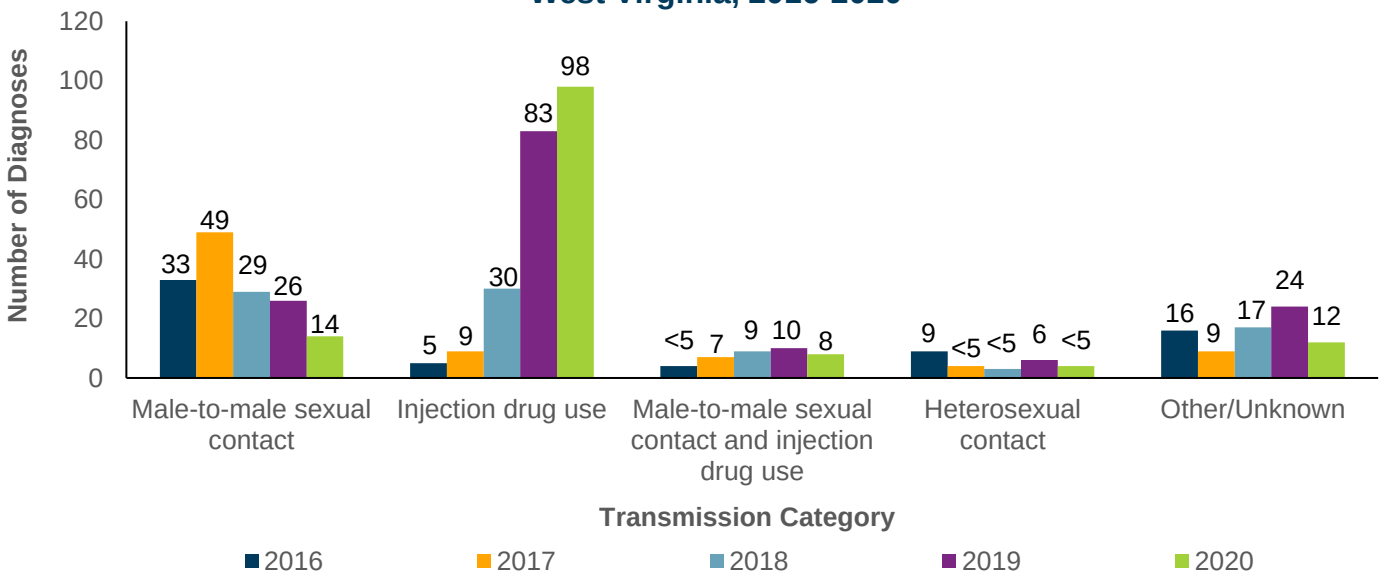
In 2016 and 2017, male-to-male sexual contact transmission was the most reported risk behavior, comprising 50% and 63% respectively, of the total number of cases in those years. Beginning in 2018, the male-to-male sexual contact transmission category was no longer the most prevalent transmission category, IDU became the most prevalent. From 2016 to 2020, there was more than an 1,800% increase in persons diagnosed with HIV reporting IDU, while no increases were observed for any other transmission category (Figure 27).

Figure 26. Percentage of Reported HIV Diagnoses by Transmission Category, West Virginia, 2020 (N=136)



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Figure 27. Number of Reported HIV Diagnoses by Transmission Category, West Virginia, 2016-2020



Note: Between 2016-2020, West Virginia had no reported cases of perinatal exposure.
Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

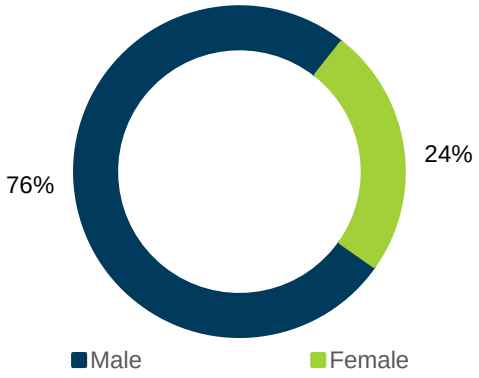
Persons Living with Diagnosed HIV (PLWH)

In West Virginia, there were 2,207 individuals living with HIV in 2020. This represents a 6% increase in the number of individuals living with HIV compared to 2019 (Table 2). The number of West Virginia individuals living with HIV has increased each year since 2016. There was a 19% increase among individuals living with HIV from 1,860 in 2016 to 2,207 in 2020. In West Virginia in 2020, more persons living with HIV were assigned male at birth (76%, n=1,676) than female at birth (24%, n=531) (Figure 28). More cisgender males are living with HIV than cisgender females or transgender males to females. As of 2020, there were no reported cases of HIV among the transgender female to male population (Figure 29).

Table 2. Persons Living with an HIV Diagnosis, West Virginia, 2016-2020

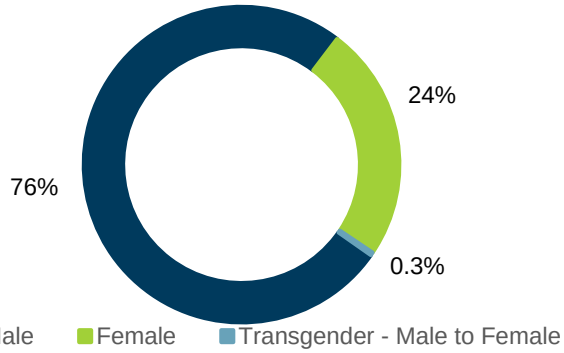
Year	Number of PLWH
2016	1,860
2017	1,933
2018	2,059
2019	2,089
2020	2,207

Figure 28. Percentage of Persons Living with Diagnosed HIV by Sex at Birth, West Virginia, 2020 (N=2,207)



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

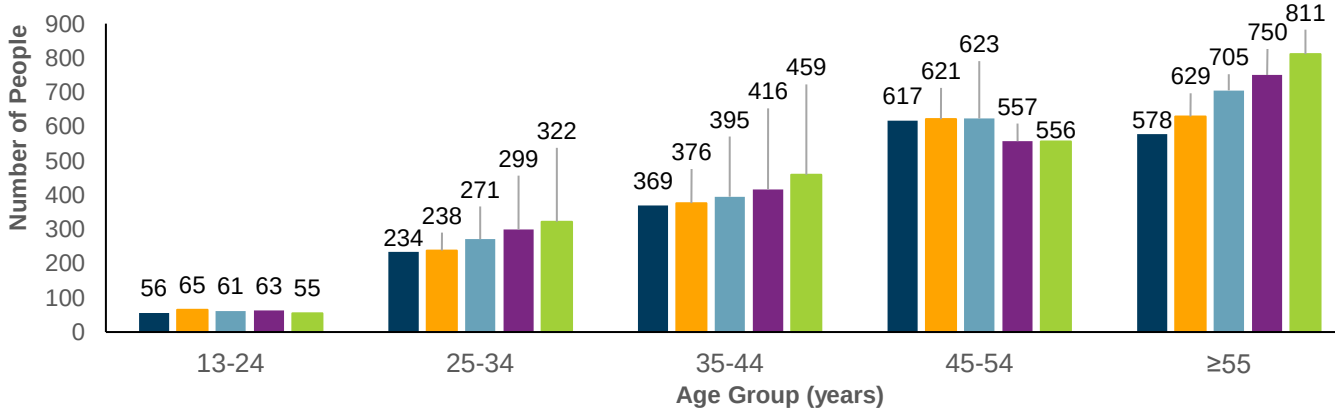
Figure 29. Percentage of Persons Living with Diagnosed HIV by Gender, West Virginia, 2020 (N=2,207)



Note: No Transgender - Female to Male were reported during the timeframe.
Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

As of 2017, the age group with the largest number of individuals living with diagnosed HIV was those 55 years and older. Among all age groups, the 55 years and older group had the largest percent increase (40%) of individuals living with diagnosed HIV from 2016 to 2020. This contrasts with the trend of recent years where the largest percentage of new cases are being diagnosed in the 25 to 34 years age group. The age group with the fewest people living with HIV is the 13 to 24 years age group (Figure 30). As the population living with HIV lives longer, it is expected that the percentage living with diagnosed HIV in the older age group will continue to increase.

Figure 30. Number of Persons Living with Diagnosed HIV by Age Group, West Virginia, 2016-2020



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

In 2020, the White population accounted for 70% of all persons living with diagnosed HIV. Racial and ethnic minority groups are disproportionately represented in the population of people living with diagnosed HIV in West Virginia. The Black/African American population comprises only 4% of the West Virginia population yet accounted for over 20% of all persons living with diagnosed HIV in West Virginia. With 2% of the population of West Virginia reported to be Hispanic/Latino, this population is also disproportionately affected, comprising almost 5% of all individuals living with diagnosed HIV (Table 3).

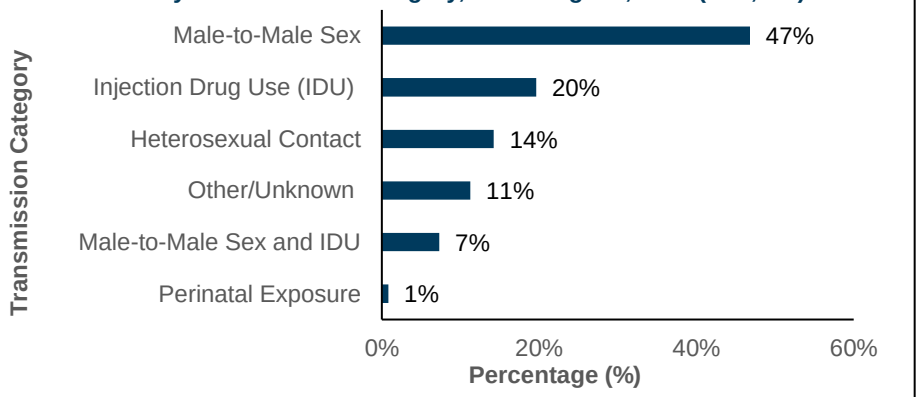
Table 3. Number of Persons Living with Diagnosed HIV by Race and Ethnicity, West Virginia, 2020

Race/ Ethnicity	All races, Hispanic	American Indian/ Alaska Native	Asian	Black	Native Hawaiian/ Other Pacific Islander	White	Multiple Races	Unknown
Number	103	<5	11	438	0	1541	107	<5
Percent	4.7	<1	<1	19.8	0	69.8	4.8	<1

Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

In 2020, the most prevalent HIV transmission category for newly diagnosed individuals was IDU at 79%. However, for persons living with HIV, the most prevalent form of transmission was male-to-male sexual contact. In 2020, male-to-male sexual contact was the source of transmission for over 50% (n=1,033) of individuals living with diagnosed HIV in West Virginia. IDU was the second most common and heterosexual contact the third most common transmission categories, accounting for 20% (n=433) and 14% (n=314), respectively (Figure 31). Between 2016 and 2020, a 70% increase in IDU transmission was observed. The male-to-male and IDU transmission category increased 31% (Table 4).

Figure 31. Percentage of Persons Living with Diagnosed HIV by Transmission Category, West Virginia, 2020 (N=2,207)



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Table 4. Number of Persons Living with Diagnosed HIV by Transmission Category, West Virginia, 2016-2020

Transmission Category	2016	2017	2018	2019	2020
Male-to-Male Sex	949	985	1057	1011	1033
Injection Drug Use (IDU)	255	271	295	353	433
Heterosexual Contact	331	331	332	323	314
Other/Unknown	184	195	210	233	248
Male-to-Male Sex and IDU	123	132	144	151	161
Perinatal Exposure	18	19	21	18	18
Total	1860	1933	2059	2089	2207

Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Linkage to HIV Medical Care

Linkage to Care Within 30 Days of Diagnosis

In 2019, 69% (n=103) of individuals newly diagnosed with HIV were linked to HIV medical care within 30 days of diagnosis. When stratified by sex at birth, a higher proportion of males (76%) were linked to care than females (56%).

A higher percentage of cisgender males (77%) and females (56%) diagnosed with HIV in 2019 were linked to HIV medical care within 30 days of diagnosis than transgender males to females (50%). There were no transgender females to males reported in 2019.

The proportion of individuals diagnosed with HIV in 2019 who were linked to HIV medical care within 30 days of diagnosis increased with increasing age. In 2019, the largest number of cases occurred in the 25 to 34 years age group, and approximately 65% (n=37) were linked to HIV care within 30 days of diagnosis in this age group. Black/African American individuals newly diagnosed with HIV had the lowest percentage (63%) of linkage to HIV care within 30 days after diagnosis among all racial and ethnic groups. Whites had a slightly higher percentage of linkage to HIV care within 30 days at 67%. Among Hispanic/Latino and individuals of multiple races, 100% were linked to care within 30 days after receiving an HIV diagnosis; however, it is important to note there are far fewer individuals diagnosed with HIV among these racial and ethnic groups.

In 2019, among all transmission categories, 69% (n=103) of individuals newly diagnosed with HIV were linked to care within 30 days of diagnosis. Persons who inject drugs were linked to care within 30 days of diagnosis less often (58%) than individuals in all other transmission categories. Less females than males with IDU transmission were linked to HIV care within 30 days of diagnosis. The heterosexual (100%) and male-to-male transmission (89%) categories had the highest percentages of linkage to HIV care within 30 days of diagnosis (Table 5).

Linkage to Care Within One Year of Diagnosis

In 2019, 93% (n=138) of individuals newly diagnosed with HIV were linked to HIV medical care within one year of diagnosis. When stratified by sex at birth, a higher proportion of males (95%) were linked to care than females (89%). Although a very small number of transgender males to females were diagnosed, all were linked to care within the first year. There were no transgender females to males reported in 2019.

Within each age group, over 90% of individuals were linked to care within the first year after HIV diagnosis. All individuals (100%) in the 55 years and older category were linked to care within the first year.

Black/African American individuals newly diagnosed with HIV had the lowest percentage of linkage to HIV care within 1 year after diagnosis among all racial and ethnic groups (88%). Whites had a slightly higher percentage of linkage to HIV care within 1 year at 93%. Among Hispanic/Latino and individuals of multiple races, 100% reported being linked to care within 1 year after receiving an HIV diagnosis; it is important to note there are far fewer individuals diagnosed with HIV among these racial and ethnic groups. Over 90% of individuals in all transmission categories were linked to care within 1 year of diagnosis (Table 5).

Table 5. Linkage to HIV Medical Care by Selected Characteristics, West Virginia, 2019

Characteristics	Persons diagnosed with HIV infection	Linkage to Care Within 30 Days of Diagnosis		Linkage to Care Within 1 Year of Diagnosis	
		≥1 Care Visits		≥1 Care Visit	
	Total	#	%	#	%
Sex at Birth					
Male	97	74	76.3	92	94.8
Female	52	29	55.8	46	88.5

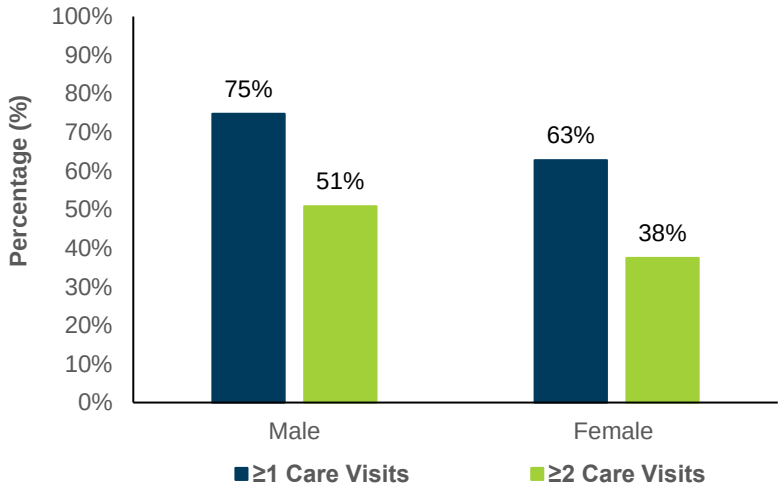
Gender					
Male	95	73	76.8	90	94.7
Female	52	29	55.8	46	88.5
Transgender-Male to Female	<5	<5	50.0	<5	100.0
Transgender-Female to Male	0	0	-	0	-
Additional Gender Identity	0	0	-	0	-
Age at Diagnosis (year)					
13-24	24	14	58.3	22	91.7
25-34	57	37	64.9	52	91.2
35-44	37	27	73.0	34	91.9
45-54	20	15	75.0	19	95.0
≥55	11	10	90.9	11	100.0
Race/ethnicity					
American Indian/Alaska Native	0	0	-	0	-
Asian	0	0	-	0	-
Black/African American	16	10	62.5	14	87.5
Hispanic/Latino	<5	<5	100.0	<5	100.0
Native Hawaiian/Other Pacific Islander	0	0	-	0	-
White	122	82	67.2	113	92.6
Multiple races	8	8	100.0	8	100.0
Unknown races	0	0	-	0	-
Transmission Category					
Male-to-male sexual contact	26	23	88.5	26	100.0
Injection drug use	83	48	57.8	74	89.2
Male-to-male sexual contact and injection drug use	10	8	80.0	9	90.0
Heterosexual contact	6	6	100.0	6	100.0
Other	24	18	75.0	23	95.8
Total	149	103	69.1	138	92.6

Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Receipt of and Retention in HIV Care

Receipt of care is defined as at least one care visit during a calendar year. Retention in care is defined as two or more visits at least 3 months (≤91 days) apart in the calendar year. These metrics were calculated on individuals who were diagnosed with HIV by the end of 2018 and who were alive at the end of 2019. This is a standardized method to measure linkage and retention in care so that data can be compared nationally across jurisdictions. Among individuals living with diagnosed HIV whose sex at birth was male, 75% (n=1,121) had at least one care visit during 2019, and 51% (n=762) were retained in care, attending two or more visits in 2019. Both receipt of and retention in care were lower for individuals living with diagnosed HIV whose birth sex was female at 63% (n=278) and 38% (n=166), respectively (Figure 32).

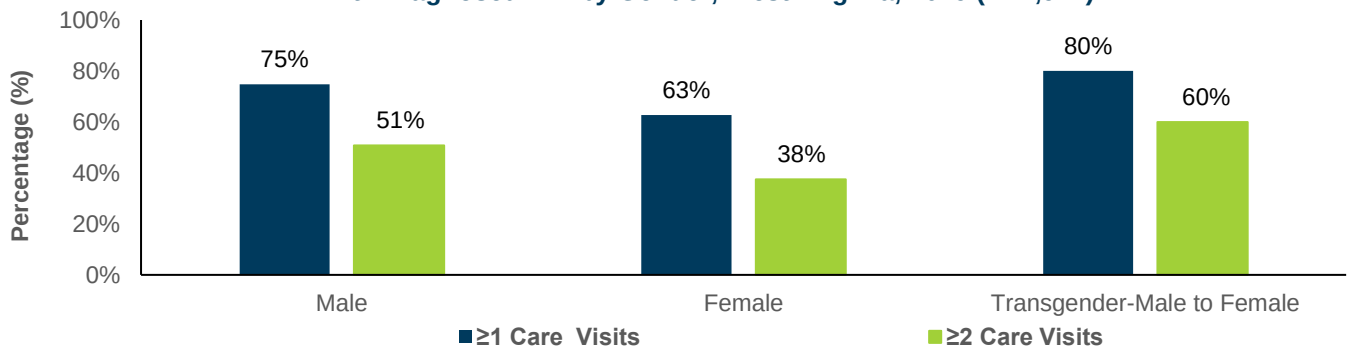
Figure 32. Receipt of and Retention in HIV Medical Care Among Persons Age ≥13 Living with Diagnosed HIV by Sex at Birth, West Virginia, 2019 (N=1,942)



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

The percent of medical care among persons living with diagnosed HIV is greatest among transgender males to females compared to cisgender males and females. In 2019, 80% of transgender males to females living with diagnosed HIV had at least one care visit, and 60% were retained in care, attending two or more visits. It is important to note the number of transgender males to females is considerably lower than the number of cisgender females and males. There were no transgender females to males identified during this timeframe. Seventy-five percent (n=1,117) of males living with diagnosed HIV had at least one care visit during 2019, with 51% (n=759) retained in care. Females living with diagnosed HIV had the lowest percent of medical care. Sixty-three percent (n=278) of females living with diagnosed HIV had at least one care visit during 2019, with 38% (n=166) retained in care (Figure 33).

Figure 33. Receipt of and Retention in HIV Medical Care Among Persons Age ≥13 Living with Diagnosed HIV by Gender, West Virginia, 2019 (N=1,942)

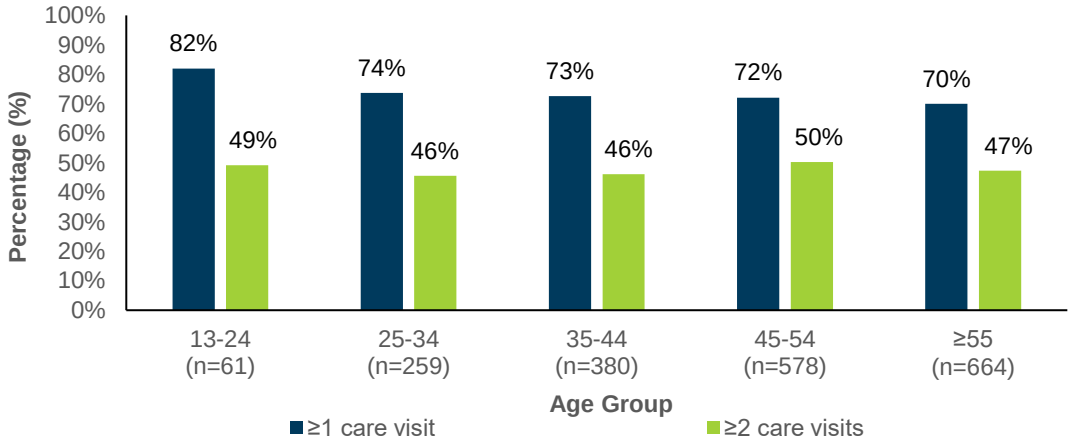


Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

In 2019, the percentage for receipt of care among individuals living with diagnosed HIV in West Virginia decreased with age, while retention in care was between 46%-50% in all age groups. Over 80% (n=50) of individuals aged 13 to 24 years and living with diagnosed HIV had at least one care visit in 2019; however, less than 50% (n=30) were retained in care. This age group had the greatest reduction from receipt of care to retention of care, with a decrease of 40%. For persons between the ages of 25 to 34 years living with

diagnosed HIV, 74% (n=191) had at least one care visit in 2019. This age group, along with 35-44 year olds had the lowest retention in care at 46% (n=118). The age group with the highest retention in care are those in the 45 to 54 years age group at 50% (n=291) (Figure 34).

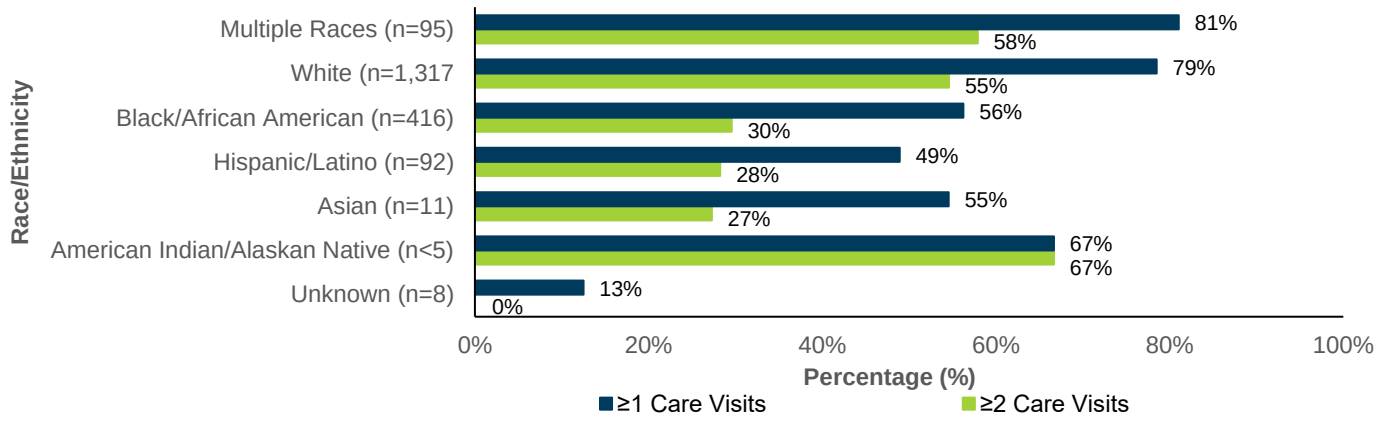
Figure 34. Receipt of and Retention in HIV Medical Care Among Persons Age ≥13 Living with Diagnosed HIV by Age Group West Virginia, 2019 (N=1,942)



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

In 2019, the highest percentage for receipt of care was in the multiracial, non-Hispanic group. Eighty-one percent (n=77) of the multiracial non-Hispanic population living with diagnosed HIV had at least one care visit, with 58% (n=55) retained in care. For the white non-Hispanic population living with diagnosed HIV in West Virginia, 79% (n=1,034) had at least one care visit during the 2019 calendar year, and 55% (n=719) were retained in care. The lowest retention of care was among the Asian and Hispanic/Latino populations, with approximately 27% and 28% retained in care, respectively (Figure 35).

Figure 35. Receipt of HIV Medical Care Among Persons Age ≥13 Living with Diagnosed HIV by Race and Ethnicity, West Virginia, 2019 (N=1,942)

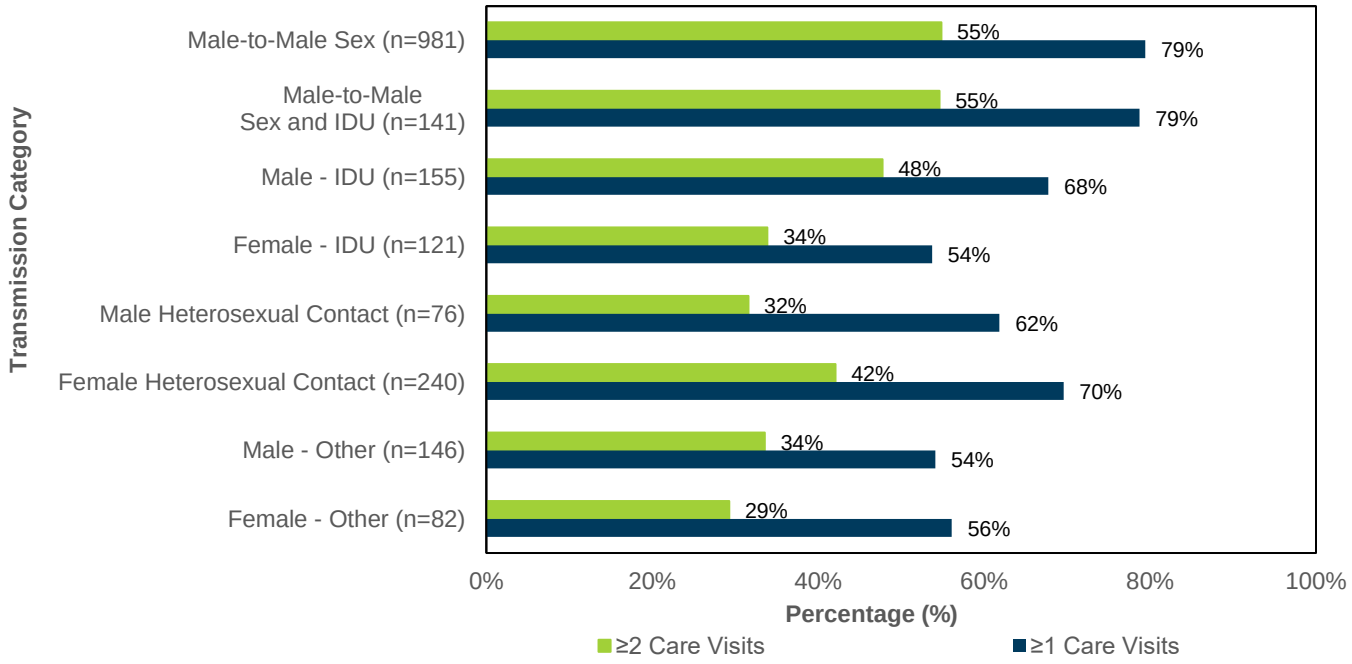


Note: In 2019, West Virginia had no reported cases among Native Hawaiians/Other Pacific Islanders. Hispanic/Latino can be any race.
Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Transmission

In 2019, the most common transmission category of new HIV diagnosis in West Virginia was IDU (56%), whereas the most common transmission category among people living with diagnosed HIV was male-to-male sexual contact (50%). Among those reporting male-to-male sexual contact, 79% (n=779) had at least one care visit and 55% (n=538) were retained in care. These were the highest care percentages reported among all transmission categories. The lowest percentage for receipt of care among those living with diagnosed HIV was in the transmission category injection drug use-females with only 54% (n=65) attending at least one medical care visit. The "other" transmission category includes persons whose HIV was attributed to hemophilia, blood transfusion, perinatal exposure or whose risk factor was not reported or not identified (Figure 36).

Figure 36. Receipt of HIV Medical Care Among Persons Age ≥13 Living with Diagnosed HIV by Transmission Category, West Virginia, 2019 (N=1,942)



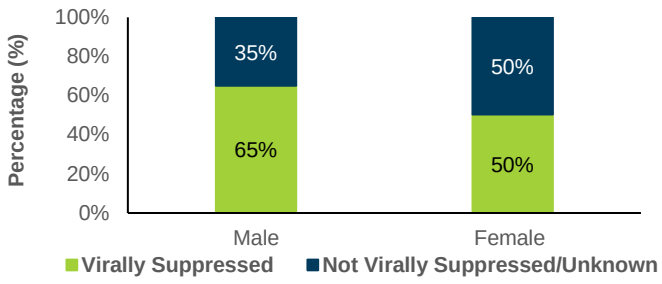
Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

HIV Viral Suppression

When taken as prescribed, HIV medication can reduce the amount of HIV present in the body, also known as the viral load. When the viral load is reduced to a very low level, known as viral suppression, the immune system works to prevent illness. Viral suppression is defined as having less than 200 copies of HIV per milliliter of blood. In some cases, the viral load can become so low that a viral load test is unable to detect HIV in the blood. This is called an undetectable viral load. Individuals with an undetectable viral load have no risk of HIV transmission to their sex partners.

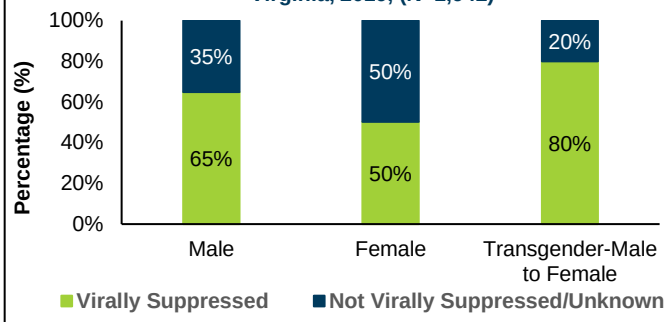
The number of individuals living with diagnosed HIV in 2019 by sex at birth revealed viral load suppression was more common among males than females. Among males, 65% (n=974) had viral suppression while only 50% (n=223) of females did (Figure 37). Stratified by gender, more cisgender males (65%) were virally suppressed than cisgender females (50%), and the highest level of viral suppression was found among transgender males to females (80%). Of note, there were no transgender female to male individuals identified during this timeframe (Figure 38).

Figure 37. Viral Load Suppression Among Persons Age ≥13 Living with Diagnosed HIV by Sex at Birth, West Virginia, 2019, (N=1,942)



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

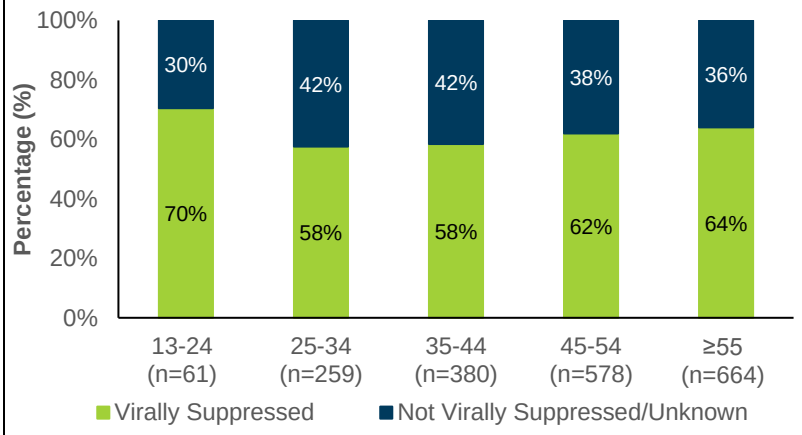
Figure 38. Viral Load Suppression Among Persons Age ≥13 Living with Diagnosed HIV by Gender, West Virginia, 2019, (N=1,942)



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

In 2019, the youngest (13 to 24 years) and oldest (55 years and older) age groups had the highest level of viral suppression at 70% (n=43) and 64% (n=425), respectively. The 25 to 34 years age group had the lowest percentage of viral suppression with 58% (n=149) (Figure 39).

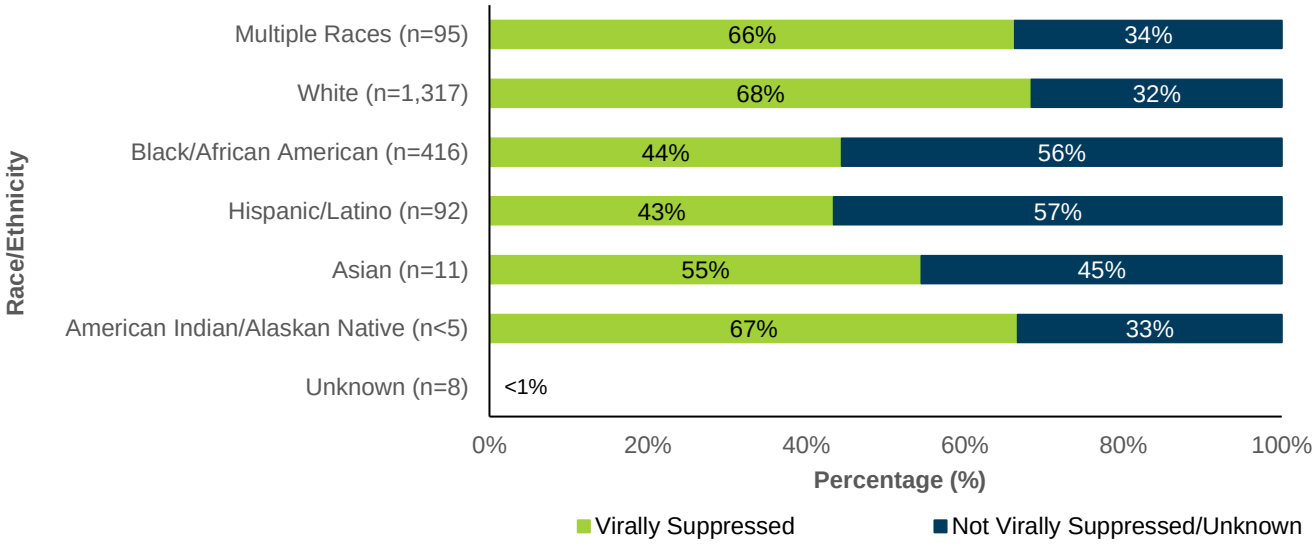
Figure 39. Viral Load Suppression Among Persons Age ≥13 Living with Diagnosed HIV by Age, West Virginia, 2019, (N=1,942)



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

By race/ethnicity, in 2019, the highest viral suppression group percentage was White (68%), followed closely by American Indian/Alaska Native (67%) and Multiple races (66%). The Hispanic/Latino population had the lowest percentage of virally suppressed individuals at less than 44% (Figure 40).

