Virginia Community HIV Planning Group
Thursday, February 12, 2026
Notes

Attendance:

Members: 16 members

VDH Staff: Ashley Yocum, Charlotte Ferguson, Marquietta Alston, Eric Mayes, Lauren Maxwell, Colin Dwyer, Carlos Aleman Cortez,

Guests: Five guests

CHPG Business:
Previous Minutes- The group approved October and December meeting minutes

Mentorship Discussion:
The group discussed reviving the mentorship program for new CHPG members, which pairs new members with experienced ones to provide guidance and support during the onboarding period. Several members shared positive past experiences as mentors or mentees, highlighting the program's value in easing transitions and clarifying processes/acronyms. Challenges included lack of enough mentors and varying levels of engagement in recent years.

Consensus: Strong support for reinstating the mentorship program on a volunteer basis to ensure quality experience.

Action Plan: Leadership will meet to plan implementation details and aim to provide a concrete update in the next meeting.

Prevention and Care Updates:

Prevention:
Portsmouth Health District was authorized to provide Comprehensive Harm Reduction (CHR) services bringing the total CHR sites in Virginia to 13.

DDP was funded by the Opioid Abatement Authority to run a 3-year pilot program for women who are pregnant or nursing who need harm reduction services.

Upcoming Events

- March 24th-25th: Hepatitis Conference
- March 31st-April 1st: HIV Prevention Summit
- April 10th-11th: Living Beyond Our Status Gathering

DDP is also holding a virtual public town hall on HIV prevention and care in Virginia. The discussion will tie direction into the Virginia Integrated HIV Services Plan.

The town hall will be held Wednesday, March 4, 2026, from 6 p.m. until 7 p.m. It is a virtual (online) meeting with a call-in option.

Contact Olivia Allison at olivia.allison@vdh.virginia.gov with questions or for more information.
Register today: https://events.gcc.teams.microsoft.com/event/1417e726-80f3-4679-9263-20c807068668@620ae5a9-4ec1-4fa0-8641-5d9f386c7309.

HIV Care Services:
Change in Leadership for HIV Care Services/VA RWHAP B

- Kimberly Scott, the HIV Care Services director for the past 10 years and PI/PD for Part B retired on Jan 12th.
- In the interim, Allison Green will serve as Interim Director, and Jonathan Albright is serving as the PI/PD for Part B until the position is recruited for.

11th Annual Virginia Ryan White Case Management Summit

The MidAtlantic AIDS Education and Training Center (MAAETC) local partner site, Virginia Commonwealth University (VCU), will be partnering with VDH, HIV case managers, and the Ryan White Program to host the 11th Annual Virginia Ryan White Case Management Summit. The summit will be held, virtually, on Tuesday April 21, from 10 a.m. until 4 p.m., and Wednesday, April 22, from 10 a.m. until 3 p.m.

The summit is open to all medical and non-medical case managers, HOPWA case managers, service navigators, community health workers, and others providing case management services to Virginians with HIV.
The theme of this year's summit is *Empowering New Pathways: The Work Continues*. Session topics will include:

- HIV/AIDS in 2026
- Partnering through internships and interprofessional education to support the next generation of the HIV workforce
- The use of technology in HIV case management
- Anger, de-escalation, and resiliency in case management
- Supporting health aging through nutrition
- Regional breakout sessions
- And more!

For questions, contact Rob Rodney, Director of the HIV Education Program at VCU, at robert.rodney@vcuhealth.rog.
Register today at: https://www.maaetc.org/events/view/30395

Bylaws Discussion and Approval:

- Clarified language around new members joining
- Clarified membership, attendance and proxy requirements
  - Virtual attendance
- **Keep in mind you are voting on the slate of changes not on each individual change**

- Current Language

  The mission of the CHPG is to develop strategies to enhance a coordinated, collaborative, and seamless approach to HIV prevention, care, treatment and support services for people with risk factors for, and living with HIV in Virginia.

- Proposed Change

  The mission of the CHPG is to develop strategies to enhance a coordinated, collaborative, and seamless approach to HIV prevention, care, treatment and support services for people ~~with risk factors for~~ **vulnerable to HIV**, and ~~living~~ **those** with HIV in Virginia.

