
Nevada Integrated HIV Prevention and Care Plan 2017-2021

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Las Vegas TGA Ryan White Part A HIV/AIDS Program

Ryan White HIV/AIDS Part B Program

HIV Prevention Program

State Office of HIV/AIDS, Nevada Division of Public and Behavioral Health



LAS VEGAS TGA
PART A HIV/AIDS PROGRAM
CLARK | MOHAVE | NYE COUNTIES

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	4
EXECUTIVE SUMMARY	5
INTRODUCTION	10
SECTION I: STATEWIDE COORDINATED STATEMENT OF NEED/NEEDS ASSESSMENT	11
A. Epidemiologic Overview.....	11
Description of Nevada	11
Socio-Demographic Characteristics of Populations At Risk for HIV, Newly Diagnosed, or Living with HIV	12
The Burden of HIV in Nevada	15
Indicators of Risk for HIV Infection in Nevada.....	31
B. HIV Care Continuum.....	39
C. Financial and Human Resources Inventory	46
HIV Workforce Capacity	48
Interaction of Funding Sources	49
Needed Resources/Services	51
D. Assessing Needs, Gaps, and Barriers.....	52
Needs Assessment Process	52
HIV Prevention Needs and Gaps	54
HIV Care Service Needs and Gaps	56
Barriers to HIV Prevention and Care Services	58
E. Data: Access, Sources, and Systems	61
Main Sources of Data	61
Data Policies	63
Desired Data and Information.....	64
SECTION II: INTEGRATED HIV PREVENTION AND CARE PLAN.....	64
A. Integrated HIV Prevention and Care Plan.....	64
Overview of Nevada’s Goals, Objectives, and Strategies for 2017-2021.....	64
Goal 1: Reducing new HIV infections	67
Goal 2: Increasing access to care and improving health outcomes for PLWH.....	74

Goal 3: Reducing HIV related disparities and health inequities	88
B. Collaborations, Partnerships, and Stakeholder Involvement	98
Contributions of Stakeholders and Key Partners	98
C. People Living With HIV (PLWH) and Community Engagement	99
SECTION III: MONITORING AND IMPROVEMENT	102
APPENDICES	103
Appendix A: List of Acronyms and Definitions	103
Appendix B Additional Epidemiological Profile Tables and Graphs.....	108
Appendix C: Jurisdictional HIV Resources Inventory	119
Appendix D: Stakeholder Meeting Representatives.....	124
Appendix E: Las Vegas TGA Needs Assessment and Customer Satisfaction Reports	126
Appendix F: Client Survey.....	127
Appendix G: Summary of Client Survey Results	129
Appendix H: Community HIV Prevention Survey	140
Appendix I: Summary of HIV Prevention Community Survey Results	143
Appendix J: Focus Group Questions	151
Appendix K: Summary of Focus Group Results	154
Appendix L: Provider Survey Results.....	161
Appendix M: Letters of Concurrence.....	169
REFERENCES	172

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Nevada Integrated HIV Prevention and Care Plan 2017-2021

EXECUTIVE SUMMARY

The Nevada Integrated HIV Prevention and Care Plan 2017-2021, including the Statewide Coordinated Statement of Need, was developed in response to the guidance provided by the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) in June 2015. The process was guided by the Integrated HIV Prevention and Care Plan Internal Workgroup, which was formed by the State Office of HIV/AIDS and the Las Vegas Transitional Grant Area (TGA) Ryan White HIV/AIDS Part A Program. The workgroup included representatives from the Las Vegas TGA Ryan White Part A Program, Ryan White Part B Program, HIV Prevention Program, Southern Nevada Health District (SNHD), and Washoe County Health District (WCHD). The School of Community Health Sciences (SCHS), University of Nevada, Reno (UNR) was contracted to conduct the needs assessment and write the plan in collaboration with the Internal Workgroup.

The Statewide Coordinated Statement of Need/Needs Assessment guided the development of the plan objectives and strategies. The majority of Nevada's population resides in Clark County (72%); and Clark County bears the heaviest burden of HIV in the state. In 2014, 88% of persons newly diagnosed with HIV and 86% of all people living with HIV (PLWH) resided in Clark County. In 2014, 87% of persons newly diagnosed with HIV in Nevada were male; and 74% of newly diagnosed males reported a transmission category of male-to-male sexual contact. Large racial/ethnic disparities exist within Nevada, especially among Blacks/African Americans. In 2014, the rate of new HIV diagnoses among Blacks was over four times that of Whites (43.6 vs. 10.5 per 100,000 population).

Developing an accurate picture of Nevada's HIV Continuum of Care was challenging since, at the time the data was collected, Nevada state law only required the reporting of CD4 values with counts below 500 per ml³ of blood and a detectable viral load (>200 copies/ml). This resulted in an underestimation of cases retained in care and virally suppressed. This issue will be resolved going forward due a change in regulation beginning in 2016 which now requires reporting of all CD4 values and all HIV viral load measurements. Of the 477 newly diagnosed cases of HIV in 2015, 81.3% were linked to care within three months after diagnosis. Among those PLWH retained in care at the end of 2015, 75.1% had suppressed viral load (<=200 copies/mL) at most recent test during 2015. Among PLWH year-end 2014 and alive at year-end 2015, 38.3% had suppressed viral load (<=200 copies/mL) at most recent test during 2015.

Nevada's Office of HIV/AIDS within the Division of Public and Behavioral Health (DPBH) manages the state's Ryan White Part B Program (RWPB) and the HIV Prevention Program. RWPB provides medications and services to eligible Nevadans living with HIV/AIDS. HIV Prevention Program staff coordinates its efforts in collaboration with the local health districts, HIV Prevention Planning Groups, HIV-infected and affected communities, state and local HIV prevention providers, and other concerned and committed citizens to improve HIV Prevention service delivery in Nevada. Clark County Social Service manages the Las Vegas Transitional Grant Area Part A HIV/AIDS Program. The Las Vegas Transitional Grant Area (TGA) funds provider agencies to deliver core medical and/or support services for PLWH in Clark and Nye Counties in

Southern Nevada. The grantee works with the Part A Planning Council in making decisions about how to use the funds.

The HIV workforce in Nevada includes licensed medical providers, mental health care providers, psychiatrists, registered dietitians that are HIV focused, community health workers, dentists and dental hygienists who have received HIV training, peer navigators, certified nurse case managers, medical case managers, paraprofessionals, counselors, and social workers. Two HIV specialty clinics are available in Nevada—Northern Nevada HOPES in the north and UMC Wellness Center in the south. Additionally, some private physicians provide HIV care. Nevada faces some challenges with the HIV workforce capacity, including a general shortage of physicians, psychiatrists, and other health care professionals across the state. Other key needs related to workforce capacity included the need for additional training for healthcare professionals related to HIV/AIDS, cultural competence, and empathy; more collaboration and communication among agencies; and more diversity among providers and healthcare workers.

The Ryan White programs in Nevada collaborate extensively to assure that services are developed and provided per identified need. Recipients and sub-recipients of all Ryan White funding streams (Part A, B, C, D and F) also meet quarterly in a meeting called The Gathering to discuss emerging issues and enhance the continuum of care across all parts. The prevention planning groups in the north and the south and Part A Planning Council in the south meet on a regular basis and facilitate the coordination of HIV prevention and care services across the state through regular communication between agency representatives, community organizations, providers, and PLWH. Service providers collaborate extensively with the state and the district health departments to assure that the continuum of care is addressed through testing to linkage and retention in care. In addition to the federally funded Ryan White efforts, the state and county health division programs interact with various organizations and assistance programs in the nonprofit sector to provide care, planning, and services in Nevada.

The needs assessment process began in April 2015 with stakeholder meetings of representatives from HIV prevention and care in the north and the south, during which participants identified unmet needs, challenges and gaps related to HIV in Nevada. Two needs assessments, one comprehensive and one targeted, and a customer satisfaction study from the Las Vegas TGA were conducted and used to inform this Statewide Coordinated Statement of Needs. The HIV client survey, prevention community survey, provider survey, and 20 focus groups for community members and HIV clients were conducted between April 2015 and May 2016.

Top HIV prevention service needs identified through the needs assessment process include basic HIV prevention education and awareness activities, reduction of stigma, free or low cost testing, access to rapid testing, routine testing by primary care providers, culturally and linguistically appropriate education, free or low cost condoms, education, awareness and access to PrEP and PEP, and syringe services programs. Service gaps in Nevada for persons at risk for HIV include education, peer support programs, and universal testing for HIV, which may contribute to reducing risk and to getting people into care as soon as possible. Culturally and linguistically appropriate HIV prevention materials were noted as lacking in the state. Both focus group and survey respondents emphasized the lack of comprehensive HIV

prevention education in schools across the state. HIV Community Survey respondents most preferred receiving information about HIV/AIDS through the internet, health care providers, and brochures.

Surveys and focus groups of PLWH revealed the most needed services including medical, dental, and vision care, food assistance, medication, transportation, and case management. Additionally, providers noted the need for legal services, substance abuse help, early intervention services, HIV and health classes, and outreach. Top gaps related to HIV care in Nevada include vision and dental care, financial assistance, transportation, specialty care, nutrition, housing, mental health services, food assistance, peer advocates, and substance abuse services.

Stigma was the main social barrier that negatively impacts HIV prevention and care efforts in Nevada. Transportation is another key barrier, particularly in southern Nevada. Lack of HIV providers, lack of specialty care providers, lack of mental health workers, and lack of case workers are barriers that impact linkage to care and retention in care. Top client barriers noted by survey respondents and focus group participants included lack of available services, health literacy, poverty, time, transportation, and conflicting responsibilities.

A stakeholders meeting was held in March 2016 to review the needs assessment data and to initiate the process of setting goals and objectives for the integrated plan. This meeting was attended by 41 participants, not including the facilitators, and represented a wide variety of participants including PLWH and representatives from providers, prevention agencies, and other community-based organizations. The Internal Workgroup and the team from the School of Community Health Sciences further developed the objectives, strategies, and activities and requested review and feedback from the HIV Community Planning Groups in the north and south and the Part A Planning Council. Community members and people at higher risk for HIV infection contributed to the development of the plan through participation in the Community Survey and a variety of focus groups. PLWH contributed to plan development through their participation in the Part A needs assessment surveys and focus groups and customer satisfaction surveys and statewide/part B client survey and focus groups. Furthermore, PLWH, community members, providers, and community based organizations are represented in the membership of the planning groups in the north and south and in the Part A Planning Council. Participants in the needs assessment were diverse and represented the Nevada population of people PLWH and people at risk for HIV infection very well.

As required in the Integrated Plan Guidance, Nevada's plan objectives align to the three National HIV/AIDS Strategy (NHAS) goals: 1) reducing new infections; 2) increasing access to care and improving health outcomes for PLWH; and 3) reducing HIV related disparities and health inequities. From two to five objectives were developed for each goal along with three strategies for each objective. Tables in Section IIA of the plan detail the timelines, responsible parties, activities/interventions, target populations, resources needed and metrics.

Nevada Integrated HIV Prevention and Care Plan 2017-2021

Goal 1: Reducing new HIV infections

Objective 1a. By 2021, 90% of people living with HIV will know their serostatus.

O1a. Strategy 1: Increase number of high risk people tested in Nevada, based on data

O1a. Strategy 2: Increase community awareness of the importance of HIV testing, including awareness of testing sites

O1a. Strategy 3: Increase the number of rapid HIV testing locations available in Nevada

Objective 1b. By 2021, reduce by 25% the number of new HIV diagnoses.

O1b. Strategy 1: Increase education and access to PrEP and PEP

O1b. Strategy 2: Increase community education of HIV/AIDS through comprehensive sexual health education

O1b. Strategy 3: Provide community-wide harm reduction strategies, including condoms and other harm reduction materials availability and utilization

Goal 2: Increasing access to care and improving health outcomes for PLWH

Objective 2a. By 2021, increase to 85% the percentage of people newly diagnosed with HIV who have been linked to a provider within the first 30 days.

O2a. Strategy 1: Improved communication between organizations

O2a Strategy 2: Link hard-to reach populations to providers to provide continuity of care for PLWH

O2a Strategy 3: Facilitate patient readiness to participate in their care and management of HIV

Objective 2b. By 2021, increase by 20% the percentage of clients in care needing mental and/or behavioral health services who went to their first appointment.

O2b. Strategy 1: Improve communication among organizations and between clients and organizations

O2b. Strategy 2: Recruit more mental/behavioral health providers

O2b. Strategy 3: Professional Development activities

Objective 2c. By 2021, 80% of people diagnosed with HIV, who have had a medical visit each year for the past two years, will be virally suppressed (VL <200)

O2c. Strategy 1: Address treatment adherence of PLWH through educational strategies and evaluation

O2c. Strategy 2: Provide education and information regarding uninterrupted access to and proper use of medication

O2c. Strategy 3: Educate both client and provider stakeholders regarding the importance of routine viral load testing and tracking of viral load data

Objective 2d. By 2021, reduce to 20% the incidence of STIs in HIV infected persons in care.

O2d. Strategy 1: Conduct provider education and disseminate recommendations regarding routine screenings for STIs

O2d. Strategy 2: Conduct public and individual education for PLWH and newly diagnosed regarding STI s

O2d. Strategy 3: Develop quality control measures to improve clinical care and outcomes

Objective 2e. By 2021, increase number of clinics screening for HIV associated comorbidities by 20%.

O2e. Strategy 1: Conduct provider education and recommendations regarding routine screenings for comorbidities

O2e. Strategy 2: Conduct public and individual education for PLWH and newly diagnosed regarding common HIV comorbidities

O2e. Strategy 3: Develop quality control measures to improve clinical care and outcomes

Goal 3: Reducing HIV related disparities and health inequities

Objective 3a. By 2021, reduce disparities in the rate of new diagnoses by at least 15 percent among Nevada's priority populations.

O3a. Strategy 1: Engage the community in order to find out how to best reach priority populations

O3a. Strategy 2: Implement HIV prevention public education through media campaigns and social network strategies to target populations

O3a. Strategy 3: Increase provider and organization capacity to test at sites in their communities

Objective 3b. By 2021, increase to 85% the percentage of newly diagnosed with HIV among Nevada's priority populations who have been linked to a provider within the first 30 days.

O3b. Strategy 1: Improve first contact and point of access to care for PLWH who experience multiple "layers" of stigma (e.g., HIV infected, gay, minority, female, transgender, IV drug user, etc.)

O3b. Strategy 2: Improve the ability of PLWH in underserved or high risk groups to navigate the HIV system of care

O3b. Strategy 3: Improve the accessibility of information for PLWH in underserved or high risk groups

The HIV Prevention and Care Integrated Plan includes strategies for ongoing monitoring and improvement. The HIV Prevention and Care Integrated Plan Internal Workgroup will meet every six months to review progress on plan implementation. The RWPA, RWPB and HIV Prevention programs have contracted the School of Community Health Sciences (SCHS) at the University of Nevada, Reno to oversee the evaluation and monitoring of the plan. SCHS will collaborate with the workgroup and planning bodies throughout the evaluation and monitoring process. An evaluation report will be produced annually to document the implementation process as well as progress towards the plan goals and objectives. The workgroup, community planning groups, and Part A Planning Council will review current epidemiological data on an annual basis and use it to make adjustments to the plan as needed.

INTRODUCTION

Following the guidance provided by the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) in June 2015, the Nevada Integrated HIV Prevention and Care Plan 2017-2021, including the Statewide Coordinated Statement of Need, was developed in collaboration with a wide variety of stakeholders involved with HIV prevention and care in Nevada. The needs assessment and plan development process began in 2014 as the administrators of Ryan White HIV/AIDS Part A Program (RWPA), Ryan White HIV/AIDS Part B Program (RWPB), and HIV Prevention Program in Nevada chose to work together to submit one Integrated HIV Prevention and Care Plan on behalf of the HRSA and CDC-funded jurisdictions in the state. The State Office of HIV/AIDS and the Las Vegas TGA RWPA program formed an internal workgroup to guide the planning process. The Integrated HIV Prevention and Care Plan Internal Workgroup included representatives from RWPB program, the HIV Prevention program, the Las Vegas TGA RWPA program, the Southern Nevada Health District (SNHD), and the Washoe County Health District (WCHD). The School of Community Health Sciences (SCHS) at the University of Nevada, Reno (UNR) was contracted to conduct the needs assessment and write the plan in coordination with the workgroup.

The workgroup solicited input on the needs assessment and integrated plan throughout the process from a wide variety of stakeholders including providers, community based organizations, people living with HIV (PLWH), people at risk for HIV infection, the HIV community planning groups in the north and south, and the Part A Planning Council. Many stakeholders were actively involved in the process and were instrumental in the development of the plan's objectives and strategies. As a result of this comprehensive planning process, Nevada has developed a collaborative statewide plan for HIV prevention and care that will guide the state forward as we work towards reducing new HIV infections, increasing access to care and improving health outcomes for people living with HIV, and reducing HIV related disparities and health inequities.

This plan is divided into three sections. Section I contains the Statewide Coordinated State of Need/Needs Assessment and includes the Epidemiologic Overview; the HIV Care Continuum; the Financial and Human Resources Inventory; the Assessment of Needs, Gaps, and Barriers; and Data Access, Sources and Systems. Section II is the Integrated HIV Prevention and Care Plan, including the description of the plan Goals, Objectives, Strategies, Activities and Resources; Collaborations, Partnerships, and Stakeholder Involvement; and People Living with HIV and Community Engagement. Finally, Section III discusses Monitoring and Improvement.

SECTION I: STATEWIDE COORDINATED STATEMENT OF NEED/NEEDS ASSESSMENT

A. EPIDEMIOLOGIC OVERVIEW

DESCRIPTION OF NEVADA

- a. *Describe (map and/or narrative) the geographical region of the jurisdiction (i.e., Metropolitan Statistical Area/Metropolitan Division, Transitional Grant Area/Eligible Metropolitan Area, and States/Territories) with regard to communities affected by HIV infection.*

DEMOGRAPHIC CHARACTERISTICS

Nevada is the seventh largest state (geographically) in the nation. It is comprised of 17 counties spread across 110,540 square miles. Nevada is a frontier state with a 2013 population estimate of almost 2.8 million (Nevada State Demographer) and is traditionally divided into three regions: Clark County (72.3% of the population), Washoe County (15.2% of the population), and all other counties (12.5% of the population). It is the fifth fastest growing state in the nation. Approximately 81.1% of Nevada's land area is owned by the federal government, with 67% administered by the Bureau of Land Management. The remaining 18.9% is under private ownership or state/local jurisdiction.