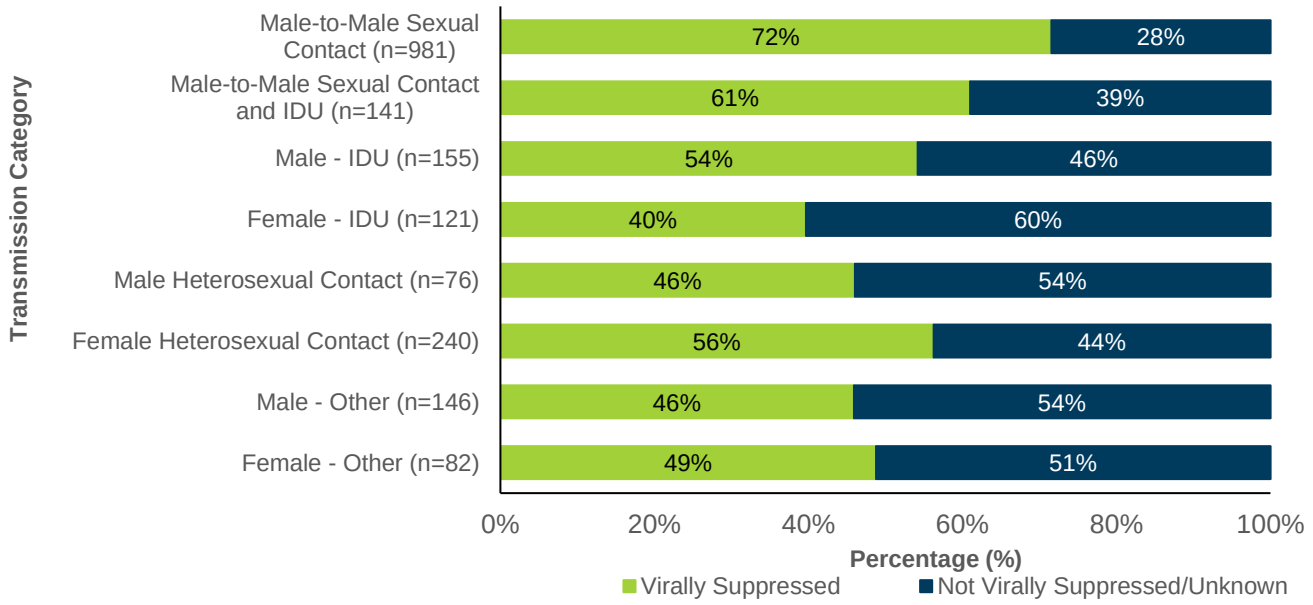
Figure 40. Viral Load Suppression Among Persons Age ≥13 Living with Diagnosed HIV by Race and Ethnicity, West Virginia, 2019, (N=1,942)



Note: Hispanic/Latino can be any race; there were no cases among Native Hawaiian/Other Pacific Islander Islander
Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

In 2019, by transmission category, the highest viral suppression group percentage was for males with infection attributed to male-to-male sexual contact (72%) and the lowest viral suppression group percentage was for females with infection attributed to IDU (40%). For many transmission categories, less than half of individuals living with diagnosed HIV have viral suppression (Figure 41).

Figure 41. Viral Load Suppression Among Persons Age ≥13 Living with Diagnosed HIV by Transmission Category, West Virginia, 2019, (N=1,942)



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Death Among Persons with HIV Diagnosed in West Virginia

The number of deaths includes persons with diagnosed HIV infection and persons with an infection ever classified as Stage 3 (AIDS), regardless of cause of death. Persons are assumed alive unless their deaths have been reported. Since the onset of HIV in the United States, it is estimated that there have been 1,300 deaths among people who have been diagnosed with HIV in West Virginia and an absent, later, or concurrent diagnosis of AIDS (Table 6).

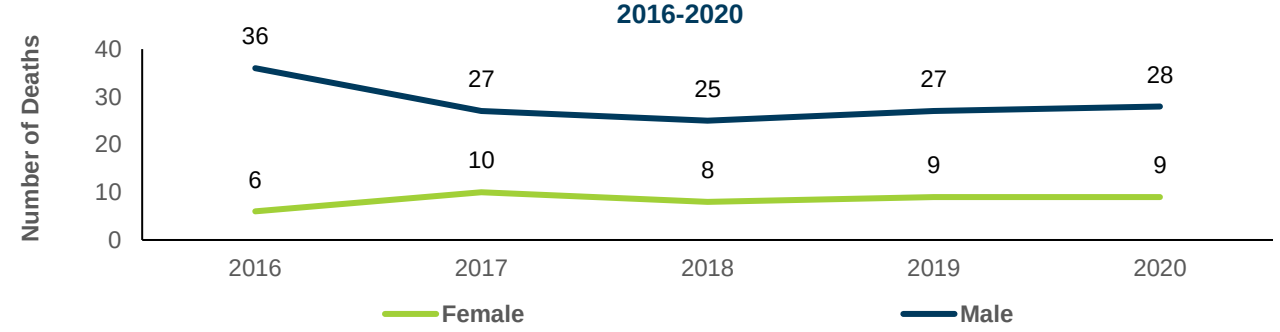
Table 6. Number of Deaths Among Persons with HIV Diagnosis, West Virginia

Year	Number of Deaths
Cumulative Deaths through 2015	1,115
2016	42
2017	37
2018	33
2019	36
2020	37
Total Deaths in West Virginia	1,300

Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

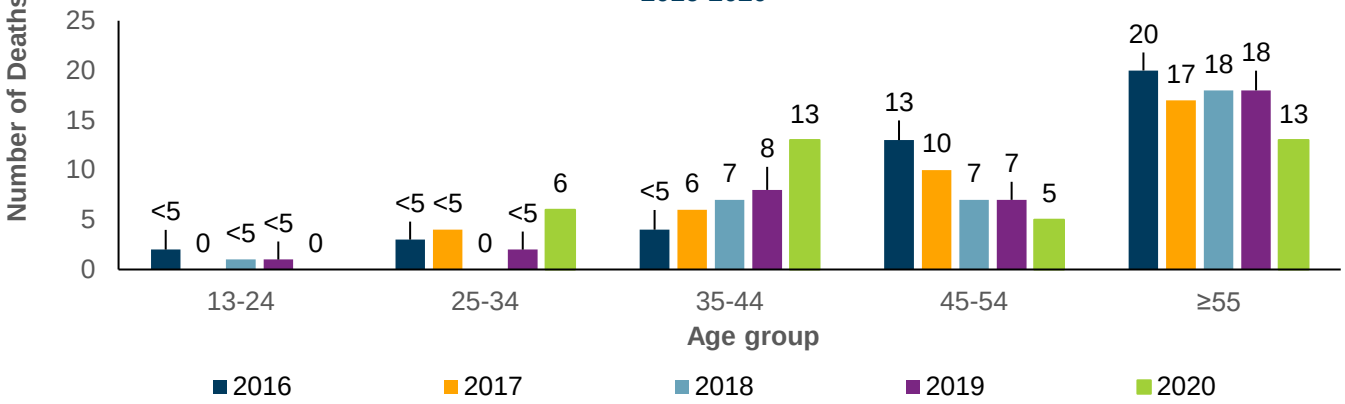
In West Virginia, from 2016 to 2020, the total number of deaths among persons with HIV has decreased 12%, from 42 to 37. In 2020, the total number of deaths among persons with HIV was 37, with 76% (28) of deaths occurring in cisgender males and 24% (9) in cisgender females (Figure 42). Note, there were no deaths among transgender male to female, transgender female to male, or any other gender identity. Although the overall number of deaths has remained fairly stable since 2016, the 35 to 44 years age group experienced a 225% increase during that time period. The 45 to 54 years age group experienced a 62% decline in the number of deaths during the 5-year period. Although the 55 years and older age group experienced a 35% decline from 2016-2020, the group continued to have the greatest number of deaths among all age groups (Figure 43).

Figure 42. Deaths of Persons with Diagnosed HIV in West Virginia by Sex at Birth, 2016-2020



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Figure 43. Deaths of Persons with Diagnosed HIV in West Virginia by Age Group, 2016-2020



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

In 2020, by race/ethnicity the largest number of deaths of persons diagnosed with HIV in West Virginia occurred in the White non-Hispanic population (n=30). All other race/ethnicity groups had 5 or less deaths in 2020. From 2016-2020, the transmission category with the highest number of deaths was among the male-to-male sexual contact category with 80 deaths (Table 7). There was a 32% decline in deaths among this transmission category from 2016-2020, from 19 to 13 deaths (Figure 44). There has been an increase in the number of deaths among the IDU transmission category from 6 in 2016 to 12 in 2020, and 46 total deaths giving it the second highest number of deaths among all transmission categories.

Table 7. Deaths of Persons with Diagnosed HIV in West Virginia by Transmission Category, 2016-2020

Transmission Category	Cumulative Deaths Through 2015	Deaths 2016-2020	Cumulative Deaths Through 2020
Male-to-Male Sexual Contact	559	80	639
Injection Drug Use (IDU)	196	46	242
Male-to-Male Sexual Contact and IDU	70	10	148
Heterosexual Contact	117	31	148
Perinatal Exposure	5	0	5
Other/Unknown	168	18	186
Total	1,115	185	1,300

Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

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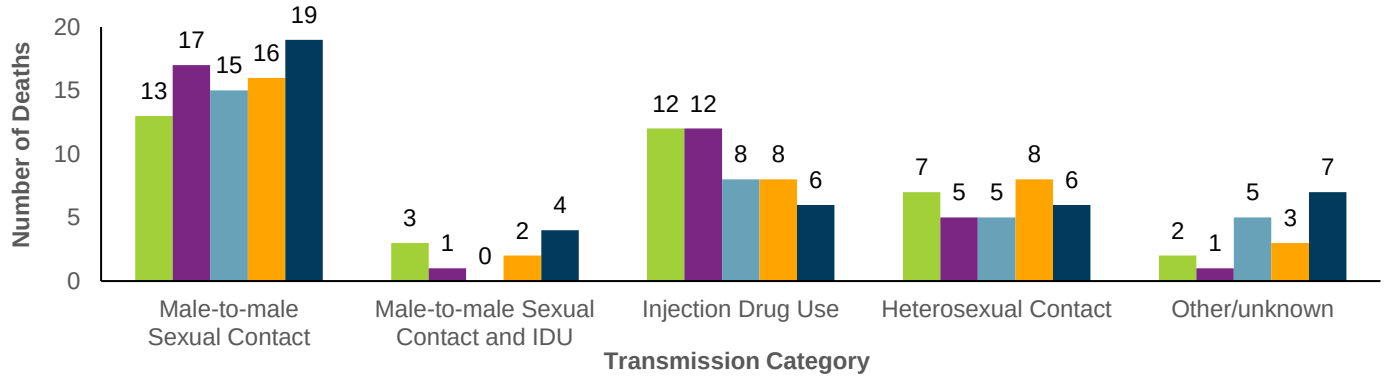
Figure 44. Deaths of Persons with Diagnosed HIV in West Virginia by Transmission Category, 2016-2020



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

HIV Clusters and Outbreaks

BPH monitors HIV diagnoses throughout the state. In collaboration with local and federal partners, BPH works to prevent, monitor, investigate, and respond to increases in HIV diagnoses. Statewide time-space analysis is conducted twice a month. Any local jurisdiction with aberrations for three consecutive months is deemed a priority cluster and triggers further response including internal evaluation of data with hepatitis and STD programs, meeting with the local jurisdiction, and development of proposed response activities.

All HIV nucleotide sequence data received is uploaded into eHARS and Secure HIV-TRACE. All case and laboratory data reports are entered and/or uploaded into eHARS as well. According to the Standards and Evaluation Report in 2020, 91% of all laboratory reports received were uploaded into eHARS within 60 days, 96% of HIV case reports were received within 6 months of diagnosis and 98% of HIV case reports were complete.

An outbreak of HIV associated with IDU was identified in Cabell County at the end of 2018. A large outbreak response including state, federal and local public health as well as community partners took place in 2019. In October 2019, BPH also identified an increase in the number of new HIV diagnoses in Kanawha County associated with IDU. Between 2016 and 2018, there were less than five HIV diagnoses associated with IDU in Kanawha County annually; however, between January and October 2019, there were 11.

Outbreak response activities were initiated in both counties to address gaps identified in HIV care and prevention including development of a community testing outreach group, utilization of non-traditional settings (i.e., homeless shelters, mobile units, meal delivery locations, etc.) for HIV outreach testing, care coordination meetings among service providers and increased staffing of disease intervention specialists to investigate cases and identify and locate named partners for testing and linkage to care. During the responses, one of the significant findings was the extremely large number of individuals coinfected with hepatitis C.

Both counties continue to experience increasing numbers of new HIV diagnoses associated with IDU. As of this writing, the Cabell County outbreak includes 202 individuals, and the Kanawha County outbreak includes 121 individuals. Many of the mitigation strategies put in place during the responses continue in these communities currently. Additionally, BPH prevention staff work with other local jurisdictions vulnerable to HIV outbreaks on implementation of these strategies preemptively.

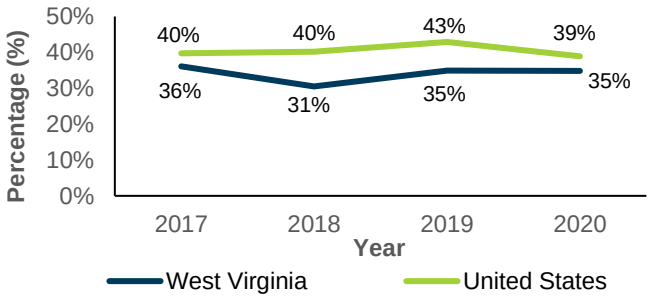
HIV and High-Risk Behaviors

In the United States, HIV is spread mainly through having anal or vaginal sex or sharing needles or syringes with an HIV-positive partner. Anal sex is the highest-risk behavior. Less than 6% of adults in the United States reportedly engage in high-risk behaviors for HIV. The CDC recommends everyone between the ages of 13 and

64 years get tested for HIV at least once. For people who engage in certain risk behaviors, including but not limited to men who have sex with men, persons who have anal or vaginal sex with someone who has HIV, and persons who share needles or syringes, it is recommended to get tested at least once a year.

From 2017 to 2020, West Virginia had a lower percentage of adults who reported ever having an HIV test compared to the United States. In 2017, 36% of adults in West Virginia reportedly had an HIV test. The percentage dropped in 2018 to 31% and then increased in 2019 to 35% and remained stable at 35% in 2020 (Figure 45).

Figure 45. Adults Who Reported Ever Having an HIV Test, West Virginia and United States, 2017-2020

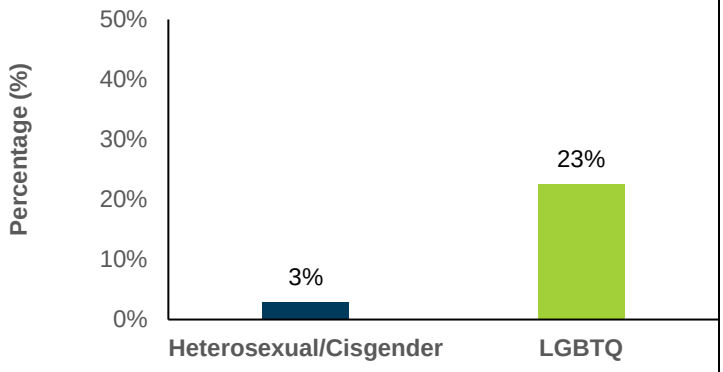


Source: West Virginia Health Statistics Center, Behavioral Risk Factor Surveillance System, 2020.

Demographics

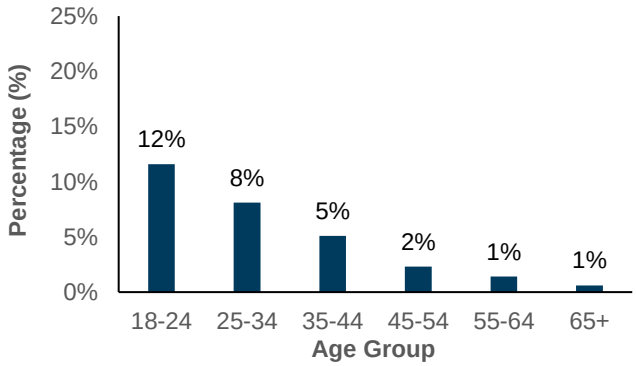
In 2020, more LGBTQ adults reported high-risk behavior for HIV in West Virginia than heterosexuals/cisgenders (Figure 46). In West Virginia, the reported engagement in high-risk behaviors for HIV decreased with age. The age group with the highest percentage of reported high-risk behavior for HIV was between 18 and 24 years and the lowest was 65 years and over (Figure 47). In West Virginia, HIV risk behaviors were most reported among the Hispanic population (Figure 48).

Figure 46. Adults Who Reported High-Risk Behavior for HIV by Sexual Orientation and Gender Identity, West Virginia, 2020



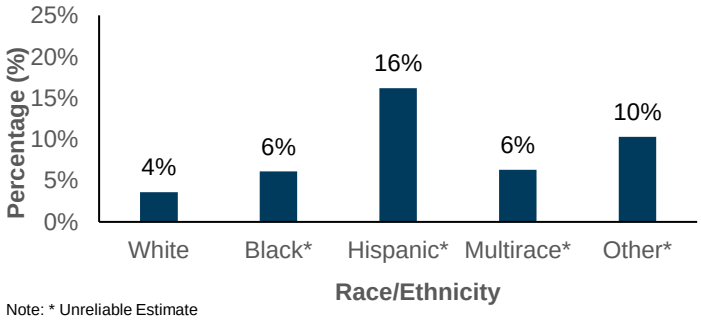
Source: West Virginia Health Statistics Center, Behavioral Risk Factor Surveillance System, 2020.

Figure 47. Adults Who Reported High-Risk Behavior for HIV by Age Group, West Virginia, 2020



Source: West Virginia Health Statistics Center, Behavioral Risk Factor Surveillance System, 2020.

Figure 48. Adults Who Reported High-Risk Behavior for HIV by Race and Ethnicity, West Virginia, 2020



Note: * Unreliable Estimate
Source: West Virginia Health Statistics Center, Behavioral Risk Factor Surveillance

Substance Use

Beginning in 2018 the state experienced an unprecedented increase of new HIV diagnoses among persons who inject drugs (PWID). In 2017, 21% of new HIV diagnoses reported IDU as a risk factor, and in 2020 that increased to 78%. Although cases are being identified across the state, this increase has been most significant in Cabell and Kanawha counties. Ongoing outbreaks in Cabell and Kanawha counties account for 83% of the total cases associated with IDU in 2020. No significant shift has occurred in the age distribution of cases or race/ethnicity over the last five years, with the most common groups being age 25 to 34 years old and White non-Hispanics. However, a substantial increase of new diagnoses identified in females has occurred. In 2016, 54 (81%) of the 67 cases

were male and 13 (19%) were female. New diagnoses in females have steadily increased each year to a high of 50 cases in 2020, representing a 280% increase since 2016, while the number of cases in males increased only 50% during the same time period. This increase corresponds with the shift in exposure category from men who have sex with men to IDU, and many of the women also report exchanging sex for drugs or money.

HIV outbreaks among PWID pose unique and complex response challenges requiring multidisciplinary strategies and engagement of community partners and stakeholders. PWID are often reluctant to seek medical and/or social services, and the state's previously low incidence of HIV and rural nature provide additional barriers to seeking assistance and care.

Perinatal HIV Exposure

Perinatal transmission of HIV can occur during pregnancy, delivery, or breastfeeding. HIV antiretroviral medication taken by the mother during pregnancy, and the infant after birth, can significantly reduce the risk of perinatal transmission to less than 1%. West Virginia has had no reported cases of perinatal HIV transmission in many years. According to birth certificate data, the number of infants born to HIV positive mothers remains low, ranging from 11 to <5 cases each year between 2017 and 2020.(Table 8).

Table 8. Perinatal Exposure of HIV, West Virginia, 2017-2020

Year	Number of Births to HIV Positive Mothers	Percent of All Births
2017	11	0.1
2018	<5	0.0
2019	9	0.0
2020	<5	0.0

Source: West Virginia Health Statistics Center, Vital Statistics System, 2022.

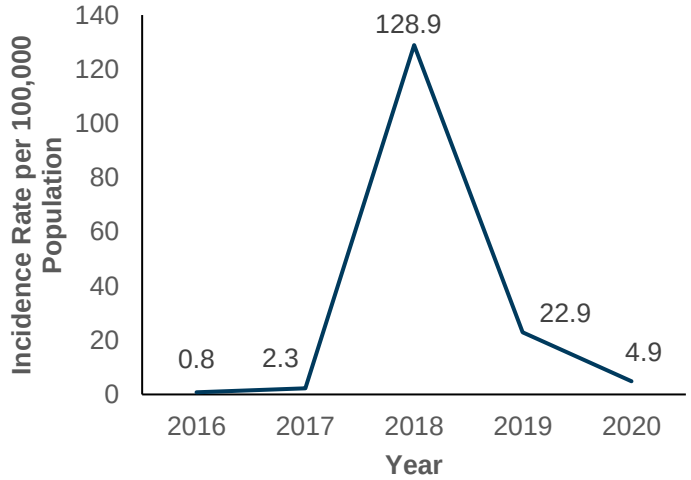
Viral Hepatitis Trends in West Virginia

Hepatitis is a general term used to describe inflammation of the liver. Viral hepatitis is a serious and preventable public health threat and puts those who are infected at increased risk for liver disease, cancer, and even death. The most common types of viral hepatitis in the United States are hepatitis A virus (HAV), hepatitis B virus (HBV), and hepatitis C virus (HCV).

Hepatitis A

Hepatitis A is a self-limiting, vaccine-preventable liver disease caused by HAV. The best way to prevent HAV infection is through vaccination. It is transmitted person-to-person through contact with the stool of a person with HAV via the fecal-oral route, or the consumption of food and water contaminated with feces. Prior to identifying a statewide outbreak of HAV in 2018, incidence rates were relatively low at 2.3 per 100,000 population (Figure 49). In March of 2018, West Virginia identified an increase in HAV cases that was later linked to a multistate HAV outbreak. The increase occurred primarily among those who used drugs, were unstably housed, and/or who were recently incarcerated. The outbreak was declared closed in August 2020. In 2020, the four most common risk factors reported among acute HAV cases in West Virginia included the following: injection drug use (43%), non-injection drug use (30%), contact of a known case of HAV (10%), and unhoused (7%).

Figure 49. Acute Hepatitis A Virus Incidence Rates, West Virginia, 2016-2020



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

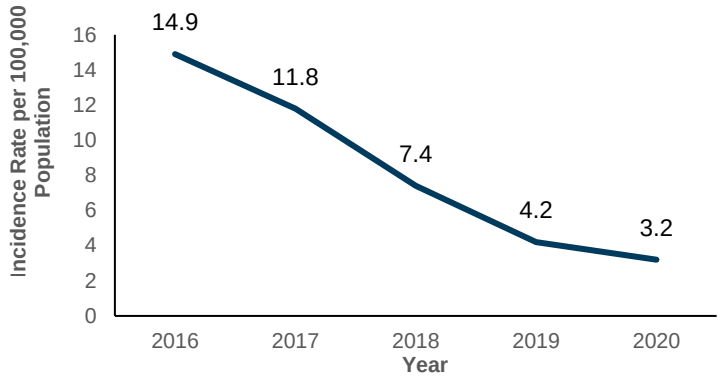
Hepatitis B

Hepatitis B is a vaccine-preventable liver disease caused by HBV. It can be transmitted through direct contact with blood, semen, or other bodily fluids of a person with HBV. Transmission of HBV can occur through sexual contact, sharing needles, syringes, other drug use equipment, or perinatally from mother to baby at birth. The long-term effects of chronic hepatitis B can include cirrhosis of the liver, liver cancer, and even death. People who have chronic HBV can be treated, though there is no cure.

Acute Hepatitis B

For several years, West Virginia reported one of the highest incidence rates of acute hepatitis B in the nation. The rate in West Virginia has declined steadily since 2017, falling to 3.2 new cases per 100,000 population in 2020 (Figure 50). In 2020, the number of reported acute HBV cases was higher for males than for females. Approximately 63% (n=35) of individuals with HBV were males, and 37% (n=21) were females. The most common race reported among acute HBV cases was White, comprising 88% of all cases. Black and Other races each accounted for 2% of the total acute HBV cases. Race was unknown for 9% individuals with acute HBV. Most acute HBV cases identified in 2020 reported their ethnicity to be non-Hispanic or Latino. Seventy-six percent of acute HBV cases identified in 2020 were among individuals aged 30 to 59 years, with the peak age group being 40 to 49 years. The age groups with the lowest number of cases were 0 to 19 years and 20 to 29 years. In 2020, the main risk behaviors reported among acute HBV cases in West Virginia were injection drug use (48%) and non-injection drug use (45%).

Figure 50. Acute Hepatitis B Virus Incidence Rates, West Virginia, 2016-2020



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Chronic Hepatitis B

For some people, acute hepatitis B leads to lifelong infection known as chronic hepatitis B. In 2020, the number of reported chronic HBV cases was higher for males than for females. Almost 69% (n=188) of individuals with a chronic HBV infection were male and 31% (n=83) were female. Most chronic HBV cases identified reported their race to be White (68%). The second most reported race among individuals with chronic HBV in 2020 was Black (7%). For 20% of all newly reported chronic HBV cases in West Virginia in 2020, the race was unknown. Newly reported chronic HBV cases were more prevalent among non-Hispanic or Latino (59%). For 40% of all cases in West Virginia in 2020, the ethnicity was unknown. Over half of the cases of chronic HBV reported in 2020 were between the ages of 30 and 49 (58%). The age group with the least number of reported HBV cases was in people between 0 and 19 years, comprising 1% of all cases. The counties of Kanawha, Cabell, and Raleigh reported the highest number of cases.

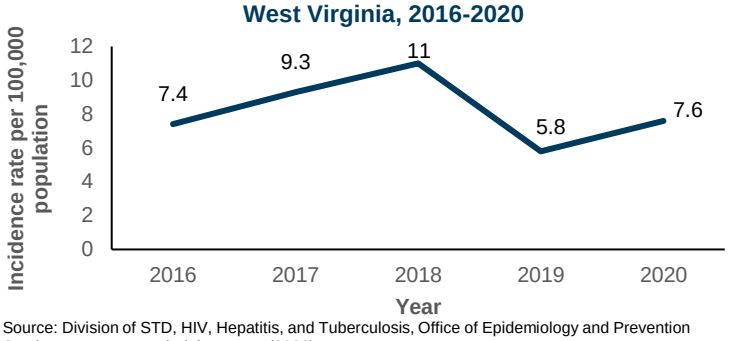
Hepatitis C

Hepatitis C is a liver infection caused by HCV. HCV is spread through contact with blood from a person who has acquired HCV. For some people, hepatitis C is a short-term illness, but for more than half of people with HCV, it becomes a long-term, chronic infection. Chronic hepatitis C can result in serious health issues such as cirrhosis and liver cancer. Most of the new HCV cases are the result of sharing injection drug equipment. No vaccine exists for HCV; however, treatments are available that can cure most people in 8 to 12 weeks. The best way to prevent HCV is to avoid behaviors that can spread the disease.

Acute Hepatitis C

West Virginia has one of the highest incidence rates of acute HCV in the nation. The incidence of acute HCV in West Virginia steadily increased from 2016 to 2018 and then decreased in 2019. In 2020, 7.6 out of every 100,000 individuals had acquired HCV (Figure 51), with 137 new cases being reported.

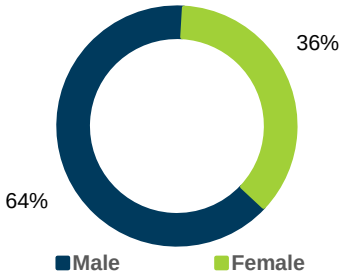
Figure 51. Acute Hepatitis C Virus Incidence Rates, West Virginia, 2016-2020



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

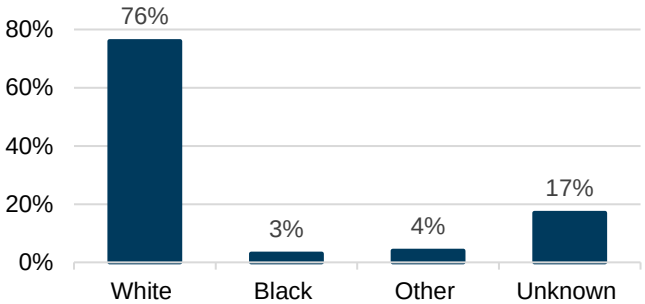
The number of reported acute HCV cases in 2020 was higher for males than for females. Approximately 64% of individuals with acute HCV were males, and 36% of individuals were females (Figure 52). Like HBV, most acute HCV cases identified in 2020 reported their race to be White (76%). Black and Other races accounted for 3% and 4% of the total acute HCV cases, respectively. For 17% of all cases in West Virginia, the race for individuals with acute HCV was unknown (Figure 53).

Figure 52. Acute HCV Cases by Sex at Birth, West Virginia, 2020 (N=137)



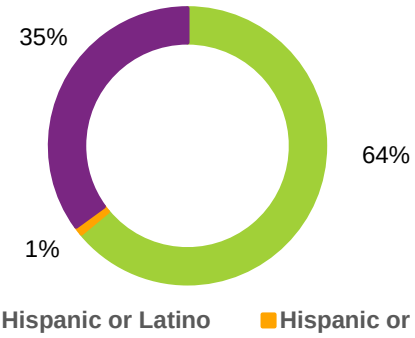
Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Figure 53. Acute HCV Cases by Race, West Virginia, 2020 (N=137)



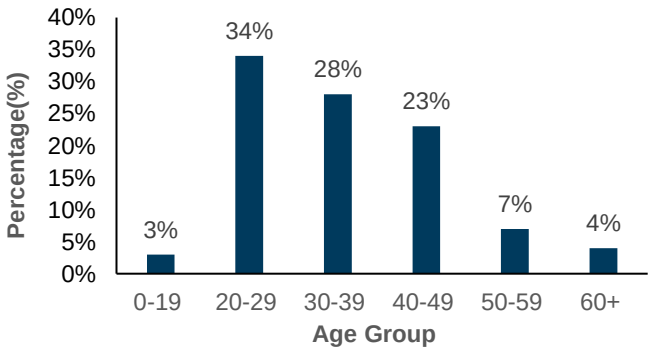
The most prevalent ethnicity in West Virginia is non-Hispanic or Latino, which has the highest percentage of acute HCV cases (64%) (Figure 54). Ethnicity was unknown or not reported for 35% of acute HCV cases in 2020. One percent of reported cases were among people with Hispanic or Latino ethnicity. Eighty-five percent of reported cases were among individuals between 20 and 49 years of age. The age group with the least number of cases was 0 to19 years, comprising 3% of all cases (Figure 55).

Figure 54. Acute HCV Cases by Ethnicity, West Virginia, 2020 (N=137)



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Figure 55. Acute HCV Cases by Age Group, West Virginia, 2020 (N=137)

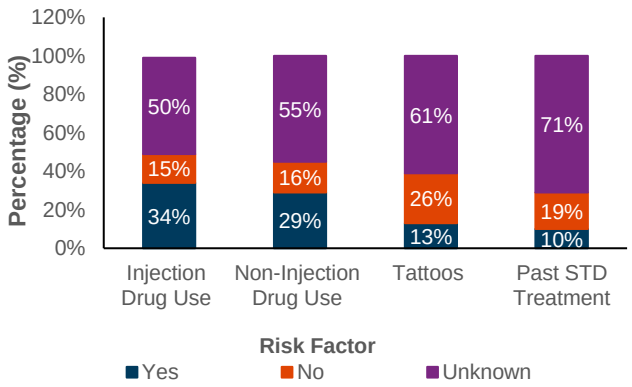


Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Risk Behavior

In 2020, four main risk behaviors were reported among acute HCV cases in West Virginia: injection drug use, non-injection drug use, tattoos, and contact of case (Figure 56). The highest reported risk behavior to acute HCV cases was injection drug use, with 34% of all cases reporting it as a risk factor, however, complete risk factor data is missing in high percentage of cases.

Figure 56. Reported Risk Behaviors Among Acute HCV Cases, West Virginia, 2020



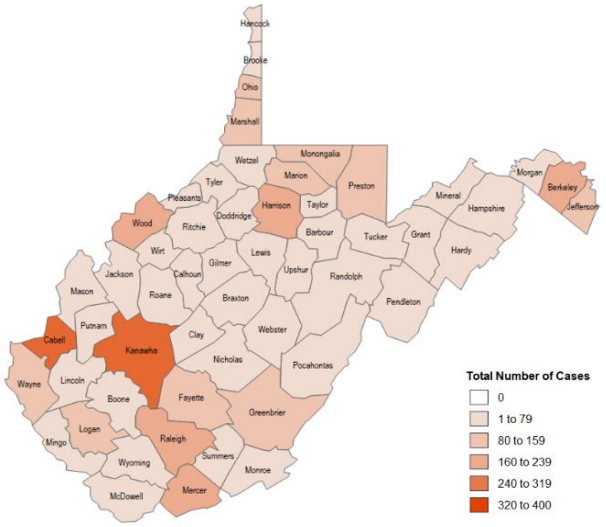
Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Chronic Hepatitis C

For some people, hepatitis C is a short-term illness, but for more than half of people who acquire HCV, it becomes a long-term, chronic infection. Chronic HCV can result in serious, even life-threatening, health problems such as cirrhosis and liver cancer. People with chronic HCV can often have no symptoms and do not feel sick. When symptoms appear, they often are a sign of advanced liver disease.

In West Virginia, 3,872 cases of chronic HCV infection were reported in 2020. Cabell and Kanawha counties reported the highest number of cases in 2020 (Figure 57).
In 2020, the number of reported chronic HCV cases was higher for males than for females. Approximately 59% of individuals with chronic HCV were males, and 41% of individuals were females (Figure 58).

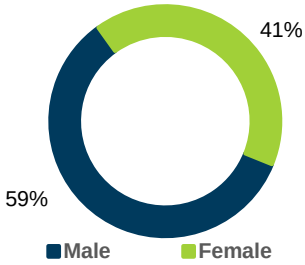
Figure 57. Number of Cases of Chronic Hepatitis C by County, West Virginia, 2020



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

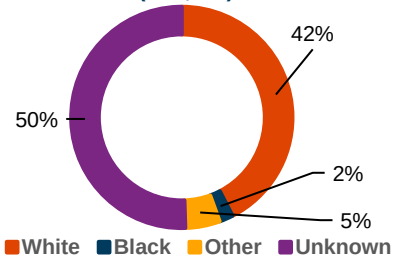
Forty-two percent of all chronic HCV cases reported their race to be White (Figure 59), and Black and Other populations accounted for 2% and 5% of the total chronic HCV cases, respectively. Race was unknown for 50% of all chronic HCV cases in West Virginia in 2020. Thirty-two percent of all chronic HCV cases (the highest percentage) were non-Hispanic (Figure 60). Chronic HCV is not assigned to the local health departments for investigation and follow-up. It is not uncommon for the facilities submitting infectious disease laboratory reports to exclude demographic information such as race and ethnicity. This could account for the increased percentage of missing ethnicity data on chronic HCV cases.

Figure 58. Chronic HCV Cases by Sex at Birth, West Virginia, 2020 (N=3,872)



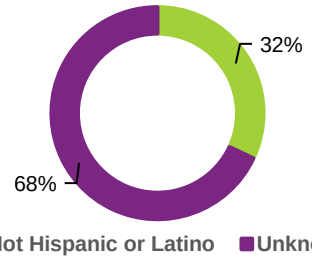
Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Figure 59. Chronic HCV Cases by Race, West Virginia, 2020 (N=3,872)



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

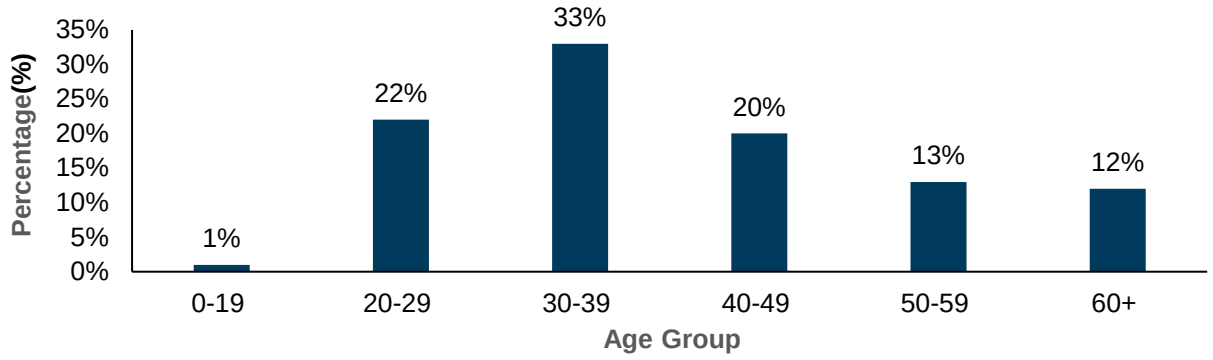
Figure 60. Chronic HCV Cases by Ethnicity, West Virginia, 2020 (N=3,872)



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

In 2020, the greatest number of chronic HCV cases reported was in individuals between the ages of 30 and 39 years, representing 33% of all cases (Figure 61). Seventy-five percent of cases were among people between ages 20 and 49 years. The age group with the least number of cases was 0 to 19 years, comprising 1% of all cases.

Figure 61. Chronic HCV Cases by Age Group, West Virginia, 2020 (N=3,872)



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Liver Cancer

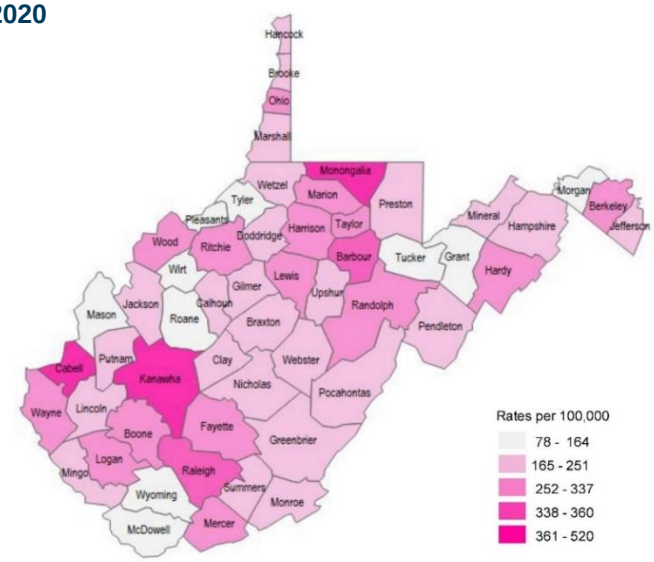
Liver cancer is one of the leading causes of cancer death in the United States. Chronic HBV and HCV infections can cause hepatocellular carcinoma (HCC), the most common form of liver cancer. People with hepatitis B and hepatitis C have the greatest risk of developing liver cancer. People living with HBV are also at risk of liver cancer even if they have not developed cirrhosis, especially if they have a high hepatitis B viral load. Among patients living in the United States with both HCV and cirrhosis, about 1% to 4% per year will develop liver cancer. In West Virginia, 206 cases of liver cancer were reported in 2019. While the U.S. rate of new cases is 8.4 per 100,000 people, the rate in West Virginia is lower, with 7.7 cases per 100,000 people. Age-adjusted liver cancer incidence rates have increased over time both nationwide and in West Virginia.