- Current Language

  Provide a thorough orientation for all new CHPG members twice a year in January for members joining in February and July for members joining in August.

- Proposed Change

  Provide a thorough orientation for all new CHPG members, **either in-person or virtual**, ~~twice a year in January for members joining in February and July for members joining in August~~.

- Current Language

  Section 7: Vacancies. The Membership Committee will seek to maintain a balance of members representing both HIV prevention and care, as well as ensuring representation from Ryan White Part A and C.

- Proposed Change

  Section 7: Vacancies. The Membership Committee will seek to maintain a balance of members representing both HIV prevention and care, as well as ensuring representation from Ryan White Part A ~~and~~ C, **D, and F**.

- Current Language

  Section 2. Attendance: Members will not be considered absent if they attend only one day of a two-day meeting. Members will not be considered absent if a representative is sent (up to two meetings per year).

- Proposed Change

  Section 2. Attendance: ~~Members will not be considered absent if they attend only one day of a two day meeting~~. Members will not be considered absent if a representative is sent (up to two meetings per year, **excluding the annual member retreat**).

- Current Language

  Section 2. Attendance: **Members must attend and be active participants for at least 75% of meeting. The first time the member will get a warning, but after that, members not present or engaged for at least 75% of the meeting will be considered absent for that meeting.**

- Proposed Change

  Section 2. Attendance: **Members are expected to be present for and engage in both in person and virtual meetings. Attending half or less of meetings will be considered an absence.**

  - **In-Person:**
    - **Laptops should not be used during presentations and discussions.**

- **Virtual:**
  - **Virtual attendees should be on camera and participate fully in presentations and discussions by unmuting or using the chat function.**

- Current Language

  Section 2. Attendance: Following one unexcused or two total absences, members will receive a letter or email from the Co-Chairs or Planners notifying them of their status, reminding them of the attendance policy, offering assistance to facilitate attendance, and requesting a commitment to the process or resignation.

- Proposed Change

  Section 2. Attendance: Following ~~one unexcused or~~ two absences, members will receive a letter or email from the Co-Chairs or Planners notifying them of their status, reminding them of the attendance policy, offering assistance to facilitate attendance, and requesting a commitment to the process or resignation.

- Current Language

  Section 2. Attendance: This charter may be amended at any regular or special meeting of the CHPG. Written notice of the proposed Charter change shall be mailed or delivered to each member at least three days prior to the date of the meeting.

- Proposed Change

  Section 2. Attendance: This charter may be amended at any regular or special meeting of the CHPG. Written notice of the proposed Charter change shall be **sent** ~~mailed or delivered~~ to each member at least three days prior to the date of the meeting.

Black History within the Fight Against HIV by Arturo Hill

The Importance of Narrative in HIV/AIDS:

- Arturo emphasized how negative or skewed narratives have lasting effects on stigma, care, and humanity for people living with HIV, especially in Black communities.
- Arturo aims to dispel myths and offer historical, social, and cultural context.

Origins and Early Spread of HIV:

- HIV is a zoonotic virus (originated from non-human primates and jumped species through activities like butchering bush meat).
- Early spread in Central Africa was facilitated by factors like labor migration, colonization, and poor living conditions.
- Blood samples from 1959 in Congo showed HIV traces, predating US recognition**.**

Colonialism and Its Impact:

- Colonial exploitation, notably under Belgian King Leopold II, devastated the Congo, leaving the population vulnerable to disease devastated the Congo, leaving the population vulnerable to disease and without infrastructure to respond to outbreaks.
- Connection drawn between historical trauma, social conditions, and epidemic spread.

Patient Zero in the US:

- Robert Rayford, a Black teenager from Missouri, is cited as the first documented American to have HIV, with symptoms starting in the mid-1960s, predating the 1981 epidemic recognition.
- His case advanced scientific understanding but also illustrates how the virus was present in the US earlier than previously thought.

The 4H Club and Stigma:

- Early CDC messaging associated HIV with four groups:
  - Hemophiliacs, Homosexuals, Haitians, and Heroin users.
- This led to severe discrimination, particularly against Haitian immigrants (travel bans, economic impact, and quarantine), as well as LGBTQIA+ individuals (job and housing loss, social ostracism, hospital visitation denial).
- The narrative created harmful stereotypes that persist today.