In 2013, the race/ethnicity composition of Nevada was 58.3% White, 26.5% Hispanic, 7.2% Black, 6.7% Asian/Pacific Islander, and 1.3% Native American or Alaska Native. Nevada is one of nine states to potentially become a minority-majority state as Nevada has a minority population of 41.7%. Over one-half of the population in Nevada was between the ages of 25 and 64 (52.8%); another one-third was between the ages of 0 and 24 (35.5); while the remaining 12.7% of population was age 65 and older. Just over half of the population (50.5%) is male with the remaining 49.5% female.¹

SOCIOECONOMIC STATUS

In 2012, the average annual pay in Nevada was \$46,716, ranking 32nd in the nation. The median household income was \$54,083, ranking 32nd in the nation.² Nevada ranks 31st in the country for persons living below the poverty level. Just over sixteen percent of Nevada's population was living below the poverty level in 2012. The poverty rates per county ranged from 8.6 in Storey County to 20.5 in Pershing County.⁵ According to the U.S. Census Bureau, 22.2% of Nevada's population of 25 years and older has a bachelor's degree or higher; and 84.4 % of Nevada's population is a high school graduate or higher.³ According to the 2012 American Community Family Survey, 57% of Nevada's population aged 16 years and older were employed. Also, an estimated 24% of children under 18 years were below poverty level.⁴

HEALTH STATUS

In 2013, the United Health Foundation ranked Nevada 37th in the nation based on 15 health indicators. Nevada's strengths are low levels of air pollution at 9.1 micrograms of fine particulate per cubic meter, a low rate of preventable hospitalizations with 57.3 discharges per 1,000 Medicare enrollees, and a low

infant mortality rate at 5.7 deaths per 1,000 live births. Some of the challenges are low immunization coverage with 65.3% of children ages 19 to 35 months receiving complete immunizations.⁵ Nevada also had the lowest rate (50%) of adults receiving the flu vaccine in the country.⁷ Nevada has low public health funding at \$37 per person and high geographic disparity in public health funding within the state at 19.1%. Nevada ranks 32nd among states for premature death (years lost per 100,000 population).⁶

In 2013, Nevada had a higher rate of uninsured residents than the national average, at 23.0% compared to 15.6%. The percentage of government funded insurance is lower in Nevada than the national average. By race/ethnicity, Hispanics had the highest uninsured rate at 35%, according to the Kaiser State Health Facts report. According to the United States Census 2012 Statistical Abstract, Nevada ranked 47th in the nation for doctors per 100,000 resident population in 2009 (most recent data).⁷ Twelve of Nevada's counties have areas or population groups within county lines that are considered to be Primary Medical Care Health Professional Shortage areas.⁸

NEVADA'S RYAN WHITE PART A, PART B AND HIV PREVENTION PROGRAMS

Nevada's Office of HIV/AIDS within the Division of Public and Behavioral Health (DPBH) manages the state's Ryan White Part B Program and the HIV Prevention Program. RWPB provides medications and services to eligible Nevadans living with HIV/AIDS. Part B of the Ryan White HIV/AIDS Treatment Modernization Act provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and 5 U.S. Pacific Territories or Associated Jurisdictions. HIV Prevention Program staff coordinates its efforts in collaboration with the local health districts, HIV Prevention Planning Groups, HIV-infected and affected communities, state and local HIV prevention providers, and other concerned and committed citizens to improve HIV Prevention service delivery in Nevada.

Clark County Social Service manages the Las Vegas TGA Part A HIV/AIDS Program. The Las Vegas Transitional Grant Area (TGA) consists of three counties that cover two conjoining states. The three counties in the TGA are Clark County, Nevada, Nye County, Nevada and Mohave County, Arizona. RWPA funds go to local areas that have been hit hardest by the HIV epidemic. Las Vegas is a TGA, meaning it is a metropolitan area with between 1,000 and 1,999 new cases of AIDS reported in the past five years and at least 1,500 cumulative living cases of AIDS as of the most recent calendar year. The grantee works with the Part A Planning Council in making decisions about how to use the funds.

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF POPULATIONS AT RISK FOR HIV, NEWLY DIAGNOSED, OR LIVING WITH HIV

- b. *Describe (table, graph, and/or narrative) the socio-demographic characteristics of persons newly diagnosed, PLWH, and persons at higher risk for HIV infection in the service area, including the following, as available in the geographical region of the jurisdiction:*
 - i. *Demographic data (e.g., race, age, sex, transmission category, current gender identity)*
 - ii. *Socioeconomic data (e.g., percentage of federal poverty level, income, education, health insurance status, etc.).*

In 2014, 87% of persons newly diagnosed with HIV were male; and 74% of newly diagnosed males reported a transmission category of male-to-male sexual contact. Among newly diagnosed females, 52% reported no identified risk/no reported risk (NIR/NRR), while 36% reported a transmission category of heterosexual contact. In 2014, 88% of newly diagnosed persons resided in Clark County (Table 1). White, non-Hispanics represented 37% of newly diagnosed persons; Hispanics comprised 31%; and black, non-Hispanics represented 24%. In 2014, 34% of newly diagnosed persons were 25-34 years old; and 23% were 13-24 years old.

Table 1. New HIV Diagnoses by Sex in Nevada, 2014

	Total N	%	Rate*	Male n	%	Rate*	Female n	%	Rate*
County of Residence									
Clark County	386	88%	18.7	336	88%	32.3	50	89%	4.9
Washoe County	40	9%	9.2	36	9%	16.4	4	7%	~
All Other Counties**	12	3%	3.6	10	3%	~	2	4%	~
Race/Ethnicity									
White, non-Hispanic	161	37%	10.5	143	37%	18.5	18	32%	2.4
Black, non-Hispanic	104	24%	43.6	80	21%	66.5	24	43%	20.2
Hispanic	137	31%	17.3	129	34%	31.9	8	14%	~
Asian/Hawaiian/ Pacific Islander	23	5%	9.2	17	4%	14.6	6	11%	~
American Indian/ Alaska Native	3	1%	~	3	1%	~	0	0%	0.0
Multi-race/Other	10	2%	NA	10	3%	NA	0	0%	NA
Age at Diagnosis									
< 13	2	0%	~	0	0%	0.0	2	4%	~
13 to 24	99	23%	23.8	91	24%	42.4	8	14%	~
25 to 34	150	34%	39.3	130	34%	66.8	20	36%	10.7
35 to 44	82	19%	20.5	72	19%	35.2	10	18%	~
45 to 54	77	18%	20.0	63	16%	31.9	14	25%	7.4
55 to 64	25	6%	7.4	24	6%	14.4	1	2%	~
65 +	3	1%	~	2	1%	~	1	2%	~
Transmission Category									
MSM	284	65%	NA	284	74%	NA	0	0%	NA
IDU	18	4%	NA	13	3%	NA	5	9%	NA
MSM+IDU	26	6%	NA	26	7%	NA	0	0%	NA
Heterosexual contact	32	7%	NA	12	3%	NA	20	36%	NA
Perinatal exposure	2	0%	NA	0	0%	NA	2	4%	NA
Hemophilia/Blood Transfusion	0	0%	NA	0	0%	NA	0	0%	NA
NIR/NRR	76	17%	NA	47	12%	NA	29	52%	NA
Total	438	100%	15.4	382	100%	26.7	56	100%	4.0

Source: Nevada State Health Division HIV/AIDS Reporting System (eHARS), (March 2016)

* Rates per 100,000 population were calculated using 2014 population projections from the Nevada State Demographer vintage 2015 data.

**All other counties include Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine counties.

In 2014, there were 4,689 PLWH (not HIV stage 3 (AIDS)) and 5,044 persons living with HIV stage 3 for a total of 9,733 PLWH. Of these 9,733 persons, 35% were diagnosed with HIV infection before coming to Nevada; and 84% were male. The highest proportion of PLWH (86%) resided in Clark County (Table 2). Nearly half of PLWH were white (47%), while 24% were black, non-Hispanics, and 23% were Hispanics. For males living with HIV, 76% reported male-to-male sexual contact as the transmissions category. Among

females living with HIV, 60% reported heterosexual contact as the transmission category. Persons between the ages of 45 and 54 years represented 24% of PLWH, while 22% were 35 to 44 years old.

Table 2. Persons Living with HIV by Sex in Nevada, 2014

	Total			Male			Female		
	N	%	Rate*	n	%	Rate*	n	%	Rate*
County of Residence									
Clark County	8,373	86%	404.6	7,056	86%	678.5	1,317	86%	127.9
Washoe County	946	10%	216.6	806	10%	366.2	140	9%	64.6
All Other Counties**	413	4%	122.5	334	4%	193.8	79	5%	48.0
Race/Ethnicity									
White, non-Hispanic	4,592	47%	300.4	4,059	50%	524.2	533	35%	70.7
Black, non-Hispanic	2,411	25%	1,009.7	1,725	21%	1,434.9	686	45%	578.6
Hispanic	2,195	23%	277.0	1,953	24%	482.2	242	16%	62.5
Asian/Hawaiian/Pacific Islander	330	3%	131.5	285	3%	244.3	45	3%	33.5
American Indian/Alaska Native	78	1%	240.6	60	1%	369.2	18	1%	111.3
Multi-race/Other	127	1%	NA	115	1%	NA	12	1%	NA
Age at Diagnosis									
< 13	13	0%	2.4	5	0%	~	8	1%	~
13 to 24	355	4%	85.2	300	4%	139.6	55	4%	27.3
25 to 34	1,552	16%	406.7	1,330	16%	683.5	222	14%	118.7
35 to 44	2,157	22%	539.9	1,773	22%	867.5	384	25%	196.8
45 to 54	3,340	34%	865.7	2,843	35%	1,440.2	497	32%	263.8
55 to 64	1,728	18%	511.1	1,455	18%	874.2	273	18%	159.1
65 +	531	5%	137.2	442	5%	245.1	89	6%	43.1
Transmission Category									
MSM	6,242	64%	NA	6,242	76%	NA	0	0%	NA
IDU	735	8%	NA	489	6%	NA	246	16%	NA
MSM+IDU	633	7%	NA	633	8%	NA	0	0%	NA
Heterosexual contact	1,219	13%	NA	291	4%	NA	928	60%	NA
Perinatal exposure	73	1%	NA	33	0%	NA	40	3%	NA
Hemophilia/Blood Transfusion	10	0%	NA	7	0%	NA	3	0%	NA
NIR/NRR	821	8%	NA	502	6%	NA	319	21%	NA
Total	9,733	100%	342.3	8,197	100%	572.2	1,536	100%	108.9

Source: Nevada State Health Division HIV/AIDS Reporting System (eHARS), (March 2016)

* Rates per 100,000 population were calculated using 2014 population projections from the Nevada State Demographer vintage 2015 data.

**All other counties include Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine counties.

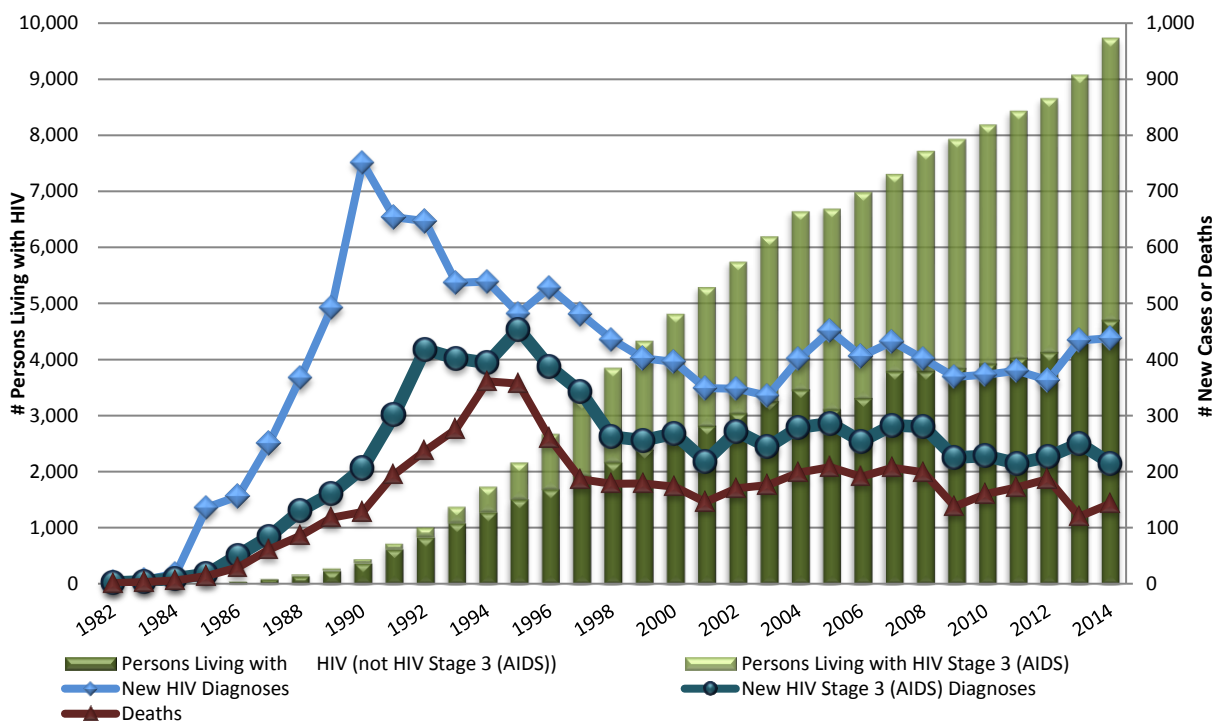
*In 2014, 84% of PLWH in Nevada were male; and,
86% resided in Clark County.*

THE BURDEN OF HIV IN NEVADA

- c. Describe (table, graph, and/or narrative) the burden of HIV in the service area using HIV surveillance data and the characteristics of the population living with HIV (i.e., number of PLWH, rates, trends, populations most affected, geographic concentrations, deaths, etc.).

In 1982, the first HIV infection in Nevada was diagnosed. Since the peak in the early to mid-nineties, the number of PLWH has steadily increased, while the number of new HIV diagnoses, new HIV stage 3 (AIDS) diagnoses, and deaths has decreased (Figure 1). Fewer people are becoming infected; and people are living longer once they do become infected.

Figure 1. Persons Living with HIV, New HIV Diagnoses, New HIV Stage 3 (AIDS) Diagnoses, and Deaths in Nevada, 1982-2014



In the five years between 2010 and 2014, the number of persons newly diagnosed with HIV infection increased almost 15%, from 373 to 438 (Table 3). From 2012 to 2013, there was a large increase in the number of new diagnoses. It is believed that this sharp increase between 2012 and 2013 is due to the closure of the Southern Nevada Health District main building in April 2012 and the subsequent disruption in testing services. With fewer people getting tested, fewer people who may have been infected were diagnosed. The number of new diagnoses from 2010 to 2012 and 2013 to 2014 has remained fairly stable between their respective years. In 2014, there were 438 new HIV diagnoses statewide, which is a small increase from the 434 new HIV diagnoses in 2013.

The number of new HIV stage 3 (AIDS) diagnoses per year has remained stable overall during this time period, with 228 diagnoses in 2010 and 215 diagnoses in 2014. There was a spike in new HIV stage 3 (AIDS) diagnoses in 2013, when 250 new diagnoses were reported, while all other years did not exceed 226 new

diagnoses. In addition, the rate of new HIV stage 3 (AIDS) diagnoses has decreased from 8.4 per 100,000 population in 2010 to 7.6 per 100,000 population in 2014.

The number of PLWH (not HIV stage 3 (AIDS)) increased 17% from 2010 to 2014; and the number of persons living with HIV stage 3 (AIDS) increased 15% from 2010 to 2014. The total number of PLWH, including HIV stage 3 (AIDS), in Nevada increased 16% from 8,191 in 2010 to 9,733 in 2014. Overall, the number of new HIV diagnoses, new HIV stage 3 (AIDS) cases, and deaths among PLWH been steadily declining. Fewer people are becoming infected; and people are living longer once they do become infected. Although many advances have been made in HIV, including HIV stage 3 (AIDS), prevention and care, geographic, sex, age, and racial/ethnic disparities still exist within our state. Since the beginning of the epidemic, 5,262 persons known to be living with HIV, including HIV stage 3 (AIDS), in Nevada have died. In this report, cause of death is not specified; some of these deaths may have been due to HIV related causes, while others may have been due to unrelated causes. Overall, the annual number of deaths among PLWH, including HIV stage 3 (AIDS) has been declining.

Table 3. Persons Living with HIV, New HIV Diagnoses, New HIV Stage 3 (AIDS) Diagnoses, and Deaths in Nevada, 1982-2014

Year	New HIV Diagnoses		New HIV Stage 3 (AIDS) Diagnoses		Persons Living with HIV (not HIV Stage 3 (AIDS))		Persons Living with HIV Stage 3 (AIDS)		Persons Living with HIV		Deaths	Cumulative Deaths
	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate	N	N
1982	3	0.3	2	0.2	0	0.0	0	0.0	0	0.0	1	1
1983	7	0.8	4	0.4	1	0.1	0	0.0	1	0.1	3	3
1984	18	2.0	10	1.1	3	0.3	0	0.0	3	0.4	6	9
1985	136	14.2	17	1.8	7	0.7	2	0.2	10	1.0	14	23
1986	156	15.7	51	5.1	39	3.9	5	0.5	48	4.8	29	52
1987	251	24.3	84	8.1	85	8.2	8	0.8	101	9.8	61	113
1988	368	33.6	131	12.0	146	13.3	20	1.8	179	16.4	86	199
1989	493	42.4	161	13.9	237	20.4	38	3.3	295	25.4	118	317
1990	751	60.8	206	16.7	372	30.1	68	5.5	470	38.0	128	445
1991	654	49.6	301	22.8	616	46.7	104	7.9	767	58.1	195	640
1992	647	47.2	418	30.5	828	60.4	186	13.6	1,074	78.3	237	877
1993	537	37.5	402	28.1	1,080	75.4	302	21.1	1,457	101.8	276	1,153
1994	539	35.3	394	25.8	1,273	83.4	470	30.8	1,826	119.7	361	1,514
1995	482	29.9	454	28.2	1,505	93.4	671	41.6	2,269	140.8	357	1,871
1996	528	31.1	387	22.8	1,682	99.2	1,008	59.4	2,789	164.4	260	2,131
1997	481	26.9	342	19.1	1,924	107.5	1,379	77.0	3,410	190.5	186	2,317
1998	436	23.3	262	14.0	2,158	115.3	1,712	91.5	3,985	213.0	178	2,495
1999	402	20.7	256	13.2	2,383	122.4	1,971	101.3	4,476	230.0	179	2,674
2000	396	19.6	268	13.3	2,598	128.8	2,232	110.6	4,959	245.8	173	2,847
2001	349	16.4	218	10.3	2,812	132.2	2,493	117.2	5,437	255.7	146	2,993
2002	348	15.8	272	12.4	3,033	137.8	2,724	123.8	5,895	267.9	170	3,163
2003	335	14.6	244	10.7	3,245	141.7	2,962	129.3	6,349	277.1	176	3,339
2004	401	16.7	279	11.6	3,458	143.8	3,194	132.9	6,796	282.7	198	3,537
2005	451	18.0	286	11.4	3,104	123.7	3,594	143.2	6,822	271.8	208	3,745
2006	406	14.9	254	9.3	3,303	121.2	3,693	135.5	6,996	256.8	191	3,936
2007	432	15.9	283	10.4	3,779	139.0	3,537	130.1	7,316	269.1	207	4,143
2008	401	15.2	280	10.6	3,780	143.1	3,943	149.3	7,723	292.4	199	4,342
2009	369	13.8	225	8.4	3,834	143.2	4,104	153.3	7,938	296.4	138	4,480
2010	373	13.8	228	8.4	3,910	144.5	4,281	158.2	8,191	302.7	160	4,640
2011	380	14.0	215	7.9	4,014	147.5	4,425	162.6	8,439	310.1	172	4,812
2012	363	13.2	226	8.2	4,120	149.8	4,543	165.2	8,663	315.0	187	4,999
2013	434	15.5	250	8.9	4,341	155.0	4,737	169.1	9,078	324.1	120	5,119
2014	438	15.4	215	7.6	4,689	164.9	5,044	177.4	9,733	342.3	143	5,262

GEOGRAPHIC CONCENTRATIONS OF HIV

At the end of 2014, there were 2,828,794 persons living in Nevada with the majority (73%) concentrated in Clark County. The next most populous county is Washoe with 15% of the population. The remaining 12% of the population are distributed across the remaining 17 counties (referred to as *all other counties*). Clark County accounts for a disproportionate amount of new HIV diagnoses (88%) and persons living with HIV (86%).