Risk Factors Based on Surveillance Data from Other Diseases

Sexually Transmitted Diseases (STDs)

STDs are infections that spread from person to person through sexual activity and can be indicators of ongoing high-risk sexual behavior, such as multiple concurrent partners and inconsistent condom use. STDs increase the likelihood of an individual contracting HIV. Having a concurrent STD can increase the likelihood that someone with HIV might transmit HIV to partners because having a sore, break in the skin, or inflammation from a STD may allow an HIV infection that could have been stopped by intact skin.

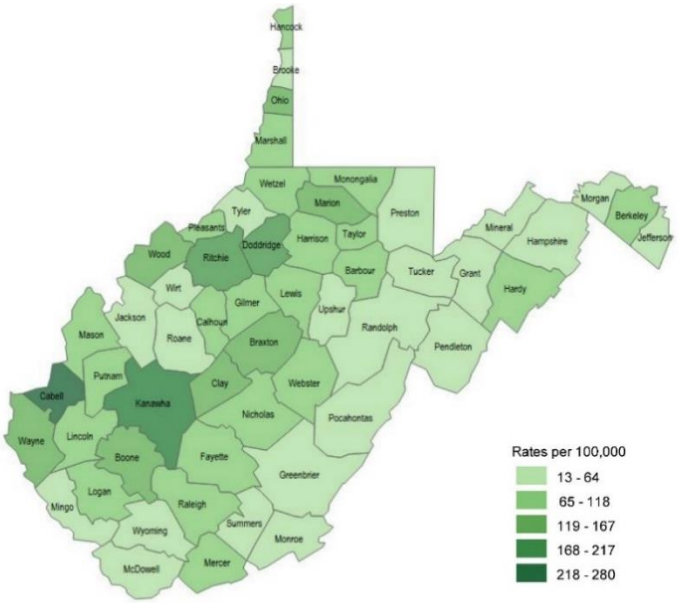
Figure 62. Chlamydia Rate by County, West Virginia, 2020



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

In 2020, 5,280 chlamydia cases were reported in West Virginia. Chlamydia was more prevalent in females (69%) than males (31%). Individuals between the ages of 15 and 25 years reported the highest percentage of chlamydia cases with the second-highest percentage being reported in the 26- to 35-year-old age group. These age groups represent approximately 92% of the total reported cases of chlamydia in 2020. Three counties (Cabell, Kanawha, and Monongalia) account for over one-third of all chlamydia cases in the state. When county population size is considered, these three counties experienced the highest rates of chlamydia in West Virginia (Figure 62).

Figure 63. Gonorrhea Rate by County, West Virginia, 2020



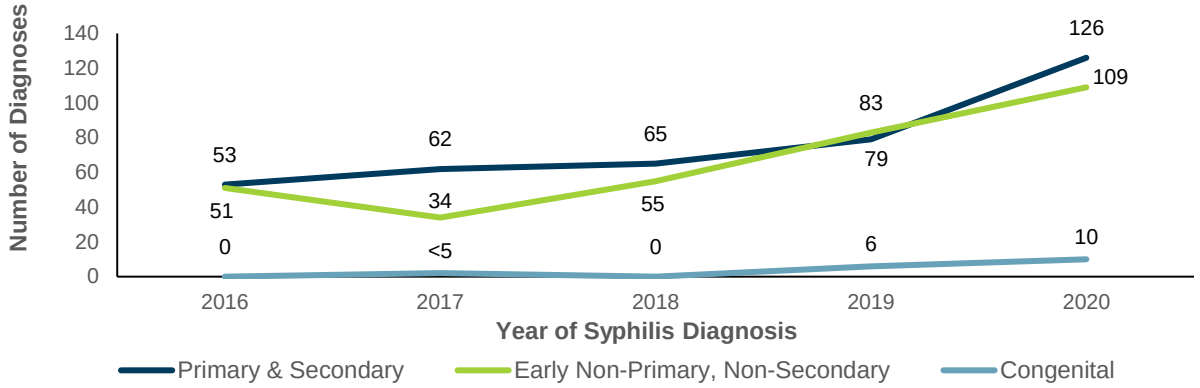
Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Gonorrhea is an STD that can cause infection in the genitals, rectum, and throat. Gonorrhea can be cured with the appropriate treatment, though it will not reverse the permanent damage caused by the STD. In West Virginia, 1,739 gonorrhea cases were reported in 2020. In 2020, 52% (n=899) of the cases occurred among males and 48% (n=840) were females (Figure 63). Younger age groups had a higher number of reported cases than older age groups. Individuals between the ages of 15 and 25 years report the highest percentage of gonorrhea cases, with the second- highest percentage being reported in the 26- to 35-year-old age group. These two age groups represent approximately 77% of the total reported cases of gonorrhea. The number of reported gonorrhea cases varies across counties (Figure 63). Three counties accounted for approximately 44% of the total reported cases in 2020: Wood (n=115), Cabell (n=274), and Kanawha (n=370). Cabell and Kanawha counties have the highest rates of gonorrhea in West Virginia.

Syphilis is an STD caused by the bacterium *Treponema pallidum*. Syphilis can be staged as primary or secondary syphilis, early non-primary non-secondary syphilis, or unknown duration or late syphilis. The early stages of syphilis, when symptoms are present, is when people are most infectious. Syphilis can also be passed on from a mother to baby during pregnancy, which results in congenital syphilis for the infant. Syphilis can cause serious health effects without adequate treatment. Across the nation, syphilis case reports continue to increase since reaching a historic low in 2000 and 2001. The number of syphilis cases in West Virginia has increased over the years across all stages. In 2020, 235 early syphilis cases were reported, an increase of 45% from 2019. From 2015 to 2020, the number of early syphilis cases increased by 155% within the state. White non-Hispanic people comprised 80.4% of cases (n=189) in 2020. However, the highest rate of reported syphilis cases occurred among the Black non-Hispanic population at 38.6 per 100,000, indicating this population is disproportionately affected. The number of reported early syphilis cases is higher for males (59%) than females (41%). Individuals between the ages of 26 and 35 years experienced the highest number of early syphilis diagnoses in 2020.

Primary and secondary syphilis cases are diagnosed based on the presence of symptoms at the time of testing. In recent years, the number of reported primary and secondary syphilis cases has steadily increased from 53 cases in 2016 to 126 cases in 2020 (Figure 64). Early non-primary, non-secondary syphilis is when the infection occurred within the previous 12 months; however, no signs or symptoms of primary or secondary syphilis are present at the time the infection is identified. The number of early cases over the years has continued to increase. From 2017 to 2020, the number of early non-primary, non-secondary syphilis cases increased by 321.6% in West Virginia. Between 2016 and 2018, the number of congenital syphilis cases was fewer than five. The number of cases increased in 2019 and has continued to increase, with 10 reported cases in the state in 2020 (Figure 64).

Figure 64. Reported Syphilis Diagnoses by Stage and Year of Diagnosis, West Virginia, 2016-2020



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

In 2020, the most reported risk behaviors among syphilis cases were: condomless sex (64%), sex while intoxicated (30%), and sex with anonymous partners (24%). The number of reported early syphilis cases varies across West Virginia counties (Figures 65 and 66). Kanawha and Wood Counties had the highest number of cases in 2020, with 46 and 41 cases respectively, and accounted for 43% of all cases statewide. In 22 of the 55 counties, no cases were reported in 2020. In 11 counties, only one case was reported (Figure 65). People residing in Kanawha County accounted for 19.6% of cases (n=46), the highest number of total cases across all counties. Doddridge and Wood counties had the highest rate of early syphilis, each at 48 per 100,000 population (Figure 66).

Figure 65. Number of Cases of Early Syphilis by County, West Virginia, 2020

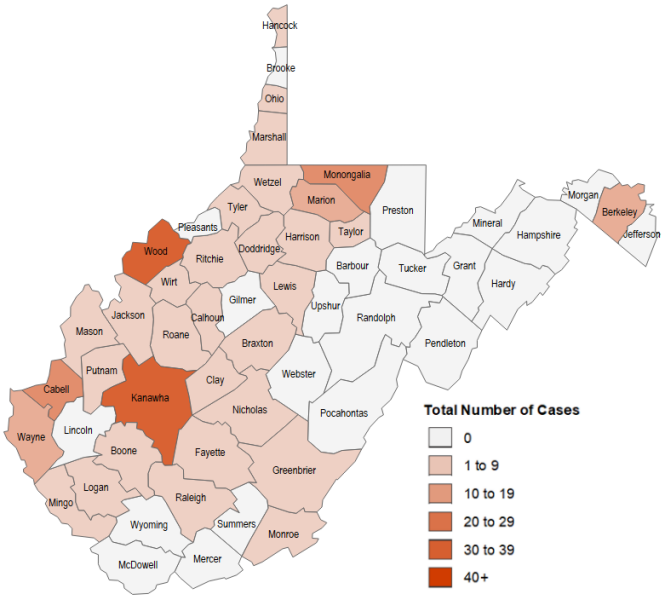
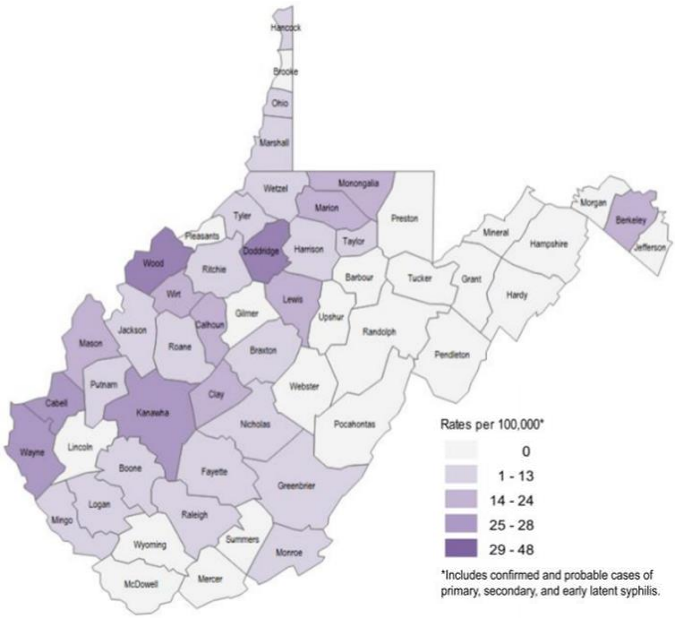


Figure 66. Early Syphilis Rate by County, West Virginia, 2020



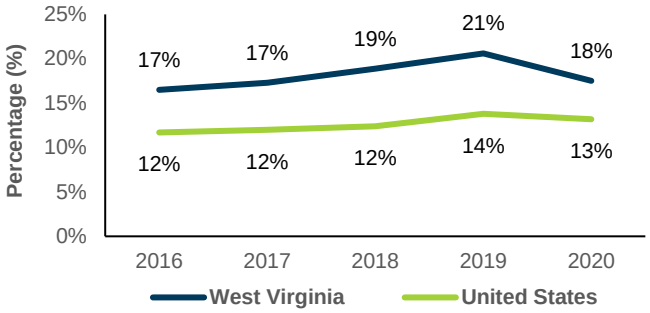
Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Mental Health and Substance Use Disorders (SUD)

Mental Health

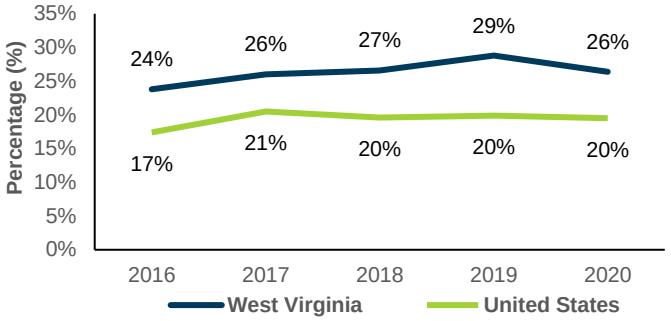
From 2016 to 2020, West Virginia had higher rates than the nation of adults reporting poor mental health days (Figure 67) and depressive disorder (Depression, Major Depression or Dysthymia) (Figure 68).

Figure 67. Adults Reporting Poor Mental Health ≥14 of the Past 30 Days, West Virginia and United States, 2016-2020



Source: West Virginia Health Statistics Center, Behavioral Risk Factor Surveillance System, 2020.

Figure 68. Adults Reporting Depressive Disorder, West Virginia and United States, 2016-2020



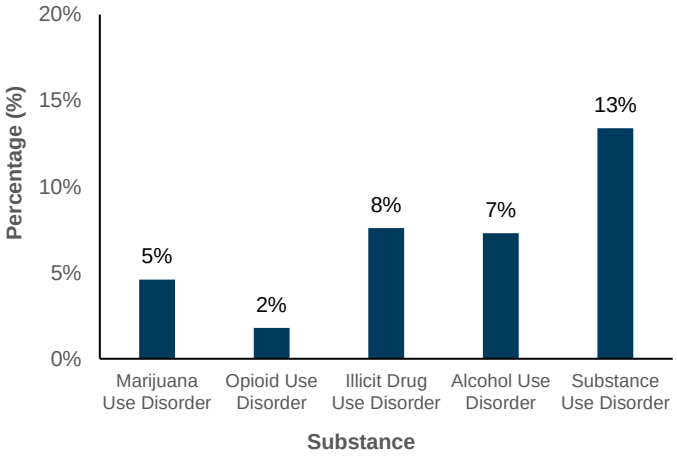
Source: West Virginia Health Statistics Center, Behavioral Risk Factor Surveillance System, 2020.

Substance Use Disorders

Substance use includes the use of cigarettes, alcohol, and illicit drugs. Youth may engage in risk behaviors for HIV, such as sex without a condom, when under the influence of drugs or alcohol. In reference to the National Survey on Drug Use and Health data in the following figures, cigarette smoking includes use in the past 30 days; alcohol use in the past month refers to having more than a sip or two from any type of alcoholic drink; illicit drug use in the past month includes any use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine, as well as misuse of prescription stimulants, tranquilizers, sedatives, or pain relievers.

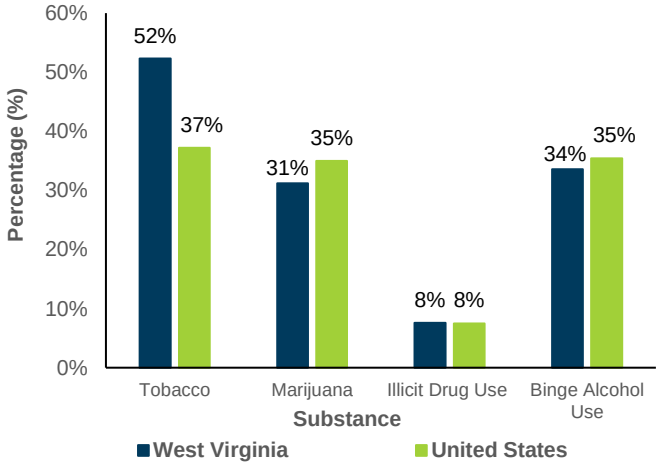
In West Virginia, from 2017 to 2019, youth aged 12 to 17 years had similar rates to the nation for reported alcohol, marijuana, and illicit drug use. Cigarette use was higher in West Virginia at 5% compared to the United States at 3%. Alcohol was the most used substance, with 9% of youth reporting alcohol use. Over 7% of youth aged 12 to 17 years in West Virginia reportedly used illicit drugs. In West Virginia, 13% of youth aged 12-17 years reported having a substance use disorder (Figure 69). Between 2017-2019, the prevalence of past-year tobacco use among young adults was 52% in West Virginia compared to the United States at 33%. West Virginia's young adult (ages 18-25 years) marijuana use, illicit drug use, and binge drinking levels were similar to that of the United States. Illicit drug use had the lowest percentage of use for West Virginia and the United States at 8% each (Figure 70).

Figure 69. Substance Use Disorder Among Youth Ages 12-17, West Virginia and United States, 2017-2019



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2004 and 2017-2019.

Figure 70. Substance Use Among Young Adults Ages 18-25, West Virginia and United States, 2017-2019

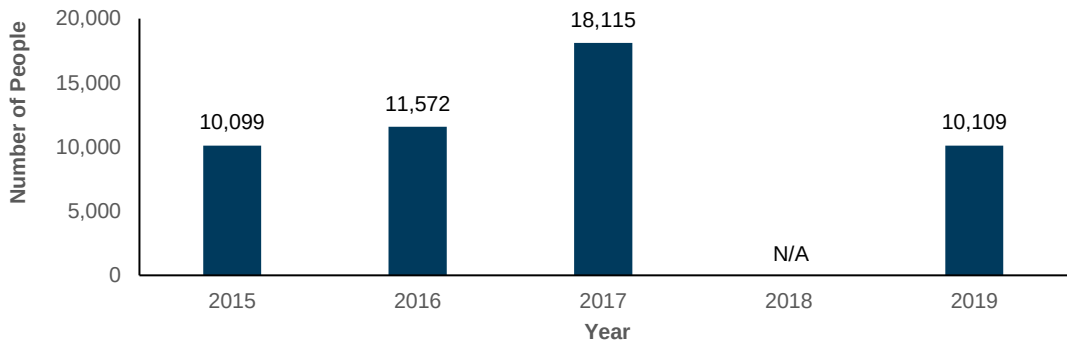


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2004 and 2017-2019.

Substance Use Treatment

In a single-day count in March 2019, 10,109 people in West Virginia were enrolled in substance use disorder treatment, a moderate increase from 10,099 people in 2015 (Figure 71). Among those enrolled in substance use disorder treatment in a single-day count in March 2019, 69% received treatment for a drug problem only, 10% received treatment for an alcohol problem only, and 21% received treatment for both drug and alcohol problems.

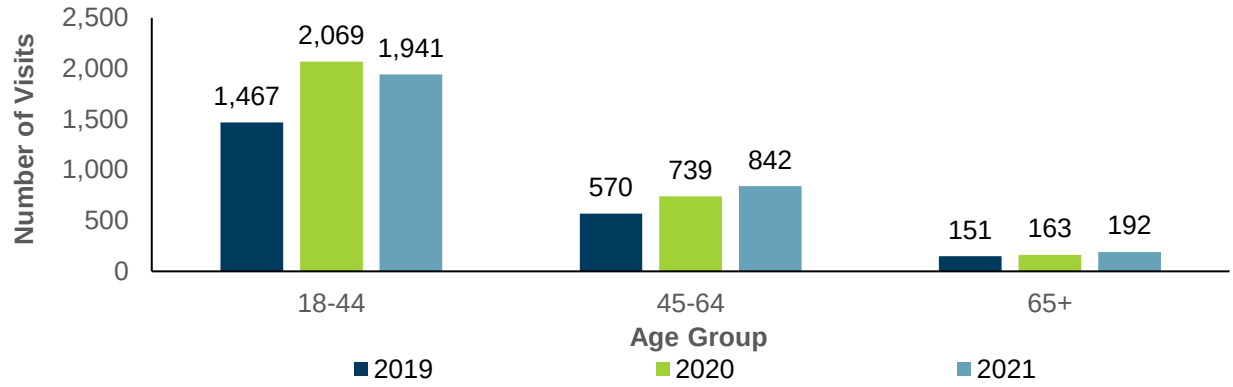
Figure 71. People Enrolled in Substance Use Treatment (Single-Day Counts), West Virginia, 2015-2019



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2004 and 2017-2019.

From 2019 to 2021, the number of non-fatal emergency room visits for opioid substance use increased 32% among the 18 to 44 years age group in the state. This age group had the most non-fatal emergency room visits involving opioids for all three years. In 2021, males in this age group had a higher percent of visits at 66% (n=1,247) compared to females at 34% (n=667). From 2019 to 2021, there was a 41% increase in the number of men ages 18 to 44 years visiting the emergency room for an opioid substance use issue, increasing from 905 males in 2019 to 1,274 in 2020. The 45 to 64 years and 65 years and older age groups increased each year in the number of individuals visiting the emergency room for any substance use issue. From 2019 to 2021, among the 45 to 64 years age group, fewer females visited an emergency room than males for an opioid use issue; however, in the 65 years and older age group, more females visited the emergency room compared to males (Figure 72).

Figure 72. Non-Fatal Emergency Room Department Visits for Substance Use, West Virginia, 2019-2021



Source: West Virginia DHHR ODCP. Non-fatal Emergency Room Department Data, 2019-2021.

HIV Prevention, Care, and Treatment Resource Inventory

HIV prevention and care services are crucial to attaining optimal health outcomes among people living with HIV, preventing further transmission of the virus, and ending the HIV epidemic. People with HIV who reach and maintain an undetectable viral load can live a close-to-average lifespan and have effectively no risk of sexually transmitting the virus to a partner without HIV. Understanding the landscape of HIV care provision across West Virginia provides BPH and stakeholders with a more complete picture of resources available for people with HIV and assists with the ability to link people to the services they need.

In September 2022, BPH collaborated with service delivery partners to compile currently available HIV prevention and care services and then worked with stakeholders to assess gaps in and other barriers to HIV care engagement in West Virginia (Table 9). Creating an inventory of available resources and identifying the service gaps allows West Virginia to prioritize and allocate resources and project future needs to meet the goals of the Plan. The inventory also examined where along the HIV care continuum the services had the most impact. The HIV care continuum outlines the stages that people with HIV move through from diagnosis to achieving and maintaining viral suppression (a very low or undetectable amount of HIV in the blood).

Table 9. HIV Prevention, Care, and Treatment Resource Inventory

Funder	Funding Source	Recipient	Annual Award Amount	Subrecipient	Services Delivered	HIV Care Continuum Steps Impacted					EHE Strategies			
						HIV Diagnosis	Linkage to Care	Engagement of Retention in Care	Prescription of ART	Viral Suppression	Diagnose	Treat	Prevent	Respond
CDC	Integrated HIV Prevention and Surveillance Programs for Health Departments	DHHR's BPH Division of STD, HIV, Hepatitis and Tuberculosis	$1,097,368.00	Ebeneezer Medical Outreach	Early intervention services (EIS), Outreach services, Capacity building/technical assistance, Community engagement, Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Perinatal HIV prevention and surveillance, Prevention for people living	✓	✓				✓		✓	✓

Funder	Funding Source	Recipient	Annual Award Amount	Subrecipient	Services Delivered	HIV Care Continuum Steps Impacted					EHE Strategies			
					with diagnosed HIV infection, Surveillance, Testing, Linkage to care for HIV treatment									
HRSA	Ryan White CARE Act, Part B	DHHR's BPH Division of STD, HIV, Hepatitis and Tuberculosis	$2,311,616.00	AIDS Task Force of the Upper Ohio Valley, Bureau for Medical Services	AIDS Drug Assistance Program (ADAP) treatments, AIDS pharmaceutical assistance, EIS, Health insurance premium and cost-sharing assistance for low-income Individuals, Medical case management, including treatment adherence services, Mental health services, Oral health care, Substance abuse outpatient care, Emergency financial assistance, Food bank/home-delivered meals, Housing, Medical transportation, Referral for health care and support services, Testing, Linkage to care for HIV treatment	✓	✓	✓	✓	✓	✓	✓	✓	✓
HRSA	Ryan White CARE Act, Part B Supplemental Funding	DHHR's BPH Division of STD, HIV, Hepatitis and Tuberculosis	$1,944,347.00	AIDS Task Force of the Upper Ohio Valley	AIDS Pharmaceutical assistance, EIS, Health insurance premium and cost-sharing assistance for low-income individuals, Medical case management, including treatment adherence services, Mental health services, Oral health care, Outpatient/ambulatory health services, Substance abuse outpatient care, Emergency financial assistance, Food	✓	✓	✓		✓	✓	✓	✓	✓

Funder	Funding Source	Recipient	Annual Award Amount	Subrecipient	Services Delivered	HIV Care Continuum Steps Impacted					EHE Strategies			
					bank/home-delivered meals, housing, Medical transportation, Outreach services, Referral for health care and support services, Community engagement, Condom distribution, Partner services, Prevention for people living with diagnosed HIV infection, Surveillance, Testing, Linkage to care for HIV treatment									
	Ryan White CARE Act, Part B Rebates	DHHR's BPH Division of STD, HIV, Hepatitis and Tuberculosis	$3,003,547.00	AIDS Taskforce of the Upper Ohio Valley, CAMC Ryan White Part C Clinic, WVU Positive Clinic, WV Health Right, Covenant House	AIDS Pharmaceutical assistance, EIS, Health insurance premium and cost-sharing assistance for low-income individuals, Medical case management, including treatment adherence services, Mental health services, Oral health care, Outpatient/ambulatory health services, Substance abuse outpatient care, Emergency financial assistance, Food bank/home-delivered meals, housing, Medical transportation, Outreach services, Referral for health care and support services, Community engagement, HIV pre exposure prophylaxis (PrEP), Condom distribution, Partner services, Prevention for	✓	✓	✓		✓	✓	✓	✓	✓

Funder	Funding Source	Recipient	Annual Award Amount	Subrecipient	Services Delivered	HIV Care Continuum Steps Impacted					EHE Strategies			
					people living with diagnosed HIV infection, Testing, Linkage to care for HIV treatment									
HRSA	Ryan White CARE Act, Part C	Charleston Area Medical Center (CAMC) Ryan White Part C Clinic,	$457,793		HIV treatment, Medical case management, Prevention for people living with diagnosed HIV infection	✓	✓	✓	✓	✓		✓	✓	✓
HRSA	Ryan White CARE Act, Part C	West Virginia University Education and Research Institute Positive Health Clinic	$407,048		HIV treatment, Medical case management, Prevention for people living with diagnosed HIV infection	✓	✓	✓	✓	✓		✓	✓	✓
CDC	Preventive Health and Health Services Block Grant (PHHSBG)	WV Office of Community Health Systems and Health Promotion	$146,000.00	WV Division of STD, HIV, Hepatitis and Tuberculosis	EIS, Home and community-based health services, Home health care, Outreach services, Referral for health care and support services, Community engagement, Community mobilization, testing, Linkage to care for HIV treatment	✓	✓	✓			✓		✓	✓
SAMHSA	State Opioid Response Medical Services	WVCTSI	$325,287.00	WVCTSI	Hepatitis C screening/testing, Linkage to care for hepatitis C treatment, Linkage to care for HIV treatment, HCV and HIV education, mentoring, and training for primary care		✓	✓			✓			✓

Funder	Funding Source	Recipient	Annual Award Amount	Subrecipient	Services Delivered	HIV Care Continuum Steps Impacted					EHE Strategies			
HRSA	Ryan White CARE Act, Part A	Shenandoah Community Health Center	$442,000.00	Shenandoah Community Health Center	Health insurance premium and cost-sharing assistance for low-income individuals, Medical case management including treatment adherence services, Medical nutrition therapy, Emergency financial assistance, Medical transportation, Outreach services		✓	✓	✓	✓	✓	✓		✓
CDC	Department of Health and Human Services	Community Education Group	$50,000.00	Shenandoah Community Health Center	Hepatitis C treatment, Hepatitis C prevention						✓	✓	✓	✓
HOPWA	HOPWA	WV Department of Economic Development	$698,124.00	Community Networks Inc., Covenant House, CHANGE Inc., Cabell-Huntington Coalition for the Homeless, Central WV Community Action Association	Home and community-based health services, Home health care, Hospice, Mental health services, Emergency financial assistance, Housing, Legal services, Medical transportation, Non-medical case management services, Referral for health care and support services, Rehabilitation services, Community engagement, Condom distribution, Testing, Linkage to care for HIV treatment	✓	✓	✓		✓	✓		✓	✓
HRSA	Ryan White CARE Act, Part F	West Virginia Regional Partner of the MidAtlantic	$264,000.00	West Virginia Regional Partner of the MidAtlantic AIDS	HIV Education, technical assistance, consultation, and preceptorship for health care providers	✓	✓	✓	✓	✓	✓	✓	✓	✓

Funder	Funding Source	Recipient	Annual Award Amount	Subrecipient	Services Delivered	HIV Care Continuum Steps Impacted					EHE Strategies			
		AIDS Education and Training Center		Education and Training Center										
CDC	Strengthening STD Prevention and Control for Health Department-Supplemental Workforce Development	DHHR's BPH Division of STD, HIV, Hepatitis and Tuberculosis	$1,070,880.00		Linkage to care, Disease investigation, Partner services	✓	✓				✓	✓	✓	✓

Service Providers

Table 10. Service Providers in West Virginia

Service Provider	Service(s)
Charleston Area Medical Center (Charleston and Beckley) *Ryan White Part C provider*	Provides services for individuals at risk for or infected with HIV, including: • PrEP • Testing • Routine care • Adherence counseling • Mental health services • Pharmaceutical services • Referrals to specialty care • Tobacco cessation counseling • Dental services • Nutrition services • Counseling services including substance abuse counseling
Community Health Centers (CHCs)	There are 28 CHCs that provide general health care services.
Equitas Health *Ryan White Part C provider in Ohio that covers part of West Virginia*	Provides primary and specialized care, pharmacy, dentistry, HIV/STD treatment and prevention, PrEP/post-exposure prophylaxis (PEP), case management, behavioral health, and care navigation. Equitas Health is one of the nations' largest LGBTQ+ and HIV/AIDS serving organizations.
Local Health Department (LHD) Systems	There are 20 LHDs (additional satellite locations) that provide services throughout West Virginia, including: • Prevention education • Condom distribution • Free confidential HIV counseling and testing • Risk-reduction information, contact notification • PrEP • STD testing and follow-up services
Shenandoah Community Health Center *Ryan White Part A provider – Washington, D.C., area*	Provides outpatient services and case management Note: Some services are covered by the Ryan White Program Part A.
West Virginia University Education and Research Institute Positive Health Clinic *Ryan White Part C provider*	Provides comprehensive HIV care including: • HIV counseling and testing • Referrals to medical case management • Outpatient mental health services • Referrals to oral health care • Client education • Referrals to specialty care • HIV testing • Medication adherence counseling • Substance abuse services referral • Financial counseling • Transportation assistance

Table 11. Community-Based Organizations (CBOs) in West Virginia

Community-Based Organization	Service(s)
All-AID International, Inc.	Provides HIV counseling and testing
Caritas House	Provides the following services: • Case management services • Advocacy • Prevention education • Transitional housing • Payment toward medication and supplies • Rent and utilities • Caregiving • Mileage reimbursement for travel related to medical care • Linkages to support groups • Condom distribution • HIV/AIDS, STD, and hepatitis literature distribution
Community Networks Inc.	Provides housing support services for clients with HIV/AIDS including: • Rental and utility assistance • Budget and placement assistance • Condom distribution • Transportation • Food vouchers • Food pantry • Medical assistance • Limited housing/rental assistance, mortgage, budget, and placement assistance
Covenant House	Provides housing for individuals living with HIV/AIDS. Three residential homes in Charleston provide housing options. Services include: • Rental payment and utility assistance • Medication and co-pay assistance • Transportation counseling within the housing program • Food pantry • Clothing closet • Education • Drop-in center • AIDS resource library with internet access • Rural health outreach program with on-site nurse • Condom distribution
Ebenezer Medical Outreach	Provides community and organizational presentations, HIV/AIDS educational/awareness outreach, medical services, healthy cooking classes, condom distribution, resource distribution, and HIV testing.
HOPWA	Funding addresses housing needs among people living with HIV/AIDS (PLWHA). There are four HOPWA sites: Caritas House (Morgantown), Community Networks (Martinsburg), Covenant House (Charleston), and West Virginia University Research Corporation (Morgantown).

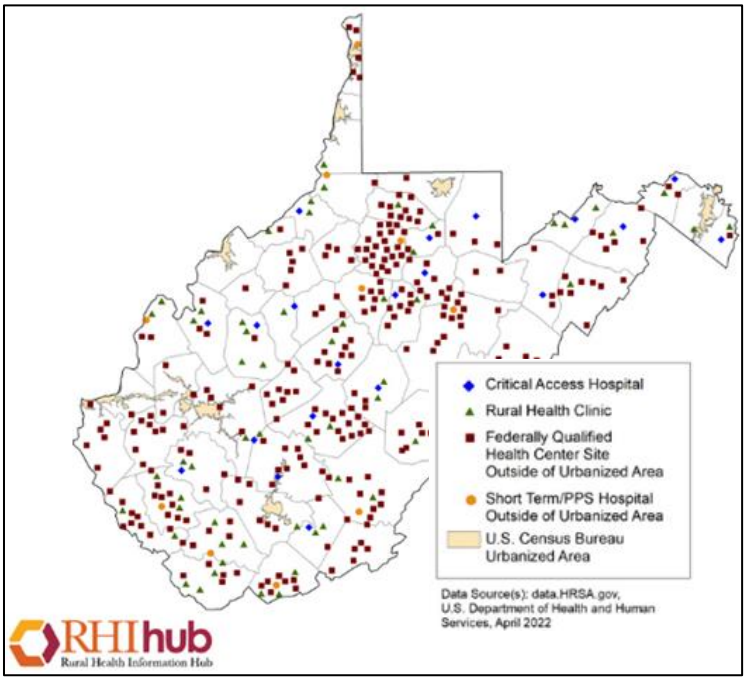
Mental Health and Substance Use Disorders (MH/SUD) Facilities	• Community Behavioral Health Center Locations:
	  ○ Prestera Center for Mental Health Services
	  ○ Mountain Laurel Integrated Healthcare
	  ○ Southern Highlands Community Mental Health Center
	  ○ FMRS Health Systems

Community-Based Organization	Service(s)
	○ Appalachian Community Health Center, Inc. ○ United Summit Center, Inc. ○ Potomac Highlands Mental Health Guild, Inc. ○ Eastridge Health Systems ○ Valley HealthCare System ○ Healthways, Inc. ○ Northwood Health Systems, Inc. ○ Westbrook Health Services, Inc. • General services vary: ○ Counseling, case management, psychiatric services, recovery, outpatient/inpatient MH/SUD treatment
AIDS Task Force of the Upper Ohio Valley (Care Consortium)	Provides Ryan White Part B services, including support for the ADAP and prevention services through the northern panhandle of West Virginia. Services include: • Medical case management • Support services include transportation, food vouchers, and limited vision service There are five office locations: Beckley, Charleston, Huntington, Morgantown, and Wheeling. These locations provide services for all of West Virginia through case management.

Geographic Coverage

BPH utilizes Ryan White Part B to fund the AIDS Task Force of the Upper Ohio Valley to maintain the West Virginia HIV Care Consortium (Care Consortium). The Care Consortium provides case management services and assistance for essential medical care and associated support services for the entire state. West Virginia has HIV medical care centers in its urban areas and LHDs and local CHCs across the state. RWHAP are throughout West Virginia. The Care Consortium provides case management services to every county throughout the state.

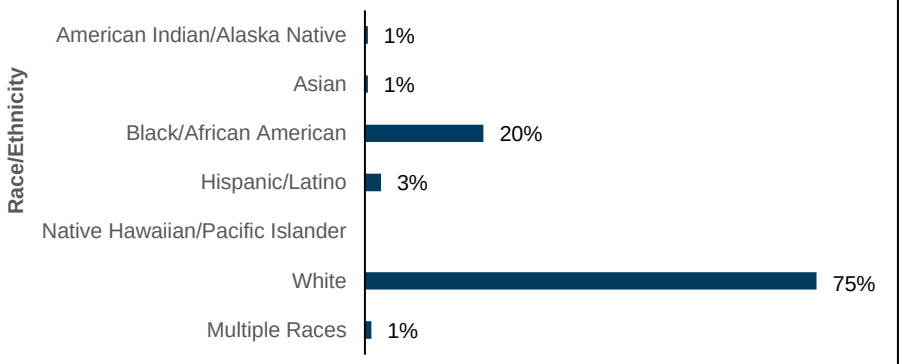
Figure 73. Rural Healthcare Facilities in West Virginia



A majority of West Virginia is considered rural, with an estimated 666,086 West Virginians living in rural areas. Most of the West Virginia rural areas are designated as a HPSA and Medically Underserved Area (MUA). Every county in West Virginia, except for Brooke and Ohio, has been designated in whole or in part as a HPSA for mental health, dental, and primary care. All RWHAP-funded organizations are located within a HPSA and MUA. West Virginia has 21 critical-access hospitals, 59 rural health clinics, 28 Federally Qualified Health Centers (FQHCs) with 397 delivery sites, and 10 short-term hospitals. In 2020, West Virginia CHCs provided over 1.6 million visits across all clinical services (Figure 73).