Pop Culture and Awareness:

- Celebrities and pop culture (Prince, TLC, Janet Jackson, Michael Jackson, Princess Diana, Magic Johnson, Arthur Ashe) played key roles in destigmatizing HIV, raising awareness, and humanizing those affected.
- Media campaigns (MTV, BET) promoted testing and education; the ballroom scene and queer spaces provided support and fundraising.

Political Responses and Policy:

- 1995 marked peak AIDS deaths in the US; in 1996, improved medications ("Lazarus effect") began saving lives.
- Subsequent developments: PrEP (2012), increased prevention tools, and the Ryan White CARE Act (1990), which provided crucial resources.
- Early policy included problematic criminalization of HIV transmission, disproportionately impacting Black communities; some reforms have since occurred.
- President Obama expanded HIV care and prevention through the Affordable Care Act.

Persistent Challenges and Disparities (2023 Data):

- Black Americans are 3-4 times more likely to be diagnosed with HIV or AIDS-related complications than other groups, including youth and children.
- Contributing factors:

    - Unemployment
    - Racism
    - Homophobia/transphobia
    - Misogyny
    - medical mistrust
    - Economic hardship
    - Genetic mutation of HIV
    - Low PrEP access,
    - Shaming
    - Lack of education
    - Resource disparities (especially in the South)

Successes and Progress:

- 12% drop in new HIV cases in Black communities from 2018-2022.
- Black Americans have higher HIV testing rates than white or Latino populations.
- Over 87% of Black Americans living with HIV are diagnosed and in care.
- Viral suppression rates are improving, though disparities remain.
- Increased in-community awareness and efforts to address stigma, mental health, and HIV openly.

Legacy of Slavery and Systemic Racism:

- Slavery's legacy continues to impact health outcomes and medical trust: stereotypes about Black bodies, forced medical experimentation (e.g., Sarah Baartman, gynecological surgeries on enslaved women, Tuskegee Syphilis Study, and similar experiments on Latinos in Guatemala).
- Medical mistrust is rooted in historical abuses and exploitation.
- Persistent stereotypes ("magical negro") strip Black people of humanity and proper care.
- Mass incarceration (13th Amendment loophole) disproportionately affects Black Americans and contributes to higher HIV rates in prisons.

The Role of the Church and Internalized Stigma:

- The Black church has been both a source of strength and a contributor to sex-related and HIV stigma.
- Religious shame can deter individuals from seeking testing or treatment.

Call to Action and Social Justice:

- Advocation for narrative change: Black communities are actively fighting HIV, not passive or complicit.
- HIV is framed as a social justice issue, intertwined with the fight for dignity and equality.
- Final message: Remember your worth and identity beyond external narratives: progress is ongoing and should not be feared.

Key Questions Raised:
How can structural racism and the legacy of slavery be addressed in public health?
What can be done to further reduce stigma and improve access to prevention and care?

Decisions and Action Plans:

- Continue mythbusting and education to shift the narrative around HIV in Black communities.
- Advocate policy changes to remove barriers to care and reduce criminalization.
- Promote community-based strategies for awareness, testing, and support.

Epidemiological Snapshot Overview by Lauren Maxwell (VDH)
What is the Epi snapshot?

- Comprehensive overview of HIV in Virginia created for the integrated plan
  - 5-year patterns
  - Priority populations
  - Coinfections
  - Late diagnoses
  - Sociodemographic characteristics
  - Network detection and response
  - Care continuum
  - Ryan White Part B

It includes data on HIV trends, priority populations, co-infections (STIs), late diagnoses, sociodemographic characteristics, network detection/response, care continuum, and Ryan White Part B statistics.

HIV Epidemiology in Virginia

General Findings:

- Central and Eastern regions have a disproportionate share of HIV cases and new diagnoses compared to their population.
- In 2024, there were 851 new diagnoses; 2025 is on track for a decrease (high 700s, pending finalization).
- Rates per 100,000 are highest in certain metro and lower Virginia areas.

AgeTrends:

- People living with HIV tend to be older; new diagnoses skew younger, especially ages 25–34. There's a national trend of new diagnoses shifting to younger age groups.