In 2014, the rate of new diagnoses in Clark County (18.7 per 100,000 population) was 2 times greater than that of Washoe County (9.2 per 100,000 population) and 5.2 times greater than that of all other counties (3.6 per 100,000 population). From 2010 to 2014, the rate of new diagnoses has remained steady in Washoe County and fairly stable in Clark County with the exception of the drop in 2012 and subsequent rise in 2013 (Figure 3). This variation is most likely an artifact caused by the unexpected closure of the SNHD main building in April 2012 and disruption in testing services.

Clark County also has the highest rate of PLWH. In 2014, the rate in Clark County (404.6 per 100,000 population) was 1.9 times higher than the rate in Washoe County (216.6 per 100,000 population) and 3.3 times higher than the rate in all other counties (122.5 per 100,000 population). From 2010 to 2014, in Clark and Washoe Counties the rate of PLWH has increased, while in the all other counties region the rate has remained stable (Figure 4). The increases in Clark and Washoe Counties suggest that HIV-positive individuals are living longer and could reflect migration of PLWH diagnosed in other states to Clark and Washoe counties.

Figure 2. Total Population, New HIV Diagnoses, and Persons Living with HIV in Nevada by County, 2014

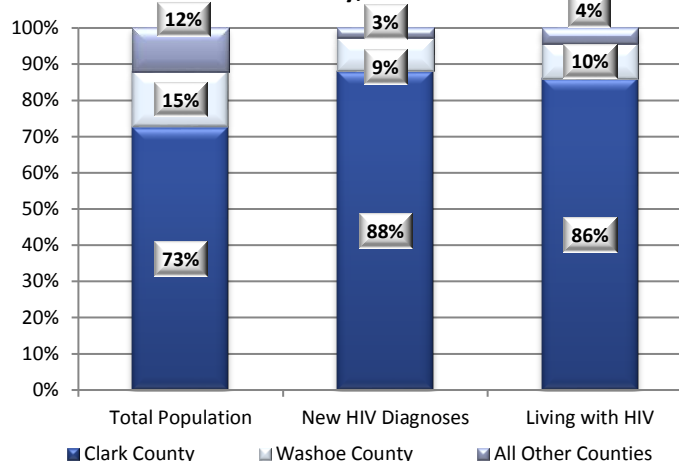


Figure 3. Annual Rate of New HIV Diagnoses in Nevada by County, 2010 – 2014

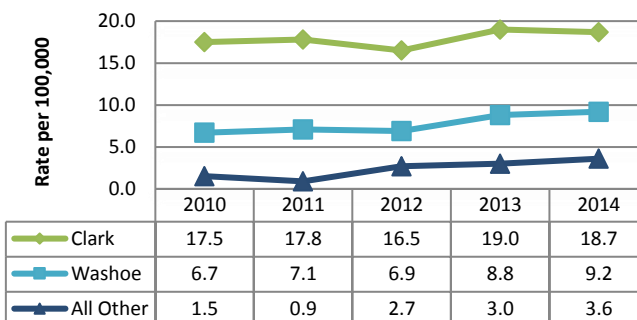


Figure 4. Annual Rate of Persons Living with HIV in Nevada by County, 2010 – 2014

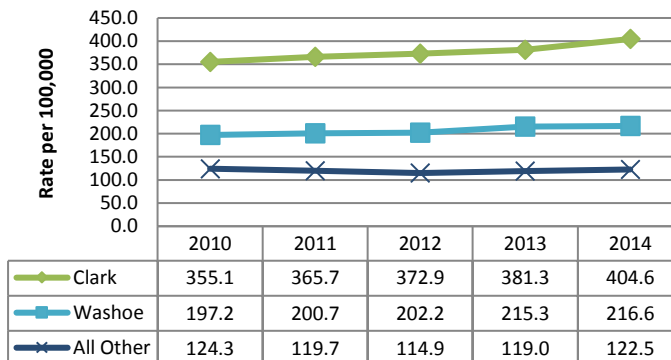
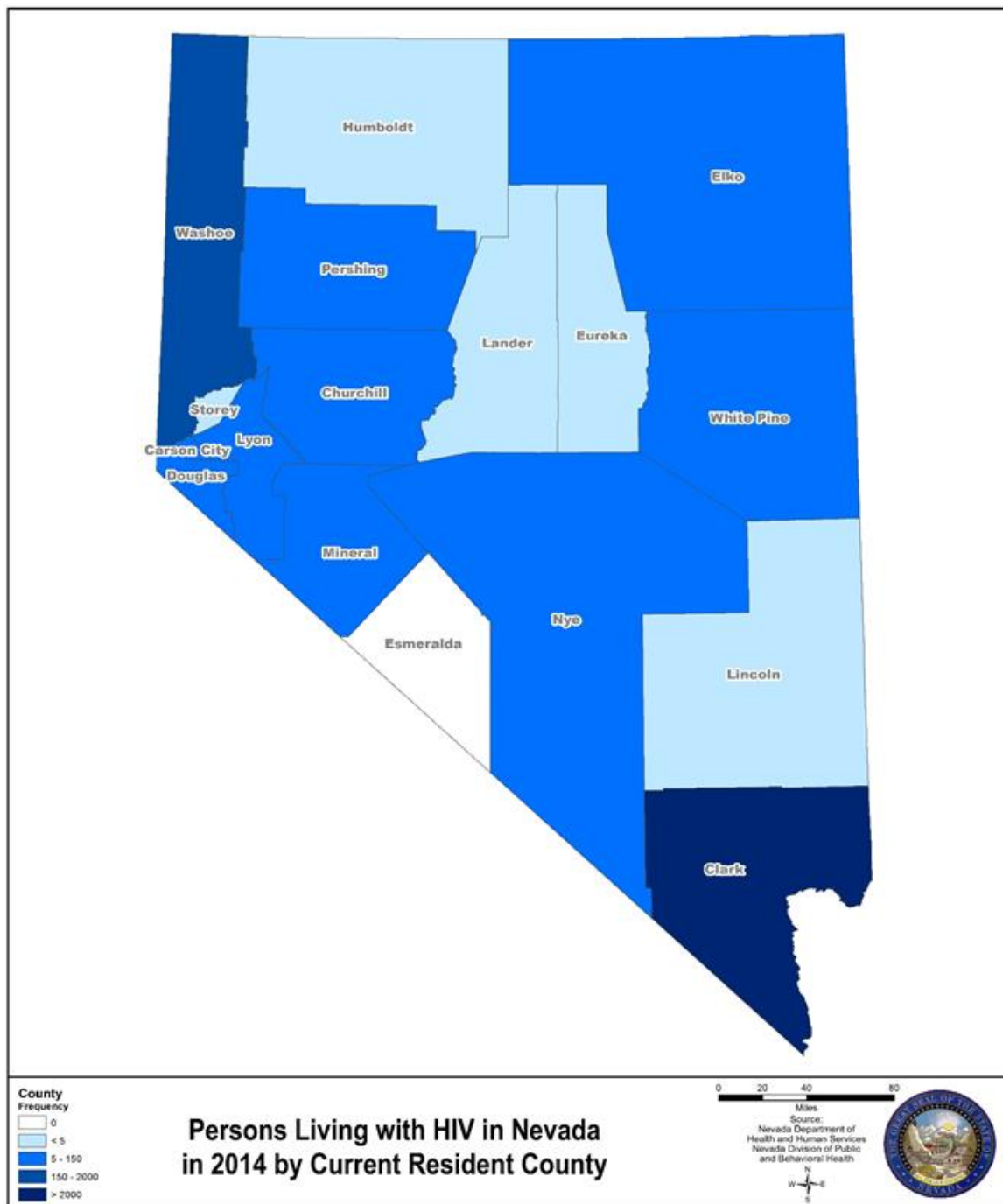


Figure 5. Persons Living with HIV by Current County of Residence in Nevada, 2014



HIV AND SEX AT BIRTH

In Nevada, males continue to be disproportionately affected by HIV, including HIV stage 3 (AIDS). In 2014, the rate of new HIV diagnoses among men (26.7 per 100,000 population) was 6.7 times that of women (4.0 per 100,000 population; Figure 6). Since 2010, the rate of new diagnoses among males increased, while among females the rate has decreased. The rate of new HIV stage 3 (AIDS) diagnoses among men is also significantly higher than that of women (12.4 vs. 2.6 per 100,000 population), but the rate of new HIV stage 3 (AIDS) diagnoses per year has been decreasing for both males and females over the last five years.

Figure 6. Annual Rate of New HIV Diagnoses and New HIV Stage 3 (AIDS) Diagnoses in Nevada by Sex, 2010–2014

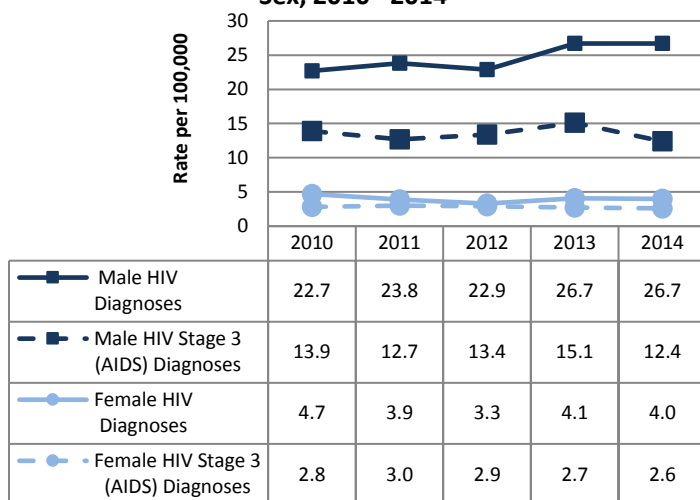
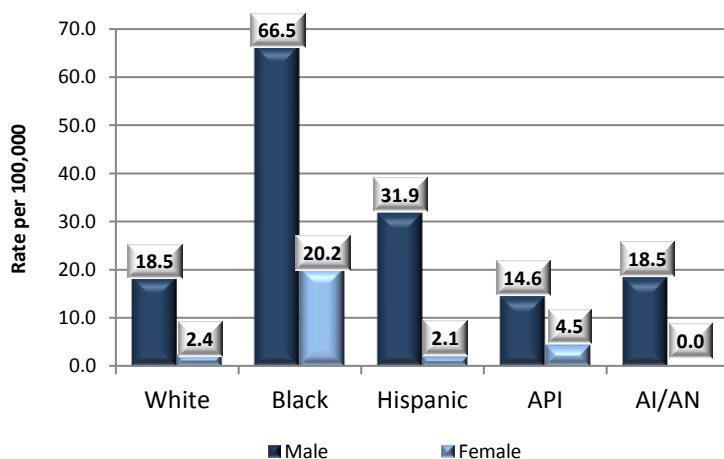


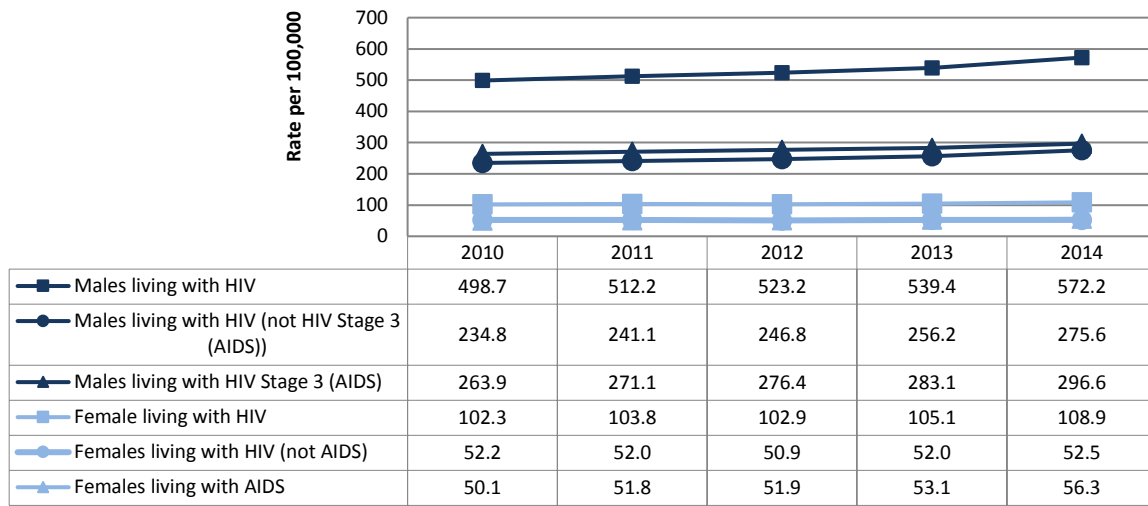
Figure 7. Annual Rate of New HIV Diagnoses in Nevada by Sex and Race/Ethnicity, 2014



In 2014, rates of new HIV diagnoses were highest among Black males (66.5 per 100,000 population) and 3.6 times higher than that of White males (18.5 per 100,000 population). The rate of new HIV diagnoses among Black females (20.2 per 100,000 population) was 8.4 times higher than that of White females (2.4 per 100,000 population; Figure 7). Hispanic and Asian/Hawaiian/Pacific Islander (API) males also experienced disparately high rates of new HIV diagnoses (31.9 and 14.6 per 100,000 population, respectively). AI/AN have very small counts causing their rates to vary greatly. In 2014, among men, the highest rates of new HIV diagnoses were among persons 25 to 34 years old (66.8 per 100,000 population), 13 to 24 years old (42.4 per 100,000 population), and 35 to 44 years old (31.9 per 100,000 population). Among women, rates of new HIV diagnoses were highest among persons 55 to 64 years old (14.4 per 100,000 population), 25 to 34 years old (10.7 per 100,000 population), and 45 to 54 years old (7.4 per 100,000 population).

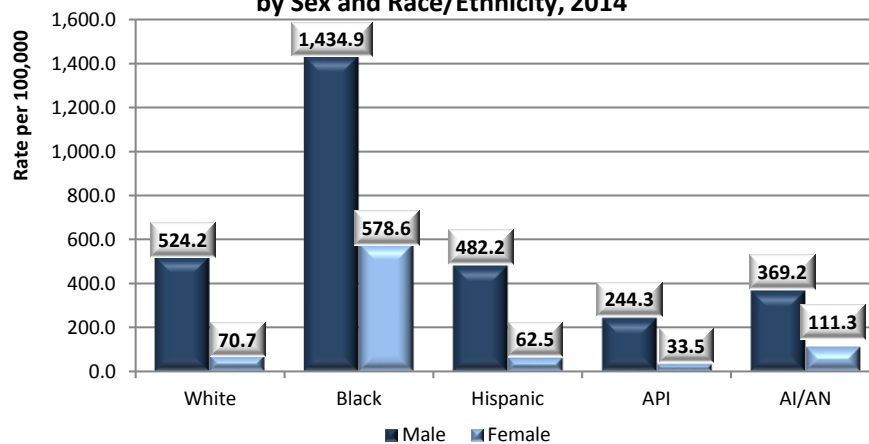
The rate of new HIV diagnoses among men was 6.7 times the rate for women in 2014.

Figure 8. Annual Rate of Persons Living with HIV, HIV (not HIV Stage 3 (AIDS)), and HIV Stage 3 (AIDS) in Nevada by Sex, 2010– 2014



For both males and females, the rate of persons living with HIV in the population has steadily increased. In 2014, the rate of males living with HIV (572.2 per 100,000) was 5.3 times that of females (108.9 per 100,000; Figure 8). The rate of persons living with HIV stage 3 (AIDS) has also been increasing for both males and females. In 2014, the rate of males living with HIV stage 3 (AIDS) (296.6 per 100,000) was 5.3 times that of females (56.3 per 100,000).

Figure 9. Annual Rate of Persons Living with HIV in Nevada by Sex and Race/Ethnicity, 2014



For both males and females, the highest rate of PLWH was among Blacks (Figure 9). The rate among Black males was 2.7 times that of White males (1,434.9 vs. 524.2 per 100,000 population), and the rate among Black females was nearly 8.2 times that of White females (578.6 vs. 70.7 per 100,000 population). The rate of PLWH was lowest among

API. API males had a rate of 244.3 per 100,000 population, and API females had a rate of 33.5 per 100,000 population. The highest rates of PLWH in Nevada among males is 45 to 54 year olds followed by 55 to 64 year olds had (1,440.2 and 874.2 per 100,000 population respectively). Rates among females were similar to those of males. Females 45 to 54 years old had the highest rate of PLWH in Nevada (263.8 per 100,000) followed by females 35 to 44 years old (196.8 per 100,000).

HIV AND MEN WHO HAVE SEX WITH MEN (MSM)

From 2010 to 2014, male-to-male sexual contact (MSM) has been the primary transmission category for the majority of new HIV diagnoses among males, accounting for 83% of new cases in 2010 and 74% of new cases in 2014 (Table 4). In 2014, 76% of males living with HIV had a transmission category of MSM. Since 2010, this has been the transmission category for 75% or more of males. For all male race/ethnicity MSM was the transmission category for the majority of new HIV diagnoses (Table 4).

Among males, MSM was the transmission category for the majority of newly infected persons across all age groups. This percentage was much lower among males 45 to 54 years old (59%). Those in the 45 to 55-year-old age group reported the highest no identified risk/no reported risk (NIR/NRR) of 22%. The age groups which reported the highest proportion of MSM as a transmission category were ages of 13 to 24 (88%) and 25 to 34 (77%). MSM youth and young adults are therefore targeted for testing due to their higher risk of exposure and transmission. Among males, MSM was the transmission category for the majority of persons living with HIV across all age groups. Those aged 25 to 34 years old had the highest proportion of MSM (85%).

MSM was the primary transmission category for 74% of new HIV diagnoses among males in 2014.