In 2020, RWHAP provided services to 1,553 clients, with 25% of clients identifying as a racial/ethnic minority (Figure 74), 51% were 50 years or older, 1% identified as transgender, and 53% were living at or below 100% of the federal poverty level. The following priority populations received services from a RWHAP: rural populations, racial and ethnic populations (including African American women), men who have sex with men, people who inject drugs (PWID), people with unstable housing, transgender women, and youth. In 2020, 90% of West Virginia RWHAP clients reached viral suppression. Among the priority populations, clients with unstable housing (67%) and PWID (75%) had a lower viral suppression rate compared to the other priority populations (Figure 75).

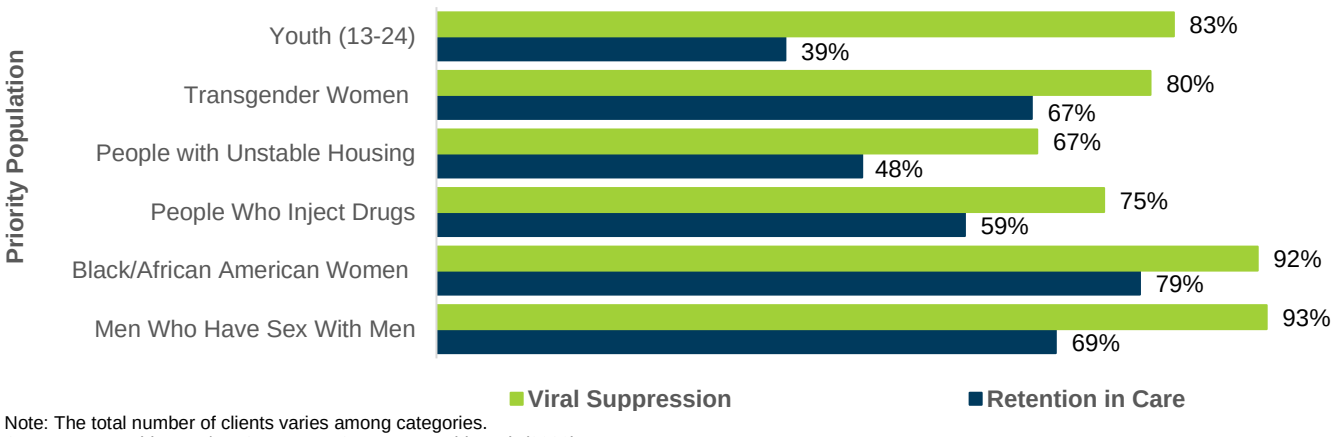
Figure 74. West Virginia RWHAP Clients by Race/Ethnicity, 2020 (N=1,552)



Note: The total number of clients varies among categories.
Source: Ryan White HIV/AIDS Program Compass Dashboard. (2020).

West Virginia has consistently had lower retention in care rates compared to those of the United States. This is due, in part, to practices of HIV care providers in the state who typically only see stable, virally suppressed individuals on an annual basis; however, the metric requires two care visits in a 12-month period. In 2020, 70% of RWHAP clients in West Virginia reached retention in care compared to the U.S. rate of 79%. In 2020, the West Virginia retention-in-care rate was the lowest it has been since 2017, likely related to the COVID-10 pandemic. Among priority populations, retention in care was lowest among youth (39%) and people with unstable housing (48%).

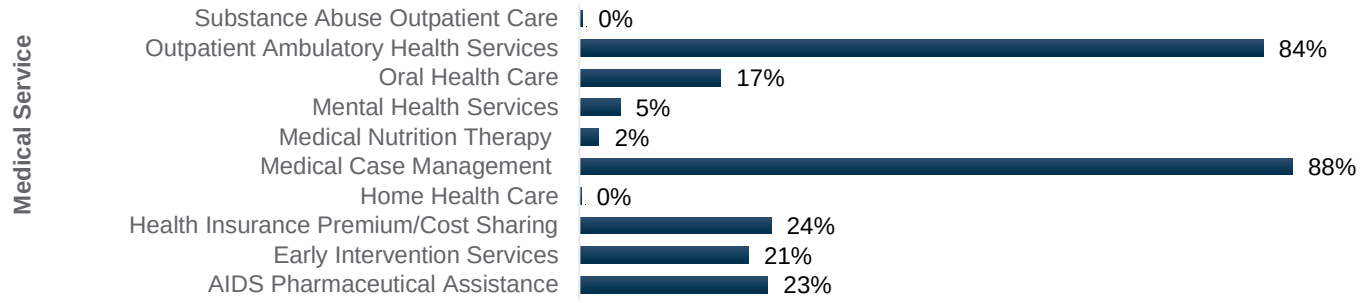
Figure 75. RWHAP Client Viral Suppression and Retention in Care by Priority Population, 2020



Note: The total number of clients varies among categories.
Source: Ryan White HIV/AIDS Program Compass Dashboard. (2020).

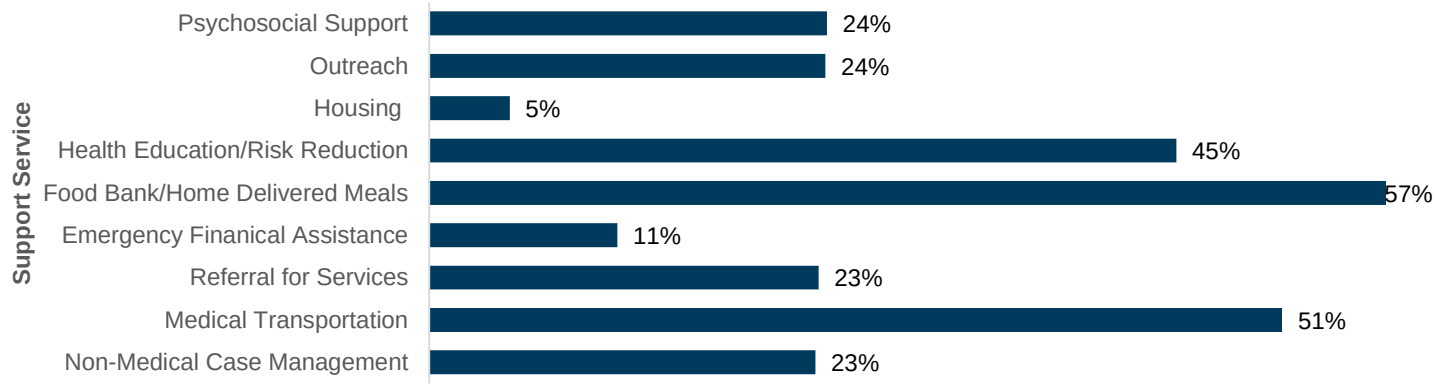
The most frequently received RWHAP medical service in 2020 was medical case management (87.8%) (Figure 76). Case management services included assessment, individualized care plans, coordination of access to care, and continuous client monitoring. The second most frequently received service was outpatient ambulatory health services (84.1%). The ADAP served 509 clients. The most frequently received support service in 2020 was food bank and/or home-delivered meals, with 57% of clients receiving those services (Figure 77).

Figure 76. West Virginia RWHAP Core Medical Services, 2020 (n=1,633)



Note: The total number of clients varies among categories.
Source: Ryan White HIV/AIDS Program Compass Dashboard. (2020).

Figure 77. West Virginia RWHAP Support Services Provided, 2020 (N=1,633)



Note: The total number of clients varies among categories.
Source: Ryan White HIV/AIDS Program Compass Dashboard. (2020).

Strengths and Gaps in HIV Prevention and Care

HIV Testing

In 2020, 6,505 HIV tests were administered in West Virginia with CDC funding; however, 19% of West Virginians with HIV are unaware of their status.

School-Based Education

The need for sexual and reproductive health services among youth is critical to combat increased rates of STDs and HIV infection. Nationally, in 2018, nearly half of the estimated 26 million new STDs were among youth aged 15 to 24 and 21% of estimated new HIV diagnoses were among youth ages 13 to 24. Research shows youth are less likely to receive HIV treatment and/or remain in care.

West Virginia has legislative requirements related to HIV/AIDS education in the school system. West Virginia law (W.Va. Code §18-2-9) requires HIV prevention education within the general health education curriculum in grades 6 to 12. According to the West Virginia Board of Education's AIDS Education Policy (2422.4), the goal of this policy is to assist in the protection of students by providing them with the knowledge and skills necessary to avoid behaviors that will put them at the risk of infection with HIV. Each county board must integrate HIV prevention education into health courses and may also include in science, social studies, and developmental guidance courses to assure total understanding of the disease and its consequences. Educators conducting classroom instruction about HIV/AIDS must be qualified professionals who participate in staff development to ensure they teach current AIDS information. West Virginia schools are required to have some HIV prevention education. Some community based organizations have been implementing

comprehensive sex education programming to address gaps in sex education; however, curricula vary across school districts.

According to the 2020 School Health Profile (Lead Health Education Teacher Surveys), the state had higher percentages of secondary schools teaching specific sexual health topics in a required course when compared to the national rates. Topics taught included efficacy of condoms, how to obtain condoms, how to correctly use condoms, methods of contraception, the importance of condoms, and relationships. The Principal Survey revealed that some secondary schools provided student referrals to organization/health care professionals for HIV treatment, PEP, PrEP, and STD treatment, with most of the schools requiring parental consent.

Preexposure prophylaxis (PrEP)

PrEP is a medication that is effective in preventing HIV when taken as prescribed. PrEP reduces the risk of getting HIV from sex by approximately 99% and reduces the risk of getting HIV from injection drug use by approximately 74%. Though preliminary data for 2020 and 2021 are available, CDC discourages the inclusion of 2020-2022 data in trend assessments. Additionally, please note that data for females across all age groups in West Virginia, and nationally, have been suppressed for PrEP coverage and PrEP prescriptions, due to further studies being conducted in those who identify as female for PrEP use and its effectiveness within this population.

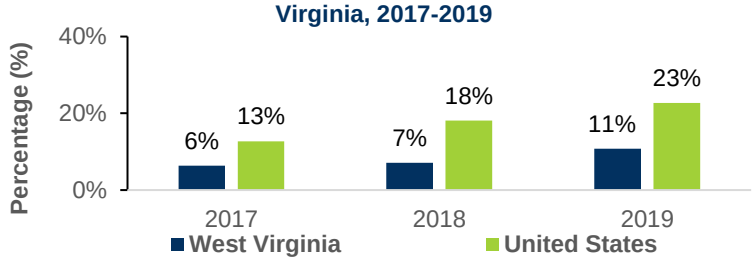
PrEP Coverage and Prescriptions

PrEP coverage is reported as a percentage of the estimated number of people aged ≥16 years with indications for PrEP who actually received a prescription. For calculating PrEP coverage in West Virginia, a PrEP prescription is defined as a person aged ≥16 years prescribed any U.S. Food and Drug Administration (FDA)-approved drug for PrEP, during the indicated year.

The percentage of PrEP coverage in the West Virginia is less than the percentage of PrEP coverage in the United States. While there was an increase in the percentage of PrEP coverage in West Virginia from 2017 to 2019, the percentage of coverage remains approximately half that of the United States (Figure 78).

The gap between PrEP coverage in the state and the United States continued to widen. In 2019, West Virginia experienced the highest percentage of PrEP coverage seen since 2017, with 10.5% (n=569) of people with an indication with PrEP coverage, while approximately 23% of the population with an indication in the United States had PrEP coverage.

Figure 78. PrEP Coverage and Prescriptions, West Virginia, 2017-2019



Source: Centers for Disease Control and Prevention. (2022). AtlasPlus.

In 2020, West Virginia harm-reduction programs dispensed HIV PrEP on 779 occasions, which decreased to a total of 184 HIV PrEP dispensed in 2021. Wyoming County Health Department accounted for 93% of PrEP dispensing among HRPs in 2020 and 33% in 2021. West Virginia Health Right, a free and charitable clinic located in Charleston, accounted for 6% of all PrEP dispensed by HRPs in 2020 and 66% in 2021.

Condom Use

In 2020, BPH distributed 115,800 male condoms, 53 female condoms (please note, BPH was informed female condoms were no longer available for order unless there is a prescription from a physician), and 3,367 packets of personal lubricants total. In 2021, BPH distributed 225,000 male condoms, 82 female condoms, and 12,679 packets of personal lubricants. In 2022 year to date, approximately 195,957 male condoms, 1,242 female condoms, and 29,459 lubricants have been distributed.

Harm Reduction and Syringe Services Programs (HRPs and SSPs)

Harm reduction is a comprehensive set of public health strategies and interventions that aim to reduce morbidity and mortality among PWID. When implemented, HRPs can reduce the likelihood of transmission of blood-borne diseases such as HBV, HCV, and HIV in an area while also reducing the potential of syringe sharing among PWID. Additionally, HRPs often have mechanisms in place to link and refer individuals to substance use disorder prevention and treatment services, behavioral health services, and other support services.

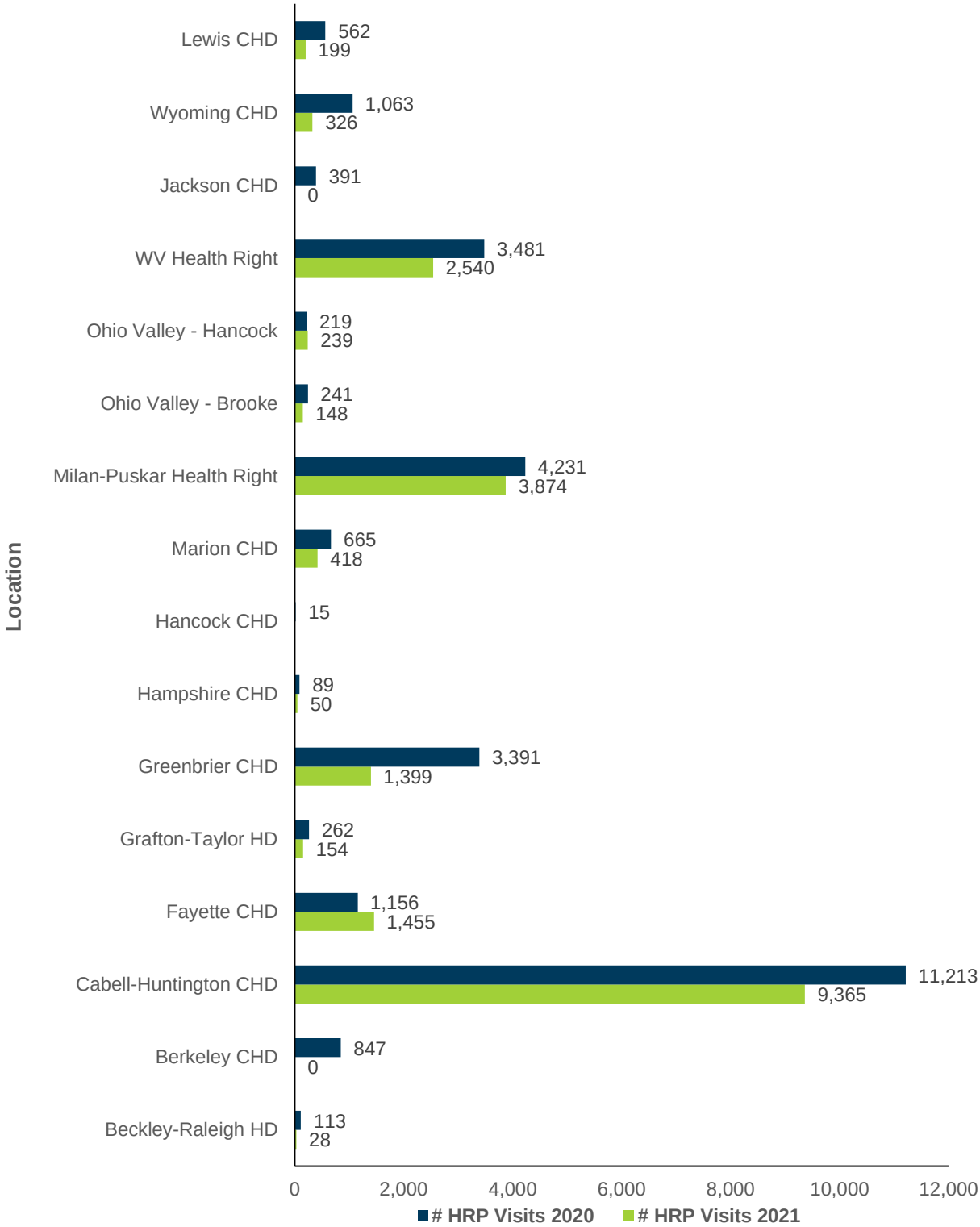
DHHR began providing funding for HRPs in 2018. The HRPs provide a range of services such as providing sterile syringes, collecting non-sterile (used) syringes, acting as points of access to prevention, testing, and treatment for blood-borne diseases, and providing family planning and referrals to medical treatment and social services (Table 12). Community support for HRPs varies widely throughout the state. New legislation passed in 2021 implemented a licensing process for SSPs which included a specific list of services that must be offered and requirements for participants and distribution of syringes. The licensing legislation went into effect on July 1, 2021, and several existing harm reduction programs chose not to apply for licensure and continue offering their programs for a variety of reasons. As of this writing, there are 9 licensed programs operating in the state.

In 2020, among the 16 operating HRPs in the state, most of which were in LHDs, 27,939 client visits occurred. The number of total visits decreased in 2021, to 20,195 visits. Fayette County Health Department is the only HRP that had an increase in visits from 2020 to 2021(Figure 79). The largest HRP was Cabell-Huntington Health Department which accounted for 40% of total visits in 2020 and 26% of total visits in 2021. The second largest HRP was Milan-Puskar Health Right, which accounted for 15% of total visits in 2020 and 19% of total visits in 2021.

Table 12: Top Services Provided by HRPs, West Virginia, 2020-2021

	Ranked Top Services Provided at HRPs in 2020
1	Syringe Dispense
2	Syringe Return
3	Substance Use Disorder Education
4	HIV Testing
5	HCV Testing
6	PrEP Dispense
7	Substance Use Disorder Treatment Referral
	Ranked Top Services Provided at HRPs in 2021
1	Syringe Dispense
2	Syringe Return
3	Substance Use Disorder Education
4	Syringe Clean-Up
5	HIV Testing
6	HCV Testing
7	Substance Use Disorder Treatment Referral

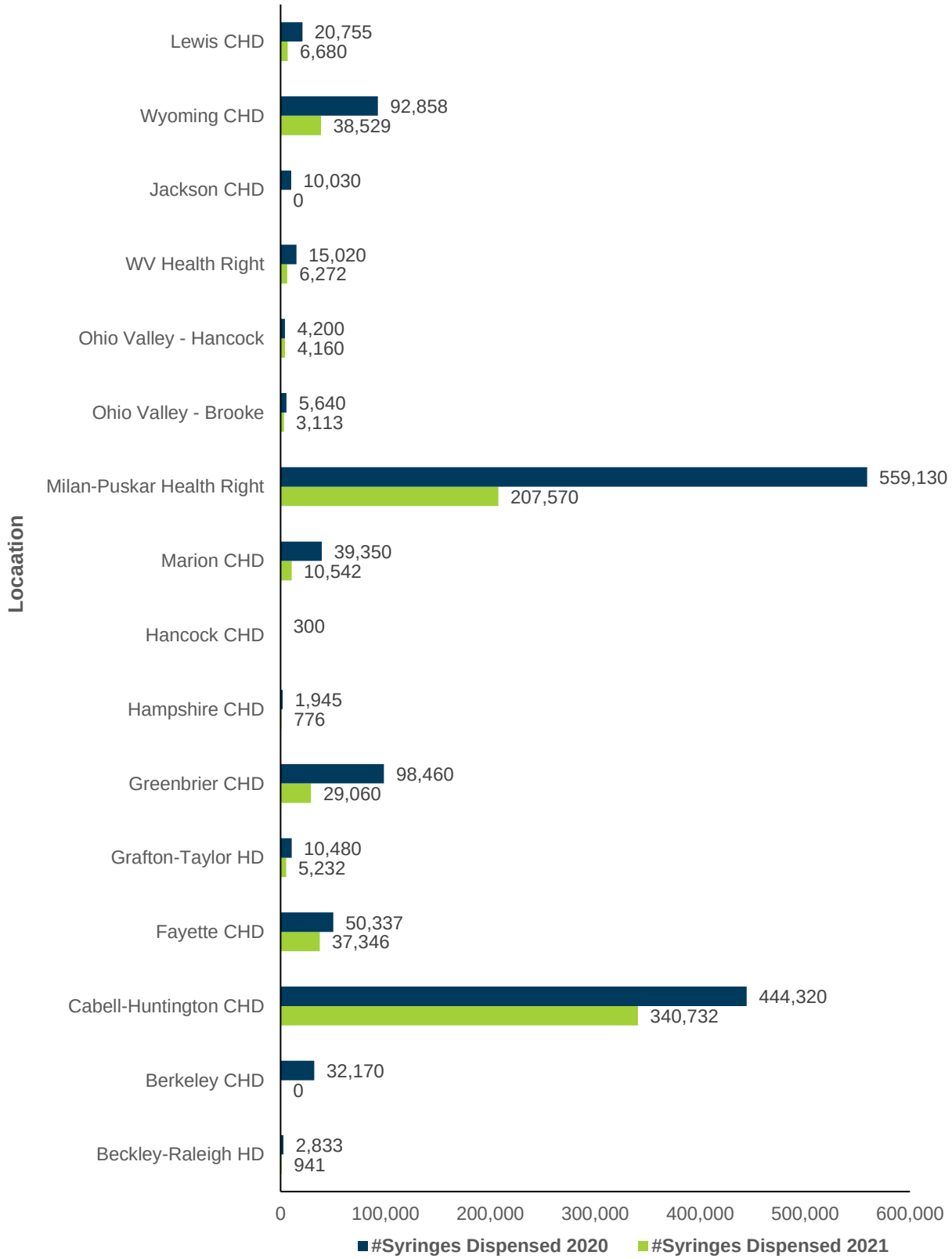
Figure 79. Harm Reduction Program Visits, West Virginia, 2020-2021



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

In 2020, the HRPs dispensed a total of 1,387,828 syringes. The number of syringes dispensed decreased by more than 50% in 2021, with a total of 690,953 syringes dispensed. In 2020, a total of 844,960 used syringes were returned to the HRPs, and in 2021, a total of 690,953 used syringes were returned (Figure 80).

Figure 80. Syringes Dispensed by Harm Reduction Programs, West Virginia, 2020-2021



Source: Division of STD, HIV, Hepatitis, and Tuberculosis, Office of Epidemiology and Prevention Services, BPH, West Virginia DHHR. (2020).

Gaps in HIV Care and Treatment Resources and Barriers to Care Engagement

In West Virginia, numerous barriers to HIV prevention and care resources exist. As discussed in previous sections, most of the state falls within a HPSA and MUA with rural areas greatly impacted by reduced access to care. Limited access to healthcare significantly impacts early HIV diagnosis, treatment, retention in care, and sustained viral suppression. In addition to service availability, biases among those most at risk for HIV spread, specifically PWID, impact HIV care, treatment, and care engagement. These views stem from experiences fueled by stigma and discrimination the population may have experienced from healthcare providers in the past.

Services and resources have been scarce within the community, lacking essential service providers that offer testing, HIV surveillance, and treatment and care tailored to PWID. A lack of eligibility for federal, state, and private funding opportunities remains the main barrier to increasing testing in West Virginia. These barriers exist for two reasons: 1) the reported incidence of new HIV diagnoses does not meet the eligibility threshold, and 2) West Virginia's demographic makeup does not meet the racial/ethnic diversity and client/patient ratio needed for eligibility. Racial and ethnic minorities account for approximately 4% of the population, making the state ineligible to apply, despite having one of the country's highest intravenous drug use-related HIV infection rates. These eligibility requirements apply to state, county, and local governments, community-based organizations, universities, and providers. Due to funding resources not increasing commensurate with the increased disease burden in the state, the HIV surveillance infrastructure in West Virginia has not increased accordingly and, therefore, disease burden and the magnitude of the HIV outbreak are likely underestimated. Treatment and care have also been impacted among the population at risk, due to internal feelings such as anger, depression, and fear post-HIV diagnosis. Antiretroviral treatment among PWID had the highest adherence rate while patients were housed in treatment facilities, eliminating housing instability. However, those without access to such care experience barriers, such as unreliable transportation, prior authorization requirements, loss or theft of prescribed medications, and difficulty remembering appointment information. Gaps in providing accessible treatment and care continue as people who live outside metro areas must travel great distances to access treatment. Travel commutes of one hour or more are a reality for many patients who receive care highlighting the difficulty in receiving sustainable care on a long-term basis. Barriers to care engagement have been identified among medical and social services with the most prominent barrier being PWID having strong negative views toward hospitals, largely due to previous experiences of stigma and discrimination. Barriers related to intrapersonal factors include:

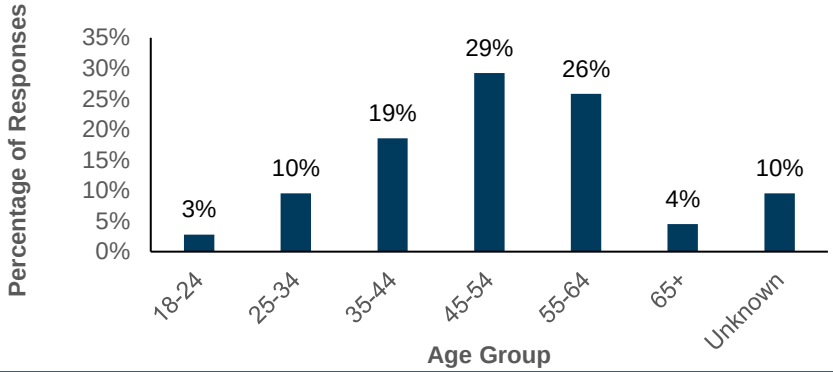
- Lack of awareness of available HIV/AIDS treatment programs and facilities
- Lack of awareness of resources such as housing facilities (HOPWA)
- Lack of availability and access to sterile syringes and SSPs
- Patients with SUD opting to leave treatment facilities against medical advice before commencing treatment or diagnosis
- Long wait times
- Housing instability
- Fear of HIV stigma or discrimination.

Needs Assessment

An HIV and HCV needs assessment was conducted by BPH and Ryan White partners with assistance from the WVCTSI Project ECHO and the West Virginia Rural Health Association (WVRHA) in October 2022. The needs assessment consisted of a survey and focus groups involving PWLE that examined prevention, treatment, and care needs as well as focus groups with infection preventionists and a provider prevention and care survey.

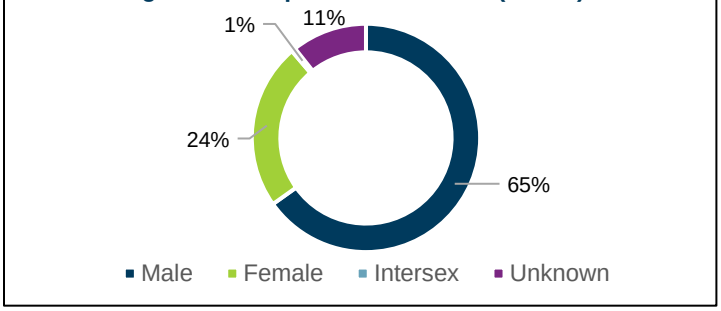
To assess met and unmet needs among PWLE, BPH and Ryan White partners conducted a survey using a convenience sampling approach. Respondents were asked about care services and answered whether they accessed the service, needed the service but did not access it, or did not need the service. The *2022 Comprehensive Needs Assessment Survey for West Virginians Living with HIV and Hepatitis C* collected information from 191 people, of whom 178 met the inclusion criteria of living in West Virginia with HIV or HCV or being at risk. Ryan White HIV/AIDS Program Part B and C service providers were key partners to reach respondents. Results were collected through an online survey and a provider-administered survey during October 2022. Most respondents reported their race as White (73%), followed by Black or African American (8%). Four percent of respondents reported being multi-racial, and another 4% reported being Hispanic or Latino. Eleven percent of the respondents did not select a race. Most respondents reported being between 35 and 64 years old, with 29% reporting being between 45 and 54 years, 26% reporting being between 55 and 64 years, and 19% reporting being between 35 and 44 years. Three percent of respondents reported being between 18 and 24 years old, 10% reported being between 25 and 34 years old, and 4% reported being 65 years or older. Unknown age was recorded for 10% of respondents (Figure 81).

Figure 81. Respondent Age Group (N=178)



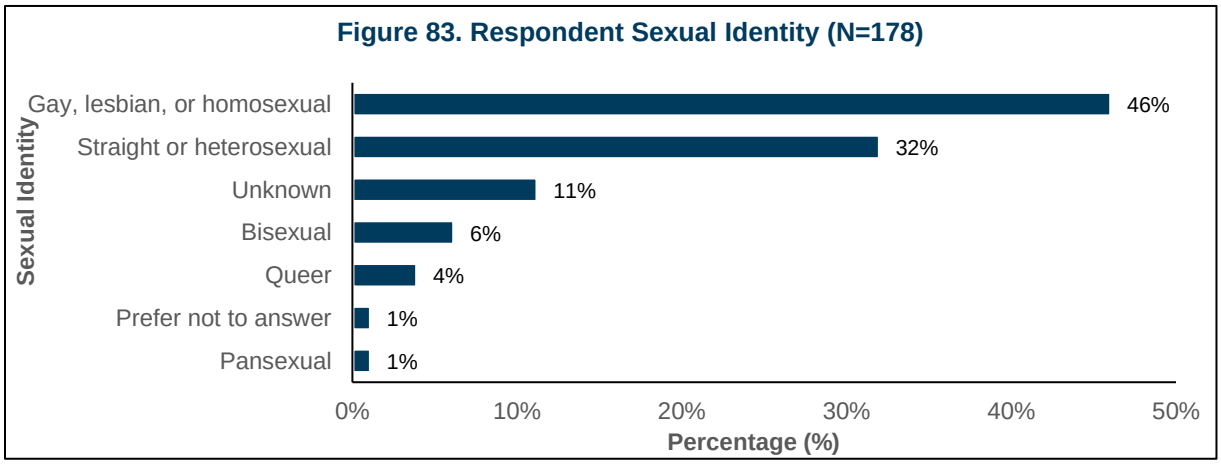
More than half of the respondents reported their birth sex as male (65%), 24% reported their sex as female, 1% reported their sex as intersex, and 11% of responses were unknown (Figure 82). Gender identity is one's own internal sense of self and gender. Most of the respondents identified as male (62%). Twenty-four percent of respondents identified as female, and 4% percent of the respondents identified as transgender or non-binary.

Figure 82. Respondent Birth Sex (N=178)



Most respondents reported their sexual identity as gay, lesbian, or homosexual (46%) followed by straight or heterosexual (32%). Six percent reported their sexual identity as bisexual, 4% as queer, and 1% as pansexual. More than 178 responses were recorded for sexual identity as respondents were able to select more than one answer (Figure 83).

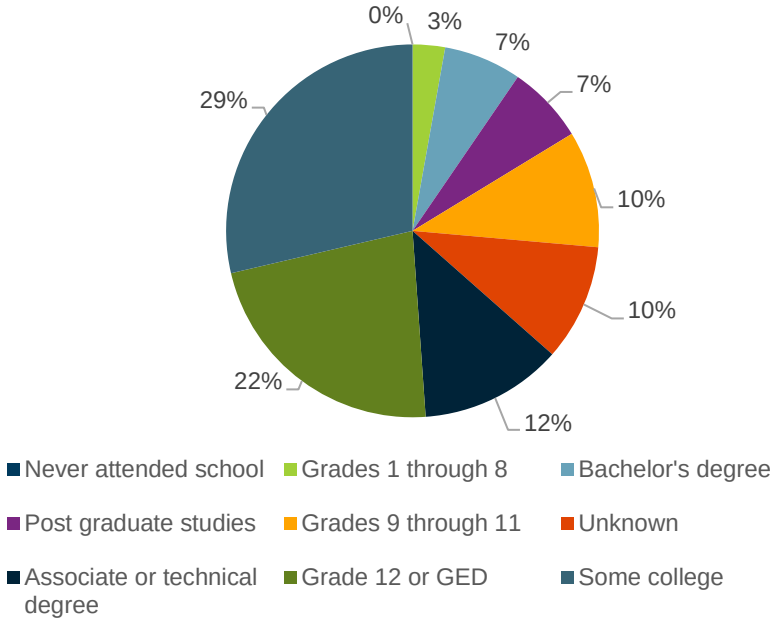
Figure 83. Respondent Sexual Identity (N=178)



Most respondents reported living in Cabell and Kanawha counties, with 24% reporting Cabell and 15% reporting Kanawha as their county of residence. U.S.-born citizens represented most of the respondents (87%).

Nearly 30% of respondents reported their highest level of education attained as some college while 22% reported grade 12 or GED, 10% reported grades 9 through 11, and 3% reported grades 1 through 8. Twelve percent reported obtaining an associate or technical degree, 7% reported obtaining a bachelor's degree, and 7% reporting having completed post-graduate studies (Figure 84).

Figure 84. Respondent Education Level (N=178)



Respondents were able to select all applicable options to report their employment status. Of the 178 respondents, 27% reported full-time employment, 13% reported part-time employment, and 7% reported self-employment. Five percent of respondents reported being out of work for less than one year while 11% reported being out of work for one year or more. One percent of respondents reported being a homemaker, 2% reported being a student, and 5% reported being retired. Eight percent of respondents reported being unable to work while 28% reported being disabled (Figure 85).

Figure 85. Respondent Employment Status (N=178)

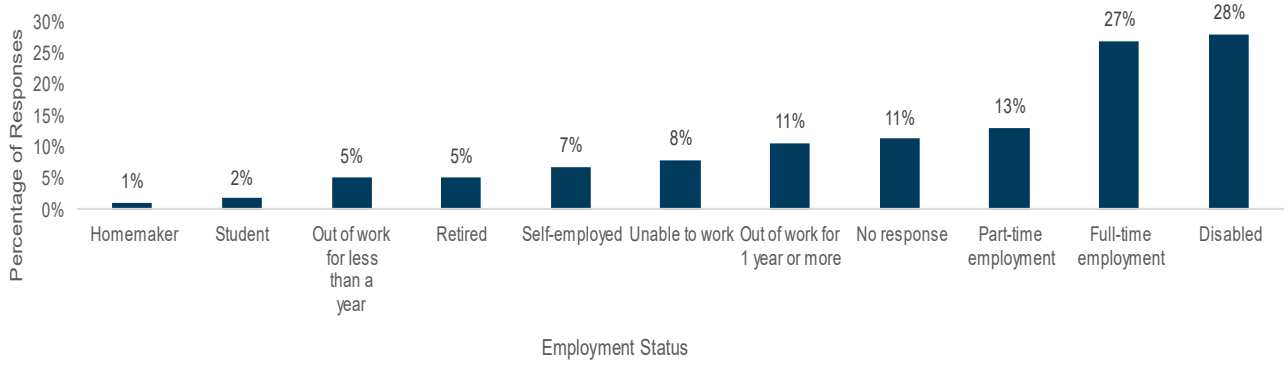
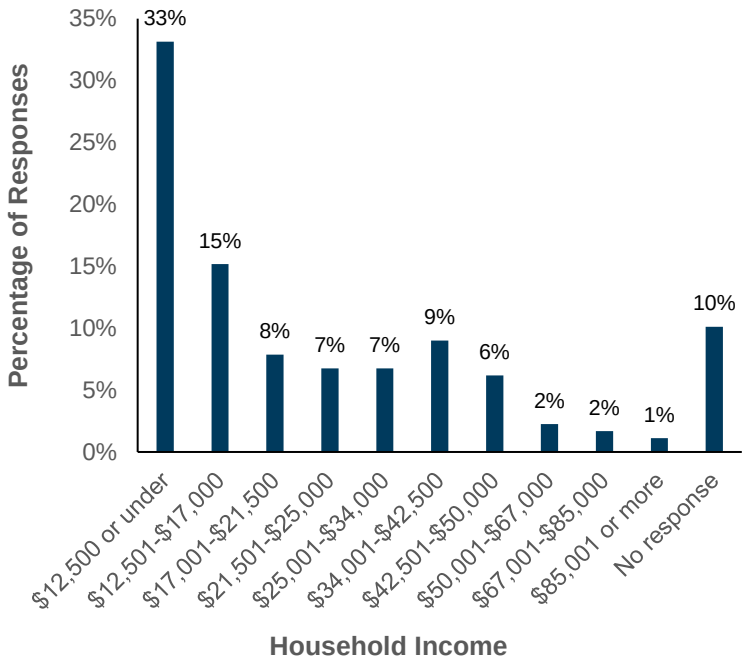


Figure 86. Respondent Household Income (N=178)



Most respondents reported their household income as either $12,500 or under (33%) or $12,501-$17,000 (15%) (Figure 86). When asked how many people, including themselves, depend on their annual household income, 50% reported only themselves. Thirty percent of respondents reported two people, 6% reported three people, 2% reported four people, and 2% reported five or more people.

Service Needs

A summary of respondents' service needs addressing social determinants of health, healthcare services, SUD services, and support services are provided in Table 13. The service needs with the highest gaps were oral health care (28%), emergency financial assistance for utilities (22%), emergency housing assistance (19%), emergency financial assistance for food/groceries (19%), emergency financial assistance for rent (18%), medical transportation services (17%), and outpatient mental health services (15%).