Socioeconomic Factors:

- Poverty and lower educational attainment are highest in the Southwest.
- Unemployment data (from 2023) is fairly consistent statewide but may not reflect recent increases.
- Foreign-born residents account for 13% of the population, with the Northern region highest (~30%).

Diagnosis and Testing Trends:

- New HIV diagnoses have decreased over the past decade, with a notable dip during COVID-19 (due to reduced testing, not necessarily fewer infections).
- Testing rates are recovering but haven't reached pre-COVID levels, with regional variations due to funding and priorities**.**

Demographic and Risk Factor Patterns:

By Sex at Birth:

- Majority of new diagnoses are among males. Data is reported by sex at birth due to lack of standardized gender identity reporting across labs.

By Race/Ethnicity:

- Black (non-Hispanic) and Hispanic/Latino populations are increasingly represented among new diagnoses.
- Hispanic/Latino groups have shown growth in new cases and often have less complete risk factor data, likely due to cultural and reporting challenges.

By Risk Factor:

- Male-to-male sexual contact is the leading reported risk, followed by injection drug use and heterosexual contact.
- Cases with no risk reported/indicated are rising, possibly due to increased privacy concerns and mistrust post-COVID-19.

Regional and Late Diagnosis Trends:

Regional:

- Central and Eastern regions have highest new diagnoses.
- Late diagnoses (AIDS within 90 days of HIV diagnosis) have decreased overall, contrary to expectations post-pandemic, except for an increase in the Northwest (possibly small numbers)

Care Continuum and Ryan White Program:

Statewide Care Continuum (2024):

- 28,277 people with HIV; 737 new diagnoses linked to care within 30 days (87%).
- Evidence of care: 72%; Retained in care: 57%; Virally suppressed: 62%. These are close to national averages.

Priority Populations:

- Youth (13–24) have higher care engagement; aging populations (65+) have lower.
- Persons who inject drugs have slightly above-average viral suppression (65%).

Ryan White Part B Clients:

- ~8,675 clients; new diagnoses linked to care within 30 days at 100%/99%.
- Evidence of care: nearly 100%; Retention: 93%; Viral suppression: 90%.
- Targeted programs like Ryan White and Charlie Program (for formerly incarcerated) show higher care and suppression rates due to focused interventions.

Data Availability and Requests

- Data is available via request and online (annual reports, profiles, care continuum, Charlie data).
- Team can provide raw data, visualizations, and assistance for projects.

Epidemiological Snapshot Group Discussion:

Notable Questions Raised:

- *What drives differences in care engagement and viral suppression between Ryan White clients and the general population?*
- *How can care standards be adjusted to better reflect real-world care patterns and viral suppression?*
- *What strategies can be used to track the impact of funding changes on care access?*
- *How can outreach and messaging be refined to engage high-risk and underserved populations without increasing stigma or risk to privacy?*

Action Items & Next Steps:

- Continue monitoring regional trends, especially late diagnoses and viral suppression disparities.
- Explore deeper analysis of care retention and viral suppression by medication type when more data becomes available.
- Encourage data requests from programs needing support or insight.
- Maintain privacy-focused data collection policies while advocating for meaningful measures (e.g., care marker standards).
- Consider forecasting studies on the effects of funding changes as data permit.

Lunch Break

Council of Community Services Agency Spotlight by Todd Rothrock

Overview of Organization

- The Council of Community Services (CCS) has operated for over 15 years, providing capacity-building for nonprofits, housing services (including HOPWA and housing referrals), and health services.
- CCS runs the 211 referral service, a key resource for case managers and the general public to access local services.
- The Drop-In Center, part of health services, offers three main programs:
    - **Status Neutral Program:** Focused on HIV and Hepatitis C testing, care linkage, treatment, and social needs assessment. Includes a mentorship program pairing stable clients with those newly diagnosed or struggling.
    - **Comprehensive Harm Reduction Program**: Provides harm reduction supplies (e.g., syringes, sharps containers), education, and referrals for people with substance use disorders. Outreach is conducted both onsite and in the community.
    - **Ryan White Program:** Offers HIV care and support across

Southwest Virginia. Recent funding cuts have forced clinic and Office closures, reducing staff, and requiring remote/itinerant case office closures, reducing staff and requiring remote/itinerant case management.