Table 4. New HIV Diagnoses in Nevada by Sex and Transmission Category, 2010-2014

Transmission Category	2010		2011		2012		2013		2014	
	n	%	n	%	n	%	n	%	n	%
Males										
MSM	257	83%	273	83%	247	78%	288	76%	284	74%
IDU	15	5%	14	4%	12	4%	13	3%	13	3%
MSM+IDU	19	6%	18	6%	20	6%	30	8%	26	7%
Heterosexual contact	5	2%	9	3%	8	3%	17	5%	12	3%
Perinatal exposure	0	0%	1	0%	0	0%	0	0%	0	0%
Transfusion/ Hemophilia	0	0%	0	0%	0	0%	0	0%	0	0%
NIR/NRR	14	5%	12	4%	31	10%	29	8%	47	12%
Subtotal	310	100%	327	100%	318	100%	377	100%	382	100%
Females										
IDU	5	8%	5	9%	5	11%	5	9%	5	9%
Heterosexual contact	50	79%	28	53%	20	44%	32	56%	20	36%
Perinatal exposure	1	2%	2	4%	0	0%	3	5%	2	4%
Transfusion/ Hemophilia	0	0%	0	0%	0	0%	0	0%	0	0%
NIR/NRR	7	11%	18	34%	20	44%	17	30%	29	52%
Subtotal	63	100%	53	100%	45	100%	57	100%	56	100%
Total	373	100%	380	100%	363	100%	434	100%	438	100%

HIV AND WOMEN ENGAGING IN HETEROSEXUAL CONTACT

Among females, heterosexual contact has been the most common transmission category for the majority of new HIV diagnoses from 2010 to 2014 (Table 4). Although the percentage of females with this risk has decreased from 2010 to 2014, this is most likely due to more stringent risk ascertainment standards and not an actual decrease in heterosexual contact. Many of the cases that would have been assigned a risk

of heterosexual contact did not meet the new risk ascertainment standards and thus were assigned as no identified risk/no risk reported (NIR/NRR) which is most likely responsible for the increase from 11% in 2010 to 52% in 2014. From 2010 to 2014, heterosexual contact has been the most common transmission category for females living with HIV, accounting for over 60% of all cases. Among females, the most common known transmission category for all race/ethnicity groups was heterosexual contact (Table 5). Among females, heterosexual contact was the transmission category for the majority of PLWH across all age groups except for those under the age of 24.

Table 5. New HIV Diagnoses in Nevada by Race/Ethnicity and Transmission Category, 2014

Transmission Category	White		Black		Hispanic		API		AI/AN		Multi-Race/Other*	
	n	%	n	%	n	%	n	%	n	%	n	%
Males												
MSM	94	66%	59	74%	105	81%	15	88%	2	67%	9	90%
IDU	11	8%	0	0%	2	2%	0	0%	0	0%	0	0%
MSM+IDU	21	15%	1	1%	4	3%	0	0%	0	0%	0	0%
Heterosexual contact	1	1%	6	8%	4	3%	0	0%	0	0%	1	10%
Perinatal exposure	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
NIR/NRR	16	11%	14	18%	14	11%	2	12%	1	33%	0	0%
Subtotal	143	100%	80	100%	129	100%	17	100%	3	100%	10	100%
Females												
IDU	4	22%	0	0%	1	13%	0	0%	0	0%	0	0%
Heterosexual contact	6	33%	9	38%	3	38%	2	33%	0	0%	0	0%
Perinatal exposure	1	6%	1	4%	0	0%	0	0%	0	0%	0	0%
NIR/NRR	7	39%	14	58%	4	50%	4	67%	0	0%	0	0%
Subtotal	18	100%	24	100%	8	100%	6	100%	0	0%	0	0%
Total	161	100%	104	100%	137	100%	23	100%	3	100%	10	100%

*Data for persons who identified as multi-racial.

HIV AND INJECTION DRUG USERS (IDU)

IDU represented 4% of all new HIV diagnoses in 2014 and 8% of persons living with HIV. Six percent of new HIV diagnoses indicated a transmission category of MSM+IDU, while 7% of persons living with HIV had that transmission category in 2014. In 2014, among females with a new HIV diagnosis, 9% reported the transmission category of IDU. In 2014, IDU was the transmission category for 16% of females living with HIV. Among new female HIV diagnoses in 2014, IDU was a transmission risk only for White and Black females (Table 5). Among females living with HIV, IDU varied across race/ethnicity groups, with the highest percentage among White females (26%) and AI/AN females (22%). IDU was much higher among older age groups of women living with HIV, with the highest proportions among females 55 to 64 (26%) and 45 to 54 years old (21%).

From 2010 to 2014, the percentage of males with a transmission category of (IDU) has decreased from 5% to 3%. Over the past five years, the percentage of newly infected males with a transmission category of MSM+IDU and injection drug use (IDU) has remained relatively stable. In 2014, 6% of males living with HIV had a transmission category of IDU, and another 8% of males had a transmission category of combined MSM and IDU. The percentage of cases with a transmission category of IDU or combined MSM and IDU has remained relatively stable since 2010. Blacks and AI/AN had the highest percentage of males living with HIV with a transmission category of IDU (8% and 7% respectively). The percentage of males with a

transmission category of combined MSM and IDU was highest among multi-racial persons (14%), Whites (10%), and AI/AN (10%).

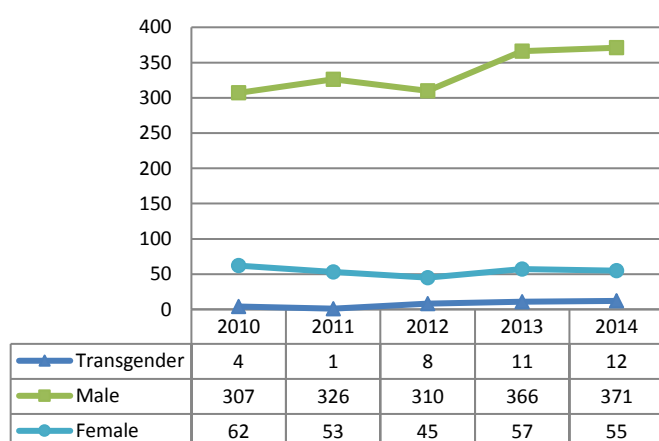
The percentage of newly diagnosed males with a transmission category of IDU was highest among males 45 to 54 years old (6%), while the transmission category of combined MSM and IDU was highest among males 25 to 34 years old (9%) and 45 to 54 years old (8%). The percentage of males living with HIV with a transmission category of Injection drug use (IDU) was highest among males 55 to 64 years old (11%), while the percentage of males with a transmission category of combined MSM and IDU was highest among 45 to 54 year olds (9%).

HIV AMONG TRANSGENDER PERSONS

Transgender is an umbrella term that refers to people whose current gender identity does not conform to their assigned sex at birth. Information on transgender identities is not collected uniformly in national HIV surveillance data, so information on HIV infection in this population is limited. However, data from local health departments and research studies indicate that this population experiences a high morbidity of HIV. Based on data from CDC funded testing programs, in 2009, 2.6% of transgender individuals tested positive for HIV compared to only 0.9% of males and 0.3% of females.⁹ In a review of studies on male-to-female (MTF) transgender women, Herbst et al.¹⁰ estimated that 27.7% [95% CI: (24.8% — 30.6%)] of MTFs tested positive for HIV infection. Considering these findings, efforts to understand the impact of HIV on Nevada’s transgender community are timely and important.

In accordance with CDC guidelines, Nevada’s HIV counseling/testing and surveillance programs use a two question model to collect data on sex/gender.¹¹ One question asks sex at birth and the second asks current gender identity. Data on transgender gender identities has been collected for some time, but not robustly or uniformly. Therefore, in 2012 HIV program staff received additional training on how to more effectively collect information on gender status. It is important to consider that implementation of these practices is new, and that data presented in this section are most likely an underestimate of HIV morbidity in the transgender population.

Figure 10. New HIV Diagnoses in Nevada by Current Gender, 2010– 2014



Due to the small number of transgender persons newly diagnosed with HIV, only limited data can be provided on new HIV diagnoses in this population. From 2010 to 2014, of the 1,988 persons newly diagnosed with HIV in Nevada, 36 identified as transgender. The number of transgender persons newly diagnosed with HIV has increased over the past five years, suggesting that gender ascertainment practices are improving and more complete information on gender will be available in the future (Figure 10).

Out of the 9,733 PLWH in Nevada at the end of 2014, 127 identified as transgender (Table 6), accounting for 1.3% of all PLWH in Nevada (not shown in table). The majority of transgender persons living with HIV in Nevada identified as MTF (58%) and were diagnosed with HIV in Nevada. Over one third (39%) of transgender persons living with HIV in Nevada were Black, with the next highest percentage identifying as White (24%) followed by Hispanic (22%). The greatest proportions of transgender PLWH were between 35 and 54 years of age (70%) at the end of 2014 for both MTF and Female-to-Male (FTM) individuals. Sexual contact was the most common transmission category for both MTF and FTM persons living with HIV in 2014 (87% and 67% respectively). The second most common mode of transmission for MTF persons was combined sexual contact + IDU (9%), while the second most common transmission mode for FTM persons was IDU (13%).

Table 6. Transgender Persons Living with HIV in Nevada, 2010-2014

	Total		Male to Female (MTF)		Female to Male (FTM)	
	N	%	n	%	n	%
Residence at Diagnosis						
Nevada	80	63%	56	58%	24	80%
Out of State	47	37%	41	42%	6	20%
Race/Ethnicity						
White, non-Hispanic	30	24%	23	24%	7	23%
Black, non-Hispanic	50	39%	36	37%	14	47%
Hispanic	28	22%	20	21%	8	27%
Asian/Hawaiian/Pacific Islander	9	7%	8	8%	1	3%
American Indian/Alaska Native	2	2%	2	2%	0	0%
Multi-race/Other	8	6%	8	8%	0	0%
Age at End of Calendar Year 2013						
< 13	0	0%	0	0%	0	0%
13 to 24	8	6%	8	8%	0	0%
25 to 34	31	24%	27	28%	4	13%
35 to 44	36	28%	26	27%	10	33%
45 to 54	37	29%	26	27%	11	37%
55 to 64	11	9%	8	8%	3	10%
65 +	4	3%	2	2%	2	7%
Transmission Category						
Sexual Contact*	104	82%	84	87%	20	67%
IDU	4	3%	0	0%	4	13%
Sexual Contact + IDU*	9	7%	9	9%	0	0%
Perinatal exposure	2	2%	2	2%	0	0%
NIR/NRR	8	6%	2	2%	6	20%
Total	127	100%	97	100%	30	100%

*Sexual contact includes any sexual contact and does not differentiate between male to male sexual contact and heterosexual contact.

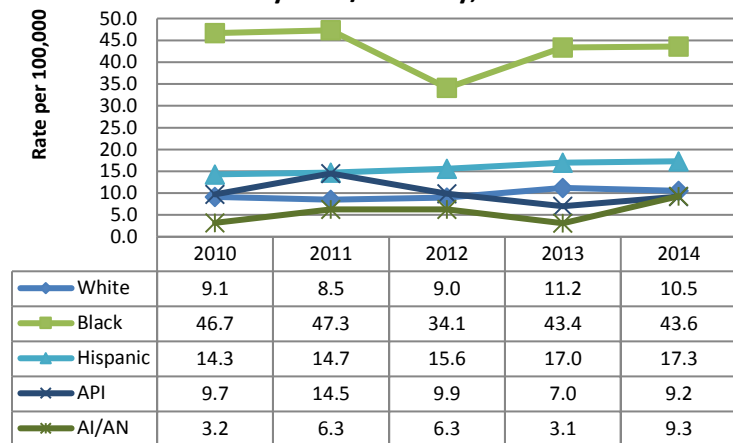
Source: Nevada State Health Division HIV/AIDS Reporting System (eHARS), (March 2016)

HIV AND RACE/ETHNICITY

Large racial/ethnic disparities exist within Nevada, especially among Blacks/African Americans. In 2014, the rate of new HIV diagnoses among Blacks was over 4 times that of Whites (43.6 vs. 10.5 per 100,000 population; Figure 11). This disparity is even greater for Black females, whose rate of new HIV diagnoses was 8.4 times higher than that of White females (20.2 vs. 2.4 per 100,000 population). In addition, the rate of new HIV diagnoses among Black youths (13-24 years) was over 9 times higher than that of White youths (90.7 vs. 9.9 per 100,000 population). From 2010 to 2014, the rate of new HIV diagnoses increased among APIs, while the rate among Blacks and Whites decreased. However, the rate among Blacks dropped suddenly in 2012, which may have been caused by the unexpected disruption in SNHD's testing services in 2012. Due to the small number of new diagnoses, the rate among American Indians/ Alaska Natives (AI/AN) has been unstable over the past five years.

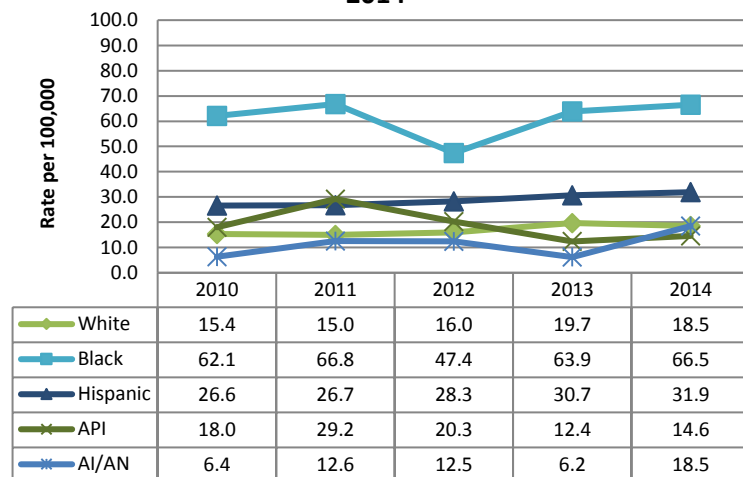
Among males, the highest rates of new diagnoses were among Blacks (66.5 per 100,000 population) and Hispanics (31.9 per 100,000). From 2010 to 2014, AI/AN males experienced a large increase in their rate of new diagnoses, from 6.4 per 100,000 to 18.5 per 100,000 population (Figure 12). During this same time period, there was a substantial decrease in the rate of new diagnoses among API males, while the rate among Black, Hispanic and White males remained relatively stable. As discussed previously, the rate among Blacks decreased suddenly in 2012, and this decline may be due to disruptions in testing services.

Figure 11. Annual Rate of New HIV Diagnoses in Nevada by Race/Ethnicity, 2010–2014*



*The number of persons who identified as multi-racial was 7 in 2010; 5 in 2011; 9 in 2012; 14 in 2013; and 10 in 2014. Data for these persons were not included in this figure.

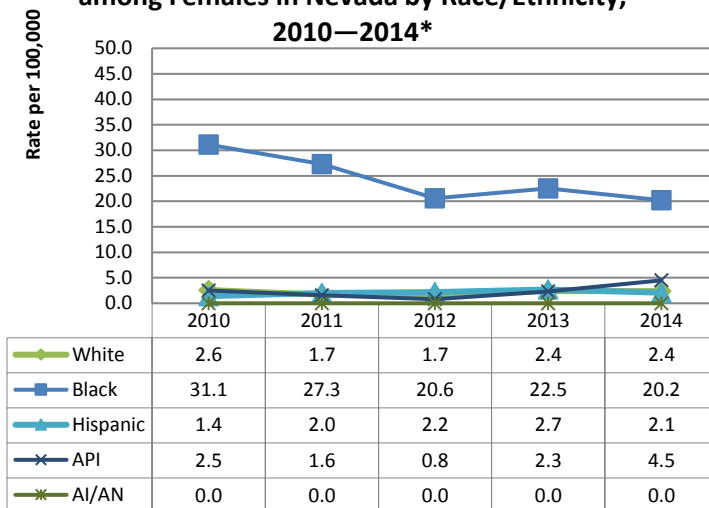
Figure 12. Annual Rate of New HIV Diagnoses among Males in Nevada by Race/Ethnicity, 2010–2014*



*The number of males who identified as multi-racial was 5 in 2010; 4 in 2011; 9 in 2012; 14 in 2013; and 10 in 2014. Data for these persons were not included in this figure.

The rate of new diagnoses among Blacks was 4 times higher than among Whites. Among females, the rate of new diagnoses is 8.4 times higher for Black females than White females.

Figure 13. Annual Rate of New HIV Diagnoses among Females in Nevada by Race/Ethnicity, 2010—2014*



For all race/ethnicity groups, the rate of new diagnoses among females has been much lower than that of males. However, the rate of new diagnoses among Black females is alarmingly high. In 2014, the rate among Black females (31.1 per 100,000 population) was 13 times higher than that of White females (2.4 per 100,000 population; Figure 13). The rate among Black women decreased greatly in 2012, and has remained fairly stable since. During this same time period, the rates among Hispanic and White females have remained stable over the five-

year period, possibly due to a lack of testing among those populations. Rates among API and AI/AN females fluctuated greatly due to the small number of new diagnoses in these populations.

HIV AND AGE

From 2010 to 2014, 25 to 34 year olds had the greatest increase in rate of new diagnoses (Figure 14). The rate among those under the age of 24 and above 55 years of age remained relatively stable. While some rates have fluctuated over the years, no significant changes occurred. From 2011 to 2012, all age groups, except for 35 to 44 year olds, experienced a decrease or no change in the rate of new diagnoses. This may have been due to the closure of SNHD's main building and disruptions in testing services.

Among males, in 2014, the highest rates of new HIV infection were among persons 25 to 34 years old (66.8 per 100,000 population), followed by persons 13 to 24 years old (42.4 per 100,000 population). From 2010 to 2014, HIV infection rates increased among 13 to 24 year olds, 25 to 34 year olds and 45 to 54 year olds. The only groups to experience declines in the rate of new diagnoses are those aged 35 to 44 and over the age of 65.

In 2014, 35 to 44-year-old females had the highest rate of new diagnoses in 2012 (10.7 per 100,000 population), followed by 45 to 55 year olds (7.4 per 100,000 population). From 2010 to 2014, there has been a steady decline in the rate of new HIV diagnoses among 35 to 44 and 55 to 64-year-old females. The rate among other age groups has fluctuated over this time period, which is most likely due to the small number of new diagnoses within each age group.

Figure 14. Annual Rate of New HIV Diagnoses in Nevada by Age at Diagnosis, 2010 – 2014

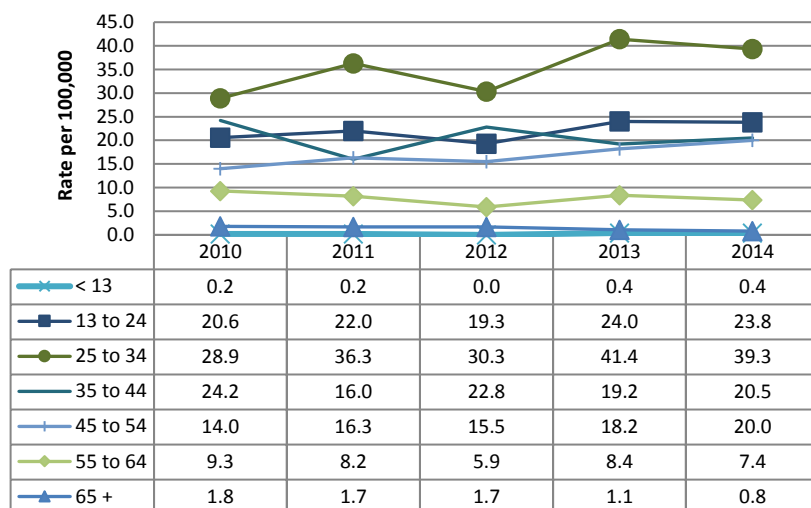
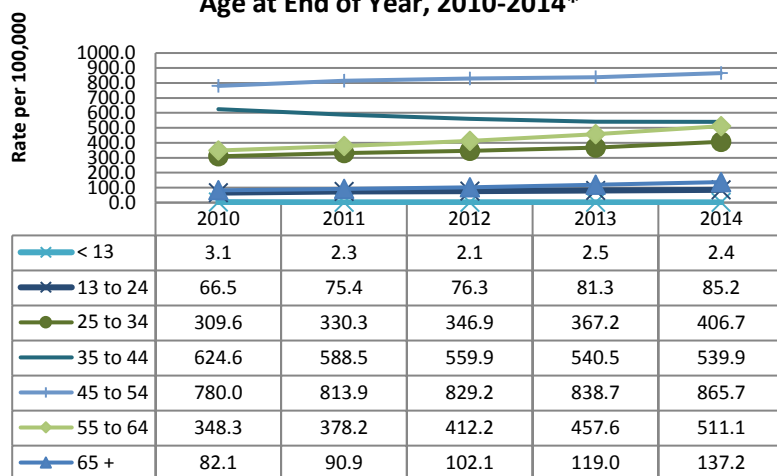


Figure 15. Annual Rate of Persons Living with HIV by Age at End of Year, 2010-2014*



*This figure reports age at end of year.