Table 13. Comprehensive Needs Assessment Survey for West Virginians Living with HIV and Hepatitis C: Service Needs

	Accessed Service		Needed But Did Not Accessed		Did Not Need*		Total Responses
	%	n	%	n	%	n	n
Services Addressing Social Determinants of Health							
Housing: Emergency Assistance	21%	32	19%	28	60%	89	149
Housing: Temporary or Transitional	9%	13	14%	21	77%	115	149
Housing: Long-Term	14%	21	15%	22	71%	104	147
Emergency Financial Assistance: Utilities	21%	31	22%	33	57%	85	149
Emergency Financial Assistance: Rent	18%	27	18%	26	64%	95	148
Emergency Financial Assistance: Food/Groceries	34%	50	19%	28	48%	71	149
Financial Assistance: Continuity of Health Insurance or Medical and Pharmacy Benefits	30%	45	13%	19	57%	85	149
Medical Transportation Services	17%	25	17%	25	66%	97	147

	Accessed Service		Needed But Did Not Accessed		Did Not Need*		Total Responses
	%	n	%	n	%	n	n
Food: Food Bank/Pantry	37%	54	12%	17	52%	77	148
Food: Home-Delivered Meals	0%	0	7%	11	93%	138	149
Food: On-Site Meals	11%	16	5%	7	84%	125	148
Healthcare Services							
Mental Health: Outpatient	31%	46	15%	23	54%	81	150
Mental Health: Inpatient	21%	31	9%	13	71%	106	150
Oral Health Care	45%	67	28%	42	27%	41	150
Home Health	3%	4	2%	3	95%	141	148
Medical Nutrition Therapy: Dietician	6%	9	5%	8	88%	130	147
Medical Nutrition Therapy: Nutritional Supplements	5%	8	11%	16	84%	125	149
Rehabilitation Services	7%	11	2%	3	91%	136	150
Health Education/Risk Reduction: Treatment Counseling	14%	21	10%	15	76%	112	148
SUD Services							
SUD Treatment/Counseling: Outpatient	10%	15	6%	9	84%	126	150
SUD Treatment/Counseling: Inpatient	3%	4	4%	6	93%	137	147
SUD Recovery Support Groups or Services	9%	14	7%	10	84%	124	148
Harm Reduction Program Access	16%	24	3%	4	81%	118	146
Clean Syringe and Supply Access	17%	25	3%	5	80%	119	149
Support Services							
Non-Medical Case Management: Benefits Counseling	11%	17	11%	17	77%	115	149
Non-Medical Case Management: Health Insurance Navigation	14%	21	13%	19	73%	109	149
Home and Community-Based Health Services	2%	3	3%	4	95%	142	149

	Accessed Service		Needed But Did Not Accessed		Did Not Need*		Total Responses
	%	n	%	n	%	n	n
Childcare Services	0%	0	1%	2	99%	148	150
Legal Services	3%	4	9%	13	89%	133	150
Linguistic Services	0%	0	1%	2	99%	148	150
Permanency Planning	0%	0	1%	1	99%	149	150
*Note. These questions focus on services received or that may have been needed during the previous 12 months. Responses were selected for each service area. *Includes not applicable responses.*							

Service Needs for Services Addressing Social Determinants of Health

Questions pertaining to respondents' needs for services addressing the social determinants of health were asked, and gaps were identified for each service. Service gaps ranged from 5% for on-site meals to 22% for emergency financial assistance for utilities. Services addressing the social determinants of health had the most service gaps identified overall.

Service Needs for Healthcare Services

Gaps for healthcare services ranged from 2% for rehabilitation services to 28% for oral health care. Oral health care had the largest service gap across all categories.

Service Needs for SUD Services

Gaps for SUD services ranged from 3% for harm reduction program access to 7% for SUD recovery support groups or services. Needs for SUD services were largely reported to not be needed by respondents.

Service Needs for Support Services

Gaps for support services ranged from under 1% (permanency planning, childcare services, and linguistic services) to 13% for non-medical case management for health insurance navigation. Support services were largely reported to not be needed by respondents other than non-medical case management for health insurance navigation or benefits counseling.

Service Needs for HIV Care

Questions pertaining to HIV care needs were asked, and gaps were identified for each service (Table 14). Unmet needs ranged from 2% for respite care to 14% for psychosocial support services.

Table 14. Comprehensive Needs Assessment Survey for West Virginians Living with HIV and Hepatitis C: HIV Care Service Needs

	Accessed Service		Needed But Not Accessed		Did Not Need		Total Responses
	%	n	%	n	%	n	N
Psychosocial Support Services	16%	21	14%	19	70%	92	132

	Accessed Service		Needed But Not Accessed		Did Not Need		Total Responses
	%	n	%	n	%	n	N
HIV Drug Assistance	65%	85	8%	10	28%	36	131
Medical Case Management	62%	80	7%	9	32%	41	130
Referral for Services	39%	51	7%	9	54%	71	131
Medical Case Management: Treatment Adherence	37%	49	6%	8	57%	74	131
HIV-Related Medical Care	63%	82	5%	6	33%	43	131
Health Education/Risk Reduction: HIV Transmission	35%	46	3%	4	62%	82	132
End-of-Life Services	4%	5	3%	4	93%	123	132
Respite Care	11%	14	2%	3	87%	112	129

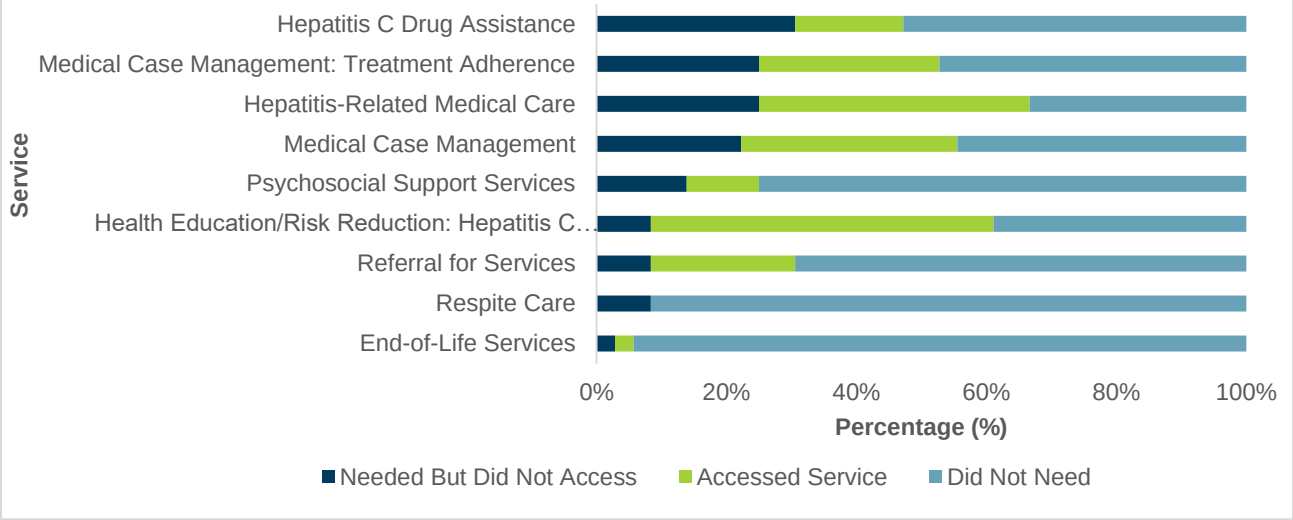
Service Needs for HCV Care

Questions pertaining to HCV care needs were asked, and gaps were identified for each service. Unmet needs ranged from 3% for end-of-life services to 31% for HCV drug assistance (Table 15). Notable service gaps (20% or more) were identified for HCV drug assistance (31%), medical case management, treatment adherence (25%), hepatitis-related medical care (25%), and medical case management (22%) (Figure 87).

Table 15. Comprehensive Needs Assessment Survey for West Virginians Living with HIV and Hepatitis C: Hepatitis Care Service Needs

	Accessed Service		Needed But Not Accessed		Did Not Need		Total Responses
	%	n	%	n	%	n	n
Hepatitis C Drug Assistance	17%	6	31%	11	53%	19	36
Medical Case Management: Treatment Adherence	28%	10	25%	9	47%	17	36
Hepatitis-Related Medical Care	42%	15	25%	9	33%	12	36
Medical Case Management	33%	12	22%	8	44%	16	36
Psychosocial Support Services	11%	4	14%	5	75%	27	36
Health Education/Risk Reduction: Hepatitis C Transmission	53%	19	8%	3	39%	14	36
Referral for Services	22%	8	8%	3	69%	25	36
Respite Care	0%	0	8%	3	92%	33	36
End-of-Life Services	3%	1	3%	1	94%	33	35

Figure 87. Service Needs for Hepatitis Care



PWLE Focus Groups

DSHHT partnered with two Ryan White care providers, AIDS Task Force of the Upper Ohio Valley and Charleston Area Medical Center, to conduct 13 focus group sessions with 87 people who were living with HIV and those co-infected with HCV. The purpose of these focus groups was to assess the needs and barriers of PWLE and to identify priority areas that need strengthened to better meet the needs of the community. Participants were 62% male, 36% female, and 2% transgender. Most participants reported their race as White (61%) followed by Black or African American (18%). The race of 10% of the participants was unknown. Participants ranged in age from 28 to 70 years old, with most individuals falling between 35 and 45 years of age. Six of the 13 focus groups consisted of people who reported intravenous drug use as their primary risk behavior, and two groups who reported their mode of exposure was through sexual activity. In the other five groups, participants either reported a mix of risk exposure or chose not to disclose their risk behaviors. Three sessions were conducted with specific populations: long-term HIV survivors, legal and illegal immigrants, and people living in rural areas of the state.

Participants reported that the most common reasons they were tested for HIV and/or HCV were hospitalization and incarceration. They were also tested because the service was offered at local clinics/health departments, the service was part of detox treatment, they were referred for testing by a Disease Intervention Specialist (DIS) or a sex partner, and they were concerned about their status or were experiencing symptoms. Most participants had a positive testing experience, citing providers who were straightforward and knowledgeable, who connected them to appropriate care after presenting options, and who supported them through connection to community outreach workers. Participants who had negative experiences stated the reasons included poor attitude of the medical professional (feeling stigmatized), lack of access to confirmatory testing/treatment, lack of follow-up services and education on infection management, and lack of confidentiality resulting in a feeling of not being safe.

The most frequently identified barriers to accessing HIV and/or HCV care and services were lack of education on available services; financial need (i.e., housing, transportation, childcare, cost of services and treatment); program and/or insurance rules requiring sobriety; need treatment approval by infectious disease specialists; inconvenient office hours; and stigma. Participants identified ways to overcome these barriers through after-hours clinics and walk-in appointments, financial assistance with care, housing, transportation, and childcare, a centralized point of contact for navigating the care system, increased number of local providers, increased HRPs, and supportive, caring, knowledgeable staff.

Poor experiences reported by the participants included negative attitudes of providers, lack of confidentiality, stigma, misinformation, and not receiving promised services. Participants identified the most positive experiences while engaged in care as financial assistance (including transportation and housing), education in the community, seeing improvement in health with treatment, removal of Medicaid treatment requirements, providers who are knowledgeable and supportive, and syringe programs.

Reasons people fall out of care were reported as poor treatment by providers, providers not rescheduling missed appointments, lack of confidentiality, fear of stigma, lack of basic needs, long wait times to receive services, occurrence of other life events, and substance use. In discussion on how to keep people engaged in care, participants noted the most important needs as access to local providers, access to long-acting injectables, caring/nonjudgmental staff, providers closer to home, convenient hours, reducing stigma from providers, peer support, shorter wait periods, and financial support (including housing and transportation). Participants shared their experiences with stigma while accessing HIV and HCV care and services. Older participants shared occasions where primary care and dental providers refused to accept them as patients. Participants felt they had been treated poorly or unfairly by an array of providers, from emergency room staff to Medicaid transportation vendors, due to their HIV and/or HCV status. It was the overwhelming fear of stigma that was identified by participants of all ages as a continual barrier to accessing care and services.

Participants were asked to share other thoughts they felt were important to improving the system of care. They reinforced the importance of education for patients, providers, and the public to increase awareness on available services and treatments, and to reduce stigma. Confidentiality was identified as crucial for patient trust, especially in rural areas where people in care can be easily identified by the community. Several participants shared experiences when their confidentiality was breached, exposing their status, and causing them hardship within their communities. Those identified as breaking confidentiality included medical providers, service providers, and outreach staff.

Across the sessions, three major themes emerged: the need for financial resources for housing, transportation, and childcare; the lack of availability of medical care due to the need for more qualified local providers and the need for non-traditional service provision hours; and the negative impact of stigma both real and feared. While most participants reported overall positive experiences in diagnosis and care, the identified issues continue to create barriers to testing and treatment. High-risk populations represented in these focus groups, including people who use drugs, sex workers, and transgender people are especially vulnerable to the negative impact of these barriers to care and services.

Infection Preventionist Focus Groups

DSHHT conducted two focus group sessions with 10 infection preventionists from multiple locations of a large healthcare system to assess barriers to HCV and HIV testing and treatment and obtain information on any intervention strategies currently utilized to improve outcomes. Individual topics included barriers to PrEP, testing, and treatment along with ways to overcome barriers and needed support.

Barriers to PrEP identified by the participants were community lack of knowledge about at-risk populations, cost, lack of access to medical care including transportation, medical facility locations, and providers who routinely offer PrEP. Solutions suggested to overcome these barriers included increasing support and access for telemedicine in rural areas, improving access to outpatient or outreach clinics, and integrating PrEP education into care of patient with HCV with ongoing risk behaviors.

Barriers to diagnosis and testing identified included patient refusal, cost, lack of knowledge of available resources, and stigma. To overcome these barriers, the focus groups suggested solutions like universal screening with or without risk factors for HIV, HBV, HCV, and STD to reduce stigma, meet screening recommendations, and increase patient awareness; electronic medical record (EMR) automation that prompts for testing; and education to physicians and medical staff on testing protocols and compassionate, trauma-informed care.

Barriers to treatment included cost, difficulty locating patients, and lack of transportation and basic human needs (i.e., food insecurity, clothing, housing, etc.). To overcome these barriers, the focus groups suggested a crisis line for patients, peer recovery coaches, utilizing physician consultation/support programs and telemedicine to increase access to treatment in rural areas (e.g., WVHAMP, WVCTSI Project ECHO), increasing housing assistance opportunities especially for transitional housing, and expanding access to EMR systems to public health to assist with location of patients.

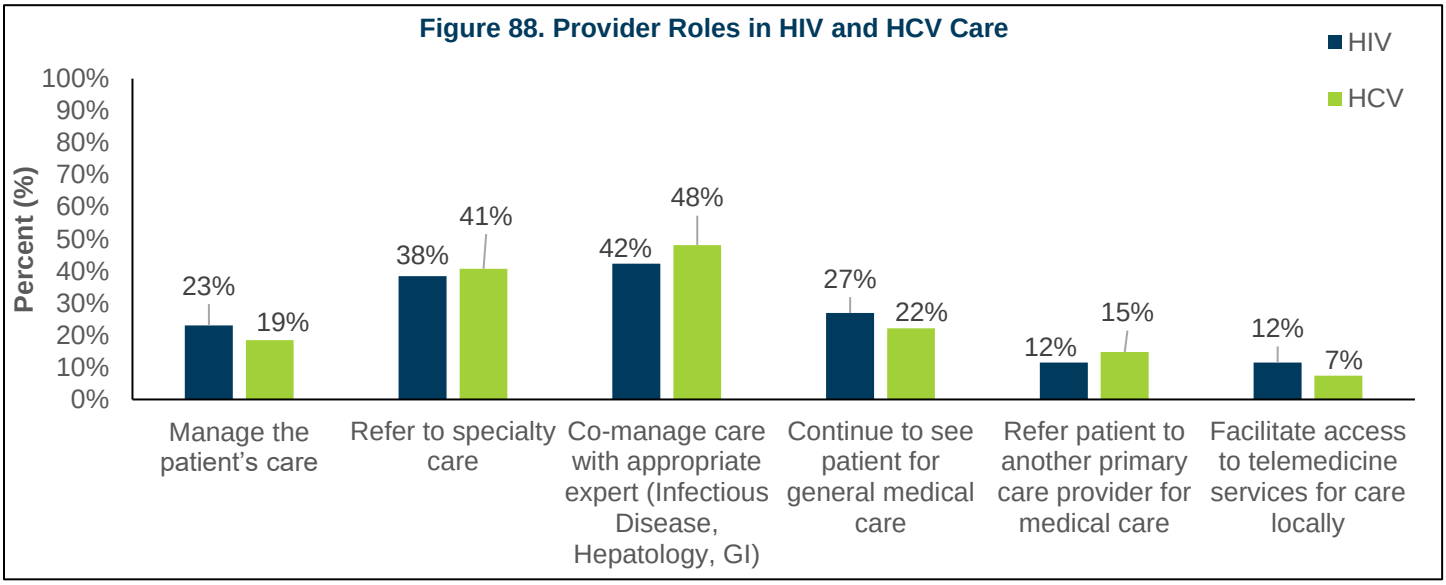
Stigma was a theme identified as a barrier to PrEP availability, diagnosis, testing, and treatment. Participants suggested strategies for reducing stigma such as mandatory stigma reduction/trauma-informed education targeted to physicians, medical staff and health profession students; expanding peer recovery coaching programs; the need for continuing education on stigma reduction for providers; having a dedicated team that has the desire to help this population; and educating that addiction is a recognized chronic medical disease and that relapses are expected.

2022 Provider Prevention and Care Survey for West Virginia HIV and HCV Elimination Plan

In October 2022, BPH administered the *2022 Provider Prevention and Care Survey for West Virginia HIV and HCV Elimination Plan* through a convenience sampling approach to the service delivery system. The purpose was to identify service needs and gaps from the provider perspective and inform the priorities of the Plan. Stakeholders, such as the WVCTSI Project ECHO and WVRHA, promoted the survey through their networks, and the survey link was distributed at the annual Perinatal Partnership Summit. A total of 53 responses were collected from West Virginia providers.

Eighty-six percent of the providers (n=31) reported having had a patient disclose their HIV positive status and/or HCV diagnosis to them. When asked about their role in HIV and/or HCV patient care, most providers reported co-managing care with appropriate experts (i.e., infectious disease, hepatology, gastrointestinal) followed by referring patients to specialty care (Figure 88).

Figure 88. Provider Roles in HIV and HCV Care

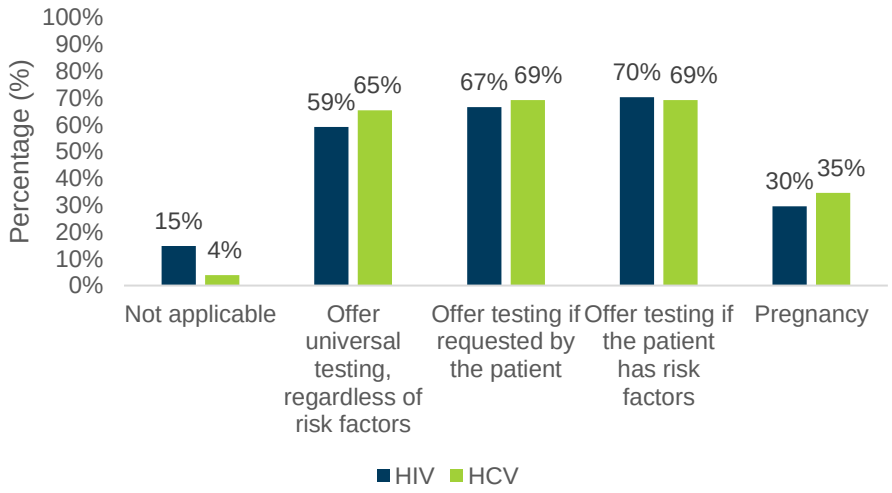


HIV and/or HCV Testing

A total of 27 providers responded about their testing practices for HIV. Of those who responded, 70% (n=19) indicated that they offer HIV testing if the patient has risk factors for HIV, 67% (n=18) offer HIV testing if requested by a patient, 59% (n=16) offer universal HIV testing regardless of risk factors, 30% (n=8) screen for HIV during pregnancy, and 15% (n=4) stated it was not applicable.

Twenty-six providers responded about their testing practices for HCV. Of those who responded, 69% (n=18) indicated that they offer testing if the patient has risk factors for HCV, 69% (n=18) offer HCV testing if requested by a patient, 65% (n=17) offer universal HCV testing regardless of risk factors, 35% (n=9) screen for HCV during pregnancy, and 4% (n=1) stated it was not applicable (Figure 89).

Figure 89. Provider Circumstances for Performing HIV and HCV Testing



There were 33 responses to the question, “Have you ever communicated a positive HIV and/or HCV test result to a patient?" Among the responses, 88% (n=29) indicated yes, and 12% (n=4) stated no. When asked about their comfort level when communicating an HIV and/or HCV test result, 73% of respondents (n=24) stated they were comfortable with both HIV and HCV, 18% (n=6) answered they were comfortable with HCV but not HIV, 6% (n=2) stated it was not applicable, and 3% (n=1) reported they were uncomfortable with both.

Thirty-two providers reported barriers that prevent testing patients for HIV and/or HCV. Of those who responded, the most common barriers were the patient declines the offer to test (72%), the patient is afraid (47%), concern that the patients won’t return for results (25%), and “Other” (22%). Respondents reported the following barriers under the “Other” category: stigma, test was not ordered when it should have been, no reliable follow up from the Emergency Room (ER), and unable to find an adequate vein for labs (Table 16).

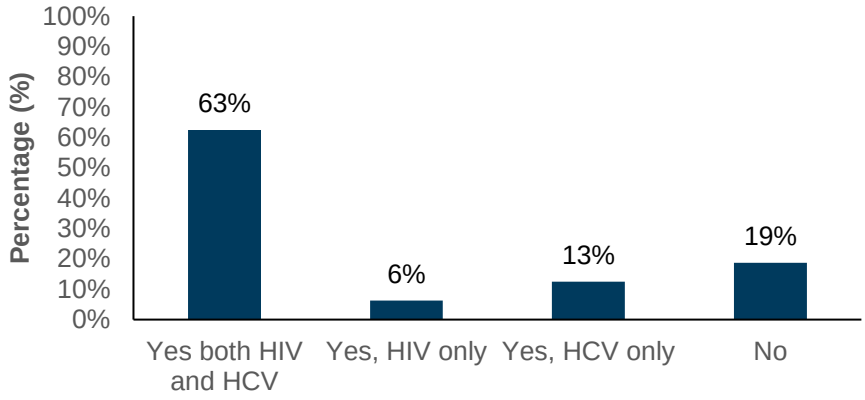
Table 16. Barriers to Testing for HIV and HCV

Answer Choices	Responses	
	Percent (%)	Number (n)
Patient declines the offer to test	72%	23
Patient is afraid	47%	15
Lack of resources to pay for the test	13%	4
Lack of access to laboratory testing	0%	0
Time-consuming work	6%	2
Competing priority	6%	2
Concerned patients won’t return for results	25%	8
Other	22%	7

HIV and/or HCV Treatment

When asked if they would be willing to treat a patient who is positive for HIV and/or HCV, 63% of respondents (n=20) reported yes to both HIV and HCV, 19% (n=6) said no, 13% (n=4) said yes, HCV only, and 6% (n=2) said yes, HIV only (Figure 90). Respondents who answered no were asked if they would be willing to treat a patient who is positive if they had specialty support. Of those who responded, 67% (n=4) stated yes and said support should include education as needed and advice on medications used. However, 33% (n=2) responded no regarding willingness to treat a patient who is positive for HIV and/or HCV even if they had specialty support.

Figure 90. Provider Willingness to Treat HIV and/or HCV



HIV PrEP

A total of 33 respondents answered the question, “Have you prescribed PrEP?” Of those who responded, 42% (n=14) said yes, while 58% (n=19) said no. In a follow-up question, providers who did not report prescribing PrEP were asked why they did not. Seventeen providers answered the question. Of those who responded, 41% (n=7) indicated that they do not have enough knowledge to prescribe PrEP, and 6% (n=1) reported being concerned about the cost of PrEP. Almost 59% (n=10) selected “Other” and commented: PAs are not allowed to prescribe HIV medications; not applicable in the ER; have not had interested patients; have no full-time physician; are not authorized; and are not available in health departments.

Systemic Barriers to Providing Care

Among 32 respondents, 44% reported health system barriers that prevent them from providing care to patients with HIV and/or HCV. In a follow-up question, the respondents who reported barriers were asked to check all barriers that applied. Of those who responded, 43% (n=6) reported a lack of HIV and/or HCV specialist support, 36% (n=5) stated a lack of funding or resources, 36% (n=5) said clinic location, 29% (n=4) reported that they are not sufficiently knowledgeable/ confident to provide HIV and/or HCV care, 14% (n=2) reported negative colleague or health system attitudes toward patients with HIV and/or HCV, 7% (n=1) stated a lack of adequate reimbursement for services, and 21% (n=3) selected “Other” and commented: no full-time physician, no reliable follow up from the ER, and time (Table 17). A total of 32 respondents reported on their

Table 17. Systemic Barriers to Providing Care for HIV and HCV

Answer Choices	Responses	
	Percent (%)	Number (n)
Clinic location	36%	5
Not sufficiently knowledgeable/confident to provide HIV and/or HCV care	29%	4
Lack of adequate reimbursement for services	7%	1
Lack of funding or resources	36%	5
Lack of HIV and/or HCV specialist support	43%	6
Negative colleague or health system attitudes toward patients with HIV and/or HCV	14%	2
Other	21%	3

telemedicine access to HIV and/or HCV experts. Of those who responded, 41% (n=13) said yes they have access to experts, 37.5% (n=12) said no, and 22% (n=7) said they were unsure.

Behavioral Risk Screening

Out of 32 respondents, 84% (n= 27) said they do complete a behavioral risk screening with patients at high-risk for or diagnosed with HIV and/or HCV, 9% (n=3) said no, and 6% (n=2) said it was not applicable. Of the 27 providers who responded yes, 100% (n=27) reported covering substance use, including injection or non-injection drug use, 93% (n=25) reported covering having unprotected sex, 93% (n=25) cover a history of STDs, 89% (n=24) cover having multiple sex partners, and 4% (n=1) reported other and commented that they cover a history of men having sex with men.

In another follow-up question, the 27 providers were asked how often they repeat the assessment. Of those who responded, 44% (n=12) stated every appointment, 26% (n=7) responded yearly, and 30% (n=8) selected "Other" and commented: admissions; upon request; sporadically; and if time permits (Figure 92).
A total of 34 providers reported on their comfort level with taking a sexual history from a patient. Of those who responded, 71% (n=25) reported that they were comfortable, 23% (n=8) stated that they were comfortable but could use more training, 3% (n=1) said that they were uncomfortable, and 3% (n=1) stated it was not applicable (Figure 92).

Figure 91. Frequency of Behavioral Risk Screening

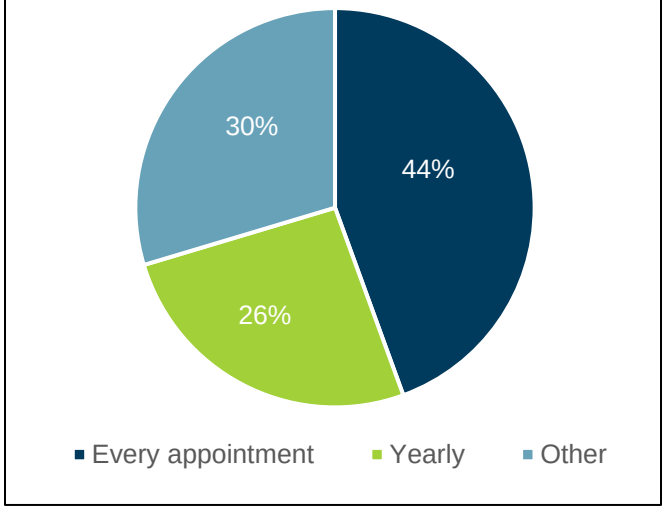
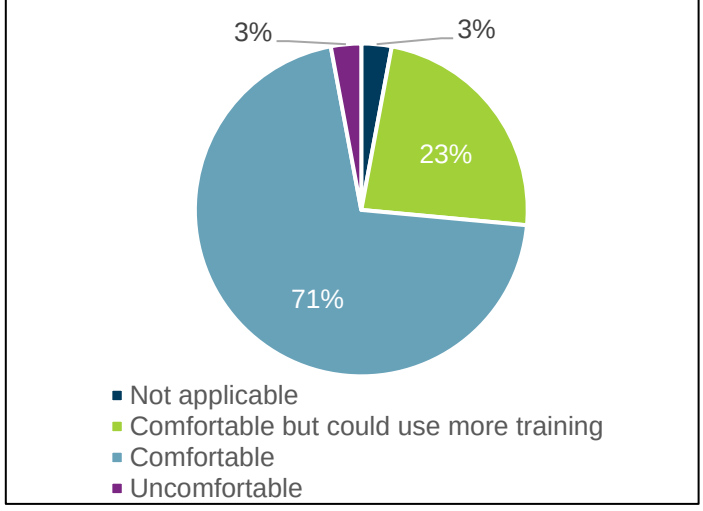


Figure 92. Provider Comfort with Taking a Patient's Sexual History

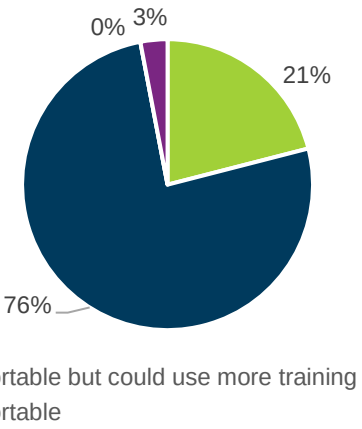


Providers were asked about their comfort level with addressing substance abuse with a patient. Of the 34 providers who responded, 76% (n=26) reported that they were comfortable, 21% (n=7) stated that they were comfortable but could use more training, and 3% (n=1) stated it was not applicable (Figure 93).

Provider Training

A total of 33 providers reported on how recently they had received training related to HCV and/or sexually transmitted diseases, including HIV. Of those who responded, 82% (n=27) stated within the last two years, 15% (n=5) reported longer than two years ago, and 3% (n=1) noted that the last training they received was in medical school/residency or another professional training program.

Figure 93. Provider Comfort with Addresssing Substance Use



Thirty-two respondents provided topics for which they would like additional training (Table 18). The most common training needs were around accessing community resources for patients living with HIV or HCV (e.g., housing) (47%), tailoring sexual health counseling and care to be more sensitive to my patient's culture and background (44%), management and treatment of HCV (41%), management and treatment of HIV (38%), HIV prevention counseling for patients who are at high risk (34%), and HCV testing and diagnosing (31%).

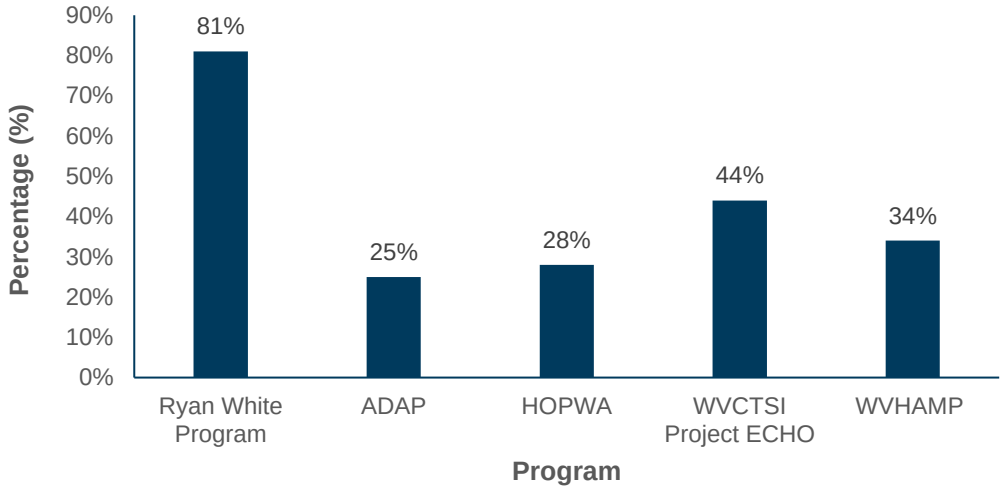
Table 18. Provider Training Needs

Training Topics	Responses	
	Percent (%)	Number (n)
Accessing community resources for patients living with HIV or HCV (e.g., housing)	47%	15
Tailoring sexual health counseling and care to be more sensitive to my patient's culture and background	44%	14
Management and treatment of HCV	41%	13
Management and treatment of HIV	38%	12
HIV prevention counseling for patients who are at high risk	34%	11
HCV testing and diagnosing	31%	10
HCV prevention counseling for patients who are at high risk	28%	9
HIV testing and diagnosing	28%	9
Prescribing PrEP	28%	9
Management, treatment, and prevention of syphilis	28%	9
Sexual health counseling in general practice	25%	8
Screening for mental health conditions	25%	8
Management, treatment, and prevention of hepatitis B	22%	7
Screening to address substance use (e.g., SBIRT)	19%	6
How to talk to patients with HIV about reducing the risk of transmission to others	16%	5
How to talk to patients with HCV about reducing the risk of transmission to others	13%	4
Taking spirituality or religion into consideration when planning treatment or counseling	13%	4
Other	9%	3

Provider Familiarity with HIV/HCV Programs in West Virginia

A total of 32 providers reported on their familiarity with the HIV/HCV programs available in West Virginia (Figure 94). Eighty-one percent (n=25) were familiar with the Ryan White program and its services. Only 25% were familiar with the ADAP. Twenty-eight percent (n=9) were familiar with HOPWA. Respondents were somewhat familiar with provider education and support programs such as WVCTSI Project ECHO HepC/HIV (44%) and WVHAMP (34%).

Figure 94. Provider Familiarity with Programs in West Virginia



Potential Limitations of the Needs Assessment Process

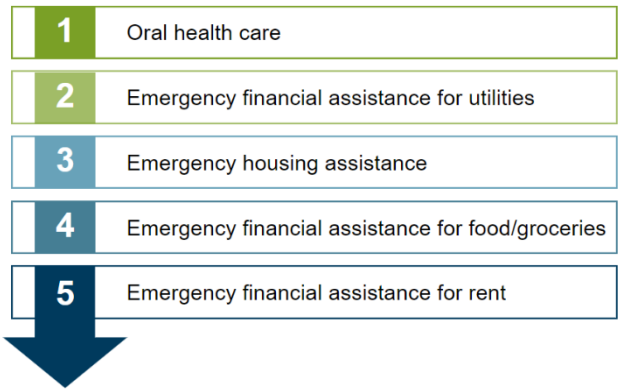
Participants were not randomly sampled for the surveys or focus groups; therefore, the results are not generalizable. All data was self-reported by participants, thus a potential for social desirability bias exists especially for questions that addressed sensitive topics such as sexual behaviors, substance use, and experiences with service providers. Despite the potential limitations of the needs assessment, the results from the surveys and focus groups provided valuable information that was used to guide the development of the Plan's goals, objectives, and strategies.

Key Findings and Priorities

Key findings and priorities emerged from the needs assessment process and are summarized below. Additional findings and priorities identified through stakeholders and providers are also discussed in more detail in Section IV: Situational Analysis.

Services people need for the social determinants of health, health care, and other support

- For all service categories, the top five unmet needs among survey respondents were reported as oral health care (28%), emergency financial assistance for utilities (22%), emergency housing assistance (19%), emergency financial assistance for food/groceries (19%), and emergency financial assistance for rent (18%). Additional unmet needs identified that impact health outcomes included medical transportation services (17%), outpatient mental health services (15%), and long-term housing (15%).



- Services addressing the social determinants of health had the most service gaps identified overall.
- While SUD services were reportedly not needed as much by PWLE survey respondents, the main unmet needs were for SUD recovery support groups and services (7%) and SUD outpatient treatment or counseling (6%).

- Non-medical case management for health insurance navigation (13%) and benefits counseling (11%) were the top unmet needs for support services among PWLE who were surveyed.
- A major need identified by PWLE focus group participants was financial resources for housing, transportation, and childcare.
- Providers surveyed expressed their primary training need as accessing community resources for patients living with HIV or HCV, such as housing resources.
- Providers reported unfamiliarity with support service programs such as ADAP and HOPWA.

Services people need to access testing

- Hospitalization and incarceration were the most common reasons that PWLE focus group participants were tested for HIV and/or HCV. Substantial needs identified were the availability of testing including more local providers and non-traditional service provision hours, and the need to address stigma, both real and perceived.
- Most PWLE focus group participants reported positive testing experiences; however, some had negative experiences. The primary reasons for these negative experiences were stigma, lack of confirmatory testing/treatment, lack of follow-up services and education on infection management, and confidentiality issues.
- Providers reported the top barrier to testing was patients declining testing, followed by patients fearing testing. Systemic barriers to testing were also cited by providers such as lack of adequate reimbursement or resources, and clinic locations.