Impact of Funding Cuts

- Significant funding reductions since 2020 forced closure of several offices and consolidation of services.
- Staff reductions have led to increased workloads for remaining staff, especially in eligibility processing.
- CCS leadership recognized the need to shift from a "scarcity mindset" and proactively adapt by seeking new revenue streams and community support.

Community Outreach & Fundraising Strategies

- CCS changed its communication strategy, becoming more open about financial needs and appealing directly to the community for support.
- Leveraged local and regional media, social media (including adding donation options), and word-of-mouth to share their story.
- Developed partnerships with faith-based organizations (e.g., Green Memorial Church), other nonprofits (e.g., The Park), local businesses, and even the punk rock community to secure resources, donations, and space for services.
- Hosted fall/winter resource festivals and community lunches to maintain engagement and provide direct access to services, especially as case management capacity decreased.

Adaptations to Service Delivery

- CCS staff now work remotely or travel to meet clients in neutral locations (libraries, etc.).
- Cross-program staffing allows more flexibility—staff from one program may step in to support another as needed.
- Donations have primarily supported critical needs like food pantries and transportation (e.g., bus passes, Uber rides), helping address gaps not covered by traditional funding.

Key Discussion Points and Questions Raised

- **Service Gaps:** Concerns were expressed about the impact of office closures in Danville and Marion, and whether similar community engagement is possible in those areas.
    - CCS leadership acknowledged the challenge and indicated that strategies for these areas are being developed as closures are finalized.
    - Offers of support from regional VACAC teams were welcomed.

- **Financial Donations:** Questioned whether unrestricted donations have enabled more flexibility in service delivery.
    - Leadership confirmed that while donations have not been enough to restore lost positions, they have allowed more flexibility in supporting transportation and other urgent needs.
    - **Service Area Clarification:** Clarified geographic service boundaries (e.g., Southside vs. Southwest Virginia).

Decisions and Action Plans

- Continue to adapt outreach, fundraising, and service models in response to funding constraints.

- Develop new strategies for maintaining service presence in affected regions (Danville, Marion) as office closures complete.
- Maintain and expand community partnerships for resources and in kind support.
- Prioritize communication and engagement with both clients and the broader community to sustain awareness and support.

Icebreaker Activity

Reaching Spanish Speaking Populations for HIV Prevention by Carlos Aleman Cortez

- Emphasis on addressing health inequities and improving care quality for Spanish speakers.
- The session included interactive questions and group discussions about personal healthcare experiences.

Patient Experiences with Healthcare

- Participants shared instances of feeling misunderstood or respected in medical settings:
    - Being listened to, offered options, and having providers take time to understand medical history increased feelings of respect.
    - Feeling dismissed when providers rushed, lacked knowledge about patient backgrounds, or failed to communicate effectively.
    - Language barriers and lack of provider preparedness were recurring themes.

Cultural Competency: Definitions and Importance

- Cultural competence was defined as understanding, respecting, and appropriately responding to the unique cultural needs of patients.
- Discussed Terry Cross's continuum of cultural competence, from destructiveness to proficiency:
    - Examples provided at each stage, with emphasis on moving toward cultural proficiency (actively seeking to learn, improve, and champion equity).
- Highlighted the importance of self-awareness, ongoing training, and humility among providers**.**

Practical Strategies for Providers

- Employ motivational interviewing and open-ended questions to better understand patient perspectives.
- Use certified medical interpreters and translated materials to bridge language gaps; avoid relying on untrained family members, especially children.
- Recognize alternative medicine and spiritual/religious practices as important aspects of some patients' healthcare decisions.
- Remain sensitive to trauma histories and cultural beliefs when recommending treatments.
- Providers should be proactive in learning about cultures they serve and acknowledge when they lack knowledge, inviting correction and feedback from patients.

Barriers to Healthcare Access for Spanish-Speaking Populations

- Immigration enforcement (ICE) presence near healthcare facilities creates fear and reduces healthcare utilization among undocumented communities.
- The lack of trust due to immigration policies undermines cultural competence efforts.
- Geographic and policy differences affect how effectively organizations can implement culturally competent care.