From 2010 to 2014, all age groups experienced an increase in the rate of PLWH, except for persons under 13 and 35 to 44 years old (Figure 15). For both age groups, these declines were most likely due to their large decreases in number of new diagnoses. There were increases in the rates of PLWH among persons 13 to 24 and 25 to 34, which may be due to the use of targeted testing which specifically focuses on high risk populations such as youth or those with certain risky behaviors. The increase in rates for those over the age of 45 could be attributed to people living longer once they become infected and “aging” into these older age groups.

Among males living with HIV, there was an increase in rates for all age groups except 35 to 44 years old (998.2 per 100,000 in 2010 to 867.5 per 100,000 in 2014). The decrease in the 35 to 44-year-old age group is likely due to the sharp decline in new diagnoses in that age group. In

2014, the highest rates of PLWH were among males 45 to 54 years old (1,440.2 per 100,000 population) followed by males 55 to 64 years old (874.2 per 100,000 population).

Overall trends among females mirrored those of males, in particular, the decline in the rate of persons less than 24 years old and 35 to 44 years old living with HIV. The highest rates of females living with HIV in 2014 were among persons 45 to 54 years old (263.8 per 100,000 population) and persons 35 to 44 years old (196.8 per 100,000 population).

PERSONS WHO KNOW THEY ARE HIV-POSITIVE, BUT WHO ARE NOT RECEIVING PRIMARY CARE

The number of clients considered “out-of-care” are also known as the “unmet need” in Nevada. The HIV/AIDS Surveillance Program has developed several strategies for identifying persons who know their status but who are not receiving primary medical care. The first project focuses on enumerating the persons who are reported as HIV infected, currently living in Nevada and receiving routine medical care versus those who are not receiving care. To be counted as receiving care, the client must have received laboratory testing in the previous year or have been enrolled and active in ADAP. The number of persons living with HIV/AIDS (PLWHA) in Nevada in 2013, was 9,114. Based on HIV/AIDS Surveillance data (eHARS) and the number of clients receiving care through ADAP, it was estimated that 5,158 (56.6%) of PLWHA were receiving primary medical care in 2013. Nevada’s RW Program, in collaboration with the HIV Prevention Program, works with partner organizations to identify PLWHA and refer them into care. RW Program case partner organizations are all required to have policies in place to follow-up with clients who drop out of service.

In 2007, a law was passed to make it mandatory that testing organizations refer HIV-positive people into treatment; if the organization does not have ability to make referrals it can access referrals through the Health Districts. The 2009 Legislative Session approved a Rapid Testing Law that allows community based organizations (CBOs) to offer rapid testing. Also in 2009, the Nevada HIV Prevention Program and State AIDS Task Force increased testing efforts statewide to identify individuals with HIV/AIDS and refer them into services.

Outreach services are provided by the SNHD, the Northern Nevada Outreach Team, ACCEPT, Washoe County Health District, and HOPES. Early intervention services are provided by HOPES, UMC Medical Services, Southern Nevada Health District, AIDS Healthcare Foundation, University of Nevada, Reno School of Medicine Clinic for high risk pregnancies and the Veterans Hospital. Clark County’s HIV program conducts database matches and identifies out-of-care positive individuals, contacts them to see if they are still in the area, and attempts to bring them into care.

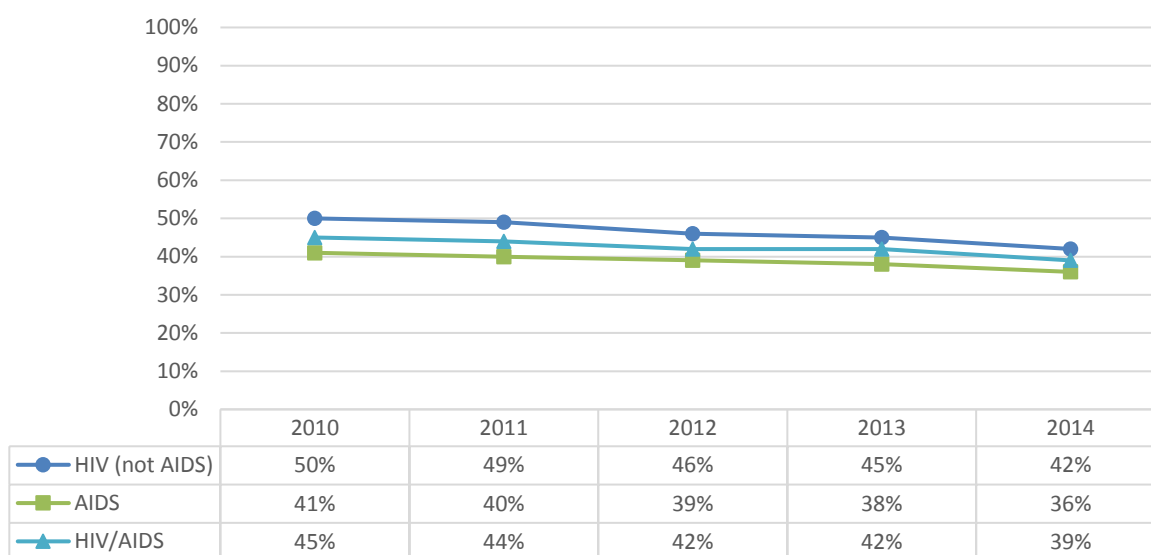
UNMET NEED AMONG PERSON LIVING WITH HIV/AIDS

Unmet need is defined as an HIV-positive individual not having any laboratory tests (i.e., CD4 count/percent and/or viral load test) or medical care visit within a one-year period. This definition is commonly used by HIV/AIDS surveillance and prevention programs across the United States. Laboratory data was obtained from eHARS, and individuals were matched to the ADAP registry in order to identify individuals who are in care but may not have had laboratory results in eHARS. One of the major limitations of this analysis is that in Nevada not all CD4 and viral load test results were reportable at the time this data was available. As stated in NAC.441A, only CD4 results less than 500 cells/ μ L and detectable viral loads are required to be reported to the state or local health department. Thus, our measures of the number of persons with unmet need are most likely over-estimates. This statute has since been revised so future profiles will have more accurate estimates.

In 2014, 39% of PLWH in Nevada had unmet need with PLWH (not AIDS) having a higher proportion of unmet needs (42%) than persons living with AIDS (36%). There were a higher proportion of males with unmet need (40%) than females (36%). All other counties region had the highest proportion of persons living with HIV/AIDS with unmet need (46%), while Washoe County had the lowest proportion of persons living with HIV/AIDS with unmet need (36%).

Ages 25 to 34 year olds had the highest proportion of person living with HIV/AIDS with unmet need (43%), followed by 13 to 24 year olds (42%). Persons 64 years and older had the lowest proportion of unmet needs (15%). Between the years of 2010 to 2014, the proportion of persons living with HIV/AIDS who were out of care decreased by 6%, overall (Figure 16). Out of care persons living with HIV (not AIDS) experienced the highest decrease (8% decrease) followed by out of care person living with AIDS (5% decrease) during the 5-year period.

Figure 16. Percentage of Persons Living with HIV (not AIDS), or HIV/AIDS in Nevada who were Out of Care, 2010-2014



HIV AND MORTALITY

In this report, death information was obtained from eHARS. Several measures are taken to ensure the quality of this data, including annual matches to the state electronic death registry, the national Social Security Death Index, and the National Death Index. Throughout this report, cause of death is not specified; some of these deaths may have been due to HIV related causes, while others may have been due to unrelated causes. In Table 7, age-adjusted death rates were calculated as the number of deaths of persons living with HIV/AIDS in Nevada per 100,000 persons and weighted to reflect standard age distributions.

In 2014, the death rate of persons living with HIV/AIDS in Nevada was 4.5 per 100,000 persons. This rate was highest in Clark County (5.2 per 100,000 population) and lowest in the all other counties region (1.0 per 100,000 population). For females, Blacks had the highest age-adjusted death rate. For males, API had the highest rate of 28.7 per 100,000 followed by 27.1 per 100,000 for Blacks. Of all age groups, 45 to 54-year-old males had the highest death rate (13.4 per 100,000 population). Among males, persons with a transmission category of male-to-male sexual contact (MSM) accounted for the greatest proportion of deaths (63%), while among females, persons with a transmission category of heterosexual contact and IDU tied accounted for the greatest proportion of deaths (35%).

Table 7. Deaths among Persons Living with HIV in Nevada, 2014

	Total			Male			Female		
	N	%	Rate*	n	%	Rate*	n	%	Rate*
County at Diagnosis									
Clark County	108	90%	5.2	90	90%	8.5	18	90%	1.8
Washoe County	9	8%	~	8	8%	~	1	5%	~
All Other Counties	3	3%	~	2	2%	~	1	5%	~
Race/Ethnicity									
White, non-Hispanic	52	43%	2.7	46	46%	4.7	6	30%	~
Black, non-Hispanic	38	32%	19.8	26	26%	27.1	12	60%	12.8
Hispanic	23	19%	4.2	21	21%	7.4	2	10%	~
Asian/Hawaiian/Pacific Islander	5	4%	~	5	5%	~	0	0%	0.0
American Indian/Alaska Native	2	2%	~	2	2%	~	0	0%	0.0
Multi-race/Other	0	0%	NA	0	0%	NA	0	0%	NA
Age at End of Year									
< 13	0	0%	0.0	0	0%	0.0	0	0%	0.0
13 to 24	5	4%	~	4	4%	~	1	5%	~
25 to 34	29	24%	7.4	24	24%	11.8	5	25%	~
35 to 44	32	27%	8.5	26	26%	13.3	6	30%	~
45 to 54	30	25%	8.0	26	26%	13.4	4	20%	~
55 to 64	18	15%	5.6	14	14%	8.9	4	20%	~
65 +	6	5%	~	6	6%	~	0	0%	0.0
Transmission Category									
MSM	63	53%	NA	63	63%	NA	0	0%	NA
IDU	26	22%	NA	19	19%	NA	7	35%	NA
MSM+IDU	11	9%	NA	11	11%	NA	0	0%	NA
Heterosexual contact	10	8%	NA	3	3%	NA	7	35%	NA
Perinatal exposure	0	0%	NA	0	0%	NA	0	0%	NA
NIR/NRR	10	8%	NA	4	4%	NA	6	30%	NA
Total	120	100%	4.5	100	100%	3.7	20	100%	0.8

Source: Nevada State Health Division HIV/AIDS Reporting System (eHARS), (March 2016)

* Rates per 100,000 population were calculated using 2014 population projections from the Nevada State Demographer vintage 2015 data.

INDICATORS OF RISK FOR HIV INFECTION IN NEVADA

- d. *Describe (table, graph, and/or narrative) the indicators of risk for HIV infection in the population covered by your service area using the following, as available in the jurisdiction:*
- i. *Behavioral surveillance data, including databases, such as National HIV Behavioral Surveillance System (NHBS), Youth Risk Behavioral Surveillance System (YRBSS), Behavioral Risk Factor Surveillance System (BRFSS) (e.g., patterns of, or deterrents to, HIV testing, substance use and needle sharing, sexual behavior, including unprotected sex, sexual orientation and gender identity, healthcare-seeking behavior, trauma or intimate partner violence, and adherence to prescribed antiretroviral therapies)*

NEVADA PRIORITY POPULATIONS

Each year the Community Planning Groups determine the priority populations for HIV prevention in Nevada after reviewing current epidemiological data and discussing rates and trends of HIV infection in the state. MSM, HIV positive individuals, and youth/young adults (13-34 years) were determined to be priority populations in both Northern and Southern Nevada. Across all priority populations, efforts will continue to emphasize minority populations disproportionately affect by HIV.

HIV Prevention Jurisdictional Priority Populations

Northern Nevada	Southern Nevada
• MSM • HIV + • Youth/Young Adult (13-34 years), including those of color • IDU • Sexually Active Heterosexuals	• MSM • HIV+ • Substance Users/Abusers • Youth/Young Adult (13-34 years), including those of color

RISKY BEHAVIORS

Individuals who partake in certain risky behaviors such as choosing not to use condoms or using them incorrectly, having a high number of sexual partners, using drugs or alcohol before or during sex, or not receiving regular STD testing if sexually active can increase the likelihood the individual will contract an STD or HIV.¹² According to the 2011 and 2012 combined Nevada Behavioral Risk Factor Surveillance System (BRFSS), of the 9,507 surveyed 4.2% had answered yes to one of more of the following questions:

- You have used intravenous drugs in the past year
- You have been treated for a sexually transmitted or venereal disease this past year
- You have given or received money or drugs in exchange for sex in the past year
- You had anal sex without a condom in the past year

Those who reported yes to one or more of these questions have an increased risk of contracting an STD and/or HIV. In 2011/2012, those ages 18-24 (14.2%) reported they had engaged in at least one risky behavior during those years. As age increases the percentage of individuals reporting “yes” decreases.¹³

YOUTH

Youth (13-24) in Nevada are an important group to target for HIV prevention/intervention activities, as they are not only showing recent increases in new HIV infections but in other STDs (Chlamydia and Gonorrhea). Additionally, there are also upward trends among new HIV diagnoses in 25-34 year olds, reiterating the importance of prevention among youth as many of these cases may have seroconverted while they were youth. Further, prevention efforts should occur prior to individuals participating in high risk taking behaviors. Engaging in sexual risk taking behaviors and having STDs are known factors to increase the likelihood of acquiring HIV. HIV/AIDS education needs to take place at correspondingly young ages, before young people engage in sexual behaviors that put them at risk for HIV infection. Statewide, STD trends from the Nevada Division of Public and Behavioral Health STD Program indicate that among 13-19 year olds there has been a significant increase in the number of new Chlamydia and Gonorrhea cases among youth.

According to the Nevada Youth Risk Behavior Survey (YRBS), 57% of sexually active youth reported using a condom during last sexual intercourse (Table 8). Young people in the United States use alcohol, tobacco, and other drugs at high rates. Both casual and chronic substance users are more likely to engage in high-risk behaviors, such as unprotected sex, when they are under the influence of drugs or alcohol. In Nevada, 31% of students reported they currently drank alcohol and 15% reported binge drinking in the past 30 days.¹⁴ Additionally, 20% of sexually active youth reported drinking alcohol or using drugs before last sexual intercourse. Fewer than 11% of Nevada YRBS respondents reported ever having been tested for HIV.

Table 8. Select Nevada Youth Behavioral Risk Survey Responses, 2015

	Yes	CI*
Who ever injected any illegal drugs	2.7	(2.1-3.4)
Who ever had sexual intercourse	38.5	(35.4-41.6)
Who had sexual intercourse for the first time before age 13 years	3.9	(3.1-4.7)
Who had sexual intercourse with four or more persons during their life	10.5	(9.0-12.0)
Who were currently sexually active	27.1	(24.5-29.6)
Who used a condom during last sexual intercourse	56.9	(53.5-60.3)
Who did not use any method to prevent pregnancy during last sexual intercourse	12.4	(10.2-14.6)
Who drank alcohol or used drugs before last sexual intercourse	20.4	(17.7-23.2)

*95% confidence intervals are calculated based on the rate

HIV SURVEILLANCE DATA

- ii. *HIV surveillance data, including HIV testing program data (e.g., data from Early Identification of Individuals with HIV/AIDS for RWHAP Parts A and B Grantees; CDC HIV testing data) and Clinical data (e.g., CD4 and viral load results)*

Of Nevadans responding to the BRFSS 2014 survey, 41% had ever been tested for HIV (Table 9). The percentage of respondents who had been tested for HIV was highest among Black, non-Hispanic respondents at 64% and lowest for other races, non-Hispanic (27%), white, non-Hispanic (39%) and Hispanic (41%). With respect to age, the lowest percentage who had been tested was 31% of respondents ages 18-24.

Table 9. Percent of Individuals Who Answered the Question, “Have you ever been tested for HIV?” on the Behavioral Risk Factors Surveillance Survey (BRFSS), Nevada 2014¹⁵

	Yes	CI*	No	CI*
Sex at Birth				
Male	42.7	(38.8-46.6)	57.3	(53.4-61.2)
Female	38.6	(35.0-42.1)	61.4	(57.9-65.0)
Race/Ethnicity				
White, non-Hispanic	39.4	(36.4-42.4)	60.6	(57.6-63.6)
Black, non-Hispanic	63.7	(54.3-73.2)	36.3	(26.8-45.7)
Hispanic	40.6	(34.2-46.9)	59.4	(53.1-65.8)
Other, non-Hispanic	27.0	(17.7-36.3)	73.0	(63.7-82.3)
Multiracial, non-Hispanic	49.5	(33.4-65.6)	50.5	(34.4-66.6)
Age at Time of Survey				
18-24	30.6	(21.8-39.4)	69.4	(60.6-78.2)
24-34	52.1	(44.9-59.2)	47.9	(40.8-55.1)
35-44	53.1	(46.4-59.8)	46.9	(40.2-53.6)
45-54	44.9	(38.8-50.9)	55.1	(49.1-61.2)
55-64	37.0	(31.2-42.7)	63.1	(57.3-68.8)
65+	22.6	(18.9-26.3)	77.4	(73.7-81.1)
Education				
Less than H.S.	40.3	(32.1-48.5)	59.7	(51.5-68.0)
H.S. or G.E.D.	38.1	(33.2-42.9)	62.0	(57.1-66.8)
Some Post H.S.	40.9	(36.5-45.4)	59.1	(54.7-63.5)
College Graduate	44.9	(40.2-49.6)	55.1	(50.4-59.8)
Household Income				
Less than \$15,000	47.4	(37.7-57.2)	52.6	(42.8-62.3)
\$15,000-\$24,000	42.5	(35.9-49.2)	57.5	(50.9-64.1)
\$25,000-\$34,999	36.8	(28.3-45.3)	63.2	(54.7-71.7)
\$35,000-\$49,999	36.3	(29.1-43.5)	63.7	(56.5-70.9)
\$50,000+	43.7	(39.6-47.7)	56.3	(52.3-60.4)
Total	40.7	(38.0-43.3)	59.4	(56.7-62.0)

Age at last test is 2011-2013 combined response to the question, "Have you ever been tested for HIV? Do not count tests you may have had as part of a blood donation" also only tests which a test date was given was included.