Services people need to stay HIV negative and/or prevent HCV: PrEP, condom use, syringe services programs, and culturally competent information and education

- PWLE focus group participants noted the importance of education for patients, providers, and the public to increase awareness of available services and to reduce stigma.
- Almost 60% percent of surveyed providers reported not prescribing PrEP for the primary reasons of not having enough knowledge to prescribe and concerns about costs of PrEP.
- Infection preventionists participating in a focus group identified the following as barriers to PrEP: lack of community knowledge about at-risk populations, costs, lack of access to medical care including transportation, medical facility locations, and stigma. Infection preventionists suggested the following solutions to increase PrEP coverage: integrate PrEP education into care of patients with HCV who have ongoing risk behaviors, increasing telemedicine access, and improving access to outpatient or outreach clinics.
- Providers indicated wanting additional training in sexual health counseling and care to be more sensitive to a patient's culture and background.

Service needs for HIV and/or HCV care

- According to PWLE survey respondents, the top unmet need for HIV care was psychological support services (14%) followed by HIV drug assistance (8%), medical case management (7%), referral for services (7%), and medical case management for treatment adherence (6%).
- PWLE survey respondents reported higher levels of unmet needs for HCV care with notable service gaps (20% or more) for HCV drug assistance (31%), medical case management: treatment adherence (25%), hepatitis-related medical care (25%), and medical case management (22%).
- Substantial needs identified by PWLE focus group participants were the availability of medical care including more qualified local providers and non-traditional service provision hours and the need to address stigma, both real and perceived.
- PWLE focus group participants identified five main barriers to accessing HIV and/or HCV care: lack of education on available services; financial needs (i.e., housing, transportation, childcare, cost of services and treatment); program and/or insurance rules requiring sobriety; need for treatment approval by infectious disease specialists; inconvenient provider office hours; and stigma.
- Adverse care experiences reported by PWLE focus group participants were attributed to negative provider attitudes, lack of confidentiality, stigma, misinformation, and not receiving promised services.

- Regarding persons retained in care, PWLE focus group participants listed the most important service needs as access to local providers, access to long acting injectables, caring and nonjudgmental staff, providers closer to home, convenient hours, reducing stigma among providers, peer support, shorter wait periods, and financial support (i.e., housing, transportation). Infection preventionists participating in focus groups identified several of these as solutions to overcome barriers to treatment.
- Participants of all ages reported the overwhelming fear of stigma as a continual barrier to accessing care and services.
- PWLE noted the importance of education for patients, providers, and the public to increase awareness of available treatment and reduce stigma.
- Providers surveyed listed limited telemedicine access, lack of specialist support and lack of sufficient knowledge or competence to provide care.

Actions Taken

The findings from the needs assessment process were reviewed by BPH and with the Steering Committee. The findings and priorities were used to inform the development of Section IV: Situational Analysis and Section V: 2022-2026 Goals and Objectives.

Section IV: Situational Analysis

Who was involved?

- BPH developed an updated epidemiologic profile, administered surveys to persons at risk and with lived experience and service providers, and conducted two focus groups with infection preventionists.
- Ryan White Part B and Part C Programs conducted a total of 13 focus groups with persons with lived experience.
- Stakeholders engaged in a series of facilitated discussions organized by pillar to identify the strengths, needs/gaps (weaknesses), opportunities, and barriers (threats).

What did the process look like?

- A Strengths/Weaknesses/Opportunities/Threats (SWOT) analysis was completed for each pillar based on the mind maps created as a result on the facilitated stakeholder discussions, the focus groups, and two surveys.
- The need for new partners and voices were identified through the stakeholder discussions.
- Four priority populations were determined beyond all persons at high risk or living with HIV and/or HCV.

What are the next steps?

- The Subcommittee Task Forces will utilize the situational analysis to understand the system's strengths, study opportunities, pinpoint weaknesses, and identify threats that should be considered throughout the planning process.
- The SWOT analysis provides the foundation for the proposed strategies in Section IV.

DHHR's BPH) is the lead agency for HIV and HCV prevention and care services in the state. BPH's Division of STD, HIV, Hepatitis and Tuberculosis (DSHHT) provides surveillance, intervention, testing, education, and care to prevent and control the spread of disease in West Virginia. DSHHT also supports the West Virginia HIV Advisory and Planning Group and the Hepatitis Elimination Technical Advisory Group who serve as the planning/advisory bodies and ensure decisions are in the best interest of people receiving HIV and/or HCV

Figure 95. Level of Stakeholder Impact

prevention and care services. Using a collective impact approach, the Plan has a shared governance structure that combines the efforts of both planning/advisory bodies and other key partners to eliminate HIV and HCV across the state and encourages the leveraging of strengths, opportunities, and strategies to address service needs, gaps, and barriers. The five-year planning period for West Virginia kicked off in January 2022 with 214 stakeholders engaged at various levels. Among engaged stakeholders, 57% currently participate at the leading and supporting levels, the two highest levels of assessed engagement. While most stakeholders do not have relative power or authority over the planning process, approximately two-thirds of stakeholders have a high level of potential impact, which suggests the engaged stakeholders can implement the Plan and create change.

West Virginia had a total population of 1.79 million in 2020 and is home to 2,207 people living with HIV and has consistently had one of the highest rates of hepatitis C in the nation. The state is mostly rural, with 32 of the 55 counties considered rural, and most of the state falls within a HPSA and MUA with rural areas greatly impacted by reduced access to care. Limited access to care can significantly impact early HIV diagnosis, treatment, retention in care, and sustained viral suppression. Additionally, the state has a lower median household income, lower rate for higher education attainment, and lower employment rate compared to the rest of the country.

HIV currently most affects the PWID population with 72% of new cases in 2020 occurring in that group; however, the largest number of individuals living with diagnosed HIV remains the men who have sex with men population. HIV incidence in West Virginia increased 103% between 2016 and 2020, and currently two large outbreaks affecting over 300 PWID are ongoing.

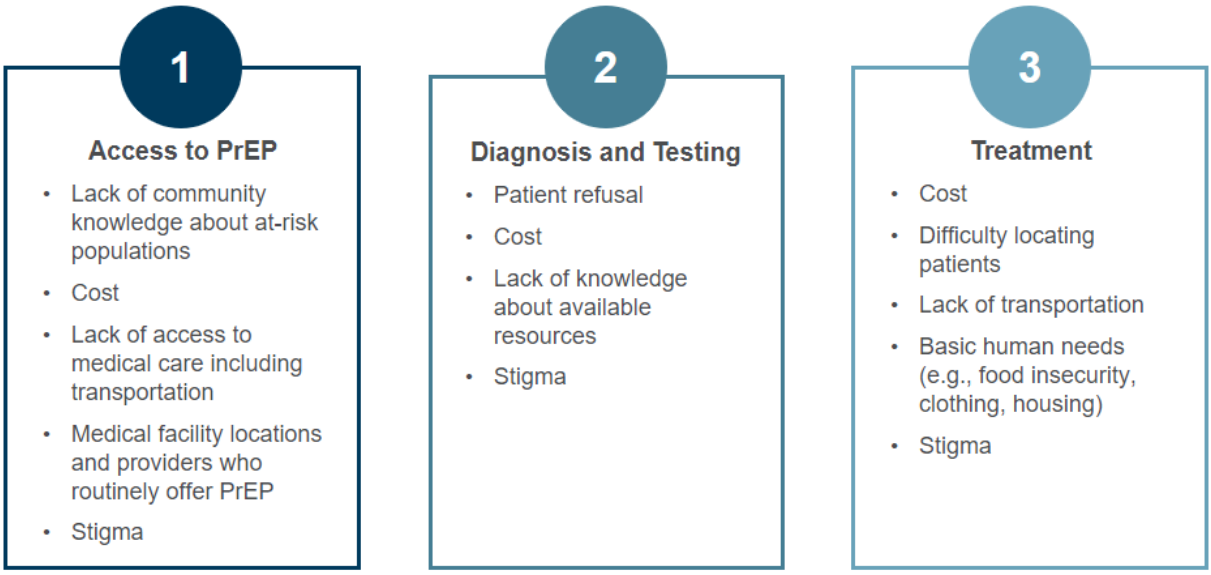
West Virginia has consistently had lower retention in care rates compared to those of the United States. This is due, in part, to practices of HIV care providers in the state who typically only see stable, virally suppressed individuals on an annual basis. The metric used to assess retention in care requires two care visits in a 12-month period. In West Virginia, barriers to care and treatment include biases, stigma, discrimination, lack of service providers, distance to existing providers and transportation issues, housing instability, lack of awareness about programs and treatment resources, and long wait times.

The state has one of the highest incidence rates of acute HCV in the nation with 7.6 out of every 100,000 individuals having acquired HCV and 137 new cases being reported in 2020. The primary risk factors reported among individuals with acute HCV during 2020 were injection and non-injection drug use. A total of 3,872 cases of chronic HCV infection were reported in 2020.

Among 191 PWLE and those at risk who were surveyed in October 2022, the greatest unmet needs identified were oral health care and emergency assistance with utilities, housing/rent, and food/groceries. Oral health care had the largest service gap for health care needs and all service needs in general. The top unmet need for HIV care was psychological support services followed by HIV drug assistance, medical case management, referral for services, and medical case management for treatment adherence. Respondents reported higher levels of unmet needs for HCV care with significant service gaps for HCV drug assistance, medical case management for treatment adherence, hepatitis related medical care, and medical case management. Although there were similarities of the types of services with significant gaps among those living with HIV and HCV, respondents living with HCV reported higher levels of unmet need pertaining to these services. This is related to the availability of dedicated funding for the treatment and care of people living with HIV through the Ryan White Care Act. Psychosocial support services were identified as a priority service gap for both populations.

Thirteen focus groups conducted with PWLE emphasized the need to address stigma, enhanced access to testing and care, education at the patient, provider, and public levels, confidentiality and trust, and peer support. BPH's DSHHT conducted two focus group sessions with 10 infection preventionists from multiple locations of a large healthcare system to assess barriers to HIV and/or HCV testing and treatment and obtain information on intervention strategies currently utilized to improve outcomes. The participants identified barriers to three HIV and/or HCV prevention and care services – access to PrEP, diagnosis and testing, and treatment (Figure 96).

Figure 96. Barriers to HIV and/or HCV Prevention and Care Services



Participants identified interventions that could address these barriers and improve health outcomes. Proposed interventions included increasing access to telemedicine, improving access to outpatient or outreach clinics, integrating PrEP education into care of patients living with HCV, implementing universal screening, automating EHRs to include testing prompts, offering provider education, establishing a crisis line for patients, utilizing peer recovery coaches, increasing housing assistance, expanding access of EHR systems to public health, promoting WVHAMP and WVCTSI Project ECHO to healthcare providers especially in rural areas, mandating trauma-informed training, and offering provider training on stigma reduction.

The *2022 Provider Prevention and Care Survey for West Virginia HIV and HCV Elimination Plan* conducted in October 2022 with 53 providers identified the following barriers to HIV and HCV care:

- Providers reported patients declining the offer to test as the top barrier to testing for HIV and HCV (72%) followed by patients being afraid (47%).
- Provider experience, knowledge, and confidence in HIV and/or HCV care are barriers.
- Almost 60% of providers reported not prescribing PrEP with primary reasons being not having enough knowledge to prescribe and concerns about the cost.
- Systemic barriers to providing HIV and/or HCV care were reported by 44% of providers with the top barriers being lack of adequate reimbursement or resources (44%), lack of specialist support (38%), clinic location (31%), and lack of sufficient knowledge or confidence to provide care (31%).
- While 41% of providers reported having telemedicine access to HIV and/or HCV experts, 37% reported no access and 22% were unsure.
- Providers reported the top five needs as accessing community resources for patients living with HIV or HCV such as housing (47%), tailoring sexual health counseling and care to be more sensitive to a patient's culture and background (44%), management and treatment of HCV (41%), management and treatment of HIV (38%), and HIV prevention counseling for patients who are at high risk (34%).
- Providers reported low levels of familiarity with ADAP (25%), HOPWA (28%), WVHAMP (34%), and WVCTSI Project ECHO HepC/HIV (44%).

Situational Analysis

A Strengths/Weaknesses/Opportunities/Threats (SWOT) analysis was completed for each pillar area to determine the best way to achieve Plan success and desired improvements along the care continuum. Stakeholders engaged in a series of facilitated discussions organized by pillar area or Subcommittee (e.g., Prevent, Diagnose, Treat, and Respond) to identify the strengths, needs/gaps (weaknesses), opportunities, and barriers (threats) across West Virginia HIV and/or HCV prevention and care activities. These conversations resulted in the creation of mind maps to provide a structured way to capture and organize the information. From these mind maps and a review of the data and focus group findings, a SWOT analysis grid organized by the identified priority areas was developed for each pillar. The SWOT analysis grids will allow the Subcommittees to understand the system's strengths, study opportunities, pinpoint weaknesses, and identify threats that should be considered throughout the planning process.

Based on the SWOT analysis, partnerships and engagement should be expanded to local pharmacies, corrections, community-based organizations (CBOs), faith-based organizations (FBOs), state health associations, healthcare system/facility administrators, and emergency department staff for successful implementation of the Plan. These new partners and voices are included in the Plan, and the Subcommittee Task Forces will continue to develop a strategic approach for outreach and engagement during the planning period.

Pillar 1: Prevent

The mission of the Prevent pillar or subcommittee is to prevent new HIV and HCV transmission by using proven interventions. Over the course of three meetings, 18 stakeholders and partners worked to identify strengths, needs/gaps (weaknesses), opportunities, and barriers/limitations (threats) to prevention and care in West Virginia.

STRENGTHS

- **Access to Care**
  Mobile services; Quick Response Team (QRT) program; Peer Recovery Support Specialists (PRSS)
- **Education**
  Community level
- **Quality of Care**
  Dedicated professionals; passion for the work
- **Programs and Partnerships**
  Ryan White programs; existing collaborations; programs that fit client needs
- **Other**
  Advocacy; innovation and creativity; connection and trust

WEAKNESSES

- **Gaps in Access to Care**
  Limited access to PrEP in rural areas; PrEP education and resources; transportation; testing in rural areas; inconvenient locations and times; lack of providers; need for expanded services and mobile blood work; accessibility; lack of communication between service providers
- **Educational Needs**
  Client, community, and provider education needs; need for trauma-informed education; stigma-free care; access to provider mentoring program
- **Quality of Care Needs**
  Stigma free; trauma informed; peer support; specialized care for infectious disease; provider capacity and attitudes; staffing levels; need for confidentiality
- **Resource Gaps**
  Housing; naloxone; support services; behavioral and mental health resources; state identification card; outreach
- **Gaps in Programs and Partnerships**
  Advocacy; policy; confidentiality among partners; syringe services programs; community service groups; harm reduction program

OPPORTUNITIES

- **Access to Care**
  Increased testing sites; use of social media; low cost; convenient locations; accessibility; outreach and service promotion; transportation
- **Education**
  Use of social media and dating apps; messaging; community and provider education; provider mentoring
- **Quality of Care**
  Recovery care; community collaboration; case management
- **Resources**
  Funding; housing; policy; community buy-in; distribute information via pamphlets
- **Programs and Partnerships**
  Syringe services programs; data sharing; provider mentoring; testing at local pharmacies; expanded pharmacy partnership

THREATS

- **Limitations to Access to Care**
  Lack of services and providers; transportation; inconvenient times; dual diagnoses; lack of mobile care; limited testing; distance to providers
- **Educational Limitations**
  Insufficient education at the client, provider, and community levels; school policy and state law
- **Limitations to Quality of Care**
  Lack of standardized care; distrust; stigma; need for trauma-informed approach to care
- **Resource Limitations**
  Lack of or unstable housing; medication storage; finances; need for harm reduction; other basic needs
- **Other Limitations**
  Politics; fear of police

Pillar 2: Diagnose

The mission of the Diagnose pillar or subcommittee is to diagnose all persons with HIV and/or HCV as early as possible. A total of 27 stakeholders and partners held discussions over three meetings and worked to identify strengths, needs/gaps (weaknesses), opportunities, and barriers/limitations (threats) within the service system across the state.

STRENGTHS

- **Access to Care**
  Existing services; affordable testing; workforce; Ryan White programs; people who want to be tested
- **Education**
  Community level
- **Quality of Care**
  Communication; dedicated professionals; passion for the work
- **Programs and Partnerships**
  Current harm reduction programs; WV Health Information Network; WVCTSI Project ECHO; community trust; existing collaborations; utilization of peer support
- **Other**
  Grant management; Medicaid expansion; innovation and creativity; state lab services; testing in non-traditional settings

WEAKNESSES

- **Gaps in Access to Care**
  Cost; transportation; need for opt-out testing and universal screening; lack of providers and services; integrated care; point of care testing; accessibility; expansion of routine testing; internet access; workforce
- **Educational Needs**
  Client, community, and provider levels; address stigma; community messaging
- **Quality of Care Needs**
  Trauma informed care; care navigation; foster trust; confirmatory and complete testing; utilization; EHR integration; standardization of testing; knowledgeable and up-to-date care; address stigma; provider attitudes; service coordination and linkages; long wait times; need for confidentiality
- **Resource Gaps**
  Housing; support services; testing awareness; funding
- **Gaps in Programs and Partnerships**
  Syringe services programs; collaboration/support; community health workers; societal inclusion; state and community support; local health departments

OPPORTUNITIES

- **Access to Care**
  Point of care testing; transportation; expanded services; low cost and incentives; mobile services and backpack testing; accessibility; increased locations
- **Education**
  Use of social media; workforce training; provider and community education; messaging
- **Quality of Care**
  Maintenance of care; anti-stigma education; provider understanding
- **Resources**
  Funding; point of care testing; syringe services programs; grant management; new ideas and policies; leverage opioid settlement
- **Programs and Partnerships**
  Syringe services programs; relationships and community support

THREATS

- **Limitations to Access to Care**
  Lack of providers and services; transportation; time and location; rapid testing for hepatitis; lack of syringe services programs; cost; active substance use
- **Educational Limitations**
  Insufficient education at the client and community levels; stigma; need to educate policymakers; workforce training
- **Limitations to Quality of Care**
  Distrust; stigma; negative experiences; provider attitudes; need for trauma-informed care; lack of confidentiality
- **Resource Limitations**
  Lack of or unstable housing; funding; finances; other basic needs
- **Limitations to Programs and Partnerships**
  Syringe services programs; community support
- **Other Limitations**
  Politics; fear of police

Pillar 3: Treat

The mission of the Treat pillar or subcommittee is to treat all people with HIV and/or HCV rapidly and effectively. Sixteen stakeholders and partners met over the course of three weeks and held discussions to identify strengths, needs/gaps (weaknesses), opportunities, and barriers/limitations (threats) within the prevention and care system across the state.

STRENGTHS

- **Access to Care**
  Existing services; Medicaid expansion; Ryan White programs; telemedicine; patient advocacy
- **Education**
  WVCTSI Project ECHO; WVHAMP; MAAETC
- **Quality of Care**
  Dedicated professionals
- **Programs and Partnerships**
  Resiliency; existing collaborations
- **Other**
  Innovation; COVID-19 resilience; financial assistance (i.e., transportation, housing)

WEAKNESSES

- **Gaps in Access to Care**
  Models of care; insurance coverage (low barrier/restrictions); transportation; providers and expanded services; state identification cards; Medicaid benefits; use of technology; accessibility; barriers to HCV medications; integrated care; transitional living; inconvenient times and locations
- **Educational Needs**
  Stigma; education needs with clients, at-risk individuals, special populations, communities, policymakers, first responders, and the workforce
- **Quality of Care Needs**
  Hope, compassion, and empathy; knowledgeable providers; cultural competence; stigma-free; quality metrics; provider education; continuity of care; address long wait times; provider attitudes; need for confidentiality; lack of follow-up services
- **Resource Gaps**
  Housing; funding; accessibility; range of workforce; transportation; WV not part of the Ending HIV Epidemic initiative; jobs; peer/field support (e.g., community health workers, peer recovery coaches)
- **Gaps in Programs and Partnerships**
  Syringe services programs; child protective services; corrections; emergency services and first responders; QRT programs; perinatal partnership; ACA specialists and pharmacies; community support

OPPORTUNITIES

- **Access to Care**
  Transitional living; integrated care; transportation; first responders and emergency department engagement; expanded services; corrections; low cost; incentives; telemedicine; accessibility
- **Education**
  Education for providers, clients, and public
- **Quality of Care**
  Quality metrics; support services; reduce stigma; case management; long acting injectables
- **Resources**
  Funding; transitional living; first responder and emergency department engagement; National Ending the HIV Epidemic program; peer support; housing and transportation support
- **Programs and Partnerships**
  Collaboration and engagement; community support; corrections; data sharing agreements

THREATS

- **Limitations to Access to Care**
  Lack of providers and services; transportation; access to housing; healthcare administration; broadband access; limited locations; models of care; cost and insurance; state regulations; substance use disorders; service delivery models; need for healthcare navigators
- **Educational Limitations**
  Needs at the client and provider levels; address stigma
- **Limitations to Quality of Care**
  Provider time with patients; clinical models; providers not rescheduling missed appointment; lack of confidentiality; fear of stigma
- **Resource Limitations**
  Lack of or unstable housing; inconsistent access to broadband; lack of healthcare navigators; basic needs
- **Limitations to Programs and Partnerships**
  Lack of support services; inter-bureau collaboration and provider relations; state health associations

Pillar 4: Respond

The mission of the Respond pillar or subcommittee is to respond quickly to potential outbreaks to get needed prevention and treatment services to people who need them. Over the course of three meetings, 18 stakeholders and partners held discussions and identified strengths, needs/gaps (weaknesses), opportunities, and barriers/limitations (threats) in West Virginia.

STRENGTHS

- **Access to Care**
  Existing services; Medicaid expansion; Ryan White programs; telemedicine; HOPWA; dedicated staff; removal of Medicaid treatment requirements
- **Education**
  WVCTSI Project ECHO; WVHAMP; MAAETC; rural areas and diverse populations
- **Quality of Care**
  Dedicated professionals; transparent communication; passion; compassion and personal connections
- **Programs and Partnerships**
  Existing collaborations; syringe services programs
- **Other**
  Innovation; attention to overlooked populations

WEAKNESSES

- **Gaps in Access to Care**
  Transportation; need for providers and expanded services; mobile units; more community health workers; use of technology; accessibility; inconvenient locations; integrated care (one stop shop)
- **Educational Needs**
  Address stigma; education needs at the client, provider, school, and community-at-large levels; communication plan for outbreaks; targeted messaging
- **Quality of Care Needs**
  Stigma-free; empathy; provider education; accountability; compassion; dedicated program staff; provider attitudes; lack of confidentiality
- **Resource Gaps**
  Access to housing and transportation; grant funding; community health workers; marketing; data availability; unrestricted funds, connections to local resources; additional state funds; community-level resources lost; state executive support
- **Gaps in Programs and Partnerships**
  Syringe services programs; transparency; data; support groups and systems; community buy-in

OPPORTUNITIES

- **Access to Care**
  Transportation; mental health services; expanded services; incentives; technology; accessibility
- **Education**
  Education at the provider, policymaker, and community levels; Project ECHO; syringe services program education; community leaders and influencers; use of television, radio, and social media
- **Quality of Care**
  Reduce stigma; mental hygiene commission warrants; awareness of resources; compassion
- **Resources**
  Funding; food and housing; expand provider/administrator education; voting
- **Programs and Partnerships**
  Change narrative around syringe services programs; mental health warrants; community support; public health staffing

THREATS

- **Limitations to Access to Care**
  Lack of services; transportation; previous experiences; locations and times; cost and insurance; broadband internet access
- **Educational Limitations**
  Stigma; fear; client knowledge
- **Limitations to Quality of Care**
  Trust; trained and informed providers; stigma; lack of compassion; trauma-informed care; lack of confidentiality
- **Resource Limitations**
  Lack of or unstable housing; funding; support systems; WV geography; advocacy; policymakers; trust
- **Other Limitations**
  Self-efficacy; hopelessness

Priority Populations

During the planning process, four priority populations emerged in addition to all persons living with HIV and/or HCV and those at high risk within the state: (1) persons with substance use disorder, (2) people who live in rural areas, (3) persons who are incarcerated, and (4) persons who are pregnant. The goals, objectives, and strategies described in Section V: 2022-2026 Goals and Objectives reflect West Virginia's effort to meet people where they are and expand prevention and care services to these populations. The SWOT analysis lays the foundation for the proposed strategies, which include client and community education, provider training and mentorship, partnerships with local organizations and prevention coalitions, mobile outreach, testing in behavioral health and correctional settings, testing in non-traditional settings, screening conducted by prenatal care providers, integrated care adoption, and local health response planning.

Section V: 2022 – 2026 Goals and Objectives

How were goals determined?

- The subcommittees developed goals that address the four pillars and align with the NHAS.

How were objectives selected?

- Objectives were drafted by the subcommittees and presented to the Steering Committee for consideration.
- Subcommittee chairpersons and BPH staff worked together to finalize the objectives, which were presented to the subcommittee members for approval.

How were strategies identified?

- The subcommittees determined the best approaches or strategies needed to achieve the stated objectives.
- Activities or action steps are outlined for all strategies.

What are the Plan highlights?

- A total of 13 key performance indicators (KPIs) will be used to measure improvements across the care continuum.
- Process measures are identified for all strategies and activities and will support monitoring efforts.

The Plan aims to reduce the burden of HIV and HCV in West Virginia and serves as a commitment to collaboration, best practices, and innovation among stakeholders and key partners, while also responding to the needs of people living with HIV and/or HCV as well as those at risk.

The Plan addresses the four pillars—Prevent, Diagnose, Treat, and Respond—which align with the NHAS, with each pillar having three goals. Each goal has at least one objective that reflects the desired results to be achieved. Each objective has at least one strategy or approach through which the objectives will be achieved. Specific activities are detailed for each strategy and provide action steps for the subcommittees and partners to accomplish the objectives. Key audiences, responsible parties, time frames, partners and resources, and process measures are identified for each activity and are defined as:

- **Key Audience:** Who should this impact?
- **Responsible Parties:** Who will do this or make it happen?
- **Time Frame:** When will this happen?
- **Partners and Resources:** What do we need to make this happen?
- **Process Measures:** How will we measure this?

A list of acronyms used in the Plan can be found in Appendix A. For monitoring progress and implementation of the Plan, Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up details how KPIs, strategies, and activities will be monitored and evaluated over the course of the planning period.

KPIs

A total of 13 KPIs have been identified for the Plan. These KPIs align with the goals and objectives and will be used to measure improvements across the care continuum during the planning period. BPH will continue to develop KPIs for the Respond pillar (Figure 97 and 98).

Figure 97. KPIs for HIV Prevention and Care

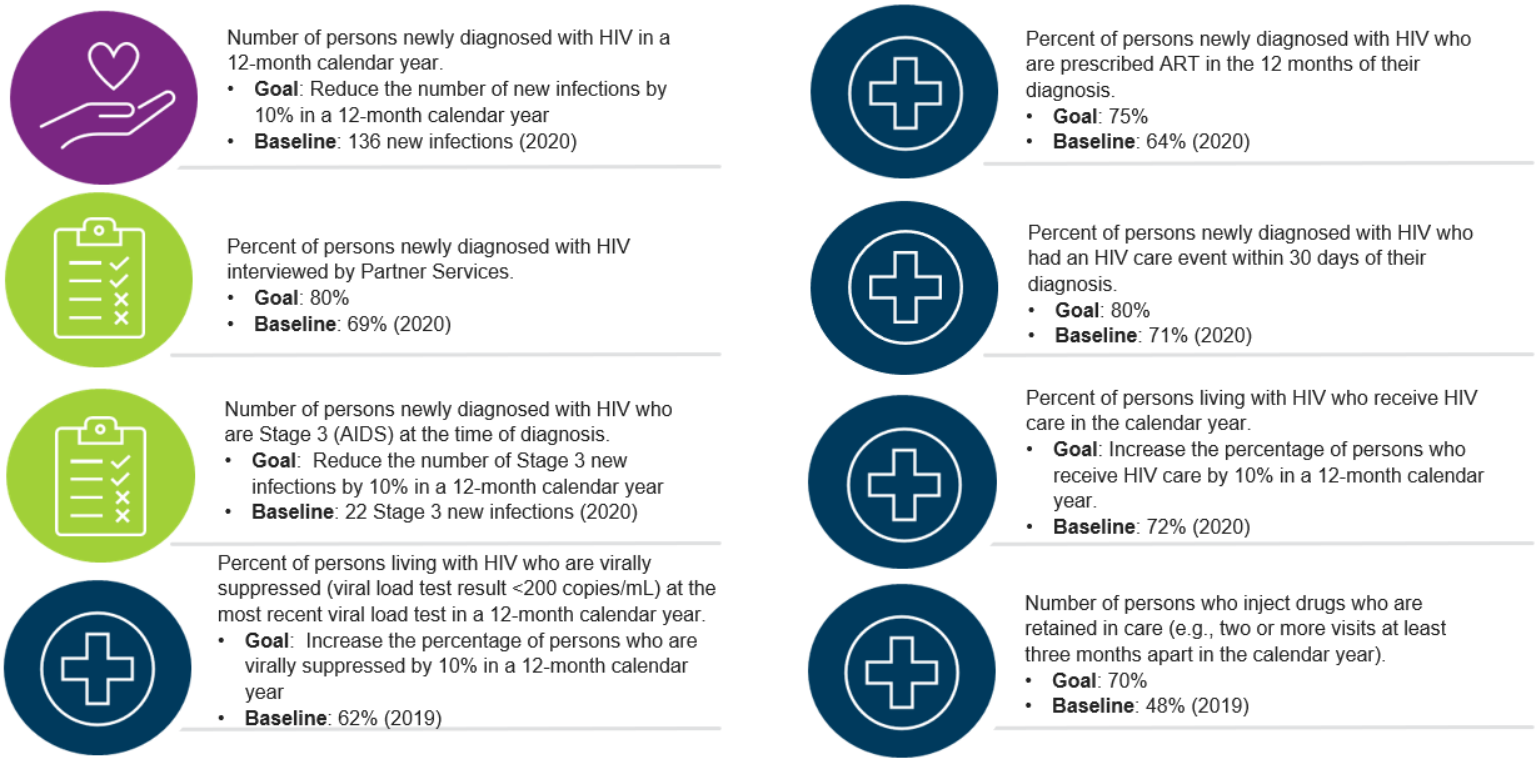
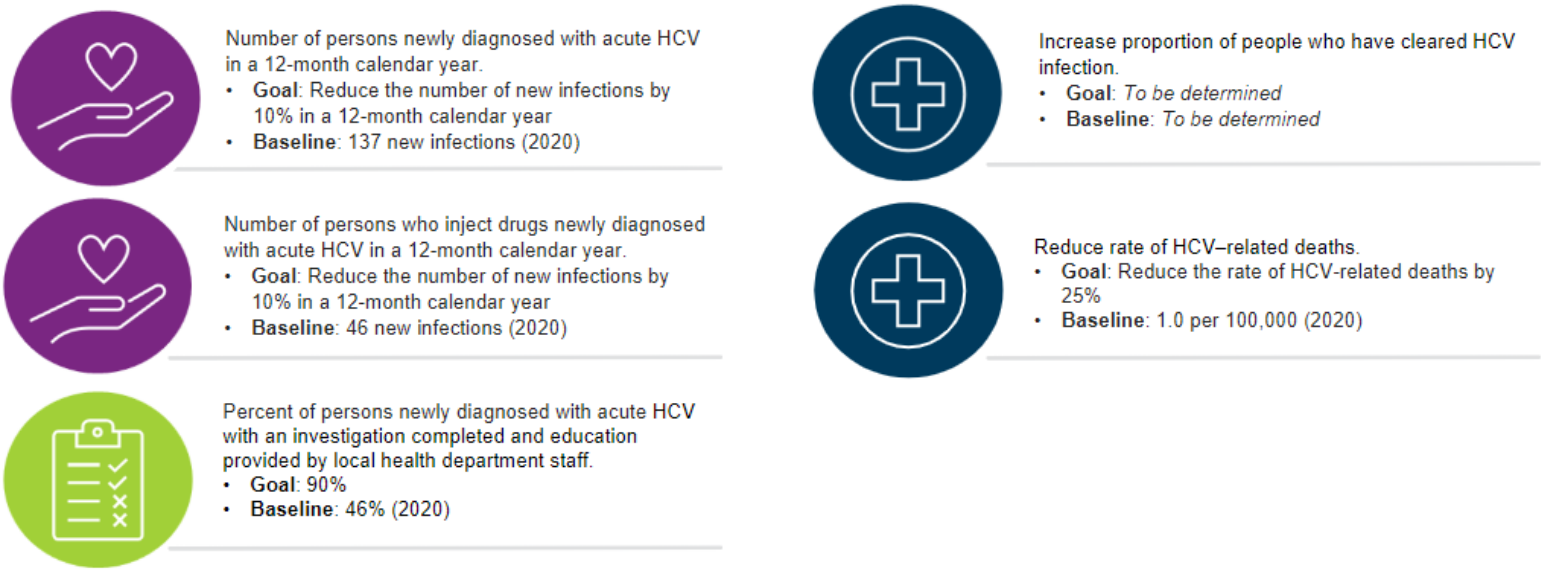


Figure 98. KPIs for HCV Prevention and Care



Goals, Objectives, and Strategies

The goals, objectives, and strategies presented below were developed through a community engagement process that involved PWLE and stakeholders. They are organized by the four pillars and were informed by the key findings from the epidemiologic snapshot, resource inventory, needs assessment, and situational analysis. A more detailed action plan that addresses activities, key audiences, responsible parties, time frames, partners and resources, and process measures for each strategy can be found in Appendix F.