Organizational Assessment & Improvement

- Staff and participants reflected on their organizations' current level of cultural competence, identifying strengths (e.g., multilingual staff and materials) and areas for improvement (e.g., funding, broader training, better interpreter services).
- Recognized that cultural competence is an ongoing process requiring continuous self-evaluation and adaptation.

Decisions Made

- Consensus on the need for more training, funding, and resources to improve cultural competence, especially in language access and staff diversity.
- Acknowledgment of the importance of advocacy for patients and continuous improvement in service delivery.

Action Plans

- Continue developing and distributing translated materials in multiple languages.
- Increase recruitment and training of bilingual/bicultural staff.
- Foster an environment of humility and openness to feedback among healthcare providers.
- Enhance outreach to immigrant and minority communities to build trust and reduce barriers to care trust and reduce barriers to care.
- Encourage organizations to regularly assess their cultural competence and seek community input.

Additional Notes

- Participants shared positive examples of organizations excelling in cultural competence (e.g., Alexandria Health Department using four languages in all materials).
- The importance of not using children as interpreters, particularly in sensitive medical contexts, was emphasized.

Ryan White Fundamentals by Robert Rodney (VCU)

Program History and Structure

- The meeting provided a detailed overview of the Ryan White HIV/AIDS Program (RWHP), including its origins, legislative history, and evolution since 1990.
- Key aspects covered included the program's purpose as a 'payer of last resort' for people living with HIV who are uninsured or underinsured.
- The law requires community and stakeholder involvement in program decision-making, a unique feature among federal health programs.

Legislative Milestones

- The program began in 1990 as the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act.
- Major reauthorizations occurred in 1996, 2000, and 2006, with significant changes such as clearer service categories, expanded eligibility (from AIDS to HIV/AIDS), and the removal of the sunset clause, making the program permanent unless Congress passes a new law.

- In 2009, the program's focus was updated to emphasize the treatment cascade (linkage, retention, and viral suppression).

Program Parts (A-F)

- Part A: Funds major metropolitan areas (EMAs and TGAs) heavily impacted by HIV/AIDS. Local jurisdictions set eligibility and services, leading to variation between cities.
- Part B: Covers states and territories, requiring drug assistance programs (ADAPs). Each state determines income eligibility and service categories. Noted that income requirements and services vary widely (e.g., 300–600% of FPL).
- Part C: Provides direct funding to medical providers for outpatient and early intervention services. Includes a cap on patient charges.
- Part D: Focuses on Women, Infants, Children, and Youth (WICY), with funding aimed at preventing perinatal transmission and supporting youth up to age 24.
- Part E: Was intended for occupational exposure but was never funded and folded into Part F.
- Part F: Funds special projects (including Minority AIDS Initiative, dental programs, and training centers like AETCs). Includes demonstration projects that can influence future service categories.

Proposed and Recent Changes

- Discussion on a proposed federal change to jurisdictional eligibility for funding: shifting from location at diagnosis to current residence, aiming for more accurate resource allocation based on patient movement.
- Potential funding impacts: Some areas may lose funding (e.g., Virginia EMAs/TGAs), while others may see increases (e.g., Las Vegas, San Francisco).
- The change is not yet final; public comment has closed, and implementation could begin in 2026.

Service Categories and Funding Limitations

- Not all allowable services are available at all agencies or jurisdictions; they depend on what the funder and agency apply for and approve.
- 75% of funds must be spent on core medical services and 25% on support services, with waivers possible.
- Navigating eligibility and services is complex for both clients and providers, especially when clients move between jurisdictions or states.

Advocacy and Funding Risks

- Emphasized the importance of local and national advocacy, especially in light of recent threats to eliminate parts of the program during government shutdowns.
- Bipartisan support for the Ryan White Program has historically been strong, but funding is always a risk.

Questions & Answers

- Impact of Medicaid changes: With potential Medicaid changes, more people may become eligible for RWHP if they lose Medicaid coverage.
- Dental services: Emergency dental care under Part B requires agency/provider determination. Part F funds comprehensive dental clinics, but none are currently in Virginia.

- ADAP and residency: ADAP eligibility is state-based; clients must reside in the state where services are received, with no workaround for cross-state convenience.

Meeting Wrap up and Evaluation

Adjourn: NEXT MEETING: Friday, April 17th, 2026