* 95% confidence intervals are calculated based on the rate.

41% of Nevada BRFSS respondents had ever been tested for HIV.

CDC funds are used to provide HIV testing through the Southern Nevada Health District (SNHD) and Washoe County Health District (WCHD). Table 10 shows the number and types of tests administered through the two health districts from 2012 to 2015. The number of rapid tests has increased since 2012 in both the north and the south.

Table 10. HIV Testing Events Southern Nevada and Washoe County Health Districts, 2012-2015

	2012		2013		2014		2015	
Test Type	SNHD	WCHD	SNHD	WCHD	SNHD	WCHD	SNHD	WCHD
Rapid tests	5575	7	5452	45	6119	153	6730	566
Conventional Tests	12387	2877	13839	1970	12985	1966	11260	1824
Total	17838	2876	19140	2003	18999	2104	17805	2345

EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS DATA FOR PART A AND PART B

The Office of Epidemiology and HIV Prevention Program collect data as it relates to testing events, newly identified positive individuals and linkages, or referrals to medical care. Additionally, SNHD collects data on clients seen at its Early Intervention Services Program and the Anti-Retroviral Treatment and Access to Services (ARTAS) Program.

Based on the data, 92% of newly identified individuals are referred to medical care. The EIIHA Program has been able to work with clients through the Early Intervention Services and ARTAS Programs to ensure a seamless transition from prevention to care. Once in care, programs work closely with clients to ensure they stay in care by removing obstacles and working with clients to access ancillary services to ensure they have the necessary tools to stay in care.

Data from Ryan White Part A grant year 2015-2016 show 462 individuals enrolled in the ARTAS program. Of the total number of clients, 189 were newly diagnosed and 273 were previously diagnosed but re-engaging in medical care from jails/prison, out of care or out of state. Newly diagnosed clients enrolled in ARTAS have a higher rate of linkage, with 79.6% and 76.1% linkage achieved by SNHD and AIDS Healthcare Foundation, respectively; whereas individuals newly diagnosed that chose not to participate in the ARTAS program saw a linkage rate of 72.3% for grant year 2015-2016.

An analysis of viral load upon entry for newly diagnosed individuals enrolled at SNHD shows 93 individuals reported a viral load of ≤ 200 -49,999; 47 individuals reported a viral load of 50,000-99,999; 43 individuals reported a viral load over 100,000. Seven individuals were missing viral load data. Viral load suppression at the end of the 2015-2016 grant year reported 121 individuals with suppressed viral load, 66 individuals with unsuppressed viral load and 3 individuals were missing labs. The number of newly diagnosed individuals with a suppressed viral load increased from 1.6% to 63.7% in the 2015-2016 grant year, an increase of 62.1%.

Table 11. EIIHA Data Las Vegas TGA Ryan White Part A Program, 2014

Definition	Jan. 1, 2014- Dec. 31, 2014
Total number of publicly funded test events:	18,999
Total number of new HIV positive tests:	386
Total number of previously diagnosed HIV positive individuals:	86
Total number of new HIV positive individuals with results received:	378
Total number of new HIV positive individuals linked to medical care:	255
Total number of previously diagnosed HIV positive individuals linked to medical care:	86
Total number of new HIV positive individuals who received partner services:	347
Total number of new HIV positive individuals linked and referred to prevention services:	347
Total number of new HIV positive individuals who received CD4 cell count and viral load testing:	370
Total number of previously diagnosed HIV positive individuals linked to and accessed CD4 cell count and viral load testing:	85

CLIENT UTILIZATION OF ADAP SERVICES

- iii. *Ryan White HIV/AIDS Program data (Ryan White HIV/AIDS Program Services Report; ADAP Data Report)*

High impact prevention targeted testing, early intervention services, outreach, linkage to care and retention programs have contributed to clients being identified as newly diagnosed, out of care, and returned to care. One service provider initiates a call to clients who have not picked up medications in 45 days and another provider calls clients who are in jeopardy of not calling in a timely manner for an eligibility appointment. The only factor contributing to a decrease in ADAP enrollment is the ACA continuation of transitioning clients eligible for Marketplace and Medicaid qualified health plans. Since the direction from HRSA is to vigorously pursue linking clients with these new health insurance entities, Nevada has experienced a decrease enrollment into ADAP (all services) of approximately 429 clients in the past two years. However, overall enrollment remains high for wrap around services.

In 2014, 1,093 clients were on ADAP and of those 678 were served with medication. In 2015, there were 1,084 active ADAP clients and of those 672 were served with medications. The majority of ADAP clients live in the major cities of Nevada—Reno, Carson City, or Las Vegas. Clients residing in rural frontier areas travel to one of these locations for services and medications can be mailed to them, if needed.

- iv. *Other relevant Demographic data (i.e., Hepatitis B or C surveillance, STD surveillance, Tuberculosis surveillance, and Substance use data)*

SEXUALLY TRANSMITTED DISEASES (STD)

According to the CDC, individuals who contract syphilis, gonorrhea, and herpes often also have HIV, or have an increased risk of contracting HIV in the future. Some STDs produce sores or breaks in the skin which may allow for HIV to be transmitted more easily. The same behaviors which put an individual at risk of contracting an STD are the same behaviors which increase an individual's risk of contracting HIV. The CDC advises the only way to avoid STDs is to not have vaginal, anal, or oral sex.

In 2013, a total of 1,401,906 cases of *Chlamydia trachomatis* infection, 333,004 cases of gonorrhea, and 56,471 cases of syphilis (P&S, early latent, late, late latent, and congenital) in the United States were reported to the CDC. In 2014, Nevada reported 12,810 cases of chlamydia, 3,399 cases of gonorrhea, and 314 cases of syphilis (primary and secondary; Table 12).

Table 12. All Reported STD Infections in Nevada by Disease, 2014*

	Chlamydia			Gonorrhea			P&S Syphilis			EL Syphilis		
	n	%	Rate*	n	%	Rate*	n	%	Rate*	n	%	Rate*
Resident County at Diagnosis												
Clark	10,184	79.5%	492.1	2,791	82.1%	134.9	268	85.4%	13.0	338	95.2%	16.3
Washoe	1,768	13.8%	404.8	497	14.6%	113.8	36	11.5%	8.2	17	4.8%	3.9
Carson/Douglas/Lyon	445	3.5%	285.5	48	1.4%	30.8	5	1.6%	3.2	0	0.0%	0.0
All Other Counties**	402	3.1%	221.9	62	1.8%	34.2	5	1.6%	2.8	0	0.0%	0.0
Total	12,810	100.0%	450.5	3,399	100.0%	119.5	314	100.0%	11.0	355	100.0%	12.5
Race/Ethnicity												
White, non-Hispanic	2,755	21.5%	180.2	784	23.1%	51.3	130	41.4%	8.5	115	32.4%	7.5
Black, non-Hispanic	1,984	15.5%	830.9	901	26.5%	377.3	67	21.3%	28.1	85	23.9%	35.6
Hispanic	2,406	18.8%	303.6	469	13.8%	59.2	90	28.7%	11.4	119	33.5%	15.0
American Indian/Alaska Native	95	0.7%	293.0	25	0.7%	77.1	1	0.3%	3.1	1	0.3%	3.1
Asian/Hawaiian/Pacific Islander	394	3.1%	157.0	67	2.0%	26.7	13	4.1%	5.2	14	3.9%	5.6
Unknown/Other	5,176	40.4%	NA	1,153	33.9%	NA	13	4.1%	NA	21	5.9%	NA
Total	12,810	100.0%	450.5	3,399	100.0%	119.5	314	100.0%	11.0	355	100.0%	12.5
Age Group												
< 9	9	0.1%	2.3	2	0.1%	0.5	0	0.0%	0.0	0	0.0%	0.0
10-14	79	0.6%	42.2	29	0.9%	15.5	0	0.0%	0.0	0	0.0%	0.0
15-19	3,104	24.2%	1,704.1	552	16.2%	303.0	8	2.5%	4.4	8	2.3%	4.4
20-24	4,794	37.4%	2,425.3	877	25.8%	443.7	67	21.3%	33.9	55	15.5%	27.8
25-29	2,433	19.0%	1,258.9	722	21.2%	373.6	66	21.0%	34.1	70	19.7%	36.2
30-34	1,106	8.6%	587.3	438	12.9%	232.6	53	16.9%	28.1	63	17.7%	33.5
35-39	619	4.8%	304.3	275	8.1%	135.2	39	12.4%	19.2	52	14.6%	25.6
40-44	307	2.4%	156.5	185	5.4%	94.3	22	7.0%	11.2	21	5.9%	10.7
45-54	280	2.2%	72.6	223	6.6%	57.8	41	13.1%	10.6	67	18.9%	17.4
55-64	55	0.4%	16.3	78	2.3%	23.1	16	5.1%	4.7	16	4.5%	4.7
65+	17	0.1%	4.4	16	0.5%	4.1	2	0.6%	0.5	3	0.8%	0.8
Unknown	7	0.1%	NA	2	0.1%	NA	0	0.0%	NA	0	0.0%	NA
Total	12,810	100.0%	450.5	3,399	100.0%	119.5	314	100.0%	11.0	355	100.0%	12.5

Source: Division of Public and Behavioral Health, Sexually Transmitted Disease Management Information Systems (STD*MIS), data as of June 2016.

*Crude rates per 100,000 population were calculated using 2015 population projections from the Nevada State Demographer vintage 2015 data.

**All other counties include Churchill, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing, Storey, and White Pine.

SUBSTANCE ABUSE

During 2013, 9,114 persons were living with HIV/AIDS in Nevada and of those 492 were also admitted to a program monitored by the Substance Abuse Prevention and Treatment Agency (SAPTA). Over 100,000 people have been enrolled in SAPTA since 2006, and of those, over 60,000 have agreed to the HIV testing offered to them when admitted to treatment in a SAPTA approved program.

**Table 13. Substance Abuse Prevention and Treatment Agency/
Persons Living with HIV/AIDS in 2013 Linkage Analysis**

	Nevada Prevalance					
	SAPTA		LINK*		HIV/AIDS	
	n	%	n	%	n	%
Sex at Birth						
Male	66,557	64%	394	80%	7,654	84%
Female	36,745	36%	98	20%	1,460	16%
Total	103,302	100%	492	100%	9,114	100%
Race/Ethnicity						
White, non-Hispanic	63,628	62%	195	40%	4,432	49%
Black, non-Hispanic	12,355	12%	186	38%	2,204	24%
Hispanic	18,618	18%	84	17%	2,004	22%
Asian/Hawaiian/Pacific Islander	1,654	2%	6	1%	298	3%
American Indian/Alaska Native	2,827	3%	7	1%	71	1%
Multi-race/Other/Unknown	4,220	4%	14	3%	105	1%
Total	103,302	100%	492	100%	9,114	100%
Age						
Missing	33	0%	0	0%	58	1%
< 13	246	0%	0	0%	11	< 1%
13 to 24	30,984	30%	28	6%	337	4%
25 to 34	27,716	27%	110	22%	1,386	15%
35 to 44	21,431	21%	123	25%	2,143	24%
45 to 54	16,930	16%	162	33%	3,204	35%
55 to 64	5,200	5%	66	13%	1,527	17%
65 +	762	1%	3	1%	448	5%
Total	103,302	100%	492	100%	9,114	100%
Transmission Category						
Male						
MSM			214	54%	5,793	64%
IDU			72	18%	490	8%
MSM+IDU			67	17%	579	6%
Heterosexual contact			19	5%	281	13%
Perinatal exposure			2	1%	33	1%
Transfusion/Hemophilia			0	0%	7	< 1%
NIR/NRR			20	5%	471	8%
Subtotal			394	100%	7,654	100%
Female						
IDU			26	27%	243	17%
Heterosexual contact			57	58%	889	61%
Perinatal exposure			0	0%	36	2%
Transfusion/Hemophilia			0	0%	3	< 1%
NIR/NRR			15	15%	289	20%
Subtotal			98	100%	1,460	100%
Total	103,302	100%	492	100%	9,114	100%

Source: Division of Public and Behavioral Health, HIV/AIDS Reporting System (eHARS), (Aug 2014)

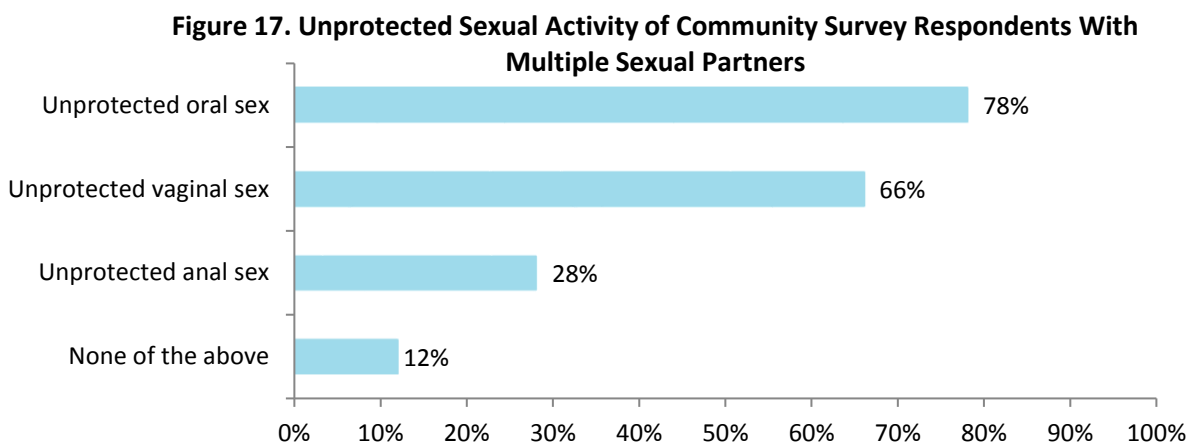
* SAPTA and PLWHA individuals were matched utilizing Link Plus. First name, last name, date of birth, and social security number were paired with its counterpart using probabilistic matching.

There have been 68 individuals who were tested for HIV by SAPTA at admission and who were diagnosed within one year with HIV/AIDS. Of the 68 individuals who tested positive for HIV/AIDS within one year of being reported to the state of Nevada, 17 were diagnosed within 30 days of admission and five were diagnosed the same day as the HIV test was administered as a result of admission to a substance abuse treatment program.

- v. *Qualitative data (e.g., observations, interviews, discussion groups, focus groups, and analysis of social networks)*

HIV COMMUNITY SURVEY RESPONDENT RISK BEHAVIORS

The HIV Community Survey was collected from 1687 respondents around Nevada from April 2015 to March 2016. The survey collected information regarding HIV risks, barriers to prevention, and community needs. Of community survey respondents who reported having more than one sexual partner in the past year (N=751), 28% reported having unprotected anal sex; and 66% reported having unprotected vaginal sex (Figure 17).



Condom use varied among types of community survey respondents. Overall, 44% of respondents reported that they seldom or never use condoms. Of transgender male to female individuals (N=13), 78% reported seldom or never using condoms. Of intravenous drug users (IDU; N=90), 58% reported seldom or never using condoms. Of those who had more than one sexual partner in the past 12 months, 27% reported seldom or never using condoms.

Six percent of the respondents (N=90) reported injecting drugs in the past 12 months. Of the IDU respondents, 51% had shared needles/works without bleaching; 40% had shared needles for tattoos/piercing with someone who they believe uses drugs; and 27% had shared a cooker, cotton or rinse water.

58% of IDU reported seldom/never using condoms
51% of IDU had shared needles/works without bleaching

B. HIV CARE CONTINUUM

- a. *Provide a graphic depiction and a descriptive narrative of the HIV Care Continuum of the jurisdiction using the most current calendar year data. The definitions of the numerator and the denominator must be clearly stated for each step. In addition to developing the HIV Care Continuum, include a discussion on the acquisition of data needed to develop it in the “Data: Use, Access, and Systems” section.*

The steps of the diagnosed-based HIV Care Continuum using the HHS indicators are described below. If any updates are made to the HHS indicators or in the NHAS indicators that would impact the descriptions below, jurisdictions should use the most up- to-date indicator language. If using the prevalence-based approach, your continuum will have an additional first step that includes the undiagnosed HIV infected individuals in the jurisdiction and a different denominator for the other steps.

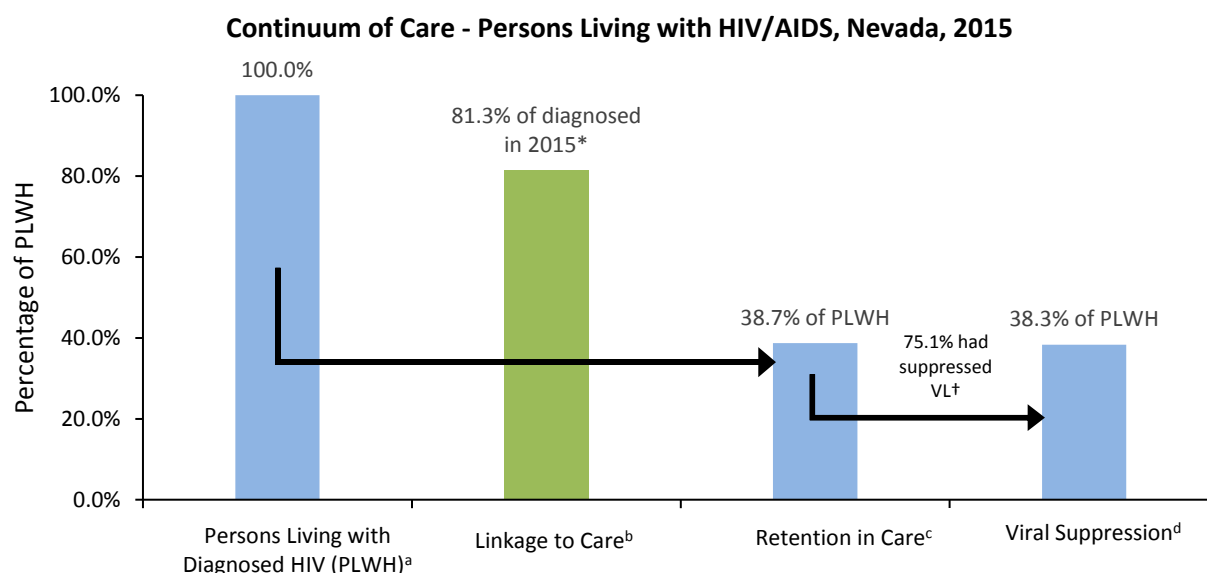
- i. **HIV-Diagnosed:** *Diagnosed HIV prevalence in a jurisdiction; the known/reported cases of HIV infection, regardless of AIDS (stage 3 HIV infection) status; this number does not include the number of persons undiagnosed, and only includes the cumulative number of persons reported to the surveillance system through the end of a given year, minus the cumulative number of persons who were reported as having died.*
- ii. **Linkage to Care:** *The percentage of people diagnosed with HIV in a given calendar year that had one or more documented medical visits, viral load or CD4 tests within 3 months after diagnosis; this measure has a different denominator than all other measures in the continuum. The denominator is the number diagnosed with HIV infection (regardless of AIDS status) in a given calendar year.*
- iii. **Retained in Care:** *The percentage of diagnosed individuals who had two or more documented medical visits, viral load or CD4 tests, performed at least 3 months apart in the observed year.*
- iv. **Antiretroviral Use:** *The number of people receiving medical care and who have a documented antiretroviral therapy prescription in their medical records in the measurement year, (if available).*
- v. **Viral Load Suppression:** *The percentage of individuals whose most recent HIV viral load within the measurement year was less than 200 copies/mL.*

Nevada has elected to use the *diagnosed-based* HIV Care Continuum (Figure 18). HIV-Diagnosed is defined as the known/reported cases of HIV infection, regardless of AIDS (stage 3 HIV infection) status. This number does not include the number of persons undiagnosed, and only includes the cumulative number of persons reported to the surveillance system through the end of a given year, minus the cumulative number of persons who were reported as having died. Retained in Care refers to the percentage of diagnosed individuals who had two or more documented medical visits, viral load or CD4 tests, performed at least 3 months apart in the observed year. Viral Load Suppression is calculated as the percentage of individuals whose most recent HIV viral load within the measurement year was less than 200 copies/mL. Caution is needed when interpreting the following analyses because at the time these labs were reported, Nevada state law only required the reporting of CD4 values with counts below 500 per ml³ of blood and a detectable viral load (>200 copies/ml); therefore, number of cases retained in care and virally suppressed will most likely be underestimated. In the future more accurate data will be available as Nevada law has recently changed to require reporting of all CD4 values and all HIV viral load measurements.