PREVENT Goal 1: Increase access to and utilization of HIV PrEP therapy

Objective 1.1: Integrate PrEP therapy into clinical workflow

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
1.1.A Achieve EHR systems change through integration of a PrEP prompt to identify people at risk and offer PrEP consultation	Identify a willing and able health system, FQHC, or clinic	Health systems; FQHCs; clinics	Prevent Task Force	Year 2	BPH; WVPCA	• Number of health systems or clinics planning an EHR system change • Number of health systems or clinics successfully implementing an EHR system change with a PrEP prompt
	Identify provider groups or teams willing to integrate a PrEP prompt into EHR system			Year 2 and ongoing	BPH; WVPCA	
	Assess feasibility of adding prompt to EHR system			Year 3	WVPCA; WVHA	
	Plan and implement EHR system change			Year 3 and ongoing	WVPCA; WVHA	
	Evaluate for barriers and effectiveness with the EHR system change and process			Year 4 and ongoing		
1.1.B Develop and implement a systematic approach to delivering PrEP in the field	Research existing and successful models for PrEP delivery in the field	N/A	BPH	Year 1	MAAETC	• Number of materials developed and shared in field settings • Number of trainings offered • Number of people trained
	Develop and share template for PrEP standing order for field outreach	HRPs; CBOs; social services providers	BPH	Year 2	MAAETC	
	Identify and develop strategies to address barriers to accessing laboratory services and associated PrEP costs for people who are uninsured or under-insured	Behavioral health providers; HRPs; SUD treatment facilities	Prevent Task Force	Year 3	BMS; BBH	

	Offer training on PrEP service delivery in the field that addresses cultural competency		BPH; MAAETC	Year 4 and ongoing	MAAETC	

PREVENT Goal 1: Increase access to and utilization of HIV PrEP therapy

Objective 1.2: Increase the number of providers trained in and prescribing PrEP

Strategy	Key Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
1.2.A Offer PrEP 101 training that addresses cultural competency and implicit bias	Develop a marketing plan for defined audiences	Existing and potential PrEP providers; LHDs; FQHCs; 8 free clinics; QRTs; MAT centers; HRP/SSPs	Prevent Task Force	Year 1	MAAETC; WVCTSI Project ECHO; WVHAMP; BPH; PRSS; DHHR Communications	• Number of training sessions conducted • Number of people receiving PrEP 101 training • Number of people receiving post-training consultation
	Offer on-demand training sessions		MAAETC	Year 1 and ongoing		
	Provide access to a consultant for post-training support and coaching		MAAETC	Year 1 and ongoing		
	Identify and promote available resources to support providers (e.g., National PrEP line)		Prevent Task Force	Year 1 and ongoing		
1.2.B Conduct post-training follow-up with providers to monitor prescribing behaviors	Design follow-up tool or approach	Providers who received PrEP 101 training	MAAETC	Year 2	MAAETC; WVCTSI Project ECHO; WVHAMP; BPH; PRSS	• Number of providers who report prescribing PrEP • Number of provider follow-up sessions conducted
	Conduct routine follow-up through multiple touch points at regular intervals		MAAETC	Year 2 and ongoing		
	Identify barriers to prescribing through multiple channels		MAAETC	Year 2 and ongoing		
	Develop a plan to address identified barriers and provide resources and tools		MAAETC; BPH; Prevent Task Force	Year 3 and ongoing		

1.2.C Identify PrEP champion to present at Grand Rounds and other venues	Identify audiences	Existing and potential PrEP providers; LHDs; FQHCs; free clinics; QRTs; MAT centers; HRP/SSPs	MAAETC; BPH; Prevent Task Force	Year 1	BPH; WVHAMP; WV HIVAMP; WVCTSI Project ECHO	• Number of champions recruited • Number of presentations conducted by PrEP champions
	Identify PrEP champions			Year 1 and ongoing		
	Conduct outreach and recruitment of champions			Year 2 and ongoing		
	Identify and/or coordinate presentation opportunities		Identified PrEP champions	Year 2 and ongoing		

PREVENT Goal 1: Increase access to and utilization of HIV PrEP therapy

Objective 1.3: Increase community awareness of PrEP availability and utilization

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
1.3.A Develop and disseminate a PrEP marketing and educational campaign	Create and/or adapt existing CDC educational materials for a PrEP Promise campaign	West Virginia citizens; people living in communities of high risk	BPH; Prevent Task Force	Year 1	CEG; CBOs; FBOs; DHHR Communications	• Number of educational campaigns created
	Identify and recruit potential community partners to collaborate on campaign implementation	Community partners (e.g., pharmacies, healthcare provider offices, CHWs, CBOs)		Year 1		• Number of partners recruited
	Distribute campaign materials through community partner channels	West Virginia citizens; people living in communities of high risk	CEG; CBOs; FBOs	Year 2	BPH	• Number of campaign materials distributed • Number of communities participating in campaign

PREVENT Goal 2: Increase access to and utilization of syringe services programs						
Objective 2.1: Increase the number of syringe services providers						
Strategy	**Activities**	**Key Audiences**	**Responsible Parties**	**Time Frame**	**Partners and Resources**	**Process Measures**
2.1.A Implement a communication strategy to improve community understanding and support	Review other states' educational approaches	Community leaders and policymakers; first responders; law enforcement	Prevent Task Force	Year 1	BPH; Hope in Action Alliance; WVDII; CEG; LHDs; BBH; OHFLAC; DHHR Communications	• Number of communication plans developed
	Identify audiences for educational campaign (e.g., first responders, law enforcement)			Year 1		
	Identify key messages and appropriate communication channels for each audience			Year 1		
	Develop a communication plan and related support materials			Year 2		
	Design educational materials tailored for local governments			Year 2		
2.1.B Disseminate an implementation/ licensing toolkit for potential service providers	Compile an SSP toolkit from existing information and materials	Potential service providers	BPH	Year 1	LHDs; BBH; OHFLAC; HRPs	• Number of toolkits developed • Number of toolkits disseminated • Number of new service providers receiving mentorship
	Incorporate key messages to address misinformation and stigma		BPH	Year 1 and ongoing		
	Promote availability and disseminate toolkit		BPH	Year 2 and ongoing		
	Offer mentorship from existing SSPs		Existing SSPs	Year 3 and ongoing		

PREVENT Goal 2: Increase access to and utilization of syringe services programs

Objective 2.2: Increase the number of SSPs offering mobile services

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
2.2.A Determine the feasibility, cost, and readiness related to offering mobile services and expanding mobile outreach efforts	Design an assessment approach	Existing and potential service providers	BPH; HRPs; LHDs	Year 1	HRP advisory councils; BBH; OHFLAC	• Number of assessments completed with HRP advisory councils • Report with findings, results, and recommendations produced
	Assess feasibility and readiness of mobile services through quarterly HRP advisory council meetings			Year 1	CAMC Ryan White Clinic; BBH	
	Identify strengths, weaknesses, opportunities, threats, and barriers and share findings			Year 2		
	Identify next steps and recommendations			Year 2		
2.2.B Expand mobile outreach with existing service providers	Assess readiness and willingness of existing SSPs to implement mobile services	West Virginia communities; existing service providers; community leaders	BPH	Year 3	HRPs; LHDs; Hope in Action Alliance	• Number of assessments completed with existing SSPs • Number of assessments completed to measure local buy-in • Number of expansion commitments with existing SSPs • Number of existing SSPs offering mobile services
	Assess municipal and community buy-in for expansion		BPH; HRPs; LHDs	Year 3		
	Determine tools and resources needed (e.g., vans, syringes)			Year 3 and ongoing		
	Obtain commitment to expansion from existing SSPs			Year 4 and ongoing		

2.2.C Offer mobile outreach training to potential service providers in collaboration with SSP champions	Identify and recruit SSP champions	Potential service providers	Prevent Task Force	Year 3	HRP advisory councils; BBH; OHFLAC	• Number of champions recruited • Amount of training curricula developed • Number of training sessions conducted • Number of potential service providers trained • Number of requests for assistance with policy and procedure development • Number of new service providers offering mobile outreach
	Develop training curricula that is adaptable to local needs and context			Year 3	SSPs; LHDs	
	Deliver training curricula in collaboration with SSP champions			Year 4 and ongoing		
	Provide technical assistance (TA) for development of policies and procedures for mobile services			Year 4 and ongoing		

PREVENT Goal 3: Increase understanding of proven HIV and HCV prevention approaches

Objective 3.1: Increase the number of healthcare providers who receive education on proven HIV and HCV prevention best practices

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
3.1.A Offer training on HIV and HCV prevention best practices to healthcare providers	Expand marketing and outreach plan to reach more providers and develop materials as needed	Healthcare providers	MAAETC	Year 1	State health profession societies; WVRHA; BPH Office of Rural Health; BBH; DHHR Communications; FQHCs; free clinics	• Number of trainings offered • Number of providers trained in proven HIV and HCV prevention best practices
	Use breakout sessions at annual healthcare profession conferences to deliver training			Year 1 and ongoing		
3.1.B	Design follow-up tool or approach	Healthcare providers who	MAAETC	Year 2	BPH	

Conduct post-training follow-up to monitor additional needs and implementation status of prevention best practices	Conduct routine follow-up through multiple touch points at regular intervals	receive prevention training		Year 3 and ongoing		• Number of providers who report implementing at least one prevention best practice • Number of provider follow-up sessions conducted
	Identify barriers to implementing prevention best practices			Year 3 and ongoing		
	Develop a plan to address identified needs and provide resources and tools			Year 3 and ongoing		

PREVENT Goal 3: Increase understanding of proven HIV and HCV prevention approaches

Objective 3.2: Increase the number of CBOs and FBOs that receive training on proven HIV and HCV prevention best practices

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
3.2.A Assess the readiness of CBOs and FBOs to implement an HIV and HCV prevention activity and/or program	Develop readiness assessment tool and approach	CBOs and FBOs	BPH Prevention staff	Year 2	LHDs; CEG; Prevent Task Force	• Number of readiness assessment tools developed • Assessment completed • Report of findings and recommendations produced
	Conduct readiness assessment			Year 2		
	Compile key findings and draft recommendations or next steps to engagement			Year 2		
3.2.B Offer training on HIV and HCV prevention best practices to CBOs and FBOs	Develop a training curriculum that is customized for CBO and FBO audiences	CBOs and FBOs	BPH Prevention staff	Year 2	LHDs; CEG; Prevent Task Force	• Number of trainings delivered • Number of CBOs and FBOs trained in proven HIV and HCV prevention best practices • Number of people trained within the CBOs and FBOs
	Develop an outreach plan to promote training availability and set training reach goals			Year 2		
	Offer training on demand			Year 3 and ongoing		

3.2.C Conduct post-training follow-up to monitor additional training needs and implementation status	Design follow-up tool or approach	CBOs and FBOs that received prevention training	BPH Prevention staff	Year 3	Prevent Task Force	• Number of CBOs and FBOs that report implementing at least one prevention best practice • Number of follow-up sessions conducted • Number of implemented HIV and HCV prevention best practices
	Conduct routine follow-up through multiple touch points at regular intervals			Year 3 and ongoing		
	Identify barriers to implementing prevention best practices			Year 3 and ongoing		
	Develop a plan to address identified needs and provide resources and tools			Year 4 and ongoing		

PREVENT Goal 3: Increase understanding of proven HIV and HCV prevention approaches

Objective 3.3: Increase outreach to high-risk populations on proven HIV and HCV prevention best practices

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
3.3.A Provide community mobilization and outreach training for prevention providers	Partner with local prevention coalitions to identify prevention providers and assess training needs	Local prevention providers	BPH Prevention staff	Year 1 and ongoing	LHDs; CEG; Prevent Task Force	• Number of trainings conducted • Number of prevention providers trained • Number of follow-ups completed • Number of prevention best practices implemented with high-risk populations post training
	Deliver training sessions on demand			Year 2 and ongoing	BPH; CEG; LHDs	
	Conduct post-training follow-up to assess additional training needs and implementation status			Year 2 and ongoing		

PREVENT Goal 3: Increase understanding of proven HIV and HCV prevention approaches						
Objective 3.4: Increase understanding of proven HIV and HCV prevention best practices among youth						
Strategy	**Activities**	**Key Audiences**	**Responsible Parties**	**Time Frame**	**Partners and Resources**	**Process Measures**
3.4.A Develop and make available an educational curriculum for high school health classes in collaboration with the WV Department of Education (WVDE)	Assess current State Board of Education requirement and implementation process	N/A	Prevent Task Force	Year 2	BPH; WVDE; local boards of education	• Number of curricula developed and made available • Number of high schools implementing the curriculum • Number of high school students reached with curriculum delivery
	Research other states' approaches	N/A		Year 2		
	Meet with WVDE to assess willingness, readiness, and support	N/A		Year 3		
	Determine need for educational curriculum and/or teaching aids	High school health classes; health teachers		Year 3		
	Develop curriculum and/or supplemental materials for high school health teachers			Year 4		
DIAGNOSE Goal 1: Increase access to HIV and HCV testing						
Objective 1.1: Increase HIV and HCV testing in nontraditional settings						
Strategy	**Activities**	**Key Audiences**	**Responsible Parties**	**Time Frame**	**Partners and Resources**	**Process Measures**
1.1.A Expand opt-out testing in	Determine baseline of which settings currently offer opt-out testing	Emergency departments; urgent care	Diagnose Task Force	Year 1	BPH Office of Emergency Medical Services;	• Baseline count established

emergency departments (urgent care clinics and emergency rooms), mental health facilities, substance use treatment programs, and the correctional system	Assess readiness and willingness to offer and/or expand opt-out testing	clinics; mental health facilities; substance use treatment programs; correctional system		Year 2	BBH; OHFLAC; Department of Corrections and Military Affairs	• Percentage of facilities conducting testing
	Identify and address barriers to opt-out testing			Year 2 and ongoing		
	Collaborate with facility administration on policy barriers and educate on the importance of testing	Service or department administrators		Year 2 and ongoing	Facility administrators	• Number of meetings with administrators • Number of proposed policy modifications • Number of modified policies
	Distribute clear recommendations for testing in clinical and non-clinical settings and supply each setting with appropriate information (e.g., handouts, posted information, materials)	Current and potential testing providers	BPH; Department of Corrections and Military Affairs; DIS	Year 2 and ongoing	BPH; Department of Corrections and Military Affairs; OHFLAC; statewide professional associations; WV Rural Health Association; WV Primary Care Association	• Number of organizations and providers that accept and implement the recommendations
	Include information about follow-up on test results upon discharge from clinical and correctional facilities	Clinical and correctional facility administrators	Clinical and correctional facility administrators	Year 3 and ongoing		
	Establish a procedure for warm hand-off linkages to care	Facility administrators	Diagnose Task Force	Year 3 and ongoing	National Association of State and Territorial AIDS Directors (NASTAD); Ryan White model; CDC; HRSA; WV Medicaid; Electronic Medical Record(EMR) staff; DIS	• Number of people who enter care

1.1.B Expand testing within nontraditional settings, such as food distribution sites, homeless shelters and encampments, social services agencies, CBOs, SSPs, and mobile outreach	Identify partners who are willing to offer or promote testing	Current and potential testing providers	Diagnose Task Force	Year 1	SSPs; county social services agencies; Ryan White partners; CBOs; FBOs	● Number of partners recruited
	Assist partners in completing start-up processes and procedures (e.g., CLIA waiver) and understanding the different rules and requirements for becoming a certified HIV testing site			Year 1 and ongoing	BPH OLS; MAAETC; BPH	● Number of partners who complete start-up process and obtain the CLIA waiver ● Number of partners who perform testing ● Number of partners who are certified as HIV testing laboratories
	Provide training/education specific to the testing environment (e.g., field safety)		SSPs; community-based partners	Year 1 and ongoing	CDC DIS guidelines; BPH	● Number of organizations reached through training and education efforts
	Identify sites willing to serve as a "testing home" and partner with another agency to conduct tests			Year 2	County health officers; housing providers	● Number of nontraditional sites serving as "testing homes"
	Identify a community champion to vouch for the person(s) doing the testing, such as a PRSS	CBOs; SSPs	TBD	Year 1 and ongoing	CBOs; SSPs	● Number of champions identified and recruited
	Share success stories and lessons learned	Current and potential testing providers	Community champions; testing providers	Year 1 and ongoing	Community champions; testing providers	● Number of stories in news and social media metrics
1.1.C Implement a street outreach team model	Partner with Threat Preparedness Region Hubs to utilize new DHHR-purchased mobile health vans for street outreach	Regional threat preparedness coordinators; LHDs	Local testing providers	Year 2 and ongoing	Threat Preparedness Region Hubs; DHHR vans; local testing providers	● Regional utilization as measured by number of testing events conducted

	Identify and partner with other local agencies and organizations to leverage available resources for street outreach	CBOs; FBOs; community leaders	BPH	Year 2 and ongoing	LHDs; CBOs; FBOs; local social services agencies	
	Assist CBOs/FBOs in establishing connections with Ryan White providers	CBOs; FBOs		Year 2 and ongoing	CBOs; FBOs; Ryan White providers	• Number of CBOs and FBOs with established connections
1.1.D Expand availability of anonymous testing	Educate partners and CBOs about anonymous testing (e.g., ability to do it, how to complete the form, benefits)	Testing providers and CBOs	MAAETC	Year 1 and ongoing	MAAETC	• Number of partners educated • Number of partners who provide anonymous testing

DIAGNOSE Goal 1: Increase access to HIV and HCV testing

Objective 1.2: Increase access to rapid and self-testing for HIV and HCV

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
1.2.A Increase the number of LHDs and QRTs offering testing	Provide in-person or online training to QRTs	QRTs	BPH; MAAETC	Year 1 and ongoing	BBH; ODCP	• Number of QRTs trained that are offering testing
	Secure and/or provide test kits	LHDs; QRTs	BPH; LHDs	Year 1 and ongoing	BBH; ODCP	• Number of test kits provided
	Promote test kit availability to LHDs and local QRTs	LHDs; QRTs	BPH	Year 1 and ongoing	BBH; ODCP; LHDs	• Number of LHDs and QRTs reached through promotion efforts
1.2.B Increase the number of self-test kits distributed within targeted settings	Distribute self-test kits at pride events and activities reaching LGBTQ+ communities	LGBTQ+ communities	BPH	Year 1 and ongoing	Fairness WV; Rainbow Pride; CEG; LHDs	• Number of test kits distributed
	Distribute self-test kits for unnamed partners during partner services interviews	Newly identified HIV cases	BPH	Year 1 and ongoing	BPH; CEG; LHDs	

1.2.C Implement an educational campaign for rapid testing aimed at healthcare providers, CBOs, and the public	Identify key messages, success stories, and lessons learned to be shared	Healthcare providers; CBOs; West Virginia citizens	Diagnose Task Force; BPH	Year 2	DHHR Communications; MAAETC	• Number of people engaged in rapid testing because of the campaign
	Develop customized campaign materials for each audience					
	Identify effective communication channels, frequency, and duration for each audience				CEG	
	Create a step-by-step roadmap for providers and/or CBOs to offer rapid testing	Healthcare providers; CBOs			BPH; WVPCA	
	Create and maintain a *Find a Test Site* map that connects people reached through the campaign to rapid test sites	West Virginia citizens; people living in communities of high risk			Healthcare providers; CBOs	

DIAGNOSE Goal 1: Increase access to HIV and HCV testing

Objective 1.3: Increase the number of providers offering routine universal opt-out HIV and HCV screening with reflex testing according to federal public health recommendations

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
1.3.A Increase the number of FQHCs that offer routine, universal opt-out (not risk-based)	Determine how many FQHCs are offering opt-out screening to establish a baseline	FQHCs	WVPCA	Year 1	BPH; WVRHA	• Number of FQHCs offering routine, universal opt-out screening to all patients • Number of FQHCs connected to treatment resources
	Identify readiness and willingness of FQHCs to			Year 1	BPH; WVRHA	

screening (for HIV and HCV) to all patients	offer routine, universal opt-out screening					
	Train FQHCs on opt-out screening			Year 2	BPH; MAAETC	
	Connect FQHCs with available treatment resources as needed			Year 2	BPH; WVCTSI Project ECHO; WVHAMP	
1.3.B Increase the number of prenatal care providers performing HIV and HCV screening of pregnant people and repeat testing in third trimester	Survey prenatal care providers to assess current HCV screening efforts	Prenatal care providers	Perinatal Partnership	Year 1	BPH; statewide professional associations; WVBOM; WVBO	• Number of providers reached • Number of providers with established treatment linkages
	Compile survey findings to inform provider outreach			Year 1	BPH	
	Conduct provider outreach to promote screening			Year 2 and ongoing	BPH	
	Connect providers with available treatment linkages and resources			Year 2 and ongoing	BPH; WVCTSI Project ECHO; WVHAMP	
1.3.C Increase the number of healthcare teams that obtain sexual practices and drug use histories to perform repeated interval risk-based screening and that tailor sexual health counseling and care to be sensitive	Develop and distribute written materials on taking sexual histories	Healthcare providers	TBD	Year 2	BPH	• Number of healthcare teams trained and successfully collecting sexual histories • Number of healthcare teams trained and successfully providing sexual health counseling and care that is culturally sensitive
	Offer experiential training for healthcare teams		TBD	Year 3 and ongoing	MAAETC	

to patients' cultures and backgrounds						

DIAGNOSE Goal 2: Increase the number of healthcare providers who know how to correctly diagnose HIV and HCV

Objective 2.1: Ensure that healthcare profession students and trainees are educated about routine, universal, opt-out screening recommendations and diagnosis for HIV and HCV

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
2.1.A Establish a multidisciplinary task force of healthcare profession educators to develop appropriate curricula for all health profession students	Identify task force membership and determine structure	Nurses; physicians; PAs; social workers; PRSS; patient navigators; dentists; pharmacists; psychologists; alcohol and drug counselors; midwives	Diagnose Task Force	Year 1	Statewide professional medical societies; administrators of health profession schools and programs	• Task force established • Number of health profession schools adopting curricula
	Convene task force members					
	Develop curricula				MAAETC	
	Integrate curricula in health profession schools			Year 2 and ongoing		
2.1.B Establish a task force of healthcare profession educators to develop appropriate curricula for health profession trainees with prescriptive authority	Identify task force membership and determine structure	Trainees in internal medicine; family medicine; psychiatry; OB-GYN; NPs; PAs; pediatricians; midwives	Diagnose Task Force	Year 1	Statewide professional medical societies; administrators of health profession schools and programs	• Task force established • Number of health profession trainee programs adopting curricula
	Convene task force					

	Develop curricula including simple workflows				MAAETC	
	Integrate curricula in training programs for health profession trainees			Year 2	Statewide professional medical societies; administrators of health profession schools and programs	

DIAGNOSE Goal 2: Increase the number of healthcare providers who know how to correctly diagnose HIV and HCV

Objective 2.2: Increase the number of practicing clinicians who are knowledgeable about screening for HIV and HCV and diagnostic testing

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
2.2.A Ensure all practicing clinicians know about collaborative learning programs (WVHAMP, WV HIVAMP, WVCTSI Project ECHO, MAAETC) that are widely available and accessible	Identify local champions who can promote participation	Practicing clinicians	WVHAMP; WV HIVAMP; WVCTIS Project ECHO	Year 1	MAAETC; professional medical societies; WVPCA; BPH	• Number of clinicians participating in collaborative learning programs • Number of collaborative learning sessions conducted
	Identify champions among statewide health professional associations	Statewide health professional associations		Year 1	Health professional associations; BPH	
	Secure administrative support for clinicians to complete collaborative learning	Healthcare administrators	WVPCA	Year 1	WVPCA; professional medical societies	
	Explore the use of incentives with HRSA	Practicing clinicians	WVPCA	Year 1	HRSA	

	to encourage participation					
2.2.B Discuss requirement for targeted continuing education credits for licensure/re-licensure with the appropriate WV licensing boards	Convene licensing boards	Licensing boards	Diagnose Task Force	Year 1	WV medical societies; health professional associations; BPH	• Number of clinicians receiving continuing education credits • Number of modifications to licensure requirements
	Research and use the pain treatment and opioid prescribing training precedent			Year 1		
	Create and present the business case to the licensing boards			Year 2 and ongoing		
	Deliver free CEs and leverage existing partners and opportunities (e.g., meetings, annual professional gatherings, collaborative learning)			Year 2 and ongoing		

DIAGNOSE Goal 3: Increase public understanding of HIV and HCV screening recommendations and diagnostic testing

Objective 3.1: Implement an educational campaign about HIV and HCV screening recommendations and the need for diagnostic testing

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
3.1.A Implement a public educational campaign	Define campaign audiences and key messages	N/A	BPH	Year 1	BPH	• Number of campaigns developed and implemented • Number of people reached because of the campaign as measured by social media
	Explore possibility of contracting with a marketing firm and	N/A		Year 1 and ongoing	DHHR Communications	

	identify available and needed resources					analytics and media impressions
	Develop campaign messaging	WV citizens; people living in high-risk communities		Year 2	MAAETC; BBH	
	Develop and execute dissemination plan or campaign materials utilizing nonprofits, CBOs, FBOs, social media, billboards, and PSAs			Year 4	CEG; DHHR Communications	
3.1.B Disseminate takeaway materials for healthcare facility waiting rooms and exam/treatment rooms	Define audiences and key messages	N/A	BPH	Year 1	BPH	• Number of partnerships with healthcare facilities • Number of campaigns developed and implemented • Number of people reached because of the campaign
	Explore possibility of contracting with a marketing firm and identify available and needed resources	N/A		Year 1 and ongoing	DHHR Communications	
	Develop messaging and/or adapt existing CDC materials	Healthcare patrons	Diagnose Task Force	Year 2	BPH	
	Secure partnerships with healthcare facilities to deliver messaging	Healthcare facility administrators		Year 3	BPH; WVHA; WVRHA; WVPCA	
	Make materials available to healthcare facilities	Healthcare patrons		Year 3 and ongoing	BPH	

DIAGNOSE Goal 3: Increase public understanding of HIV and HCV screening recommendations and diagnostic testing						
Objective 3.2: Improve West Virginia policymakers' understanding of HIV and HCV screening recommendations and the need for diagnostic testing						
Strategy	**Activities**	**Key Audiences**	**Responsible Parties**	**Time Frame**	**Partners and Resources**	**Process Measures**
3.2.A Support awareness and educational opportunities for policymakers (e.g., white coat days)	Support advocacy efforts by statewide professional organizations through promotion of and participation in white coat days	Community leaders; local and state policymakers	Diagnose Task Force	Year 1 and ongoing	Hope in Action Alliance; CEG; BPH; WV Recovery Alliance; WVSOM; DHHR Communications	• Number of awareness and educational opportunities supported • Number of policy consultations completed
	Offer expert support on policy measures as needed			Year 1 and ongoing		
	Develop customized, key educational messages for local and state policymakers (e.g., cost savings)			Year 2		
	Support local advocacy efforts utilizing local data and stories to disseminate shared messaging			Year 2 and ongoing		
	Identify people with lived experience to share their stories			Year 2		

TREAT Goal 1: Increase healthcare provider and public awareness of HIV (goal: viral suppression) and HCV (goal: cure) therapies						
Objective 1.1: Increase the exposure of healthcare students and trainees to clinical management of HIV and HCV						
Strategy	**Activities**	**Key Audiences**	**Responsible Parties**	**Time Frame**	**Partners and Resources**	**Process Measures**
1.1.A Create a task force of healthcare profession educators to provide standardized education and guidance	Identify membership and convene task force	Faculty at WV health profession schools (public health, primary care – family and internal medicine, OB-GYN, and infectious disease)	Treat Task Force	Year 1	MAAETC; state professional associations (support); administrators of health profession schools and programs	• Task force established • Number of guidance documents created for curriculum enhancement
	Develop guidance documents and obtain commitment to implement curriculum from health profession schools and programs					
1.1.B Deliver a standardized curriculum on the clinical management of HIV and HCV that includes SDoH and addresses stigma	Develop specialty-specific curriculum	Administration with oversight of curriculum	Treat Task Force	Year 2	MAAETC; state professional associations (support); administrators of health profession schools and programs	• Number of profession-specific curricula developed • Number of health profession schools and programs that adopt the enhanced curriculum • Measured increase in knowledge and competency
	Design evaluation plan for curriculum			Year 2		
	Track process and outcome measures (e.g., participation, knowledge gain)			Year 3 and ongoing		

TREAT Goal 1: Increase healthcare provider and public awareness of HIV (goal: viral suppression) and HCV (goal: cure) therapies

Objective 1.2: Increase the number of PCPs and addiction treatment clinicians who are knowledgeable and comfortable treating HIV and HCV

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
1.2.A Increase the number of clinicians involved in collaborative learning (WVHAMP, WV HIVAMP, WVCTSI Project ECHO, and MAAETC)	Determine baseline of current collaborative participants who are engaged in treatment	Behavioral health; FQHCs; primary care; MAT clinics; SSPs; correctional facilities; free clinics; LHDs	WVCTSI Project ECHO; WVHAMP; WV HIVAMP	Year 1	MAAETC	● Number of clinicians participating in collaborative learning, with a goal to double the number each year ● Number of clinicians from collaborative learning programs who are actively treating, with a goal to double the number each year ● Number of counties that have clinicians who are actively treating, with a goal to double each year
	Develop and implement a marketing and outreach strategy with defined key audiences and underserved geographic areas		Treat Task Force	Year 1 and ongoing	Ryan White care coordinators; MAAETC; WVPCA; WVRHA; professional societies; LHDs; WVSMA; WVOMA	
1.2.B Obtain administrative support for the time clinicians will need to participate in collaborative learning on HIV and HCV treatment	Create a one-pager explaining the benefits and values for patients and the system/facility's bottom line	System and facility administrators; FQHCs	Treat Task Force	Year 1	Primary Care Association; Behavioral Healthcare Association	• Number of administrators who support clinician participation in collaborative learning
	Identify and recruit messenger(s) to distribute the one-pager and garner support			Year 1		
	Partner with FQHCs and federal funders to			Year 2		

	garner administrator support					
1.2.C Discuss requiring targeted continuing education credits for treatment of HIV and HCV with licensure/re-licensure with the appropriate WV licensing boards	Engage licensing boards	Licensing boards	Treat Task Force	Year 1	Health profession societies; Diagnose Task Force	• Number of clinicians receiving continuing education credits for treatment of HIV, HCV, and HIV PrEP • Number of licensing boards that add treatment of HIV/HCV training to licensure requirements
	Deliver free CE offerings and venues for delivery (e.g., meetings, annual professional gatherings, collaborative learning programs, webinars)	Healthcare providers	Treat Task Force	Year 2 and ongoing		

TREAT Goal 1: Increase healthcare provider and public awareness of HIV (goal: viral suppression) and HCV (goal: cure) therapies

Objective 1.3: Increase public understanding about HIV and HCV treatment regimens and their success

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
1.3.A Implement an educational campaign to increase public understanding	Identify resources that are needed and available	N/A	Treat Task Force; BPH	Year 1	Foundations; state health professional associations; WVHAMP; WVCTSI Project ECHO; DHHR Communications	• Number of people reached through the campaign as measured by social media analytics and media impressions
	Define key audiences and develop tailored messages	N/A		Year 1		
	Determine appropriate and effective communication channels for the campaign in various settings	General public		Year 1		
	Produce a campaign that considers frequency, reach, and duration	General public		Year 2 and ongoing		

	Develop and launch an easy-to-navigate website with campaign materials	General public		Year 3		
1.3.B Develop and implement an educational campaign delivered through healthcare settings	Identify resources that are needed and available	N/A	Treat Task Force; BPH	Year 1	Foundations; MCOs; EMS; county medical associations; state health professional associations; HIVMA; AAHIVM; WVHAMP; WVCTSI Project ECHO; DHHR Communications; WV HIVAMP	• Number of campaigns developed and implemented
	Identify priority healthcare settings and design tailored educational messages	Private practice providers; SUD treatment providers; STI clinic providers; mental health providers		Year 1		
	Produce a campaign that considers frequency, reach, and duration			Year 2 and ongoing		
	Develop and launch an easy-to-navigate website with campaign materials			Year 3		
1.3.C Develop and distribute a communication toolkit for use by CBOs and FBOs to promote awareness observances	Identify existing resources to develop and promote toolkit	CBOs; FBOs	BPH; Treat Task Force	Year 1	CDC and other national partners (NVHR, NASTAD)	• Number of toolkits developed and distributed
	Develop a toolkit that includes available resources, sample social media posts, webpage banners, etc.			Year 2	BPH; DHHR Communications	
	Promote and distribute toolkit			Year 3	CEG; Council of Churches; FBOs	

TREAT Goal 2: Increase access to care to improve outcomes for all people living with HIV and/or HCV and reduce health disparities

Objective 2.1: Increase the number of PCPs providing integrated care for substance use disorder, HIV, and HCV at FQHCs, free clinics, and hospital-based primary care clinics

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
2.1.A Increase administrative support for at least one provider per clinic to provide these services and encourage integrated care (defined as providing SUD treatment, HIV care, HIV PrEP, and HCV treatment as part of primary care)	Review and communicate HRSA and SAMHSA directives, standards, and guidelines	Administrative structure of the treatment facilities	Treat Task Force	Year 1	CEG; WVPCA; WVRHA	• Review completed • Number of new clinics providing integrated care
	Garner administrative support for relief from clinical duties to acquire the new skills	Administrative structure of the treatment facilities	WVHAMP, WVCTSI Project ECHO	Year 1	WVPCA; WVRHA; state medical and osteopathic associations	
	Determine a baseline number of clinics providing integrated care via a survey		Treat Task Force	Year 1	BIRCH Project; WVHAMP; WVCTSI Project ECHO	
	Share information about expanding compensation recovery with administrators (FQHCs RVUs)	Administrators and CEOs of healthcare settings		Year 1 and ongoing	BIRCH Project; WVPCA	
	Develop a business case with patient testimonials	Administrators and chief medical officers		Year 3 and ongoing	Public relations support	

TREAT Goal 2: Increase access to care to improve outcomes for all people living with HIV and/or HCV and reduce health disparities

Objective 2.2: Expand the number of nontraditional settings, such as addiction treatment programs and syringe services programs, that offer curative treatment for HCV and have a collaborative arrangement for HIV care

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
2.2.A Increase on-site HCV care in nontraditional settings	Provide training and implementation support to staff in nontraditional settings, including medical contractors for correctional facilities, mobile services, etc.	Nontraditional settings; free clinics; FQHCs; corrections	WVHAMP; WVCTSI Project ECHO; MAAETC	Year 1 and ongoing	DOC medical contractor	• Number of trainings conducted
	Create a list of resources and required services (e.g., insurance, labs, ultrasound, telehealth)		Treat Task Force	Year 2	WVHAMP; WVCTSI Project ECHO	• List created
2.2.B Establish agreements between nontraditional settings that lack the capability to treat HIV with HIV care providers with a warm hand-off	Create a list/registry of local practitioners who can be part of warm hand-off	Nontraditional settings	Treat Task Force	Year 1 and ongoing	WV HIVAMP; WVCTSI Project ECHO; Ryan White programs	• Number of nontraditional settings that offer HIV diagnosis and have a collaborative agreement for HIV treatment
	Provide training and implementation support to staff in nontraditional settings, including medical contractors for correctional facilities, mobile services, etc.		WV HIVAMP; WVCTSI Project ECHO; Ryan White programs	Year 2 and ongoing		

	Develop template for bidirectional MOUs including clear communication between practitioners and the nontraditional settings	Nontraditional settings and HIV treatment providers	Treat Task Force			

TREAT Goal 3: Increase the number of people with HIV and/or HCV who are engaged and retained in care and virally suppressed (HIV) or cured (HCV)

Objective 3.1: Increase the number of people living with HIV who are linked to care within one month of diagnosis

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
3.1.A Utilize existing resources for warm hand-off, linkage to care	Provide information about where care can be accessed to people living with HIV	People diagnosed with HIV in past 30 days	Linkage to care coordinators and DIS	Year 1 and ongoing	BPH; QRT; Ryan White programs	• Number of individuals linked to care
3.1.B Create new resources for warm hand-off, linkages to care	Develop or adapt materials to distribute through nontraditional settings, LHDs, CBOs, FBOs, and public places on what HIV care is and how to access it	N/A	Linkage to care coordinators and DIS	Year 3	MAAETC, CDC	• Number of resources developed

TREAT Goal 3: Increase the number of people with HIV and/or HCV who are engaged and retained in care and virally suppressed (HIV) or cured (HCV)

Objective 3.2: Increase the number of people living with HIV who are engaged and retained in care and who achieve viral suppression

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures

3.2.A Increase the number of people engaged in care defined as initial evaluation and ≥ 1 – 2 visits/year	Share information on available wraparound services and how to access them	People diagnosed with HIV	Linkage to care coordinators	Year 1 and ongoing	HOPWA; Ryan White programs; PRSS; SSPs; WV Recovery Alliance	• Number of PLWH in care within one, two, and six months of diagnosis
	Promote use of peer support such as QRTs and explore development of a buddy system	People diagnosed with HIV; PRSS		Year 2 and ongoing	QRTs; ODCP; BBH; WVCBAPP	
	Provide information for mental healthcare resources available locally or regionally	People diagnosed with HIV			State Behavioral Health Association	
	Build support and encouragement from community points of contact (e.g., faith leaders)	FBOs; CBOs; SSPs			HOPWA; Ryan White programs; WV Recovery Alliance	
3.2.B Develop mechanisms to extend existing Ryan White Care Act case management and wraparound services to PCPs practicing outside designated RWCA clinics	Develop relationships between primary care providers and the Ryan White clinics	PCPs	Ryan White programs	Year 1 and ongoing	BPH	• Number of PCPs utilizing Ryan White Care Act case management and wraparound services
3.2.C Increase the number of individuals with HIV who achieve viral suppression (maximum benefit from treatment)	Increase the number of linkages to care specialists around West Virginia	Healthcare providers	Treat Task Force; Ryan White Part B linkage to care specialists; BPH	Year 1	Medicaid; HOPWA; Ryan White programs; PRSS; SSPs; WV Recovery Alliance	• Proportion of retained persons who achieve viral suppression
	Create a ‘not in care’ list for linkage to care specialists to help			Year 2 and ongoing		

	facilitate re-engagement into care					

TREAT Goal 3: Increase the number of people with HIV and/or HCV who are engaged and retained in care and virally suppressed (HIV) or cured (HCV)

Objective 3.3: Increase the number of people with HCV who are cured

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
3.3.A Develop a surveillance plan for HCV care cascade data	Participate in a TA meeting with jurisdictions receiving negative HCV RNA reports	N/A	BPH	Year 1	NASTAD; CDC; WVEDSS vendor; WV Medicaid	• TA meeting attendance
	Explore surveillance system capabilities for receiving HCV RNA reports	N/A		Year 2		• Compiled surveillance system capabilities
	Develop a surveillance system process for receiving and managing negative HCV RNA reports	Reporting facilities and providers		Year 3		• Surveillance system receives and manages negative HCV RNA reports
	Utilizing HCV negative reporting, develop a report in the surveillance system to identify HCV cases that are cured	N/A		Year 4 and ongoing		• Report developed and utilized
3.3.B Develop support systems to engage and	Promote use of peer support, such as exploring the	People diagnosed with HCV; PRSS;	Treat Task Force	Year 2 and ongoing	QRTs; ODCP; BBH; WVCBAPP; WV Recovery Alliance	• Resource guide developed • Number of trainings on social services provided

retain individuals in care	development of a buddy system	healthcare providers				• Number of mental healthcare resources provided to PRSS
	Provide information for mental healthcare resources available locally or regionally				WV Behavioral Healthcare Providers Association	
	Provide education and training on available support services and promote wraparound services				BPH	
	Develop an HCV resource guide of care providers		WVHAMP; WVCTSI Project ECHO	Year 2	BPH; WVRHA; BMS	
	Explore the development of a linkage to care program for people with HCV		BPH	Year 3	CDC; NASTAD	

RESPOND Goal 1: Identify, assess, and strengthen statewide, regional, and local capacity to respond to potential, emerging, and existing outbreaks

Objective 1.1: Assess local health department outbreak/cluster response capacity

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
1.1.A Conduct a needs assessment of local health department response capacity	Develop a needs assessment tool and approach	Local health jurisdictions	Center for Threat Preparedness; BPH	Year 2	LHDs; local health associations	• Needs assessment tools developed • Number of local assessments completed • Number of recommendation reports delivered
	Conduct local needs assessments			Year 3		
	Evaluate needs assessment results and compile findings			Year 3		

	Develop and provide recommendations to address identified gaps and needs in local health department response capacity			Year 4		

RESPOND Goal 1: Identify, assess, and strengthen statewide, regional, and local capacity to respond to potential, emerging, and existing outbreaks

Objective 1.2: Increase the number of local/regional jurisdictions with outbreak response plans addressing HIV and viral hepatitis coinfections