Of persons who had been diagnosed with HIV through year-end 2014, 9,062 were alive at year-end 2015. Of those 9,062 PLWH, 38.7% were retained in care (percentage of persons who had ≥ 2 CD4 or viral load tests at least three months apart during 2015 among those diagnosed with HIV through year-end 2014 and alive at year-end 2015). Among those retained in care at the end of 2015, 75.1% had suppressed viral load (≤ 200 copies/mL) at most recent test during 2015. Among PLWH year-end 2014 and alive at year-end 2015, 38.3% had suppressed viral load (≤ 200 copies/mL) at most recent test during 2015.

Of the 477 newly diagnosed cases of HIV in 2015, 81.3% were linked to care within three months after diagnosis during 2015.

Figure 18. Persons Living with HIV/AIDS Infections Continuum of Care Cascade for Nevada, 2015



Source: Division of Public and Behavioral Health, HIV/AIDS Reporting System (eHARS), data as of March 2016.

^aPersons Living with HIV indicate any person regardless of HIV staging, including HIV stage 3 (AIDS).

^bDefined as persons diagnosed with HIV infection (regardless of stage of disease) through year-end 2014, who were alive at year-end 2015.

^cCalculated as the number of persons linked to care within 3 months after HIV diagnosis during 2015, divided by the total number of persons diagnosed with HIV infection in 2015. Linkage to care is based on the number of persons diagnosed during 2015, and is therefore shown in a different color than the other bars with a different denominator.

^dCalculated as the percentage of persons who had ≥ 2 CD4 or viral load test results at least 3 months apart during 2015 among those diagnosed with HIV through year-end 2014 and alive at year-end 2015.

[†]Calculated as the percentage of persons who had suppressed VL (≤ 200 copies/mL) at most recent test during 2015, among those diagnosed with HIV through year-end 2014 and alive at year-end 2015.

^{*}Calculated as number of persons who had suppressed VL (≤ 200 copies/mL) at most recent test during 2015, among those who were retained in care during 2015.

^{*}Preliminary data. Due to delays in reporting, more individuals may be linked to care than currently represented.

While Nevada's rates of retention in care and viral suppression for PLWH appear low, they are underestimated due to the lack of complete data for CD4 values and viral load measurements at the time this plan was written.

- b. Provide a narrative (and graphic, if available) description of disparities in engagement among key populations (e.g., young MSM, IDU, African-American heterosexual women, etc.) along the HIV Care Continuum.

Some disparities exist in Nevada's HIV Care Continuum by sex, race/ethnicity, and age. Figure 19 compares the percentages of individuals newly diagnosed with HIV who were linked to care within 90 days of diagnosis. A lower percentage of males compared to females were linked to care within 90 days. Comparing individuals of different races/ethnicities, linkage to care was similar across groups but was slightly lower for newly diagnosed black clients (79%). With respect to age, the lowest percentages of newly diagnosed clients linked to care within 90 days were in the age groups of 13 to 24 years, 35 to 44 years, and 65 years and older respectively (Figure 20).

Figure 19. Linkage to Care within 90 Days of Diagnosis, by Sex and Race, Nevada, 2015

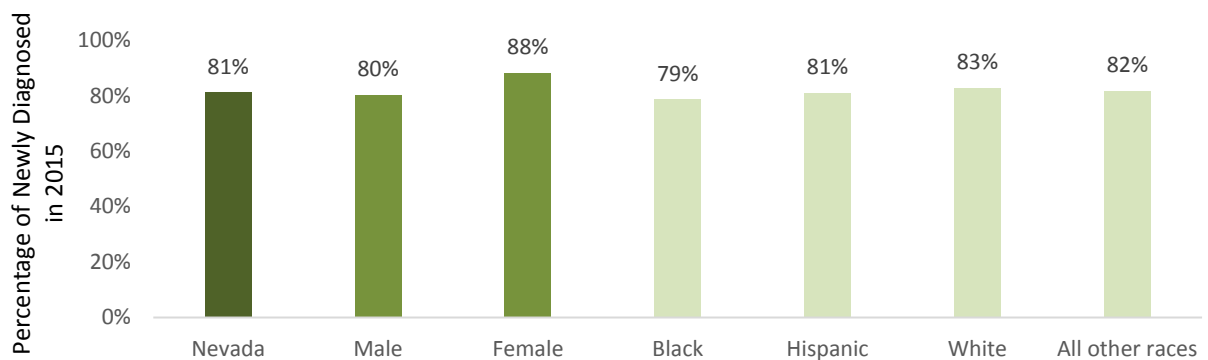
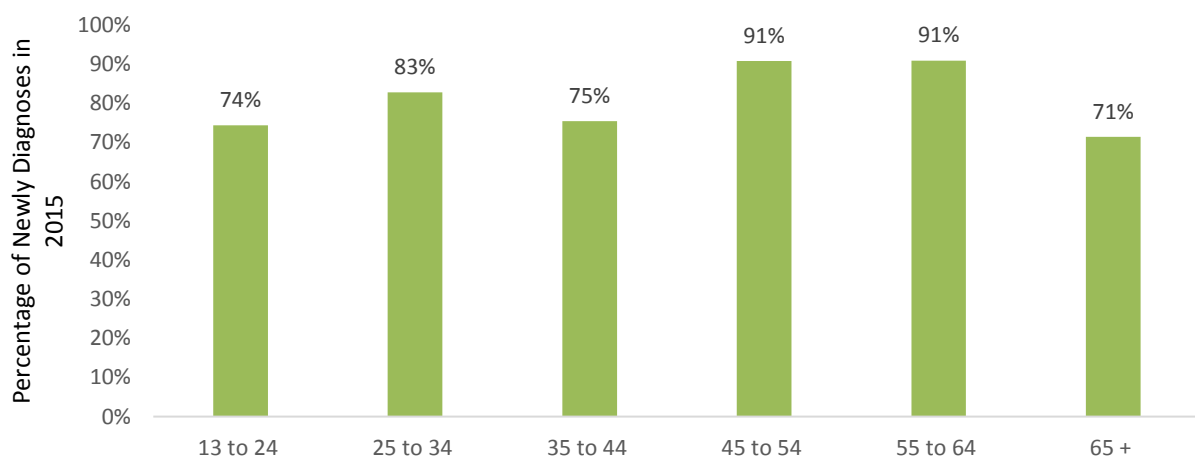
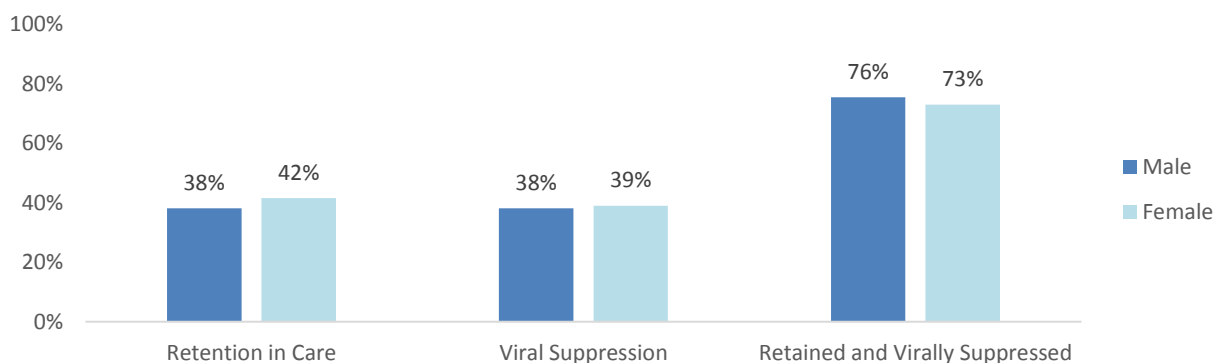


Figure 20. Linkage to Care within 90 days of Diagnosis, by Age, Nevada, 2015



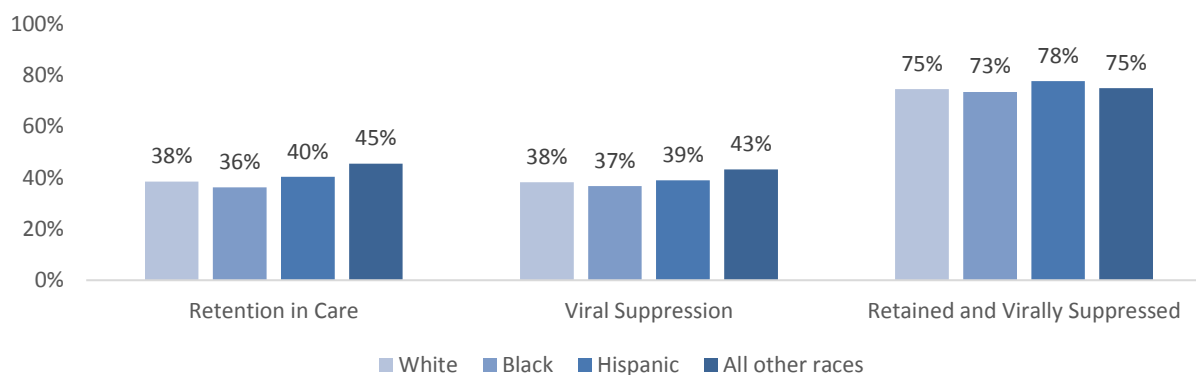
Of PLWH in Nevada, females were more likely to be retained in care than males and slightly more likely to be virally suppressed. However, among those who were retained in care during 2015, a higher percentage of males (76%) than females (73%) were virally suppressed (Figure 21).

Figure 21. Retention in Care and Viral Suppression-Persons Living with HIV/AIDS by Sex, Nevada, 2015



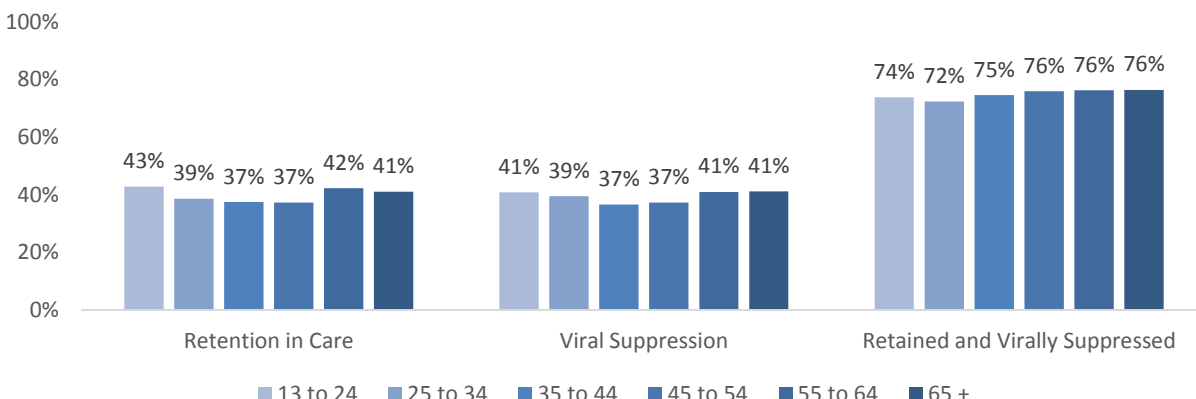
Of PLWH in Nevada, Black clients had the lowest rates of retention of care and viral suppression. Hispanics and all other races had the highest rates of retention and viral suppression, although overall numbers are low. Among those who were retained in care during 2015, the highest percentage of virally suppressed clients was Hispanic and the lowest was Black (Figure 22).

Figure 22. Retention in Care and Viral Suppression-Persons Living with HIV/AIDS by Race/Ethnicity, Nevada, 2015



Lowest rates of retention in care and viral suppression were for the age groups 35 to 44 years and 45 to 54 years. Among those who were retained in care during 2015, the lowest percentage of viral suppression was among clients ages 25 to 34 (Figure 23).

Figure 23. Retention in Care and Viral Suppression-Persons Living with HIV/AIDS by Age, Nevada, 2015



These findings suggest that across genders, ethnicities and age, viral suppression requires retention in care. Differences in viral suppression among groups retained in care appear minimal. Although linkage to care was successfully recorded in over 80% of newly diagnosed HIV+ persons, retention appears to be the primary concern to improve statewide viral suppression results. Lack of viral suppression contributes to ongoing transmission and ongoing morbidities in those infected with HIV.

COMPARATIVE ANALYSIS OF CARE CONTINUUM FOR CURRENT RYAN WHITE PART A CLIENTS

A comparative analysis of the care continuum on gender, age, race/ethnicity, HIV risk factor, and insurance status in relation to current Ryan White Part A clients was conducted. Strong disparities were seen with health insurance status and race, which could be largely attributed to data collection practices. For health insurance, those with no insurance had much better outcomes for retention in care, ART prescription, and viral load suppression compared to those with Medicaid, Medicare, and private insurance. This may be attributed to clients in the Ryan White Part A program that have better outcomes due to the measurement of standards of care, HAB performance measures, and other monitoring activities the Ryan White program requires. Another factor is the data collection practices under the RSR funded scope reporting guidelines. Individuals with no insurance have most of their medical services entered in CAREWare, as Ryan White is the only pay source. Individuals with other health care coverage would not have their medical services entered in CAREWare as they are covered by another pay source.

For race, Hispanics had much better outcomes across the continuum compared to other groups. However, most Hispanics had no insurance, so their positive outcomes were most likely correlated to full reporting of their medical service data, whereas other race/ethnicity groups with other types of insurance did not have all of their medical services reported. The Las Vegas TGA implemented eligible scope reporting in 2015. It is hoped that this will help eliminate bias and provide more accurate engagement estimates.

Linkage to care: In the Las Vegas TGA, 83% of individuals are linked to care which may be attributed to the ARTAS program—an individual-level, multi-session, time limited intervention to link newly diagnosed individuals to medical care. When analyzing the transmission risks, a statistical difference was seen with

heterosexual clients having a lower linkage rate (78%) compared to MSM (85%), IDU (83%), and MSM/IDU (88%). The TGA has programs for heterosexual clients including a straight support group (men and women), a women's support group, and a healthy relationships class for women who have sex with men. As the peer navigation program develops, the grantee's office will recruit navigators specifically to reach this population and increase the linkage rate among Heterosexuals.

Received Any Care: Overall, 59% of RWPA clients had at least one medical visit in CY 2014. Women were less likely to have received any care with 54% having a least one visit, compared to men with 60% reporting at least one visit and transgender clients at 86%. The straight support group and women's support group discuss the importance of regular care with clients. Currently a targeted effort of engaging women in their medical care, especially obtaining a Pap smear yearly is underway. When women visit the clinic for any reason, they have a one-on-one medical consult with a female physician to develop a relationship and to discuss the benefits of regular medical care, including a Pap smear. There is also a focused effort on creating and sustaining healthy relationships in a six-week class through Health Education/Risk Reduction.

Retained in Care: According to *Figure 24 Continuum of Care for Ryan White Clients in the Las Vegas TGA, 2014*, 25% of all clients are retained in care. However, this number may be artificially low due to inaccurate reporting from individuals with other insurance. In CY 2015, eligible scope reporting was instituted which will provide a more accurate number of individuals retained in care. Clients who reported IDU alone (14% retention rate) or MSM and IDU (4% retention rate), lower percentages of retention were seen than all other categories. Clients 45 and older (21% retention rate or less) are less likely to be retained in care. This may be attributed to a number of factors, including other co-morbidities such as substance use and mental health issues.

A number of interventions are in place to encourage individuals to stay in care, including health education classes and support groups. Also, medical case managers are required to have a face-to-face meeting with clients at least every three months and make contact calls to individuals that have not been seen in nine months in an effort to bring them back into care.

Figure 24. Continuum of Care for Ryan White Clients in the Las Vegas TGA, 2014

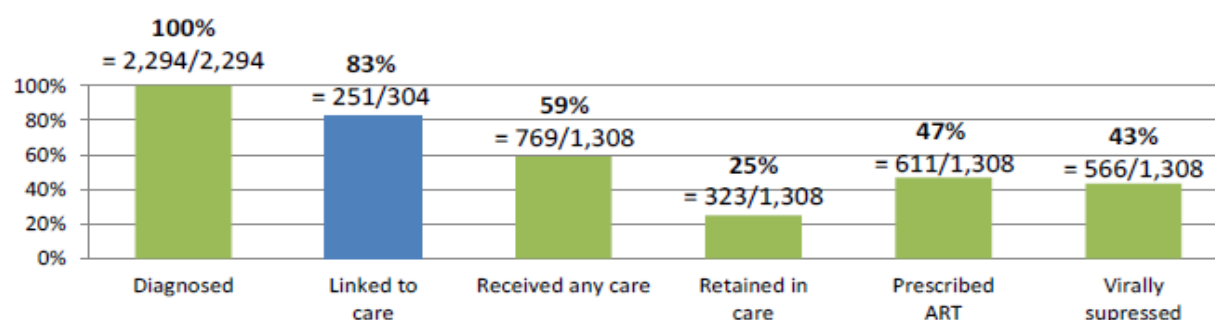
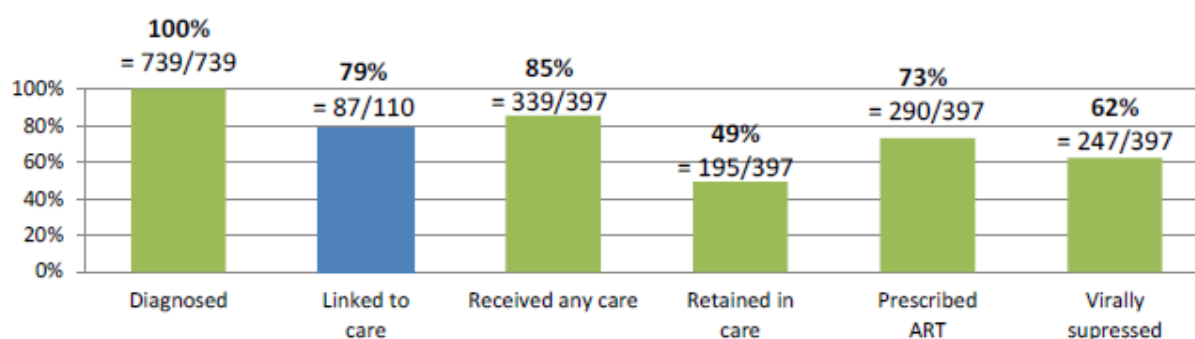


Figure 25. Continuum of Care for Ryan White Clients with No Insurance in the Las Vegas TGA, 2014



Source: Ryan White Service Data, CAREWare October 2015

Prescribed ART: Significant differences in prescription of ART were seen with gender, race, risk factor, and age. Women were less likely to have been prescribed ART (41% prescribed ART) compared to men (48% prescribed ART) and transgender clients (71% prescribed ART). African American clients had the lowest percentage of ART prescription, 32% were prescribed ART in comparison to 71% of Hispanic clients. Clients aged 13-24 and 55 and older were less likely to have been prescribed ART (32% and 39% respectively). Targeted interventions focusing on the necessity of medication, self-care, and advocating for one's needs are available through support groups, classes and one-on-one medical case management. A portion of the difference in numbers reported may be attributed to the data collection challenges, which should be diminished with the move to eligible scope reporting and the state requirement for all CD4 and Viral Load results to be reported.