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
1.2.A Strengthen local and regional response plans	Research existing planning templates used by other states and jurisdictions	Local health jurisdictions	Center for Threat Preparedness; BPH	Year 2	LHDs; local health associations	• Dissemination of a response plan template
	Identify and recruit key partners needed for template development			Year 2		
	Identify and outline the key elements of the planning template			Year 3		
	Develop response plan template			Year 3		
	Communicate template availability and the expectations to local and regional partners			Year 4		
	Develop and deliver a “Train the Trainer”			Year 4	LHDs; local health associations;	• Number of trainers trained

	model for response planning				WVCTSI Project ECHO	
	Provide education and support to local and regional partners to develop and submit response plans			Year 4 and ongoing		• Number of trainings or mentoring sessions conducted
	Provide coaching and mentoring during plan development			Year 4 and ongoing		
	Develop and utilize a communication plan toolkit for use during local response			Year 4 and ongoing	LHDs; local health associations	• Number of communication plans developed for local response
	Evaluate and review the submitted response plans, including the Crisis and Emergency Risk Communication (CERC) plan			Year 4 and ongoing	SMEs	• Number of plans submitted and reviewed • Number of local and regional jurisdictions with an outbreak response plan • Percentage of state covered by an outbreak response plan

RESPOND Goal 1: Identify, assess, and strengthen statewide, regional, and local capacity to respond to potential, emerging, and existing outbreaks

Objective 1.3: Enhance capacity to implement and adapt the outbreak/cluster response plan

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
1.3.A Conduct annual review of response plans	Schedule and complete annual plan review	Local and regional jurisdictions	Center for Threat Preparedness	Year 4 and ongoing	BPH	• Number of annual local response plan reviews completed • Number of revised plans submitted for review
	Identify new partners and resources to address any noted					

	gaps and needs (i.e., staffing, training) Revise the plan as needed and communicate changes to key partners Submit the revised plan as required (annex to emerging infectious diseases (EID) plan)					
1.3.B Identify and resolve barriers on situational reports during active response efforts	Review reports and identify needs Provide TA to address identified needs	Local and regional jurisdictions	Center for Threat Preparedness	Year 4 and ongoing	BPH	• Number of jurisdictions receiving TA
1.3.C Address needs and barriers identified on after-action reports and improvement plans during the recovery phase	Review after-action reports and identify areas for improvement Follow up on educational and training needs identified during the response Provide TA to address identified needs Share lessons learned with other jurisdictions	Local and regional jurisdictions	Center for Threat Preparedness; BPH	Year 4 and ongoing	LHDs; local health associations	• Number of action reports reviewed • Number of jurisdictions receiving TA

RESPOND Goal 2: Identify and strengthen organizational and system-level capacity for data collection, analysis, outbreak detection, data dissemination, and evaluation

Objective 2.1: Increase state capacity to process, evaluate, and summarize surveillance data

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
2.1.A Increase HIV and HCV surveillance staffing resources to address the increase in disease incidence	Conduct a workforce gap assessment as part of BPH workforce development efforts	BPH	BPH	Year 1	Schools of public health; DHHR-contracted project management firm	• Number of staffing gaps identified
	Develop partnerships with schools of public health to engage students in practicum experiences to supplement surveillance staffing		BPH	Year 2	Schools of public health	• Number of partnerships established with schools of public health
	Apply for federal HIV and viral hepatitis funding opportunities		BPH	Year 1 and ongoing	BPH; CDC; HRSA	• Number of federal funding applications submitted by BPH • Number of federal funding opportunities awarded to BPH
	Request additional appropriations for staffing from the WV legislature		BPH	Year 1 and ongoing	BPH	• Increase in state appropriations to support HIV and HCV surveillance
2.1.B Incorporate improved and/or expanded technologies for electronic case reporting (eCR) from providers	Explore options for integrating HIV case reporting from providers into current eCR (e.g., REDCap, HL7) and identify solution	Healthcare providers	BPH	Year 2	CDC; other state jurisdictions	• Number of options explored • Number of solutions identified and implemented • Number of trainings developed • Number of providers who receive training on the eCR process
	Integrate identified solution for eCR			Year 3		

	Develop training on eCR process			Year 4		
	Disseminate eCR training to providers			Year 4 and ongoing	WVCTSI Project ECHO; MAAETC; WV Rural Health Association; WVPCA; professional medical societies; WV-APIC	
2.1.C Improve use of surveillance tools for cluster and outbreak detection	Work with laboratories to increase the number of HIV cases reported with a molecular sequence	Laboratories; LHDs	BPH	Year 1 and ongoing	OLS	• Number of new HIV cases with molecular sequence (≥60%)
	Develop a protocol for notification to local health departments of identified increases in their jurisdictions	LHDs		Year 2	LHDs	
	Train staff members on methods of interpretation of molecular analysis (Secure HIV-TRACE)	HIV surveillance staff		Year 3	TBD	

RESPOND Goal 2: Identify and strengthen organizational and system-level capacity for data collection, analysis, outbreak detection, data dissemination, and evaluation

Objective 2.2: Increase the accessibility of HIV and HCV indicator data for partners and the public to support an early warning system

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
2.2.A	Identify data indicators for dashboard		BPH	Year 1	OMIS	

Make available a public-facing online dashboard with data at the lowest level possible	Establish data standards for dashboard	Community partners and stakeholders		Year 1		• Number of data indicators identified • Data standards completed • Number of dashboards launched with a maintenance plan
	Develop and launch dashboard			Year 2		
	Communicate or market dashboard availability			Year 2 and ongoing		
	Develop a plan to maintain and update the dashboard on a set basis			Year 2 and ongoing		
2.2.B Develop data sharing agreement templates for use during outbreak/cluster response	Develop or adapt a data sharing agreement template	Outbreak/cluster response partners	BPH	Year 2	LHDs; community service providers	• Template developed and distributed • Number of executed data sharing agreements with partners
	Make template available to partners			Year 2	BPH	
	Execute data sharing agreements with partners			Year 3	BPH	

RESPOND Goal 3: Educate the public and stakeholders on HIV and HCV outbreak response

Objective 3.1: Increase public awareness of outbreak/cluster response

Strategy	Activities	Key Audiences	Responsible Parties	Time Frame	Partners and Resources	Process Measures
3.1.A Make a statewide outbreak response plan publicly available	Develop a statewide outbreak response plan	WV citizens; partners and stakeholders	BPH	Year 1	Ryan White programs; LHDs; community providers	• Number of statewide plans publicly available
	Make final plan available on BPH website					

3.1.B Develop and disseminate educational materials to communicate key response activities and messages	Review existing materials, services, and providers that could be adapted or updated	WV citizens; partners and stakeholders	Center for Threat Preparedness; BPH	Year 1	CDC; LHDs; community service providers; DHHR Communications	• Number of educational materials developed • Number of educational outreach activities conducted
	Develop key messages including summary or high-level materials and define target population(s) or audiences			Year 2		
	Identify communication channels and spokespersons for each audience			Year 2		
	Determine the frequency and timing of key messaging			Year 2		
	Deliver educational outreach			Year 3		

Section VI: 2022 – 2026 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow-Up

Who is involved in the monitoring process?

- BPH, Subcommittee Task Forces, and planning/advisory bodies

What components are monitored quarterly?

- Process measures for strategies and activities

What components are monitored annually?

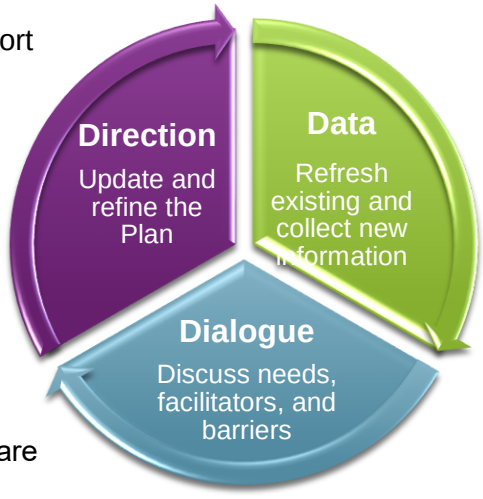
- Key performance indicators
- Plan content (e.g., partners, resources, activities, strategies)
- Epidemiologic data

How does BPH monitor planning and aspects of Plan implementation?

- BPH is the lead agency for coordination of HIV prevention and care resources.
- BPH will develop and utilize a tracking tool to measure stakeholder engagement levels and quarterly progress on the process measures.
- BPH will identify refreshed and new data annually and analyze data on the key performance indicators.

Due to the range of the proposed strategies and activities in the Plan and the diversity of stakeholders, engagement will be regularly conducted throughout all phases of implementation, monitoring, evaluation, and improvement. BPH will assume primary responsibility for monitoring and evaluating the Plan's implementation and will work closely with the Subcommittee Task Forces to track and report progress associated with goals, objectives, strategies, and activities. BPH will report to the planning/advisory bodies on a biannual basis and update stakeholders and the public annually. BPH receives funding from both the CDC and HRSA and can leverage that funding to help ensure coordination and synergy of services. BPH works closely with Ryan White Part C providers to supplement services and respond to outbreaks.

The subcommittees will refine their structures during 2023 to better support the Plan's implementation and will establish task forces when needed to champion evidence-based interventions and the completion of key activities from a collective impact approach. The task forces will be created from the subcommittees used during the initial planning process.



Implementation

BPH, in partnership with the Prevent, Diagnose, Treat, and Respond Task Forces (Task Forces) and under the guidance of the planning/advisory bodies, will support the five key phases of integrated planning over the Plan's time frame to help ensure goals and objectives are met. The Task Forces are comprised of diverse partners, providers, and administrators from different funding streams and will convene quarterly to help assure that stakeholder engagement is an ongoing priority. The Task Forces' engagement will be strategically used to help ensure processes and Plan activities accurately reflect West Virginia context and address community needs. The goals, objectives, KPIs, and process measures provide a foundation to continually assess progress and determine the need for Plan adjustments throughout implementation. A three-step framework will be utilized for Plan implementation and will support the integrated planning process: Data, Dialogue, and Direction.

Step 1: Data

To guide long-term planning efforts, BPH has identified KPIs to measure the success of the Subcommittee Task Forces in meeting the Plan's objectives and goals. The KPIs allow for strategic and operational improvement across the care continuum, provide a basis for data-driven decision-making, and will help BPH and the Subcommittee Task Forces focus on what matters most.

Surveillance and program data are critical to West Virginia's integrated planning efforts as well as to helping ensure positive health outcomes, health equity, and the quality of the HIV and HCV service delivery systems. The HIV care continuum provides a common set of indicators that West Virginia can use to gauge its own progress and how it is doing compared with the nation. BPH will identify refreshed and new data on a regular basis and analyze data on the KPIs annually. Surveillance and program data will be utilized to improve access and health outcomes along the HIV care continuum. By identifying demographic, geographic, and other disparities along the care continuum, strategies and activities can be developed, tailored, and implemented within populations or areas of highest need.

Step 2: Dialogue

The Subcommittee Task Forces will be convened quarterly to coordinate implementation and assist with ongoing monitoring of activities and strategies, as well as to discuss barriers within the process and apply findings for continuous improvement. Process measures have been identified for each strategy and linked to relevant activities to monitor general progress. BPH will develop a tool to track process measures quarterly and report on them annually through a publicly available and accessible online dashboard. Subcommittee Task Force progress updates will be provided by BPH to the planning/advisory bodies on a biannual basis. Additionally, BPH will obtain feedback from the stakeholders as part of continuous quality improvement. The planning/advisory bodies include PWLE to help ensure inclusion of their perspectives and to identify and advise on new or emerging community needs.

Step 3: Direction

During the fourth quarter of each year, BPH and the Subcommittee Task Forces will review overall progress toward the Plan's goals, objectives, KPIs, and strategies and make necessary adjustments to the Plan based on the surveillance and program data, process measures, and stakeholder feedback. Plan refinements will be shared with stakeholders annually and made publicly available online.

Monitoring and Improvement

To help ensure available resources are maximized and adapted to meet the needs across the care continuum, West Virginia will utilize a continuous quality improvement approach that emphasizes ongoing monitoring, feedback, and adjustments. The Subcommittee Task Forces and BPH will evaluate the Plan's overall progress on an annual basis and make modifications as needed based on new and/or updated data, the process measures outlined in the Plan, and input received from stakeholders and PWLE. This process will allow BPH and the Subcommittee Task Forces to adjust, revise, and prioritize strategies and the associated activities in a timely manner in response to changing or emerging needs or profiles of the HIV and HCV epidemics. BPH will present the Plan revisions to the planning/advisory bodies for review and final guidance annually.

On a quarterly basis, the Subcommittee Task Forces will meet to discuss the status of activities under the strategies and report on the process measures. BPH will communicate progress to the planning/advisory bodies biannually and solicit input to make revisions and improvements. The planning/advisory bodies include PWLE to help ensure inclusion of their perspectives and to identify and advise on new or emerging community needs.

BPH will develop a tool to track the identified process measures in the Plan and will review progress with the Subcommittee Task Forces and planning/advisory bodies at regular, defined intervals. The tool will be designed to effectively collect the details needed to accurately monitor all aspects of Plan implementation using a simple and efficient format. BPH will monitor the Plan quarterly throughout the planning period to assess progress toward meeting the goals and will continue to track stakeholder engagement levels. An online dashboard that is publicly accessible and available will be developed and published by BPH to keep stakeholders and the public informed of Plan progress.

BPH will continue to review available data sets and determine the need for further studies over the planning period. BPH will issue a surveillance report annually as refreshed and/or new data become available and make updates available online. In addition, BPH will coordinate an annual review of the KPIs according to the assigned pillar areas (Prevent, Diagnose, Treat, Respond). For example, the Prevent Subcommittee may examine changes in the number of new infections each calendar year, and the Treat Subcommittee will continue to monitor data on people engaged and retained in care.

To assess the extent to which objectives are being met, the following guiding principles and monitoring questions will facilitate the process.

Prevent Pillar

Guiding Principle: To help prevent new HIV and HCV infections
Primary focus will be placed on increasing access to and utilization of PrEP therapy, increasing the number of SSPs offering mobile services, and expanding understanding of proven prevention approaches.

Monitoring Questions:

- To what extent have health systems or clinics successfully implemented an electronic health record (EHR) system change?
- To what extent do healthcare providers report prescribing PrEP?
- To what extent are existing SSPs offering mobile services?
- To what extent are new SSPs offering mobile outreach?
- To what extent are providers, CBOs, and faith-based organizations (FBOs) trained in proven HIV and HCV prevention best practices?
- To what extent are providers, CBOs, and FBOs implementing at least one prevention best practice?
- To what extent are prevention best practices being implemented with high-risk populations?

Diagnose Pillar

Guiding Principle: To reduce late-stage HIV diagnosis and increase the number of people who are newly diagnosed and have been in contact with Partner Services (HIV) or local health department staff (HCV)
Primary focus will be placed on increasing access to HIV and HCV testing, improving the number of healthcare providers who know how to correctly diagnose HIV and HCV, and increasing public understanding of screening and testing.

Monitoring Questions:

- To what extent has HIV and HCV testing been expanded in nontraditional settings?
- To what extent are facilities offering opt-out testing?
- To what extent are QRTs offering HIV and HCV testing?
- To what extent has curricula been developed for health professions students and trainees?
- To what extent are clinicians participating in collaborative learning programs?
- To what extent are policymakers, patients, and the public reached through educational campaigns?
- To what extent are stakeholders providing policy consultations for local and state policymakers?

Treat Pillar

Guiding Principle: To increase the number of people living with HIV who are virally suppressed and the number of people with HCV who are cured
Primary focus will be placed on increasing healthcare provider and public awareness of HIV and HCV therapies, improving access to care to improve outcomes and reduce health disparities, and increasing the number of people engaged and retained in care.

Monitoring Questions:

- To what extent has curricula been developed on the clinical management of HIV and HCV that includes the social determinants of health and addresses stigma?
- To what extent are healthcare providers participating in collaborative learning programs on HIV and HCV treatment?
- To what extent are people reached through educational campaigns about HIV and HCV therapies?
- To what extent are clinics providing integrated care?
- To what extent are nontraditional settings offering curative treatment for HCV and have a collaborative agreement for HIV treatment?
- To what extent are primary care physicians in private practice offering HIV and/or HCV treatment and HIV PrEP?
- To what extent are people living with HIV remaining in care within one month, three months, and six months?

Respond Pillar

Guiding Principle: To respond quickly to potential outbreaks
Primary focus will be placed on strengthening state, regional, and local capacity to respond, enhancing organizational and system capacity for data collection, analysis, outbreak detection, data dissemination, and evaluation, and educating the public and stakeholders about outbreak response.

Monitoring Questions:

- To what extent have local assessments and response plans been completed?
- To what extent are annual plan reviews being conducted?
- To what extent have HIV and HCV surveillance staffing resources been increased?
- To what extent has electronic HIV case reporting from providers been integrated into HIV surveillance processes?
- To what extent are new HIV cases being reported with a molecular sequence?
- To what extent has data sharing increased with partners and the public?
- To what extent are stakeholders and the public aware of outbreak/cluster response plans?

Evaluation

BPH has identified 13 KPIs for the 2022–2026 planning period (page 93). These KPIs align with the Plan's goals and objectives, which connect to the national goals for HIV and HCV. The KPIs serve as the Plan's gauge for strategic and operational improvement across the care continuum and will be used annually to evaluate progress toward the Plan goals. BPH will continue to develop KPIs relevant to the Respond pillar. BPH will convene an annual meeting of the planning/advisory bodies and the Subcommittee Task Forces dedicated to reviewing refreshed and new data, assessing the direction of the stated objectives and status of the KPIs, discussing the outcomes and stakeholder/community input, and compiling findings. From this review process, the need for Plan revisions and improvements will be determined and addressed. The Subcommittee Task Forces include stakeholders from all Ryan White parts, the planning/advisory bodies, BPH, and other key partners. Members with lived experience will be actively engaged in this annual review process and will provide guidance and recommendations to the Subcommittee Task Forces and planning/advisory bodies. Once all

feedback is incorporated and revisions are finalized, the annual Plan update will be shared with stakeholders and made publicly available online.

Reporting and Dissemination

BPH and partner programs will report progress on the Plan's goals and objectives through reporting requirements established by the CDC and HRSA as part of the monitoring process for federal funds. These reporting updates will document West Virginia's efforts to monitor and evaluate the implementation of the Plan's goals, objectives, strategies, and key performance measures. BPH will provide progress updates during meetings and via email to members of the Subcommittee Task Forces and the relevant planning/advisory bodies.

Additionally, BPH will publish an annual dashboard for the Plan on its website that highlights progress toward the KPIs supporting the goals and objectives as well as completion percentages to date for the strategies. Success stories and lessons learned will be compiled as needed and made available publicly on the BPH website, as will the Plan and annual updates. Progress and success stories will be shared through direct email contact with partners and the DHHR and stakeholders' social media platforms to keep stakeholders, PWLE, and the citizens of West Virginia informed. PWLE will receive updates from their planning/advisory body representatives, the BPH website, and social media posts.

APPENDICES

Appendix A: List of Acronyms

Table 1 lists the acronyms that appear throughout this plan.

Table 1: Acronym Glossary

Acronym	Definition
AAHIVM	American Academy of HIV Medicine
ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ATSDR	Agency for Toxic Substances and Disease Registry
BBH	West Virginia Department of Health and Human Resources, Bureau for Behavioral Health
BIRCH	Blunted Immune Recovery in CORE Patients with HIV
BMS	West Virginia Department of Health and Human Resources, Bureau for Medical Services
BPH	West Virginia Department of Health and Human Resources, Bureau for Public Health
CAMC	Charleston Area Medical Center
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CE	Community Engagement
CEG	Community Engagement Group
CEO	Chief Executive Officer
CERC	Crisis and Emergency Risk Communication
CHW	Community Health Worker
CLIA	Clinical Laboratory Improvement Amendments of 1988
CY	Calendar Year
DAF	Deliverable Acceptance Form
DED	Deliverable Expectation Document
DHHR	Department of Health and Human Resources
DIS	Disease Intervention Specialists
DO	Doctor of Osteopathic Medicine
DOC	Department of Corrections
DSHHT	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis, and Tuberculosis
ECHO	Extension for Community Healthcare Outcomes
eCR	Electronic Case Reporting

Acronym	Definition
eHARS	Enhanced HIV/AIDS Reporting System
EHR	Electronic Health Record
EID	Emerging Infectious Diseases
EIS	Early Intervention Services
EMR	Electronic Medical Record
EMS	Emergency Medical Services
FBO	Faith-Based Organization
FCC	Federal Communications Commission
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Centers
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HIVMA	The HIV Medicine Association
HIVAMP	Human Immunodeficiency Virus Academic Mentorship Partnership
HEPLEA	Health Equity and People with Lived Experience Advisory
HOPWA	Housing Opportunities for People with AIDS
HPSA	Health Professional Shortage Area
HRP	HIV Research Program
HRSA	Health Resources and Services Administration
IDU	Injecting Drug User
KPI	Key Performance Indicator
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, and others
LHD	Local Health Department
LPN	Licensed Practical Nurse
MAAETC	MidAtlantic AIDS Education and Training Center
MARP	Medical Access Roads Program
MAT	Medication-Assisted Treatment
MCO	Managed Care Organization
MD	Medical Doctor
MOU	Memorandum of Understanding
MOUD	Medications for Opioid Use Disorder
MUA	Medically Underserved Area

Acronym	Definition
NASTAD	National Alliance of State and Territorial AIDS Directors
NHAS	National HIV/AIDS Strategy
NP	Nurse Practitioner
NVHR	National Viral Hepatitis Roundtable
OB-GYN	Obstetrician-Gynecologist
ODCP	Office of Drug Control Policy
OEMS	West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Emergency Medical Services
OHFLAC	West Virginia Department of Health and Human Resources, Office of Inspector General, Office of Health Facility Licensure and Certification
OLS	West Virginia Department of Health and Human Resources, Bureau for Public Health Office of Laboratory Services
OMCFH	West Virginia Department of Health and Human Resources, Bureau for Public Health Office of Maternal Child and Family Health
OMIS	West Virginia Department of Health and Human Resources, Office of Management Information System
PA	Physician Assistant
PHHSBG	Preventive Health and Health Services Block Grant
PLWH	People Living With HIV
PrEP	Pre-Exposure Prophylaxis
PRSS	Peer Recovery Support Specialist
PSA	Public Service Announcement
PWID	People Who Inject Drugs
PWLE	People With Lived Experience
QRT	Quick Response Team
RN	Registered Nurse
RNA	Ribonucleic Acid
RWHAP	Ryan White HIV/AIDS Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SCSN	Statewide Coordinated Statement of Need
SDOH	Social Determinants of Health
SME	Subject Matter Expert
SSP	Syringe Services Programs
STD	Sexually Transmitted Disease
SUD	Substance Use Disorder

Acronym	Definition
SVI	Social Vulnerability Index
SWOT	Strengths/Weaknesses/Opportunities/Threats
TA	Technical Assistance
TB	Tuberculosis
USDA	United States Department of Agriculture
WV	West Virginia
WV-APIC	West Virginia Association for Professionals in Infection Control and Epidemiology
WVBO	West Virginia Board of Optometry
WVCBAPP	West Virginia Certification Board for Addiction and Prevention Professionals
WVCTSI	West Virginia Clinical and Translational Science Institute
WVDE	West Virginia Department of Education
WVDII	West Virginia Drug Intervention Institute
WVEDSS	West Virginia Electronic Disease Surveillance System
WVHA	West Virginia Hospital Association
WVHAMP	West Virginia Hepatitis Academic Mentorship Partnership
WVOMA	West Virginia Osteopathic Medical Association
WVPCA	West Virginia Primary Care Associates
WVRHA	West Virginia Rural Health Association
WVSMA	West Virginia State Medical Association
WVSOM	West Virginia School of Osteopathic Medicine

Appendix B: Steering Committee Membership

Table 2 lists the Steering Committee Members.

* Denotes representation from the required 26 stakeholder categories.

Table 2: Steering Committee Membership

Name	Organization or Group	Role
A. Toni Young	Community Education Group	Member
Alana Hudson	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Amy Atkins	West Virginia Department of Health and Human Resources, Bureau for Public Health	Member *
Dr. Arif Sarwari	West Virginia University Health Sciences Center	Member *
Ayne Amjad	West Virginia Department of Health and Human Resources, Bureau for Public Health	Member
Brian Thompson	West Virginia Department of Health and Human Resources, Bureau for Medical Services	Member *
Christina Mullins	West Virginia Department of Health and Human Resources, Bureau for Behavioral Health	Member *
Deb Koester	West Virginia Association of Local Health Departments	Member *
Emma White	West Virginia Primary Care Association	Member *
Janine Breyel	WV Perinatal Partnership	Member *
Jay Adams	West Virginia AIDS Taskforce of the Upper Ohio Valley	Member *
Jim Jeffries	West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Maternal Child and Family Health	Member
Dr. Judith Feinberg	West Virginia University School of Medicine	Member
Kathy Cummons	West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Epidemiology and Prevention Services	Member
Mark Drennan	West Virginia Behavioral Healthcare Providers Association	Member *
Dr. Matthew Christiansen	West Virginia Department of Health and Human Resources, Office of Drug Control Policy	Member
Natasha Stone	Fairness West Virginia	Member *
Shannon McBee	West Virginia Department of Health and Human Resources, Bureau for Public Health	Member
Dr. Shelda Martin	Charleston Area Medical Center, Ryan White Clinic	Member *
Sherri Ferrell	West Virginia Primary Care Association	Member *
Suzanne Wilson	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Chair

Appendix C: Subcommittee Membership

Tables 3 - 7 lists the members for the Prevent, Diagnose, Treat, and Respond subcommittees and the HEPLEA Group.

* Denotes representation from the required 26 stakeholder categories.

Table 3: Prevent Subcommittee Members

Member	Organization or Group	Role
Abhishek Shankar	Community Education Group	Member
Alana Hudson	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Alex Alston	West Virginia Department of Health and Human Resources, Bureau for Behavioral Health	Member
Amy Snodgrass	Hope In Action Alliance	Member
Angelica Willis Breidel	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Anita Stewart	Harm Reduction Coalition of West Virginia	Member
Anndy Rogers	West Virginia University Positive Health Clinic	Member *
Carol Ward	West Virginia Department of Education	Member
Cassie Province	Covenant House	Member *
Christine Teague	Charleston Area Medical Center, Ryan White Clinic	Member *
Crystal Bauer	Project HOPE	Member *
Darryl Cannady	South Central Educational Development	Member
Deb Koester	West Virginia Association of Local Health Departments	Member *
Ellie Johnson	West Virginia Coalition to End Homelessness	Member *
Jeannette Southerly	West Virginia Regional Partner of MAAETC	Member
John Law	West Virginia State Medical Association	Member *
Julie Mundell	Monroe Health Center	Member *
Lara Sitler	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of Immunization Services	Member
Lee Lucas-Neel	Charleston Area Medical Center, Ryan White Clinic	Member *
Lindsay Acree	University of Charleston School of Pharmacy	Member
Malik Witten	Partnership of African American Churches	Member *
Mark Drennan	West Virginia Behavioral Healthcare Providers Association	Member *
Markie McCoy	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of Cancer Epidemiology	Member
Matthew Christiansen	West Virginia Department of Health and Human Resources, Office of Drug Control Policy	Member
Robin Pollini	West Virginia University	Member

Member	Organization or Group	Role
Shawn Balleydier	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Chair
Stephanie Moore	West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Rural Health	Member
Susan Bissett	West Virginia Drug Intervention Institute	Member *
Suzanne Wilson	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Tennysa Mace	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member

Table 4: Diagnose Subcommittee Members

Member	Organization or Group	Role
Alana Hudson	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Alex Alston	West Virginia Department of Health and Human Resources, Bureau for Behavioral Health	Member
Angie Gray	Hope In Action Alliance	Member
Anita Ferguson	West Virginia Department of Health and Human Resources, Bureau for Medical Services	Member *
Anita Stewart	Harm Reduction Coalition of West Virginia	Member *
Anndy Rogers	West Virginia University Positive Health Clinic	Member *
Bianca Huff	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Cassie Province	Covenant House	Member *
Christi Clark	West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Laboratory Services	Member *
Collin John	Project WATCH/West Virginia Birth Score Program	Member *
Deb Koester	West Virginia Association of Local Health Departments	Member *
Dondeena McGraw	West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Laboratory Services	Member *
Heather Hoffman	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Jackson Austin	Southern West Virginia Health System	Member *
Janine Breyel	West Virginia Perinatal Partnership	Member *
Jeannette Southerly	West Virginia Regional Partner of MAAETC	Member
Judith Feinberg	West Virginia University School of Medicine	Chair

Member	Organization or Group	Role
Kady Pack	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Katherine Tobin Chase	Shenandoah Community Health	Member *
Kathleen O'Neil	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Kathy Pauley	West Virginia Division of Corrections	Member *
Kim Houchin	Minnie Hamilton Health Systems	Member *
Lee Storrow	Community Education Group	Member
Lesli Bosse-Ryan	Charleston Area Medical Center, Ryan White Clinic	Member *
Lindsay Acree	University of Charleston School of Pharmacy	Member
Miracle Boltz	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Robin Pollini	West Virginia University	Member
Shawn Balleydier	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Suzanne Wilson	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Tennysa Mace	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Trista Steward	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Will Cohen	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member

Table 5: Treat Subcommittee Members

Member	Organization or Group	Role
Alana Hudson	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Alex Alston	West Virginia Department of Health and Human Resources, Bureau for Behavioral Health	Member
Angela Kamer-Lay	Anthem	Member
Arif Sarwari	West Virginia University Health Sciences Center	Member
Briana Martin	Covenant House	Member *
Cassie Province	Covenant House	Member *
Christine Teague	Charleston Area Medical Center, Ryan White Clinic	Member *
Christopher Scott	The Ezekiel Project	Member *

Member	Organization or Group	Role
Denise Heflin-Peyton	Charleston Area Medical Center, Ryan White Clinic	Member *
Ed Kairis	The Health Plan	Member
Heather Hoffman	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Jackson Austin	Southern West Virginia Health Systems	Member *
Jay Mason	West Virginia Clinical & Translational Science Institute Project ECHO	Member
Jeff Wiseman	The Health Plan	Member
Jill Upson	Herbert Henderson Office of Minority Affairs	Member
Jostin Holmes	West Virginia Department of Health and Human Resources, Office of Drug Control Policy	Member
Judith Feinberg	West Virginia University School of Medicine	Chair
Katherine Tobin Chase	Shenandoah Community Health	Member *
Kathy Pauley	Division of Corrections	Member *
Luke Cecil	The Health Plan	Member
Sanjoydeb Mukherjee	Anthem	Member
Sara Vincelli	West Virginia Regional Partner of MAAETC	Member
Shelda Martin	Charleston Area Medical Center, Ryan White Clinic	Member *
Suzanne Wilson	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Tennysa Mace	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Tonda Johnson	Covenant House	Member *
Tricia Christensen	Community Education Group	Member
Vicki Cunningham	West Virginia Department of Health and Human Resources, Bureau for Medical Services	Member *

Table 6: Respond Subcommittee Members

Member	Organization or Group	Role
Abir Rahman	Cabell-Huntington Health Department	Member *
Alana Hudson	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Anndy Rogers	West Virginia University Positive Health Clinic	Member *
Beth McCreight	West Virginia Coalition to End Homelessness	Member *
Briana Martin	Covenant House	Member *
Brooke Parker	Charleston Area Medical Center, Ryan White Clinic	Member *

Member	Organization or Group	Role
Bruce Whitten	West Virginia Drug Intervention Institute	Member
Cassie Province	Covenant House	Member *
Christine Teague	Charleston Area Medical Center, Ryan White Clinic	Member *
Christopher Scott	The Ezekiel Project	Member *
Crystal Bauer	Project HOPE	Member *
Henry Hatfield	Office of Economic Development, Housing for People with AIDS	Chair
Jay Mason	West Virginia Clinical & Translational Science Institute Project ECHO	Member
Jeannette Southerly	West Virginia Regional Partner of MAAETC	Member *
Joanna Vance	Hope In Action Alliance	Member
Katherine Tobin (Chase)	Shenandoah Community Health	Member *
Kathy Pauley	West Virginia Division of Corrections	Member *
Lindsey Mason	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Lovina John	Community Education Group	Member
Margret Watkins	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Misty Arnold	Minnie Hamilton Health Systems	Member *
Nathan Kirk	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Robin Pollini	West Virginia University	Member
Rodney Robinson	Partnership of African American Churches	Member *
Shawnna Walker	Charleston Area Medical Center, Ryan White Clinic	Member *
Susan Hall	West Virginia Department of Health and Human Resources, Bureau for Medical Services	Member *
Suzanne Wilson	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Tennysa Mace	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Tim Priddy	West Virginia Department of Health and Human Resources, Center for Threat Preparedness	Member
Tonda Johnson	Covenant House	Member *
Traci Thornsbury	Williamson Health & Wellness	Member *

Table 7: Health Equity and People with Lived Experience Advisory Group Members

Member	Organization or Group	Role
Alana Hudson	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Ashley Murphy	Charleston Area Medical Center, Ryan White Clinic	Member *
A. Toni Young	Community Education Group	Chair
Briana Martin	Covenant House	Member *
Carolyn Kidd	West Virginia Regional Partner of MAAETC	Member
Cassie Province	Covenant House	Member *
Christopher Scott	The Ezekiel Project	Member *
Crystal Bauer	Project HOPE	Member *
Henry Hatfield	Office of Economic Development, Housing for People with AIDS	Member *
Megan Ross	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of Health Promotion and Chronic Disease	Member
Melissa Thompson	E.A. Hawse Health Center Inc	Member *
Rich Sutphin	West Virginia Rural Health Association	Member
Robert Wines	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of Immunization Services	Member
Suzanne Wilson	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Tennysa Mace	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member
Tonda Johnson	Covenant House	Member *
Will Cohen	West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of STD, HIV, Hepatitis and Tuberculosis	Member

Appendix D: HIV and Hepatitis Elimination Plan Letter of Concurrence

Letter of Concurrence
Between HIV Prevention Planning Group and West Virginia Bureau for Public Health

December 6, 2022

Centers for Disease Control and Prevention
Ms. Valerie McCloud
Grants Management Branch, Procurement and Grants Office
Funding Opportunity Announcement: PS 18-1802
CDC MS E- 15
2920 Brandywine Road, Room 3000 Atlanta, GA 30341-4146

Dear Ms. McCloud:

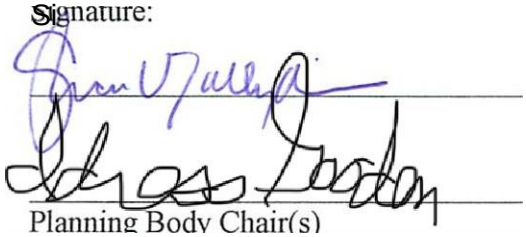
The West Virginia HIV/AIDS Planning and Advisory Group concurs with the following submission by the West Virginia Department of Health and Human Resources Bureau for Public Health Division of STD, HIV, Hepatitis and Tuberculosis in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 20222026.

The planning body (e.g., planning council, advisory council, HIV planning group, planning body) has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

Members of the West Virginia HIV/AIDS Planning and Advisory Group participated in the process of the plan's development as members of the Steering Committee as well as members and chairpersons of subcommittees. Planning group members were very active and involved in the plan's development and were instrumental in its completion.

The signature(s) below confirms the concurrence of the planning body with the Integrated HIV Prevention and Care Plan.

Signature: Date: 12/7/22



Planning Body Chair(s)

Appendix E: HIV and Hepatitis Elimination Letter of Commitment

Letter of Commitment
Between the Hepatitis Elimination Technical Advisory Group (HETAG) and
West Virginia Department of Health and Human Resources Bureau for Public Health

December 6, 2022

Ms. Valerie McCloud
Centers for Disease Control and Prevention (CDC)
Grants Management Branch, Procurement and Grants Office Funding Opportunity Announcement: PS 18=1802
CDC MS E-15
2920 Brandywine Road, Room 3000 Atlanta, GA 30341-4146

Dear Ms. McCloud:
The Hepatitis Elimination Technical Advisory Group (HETAG) is currently being formed by the Division of STD, HIV, Hepatitis and Tuberculosis within the Bureau for Public Health. Key stakeholders who participated in the process of developing the West Virginia 2022-2026 HIV and Hepatitis C Elimination Plan (Plan) as part of the Prevent, Diagnose, Treat, and Respond subcommittees are requested to serve on this advisory body.

The HETAG will support viral hepatitis elimination planning by carrying out the goals and objectives set forth in the Plan to ensure that resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of viral hepatitis and HIV.

Dr. Judith Feinberg, Professor of both Behavioral Medicine & Psychiatry and Medicine/Infectious Diseases at West Virginia University School of Medicine will serve as Co-Chair of the HETAG along with Tennysa Mace, Viral Hepatitis Prevention Coordinator with the Bureau for Public Health.

The signatures below confirm the commitment of the Co-Chairs to formation of the advisory and implementation of the Plan.

Judith Feinberg
Dr. Judith Feinberg

Professor, Behavioral Medicine & Psychiatry and Medicine/Infectious Diseases
West Virginia University School of Medicine

12/6/22

Tennysa Mace 12/6/22
Tennysa Mace
Viral Hepatitis Prevention Coordinator, Bureau for Public Health