Viral suppression: Race and insurance status were the only characteristics for which there was a statistical difference in viral load suppression. White, Black and Other race all reported that 36% were virally suppressed in contrast to 59% of Hispanic clients with viral suppression. Clients with no insurance had a 62% rate of viral suppression while clients with Medicaid and Medicare reported a 38% and 26% viral suppression rate respectively. Although not statistically significant, IDU and MSM/IDU had lower rates of suppression, 35% and 29% respectively. A portion of the difference in numbers reported may be attributed to the data collection challenges which should be diminished with the move to eligible scope reporting and the state requirement for all CD4 and viral load results to be reported. Grantee staff members are planning for implementation of a peer navigator program in 2016 which will focus, in part, on the importance of medication adherence to achieve viral suppression.

- c. *Describe how the HIV Care Continuum may be or is currently utilized in (1) planning, prioritizing, targeting, and monitoring available resources in response to the needs of PLWH in the jurisdiction, and (2) improving engagement and outcomes at each stage of the HIV Care Continuum.*

Nevada uses the HIV Care Continuum to closely examine the proportion of PLWH engaged in each of the stages of the continuum to pinpoint where gaps may exist in connecting PLWH to sustained quality care and to implement system improvements and service enhancements that better support individuals as they move from one stage in the continuum to the next. Knowing where the drop-offs are most

pronounced, and for what populations, is vital to knowing how, where, and when to intervene to break the cycle of HIV transmission in Nevada. With the change in Nevada law that requires reporting of all CD4 measures and HIV viral load now in effect, going forward Nevada will have enhanced data to pinpoint gaps and implement improvements, thereby increasing the proportion of PLWH who are prescribed ART and are able to adhere to their treatment so that they can achieve viral load suppression. This will allow them to live healthier, longer lives and reduce the chances that they will transmit HIV to others.

The HIV Care Continuum is currently used in the following ways in the Las Vegas TGA: 1) Planning Council's Priority Setting and Resource Allocation (PSRA) process; 2) analyzed and evaluated by the Planning Council's Strategic Planning and Assessment committee for possible trends, gaps and opportunities for improvement; 3) aids in the selection of target populations for the EIIHA plan; 4) supports the development of the implementation plan; 5) supports planning quality improvement projects; 6) used to assist in determining target populations for targeted needs assessments; 7) supports the development of the Integrated HIV Prevention and Care Plan; 8) utilized by sub-populations to better understand any disparities and how to better tailor engagement efforts to specific communities; and 9) used as part of the annual TGA-wide "out of care" project that brings people who have fallen out of care back in to care. Future plans include using the continuum at the provider level to help agencies frame their programs in terms of the care continuum. The Grantee's office will work with providers to identify interventions targeted at specific steps of the continuum to improve engagement and outcomes. Plans include providing an agency specific care continuum on a quarterly basis, which will quickly illustrate successes and opportunities for improvement at an agency specific level. Additionally, the quarterly reports will help focus each provider on the National HIV/AIDS Strategy goals for the HIV Care Continuum.

C. FINANCIAL AND HUMAN RESOURCES INVENTORY

a. Provide in a table format a jurisdictional HIV resources Inventory, that includes: (1) public and private funding sources for HIV prevention, care, and treatment services in the jurisdiction, (2) the dollar amount and the percentage of the total available funds in fiscal year (FY) 2016 for each funding source; (3) how the resources are being used (i.e., services delivered); and (4) which components of HIV prevention programming and/or steps of the HIV Care Continuum is (are) impacted. At a minimum, the table should contain the following information:

- i. Funding Sources (e.g., Ryan White HIV/AIDS Program (RWHAP) Parts A-F, including Special Projects of National Significance (SPNS) and the AIDS Education and Training Centers (AETC) Program, CDC HIV Prevention and Surveillance Programs, Minority AIDS Initiative (MAI), SAMHSA, HUD/ HOPWA, Medicaid expenditures, Bureau of Primary of Health Care, Federal Office of Rural Health Policy, Indian Health Service; Office on Women's Health, Office of Minority Health, Office of Population Affairs, Administration for Children and Families, and other public and private funding sources);*
- ii. Funding Amount (\$)*
- iii. Funded Service Provider Agencies*
- iv. Services Delivered*
- vi. HIV Care Continuum Step(s) Impacted (please see Section I. B. HIV Care Continuum)*

The Nevada HIV Funding Resources Table found in Appendix C provides details on the funding sources for HIV prevention, care and treatment sources in the state including the dollar amount and percentage of total available funds in fiscal year 2016 for the funding sources, how resources are being used and which components of HIV prevention programming and/or steps of the HIV Care Continuum are impacted.

RWPA funds provider agencies to deliver core medical and/or support services for PLWH in Clark and Nye Counties in Southern Nevada and Mojave County in Arizona. Part A providers include Aid for AIDS of Nevada (AFAN); AIDS Healthcare Foundation (AHF); Community Counseling Center (CCC); Community Outreach Medical Center (COMC); UMC Wellness; Horizon Ridge Clinic; North Country Health Center; Nye County Health and Human Services, Southern Nevada Health District (SNHD); UNLV School of Dental Medicine; Golden Rainbow; and Clark County Social Service.

RWPB HIV/AIDS services are predominantly located in the Las Vegas and Reno areas. The Nevada continuum of care includes Access to Healthcare Network (AHN) medical discount plan, Northern Nevada HIV Outpatient Program, Education, and Services (HOPES)-Reno, Carson City Health and Human Services (CCHHS), Community Outreach Medical Center (COMC)-Las Vegas, University Medical Center of Southern Nevada (UMCSN), SNHD, WCHD, The Center, AFAN, CARE Coalition, Community Counseling Center, Access for Community & Cultural Programs & Training (ACCEPT), Dignity Health, Las Vegas Urban League, and Southern Nevada AIDS Research & Education Society (NARES). Services are delivered either directly or via network membership/referral. Medical and non-case management supports clients accessing and remaining in care.

Nevada has three health districts that serve metropolitan or urban areas of the state—Southern Nevada Health District (SNHD), Washoe County Health District (WCHD), and Carson City Health & Human Services (CCHHS). The rest of the state has access to medical services through the state community health nursing programs, although there are some counties that have no services. SNHD serves Clark County residents. SNHD receives State of Nevada federal through funding from the CDC for HIV prevention, sexually transmitted disease control and HIV surveillance activities. HIV prevention funding through the SNHD is used for rapid testing and the activities of the Comprehensive Risk Counseling Services (CRCS) as defined by CDC protocols in identifying individuals unaware of their HIV status. SNHD also receives Part A and Part B funding for Early Intervention Services and Medical Case Management. HIV/AIDS services provided by SNHD include HIV and STD testing, partner notification, HIV Client Centered Counseling; Adult Evaluation Clinic for persons living with HIV; case management; assistance with partner counseling; outreach programs; community referrals; distribution of safer sex items for the prevention of HIV; and, training for Client Centered Counseling.

WCHD serves Washoe County residents and receives federal CDC pass through funding through the state for HIV prevention. Through the Sexual Health Program, WCHD provides screening, testing and counseling for STDs, including HIV; HIV and STD prevention education; community outreach; partner notification; and referrals for PLWH. WCHD also receives funding for STD disease control and HIV surveillance. WCHD provides safer sex supply distribution, as well as trainings for client-centered counseling (RESPECT model) with the prevention education. Both SNHD and WCHD have implemented Anti-Retroviral Treatment and Access to Services (ARTAS) programs in their jurisdictions, which allow for a seamless transition from HIV

identification to care services. Linkage coordinators work with clients over six sessions to reduce client barriers to accessing services, and the coordinators help clients access services. CCHHS serves Carson City, Douglas, Lyon and Storey Counties. With the CDC funding for HIV prevention, CCHHS provides counseling, testing and referral services, partner notification, and HIV/STD education.

HIV WORKFORCE CAPACITY

- b. Provide a narrative description of the HIV Workforce Capacity in the jurisdiction and how it impacts the HIV prevention and care service delivery system. The jurisdiction must define the workforce (e.g. licensed providers, community health workers, paraprofessionals) as applicable to the jurisdiction.*

The HIV Workforce in Nevada includes licensed medical providers, mental health care providers, psychiatrists, registered dietitians that are HIV focused, community health workers, dentists and dental hygienists who have received HIV training, peer navigators, certified nurse case managers, medical case managers, paraprofessionals, counselors, and social workers. Two HIV specialty clinics are available—Northern Nevada HOPES and UMC Wellness Center in the south. Additionally, some private physicians provide HIV care. Nevada has a variety of education and training opportunities to help expand and improve the HIV workforce capacity. The University of Nevada School of Medicine is in the process of reorganizing so that there will be two separate schools of medicine in the state—one in the south and one in the north. Nevada AIDS Education and Training Center (NAETC) provides AIDS education for providers across the state. The University of Nevada Las Vegas (UNLV) dental school includes an HIV program, and the College of Southern Nevada (CSN) includes HIV training for dental hygienists. UNLV and UNR each have a school that offers degrees in public health. Nursing, physician assistant, medical assistant, physical therapy training programs are also available in the state. Three AHEC centers are located in Nevada in Reno, Elko and Las Vegas. AHEC programs enhance access to quality health care, particularly primary and preventive care, by increasing the number of health care professionals and through extensive continuing education and training facilitated by community and academic partnerships.

Nevada has a variety of challenges with respect to HIV workforce capacity. Across the state, there is a shortage of physicians in general. In the United State, Nevada ranks 47th in physician to population ratio, with 225.7 MDs per 100,000 in Nevada compared to 331 per 100,000 in the U.S. Shortages exist in nearly all medical specialties, with the number of MDs per capita in Nevada at 68.2% of the average rate for the U.S.¹⁶ Nevada ranks 47th in the U.S. for number of licensed psychiatrists per 100,000 population and 48th in psychologists.¹⁷ Shortages also exist in Nevada across most other types of healthcare workers.

Linkage to care and retention in care for PLWH can be negatively impacted by the lack of physicians and other healthcare providers in Nevada. The lack of physicians can make it difficult to get clients linked to care promptly after diagnosis. The lack of physicians, HIV providers, specialty physicians, psychiatrists, nurse practitioners, physician assistants, dentists, registered dietitians, outreach providers, social workers, case managers, eligibility specialists, and peer advocates were frequently mentioned as key needs from a variety of stakeholders during the various needs assessment data collection efforts. Other key needs related to workforce capacity include the need for additional training for healthcare

professionals related to HIV/AIDS, cultural competence, and empathy; more collaboration and communication among agencies; and more diversity among providers and healthcare workers. PLWH in rural areas are needed as rural HIV positive clients have greater difficulty accessing needed services. While there are some providers that are doing well serving the African American and Latino populations, more providers to better serve Asian and Pacific Islanders are needed. Additionally, providers that have knowledge about how to serve refugees are needed. PEP and PrEP providers do exist in Nevada; however, there can be delays to accessing those services. There is a general lack of knowledge about PEP and PrEP among providers and the public.

INTERACTION OF FUNDING SOURCES

- c. Provide a narrative description of how different funding sources interact to ensure continuity of HIV prevention, care, and treatment services in the jurisdiction.*

The Ryan White programs in Nevada collaborate extensively to assure that services are developed and provided per identified need. RWPA serves Clark and Nye Counties in Nevada and Mohave County in Arizona. RWPA addresses coordination of services by ensuring that RWPA dollars are utilized as a last resort. Eligibility specialists are required to exhaust all other avenues for assistance before approving Part A services. Clients new to the system of care in the TGA and those already receiving Ryan White services are provided with an eligibility assessment and a comprehensive assessment of their medical and social support needs. Based on the client's individual treatment plan, a referral plan is developed that incorporates Ryan White funded and non-Ryan White funded service providers. The TGA's case management agencies serve as the hub for the coordination of all these services. Clients are linked into service agencies that address their specific needs. Case managers in the Ryan White funded case management agencies have established and maintain strong working relationships with the case workers and case managers in these outside service agencies. Additionally, the Part A Grant Administrator sits on the Southern Nevada Regional Planning Coalition's Committee on Homelessness – Continuum of Care Evaluation Working Group to maintain connections with housing services in the community.

Together, the case manager and the client work together to address the client's needs through cooperative, coordinated service provision. The care system ensures a coordination of medical care for clients, not only for HIV services, but for non-HIV specialty services as well. Ryan White funded medical providers see the majority of clients with HIV/AIDS in the TGA. To address the unique medical needs of the client, a network of specialty medical providers exists to ensure services such as psychiatry, ophthalmology and physical rehabilitation are available. These services are coordinated through a medically based system of case management, with the nursing case managers in Ryan White funded clinics serving as the primary linkage point.

The TGA case management providers maintain effective working relationships with other governmental and non-profit service providers. This linkage ensures that Ryan White services compliment the services of other providers. Included in the network of partner agencies is Nevada State Medicare and Medicaid offices, Nevada State Welfare, the Veteran's Administration, the Southern Nevada Health District, Clark County Social Services, Catholic Charities of Southern Nevada, Nevada Partners (work related skills

training), Section 8 housing providers, Help of Southern Nevada, Southern Nevada Adult Mental Health, West Care Treatment Corporation, and Bridge Counseling.

All of these service providers, Ryan White and non-Ryan White, are coordinated by the case managers in conjunction with the client to address all identified barriers to accessing care services, all barriers to remaining compliant with care services and all social support issues hindering the effective management of the client's disease.

RWPB maintains continuous oversight of State programs and assures that programs, care and services are created, supported, implemented and evaluated to address needs per the SCSN, state epidemiologic data and an ongoing process of needs assessment and input. Nevada continues to research alternative sources of payment for all clients. This is successfully managed through the eligibility vendors with enrollment responsibilities.

Parts C and D assure that clinical services are offered and address scope of work and reporting requirements. All of these various component parts must assure that HRSA and State eligibility requirements are met and updated and must accomplish their scope of work while collaborating with each other. Part F, the Nevada AETC and other programs provide a supportive infrastructure for practitioners assuring that up-to-date resources, clinical consultation, guidance and practice development and transformation and educational and skill development programs are always available to support the infrastructure of care.

Several mechanisms are in place to ensure that sub-recipients funded through multiple Ryan White parts are able to distinguish which clients are served by each individual funding stream to avoid duplication of services. The Las Vegas TGA currently receives Part A, Part B, Part C, Part D and MAI funding. Agencies track funding for services by funding stream. On a weekly basis, case conferences are held. This provides a forum for medical case management staff, medical providers, and other core members of service delivery to discuss specific clients and their needs. Recipients and sub-recipients of all Ryan White funding streams (Part A, B, C, D and F) also meet quarterly in a meeting called The Gathering, to discuss emerging issues and enhance the continuum of care across all parts. The Gathering also allows providers funded through one part to learn about services provided by other Ryan White parts and identify any situations where service delivery is duplicated or not working.

Ryan White All Parts Gathering also take place in northern Nevada which improves coordination of services. The Gatherings include at least one representative from each provider funded by Parts B, C, and D. The Gathering provides the venue to communicate program updates, training, ACA communication, discuss eligibility issues, service coordination, partner introductions, grant opportunities as well as bring in guest speakers.

In the North, Northern Nevada HOPES is a nonprofit community health center in Reno that is designed in a way that facilitates coordination of care and services for clients. HOPES offers integrated medical care and wellness services. HOPES receives Part B, Part C, Part D funding. In addition to HIV care, within the federally qualified health center, HOPES provides chronic disease management, wellness and nutrition, behavioral health counseling, substance use counseling, case management, pharmacy. Additionally,

HOPES has a harm reduction center which houses a syringe services program and provides syringes, harm reduction supplies, counseling, and free HIV and hepatitis C testing.

Interaction of funding sources is also evident in the state with the coordination among providers and funding streams related to testing, early intervention services, and medical case management. For example, as the regional public health authority in the Las Vegas TGA, the SNHD is the recipient of state of Nevada pass through funding from the CDC for HIV prevention, sexually transmitted disease control and HIV surveillance activities. SNHD is also the recipient of Part A and Part B funding for Early Intervention Services and Medical Case Management. HIV prevention funding through the SNHD is used for rapid testing and the activities of the Comprehensive Risk Counseling Services (CRCS) as defined by CDC protocols in identifying individuals unaware of their HIV status. The SNHD has conducted activities related to evidence-based testing and education in numerous locations, venues and through targeted testing for decades. AIDS Healthcare Foundation (AHF) provides mobile HIV testing in the community. The combination of targeted testing by SNHD and broad-based testing provided by AHF ensures that the TGA is well covered in relaying the important message of testing and the critical linkage steps that occur once an individual receives a positive test result. SNHD has HIV Prevention-funded testing staff, and AHF has a Linkage Coordinator in order to inform individuals of their HIV test results. Procedures are in place to counsel individuals with positive results and link them into care. Individuals who are newly diagnosed with HIV are enrolled into the Anti-Retroviral Treatment and Access to Services (ARTAS) program which is designed to link newly diagnosed individuals to medical care.

The prevention planning groups in the north and the south and Part A Planning Council in the south meet on a regular basis and facilitate the coordination of HIV prevention and care services across the state through regular communication between agency representatives, community organizations, providers, and PLWH. Service providers collaborate extensively with the state and the district health departments to assure that the continuum of care is addressed through testing to linkage and retention in care. In addition to the federally funded Ryan White efforts, the state and county health division programs interact with various organizations and assistance programs in the nonprofit sector to provide care, planning, and services in Nevada.

NEEDED RESOURCES/SERVICES

- d. Provide a narrative description identifying any needed resources and/or services in the jurisdiction which are not being provided, and steps taken to secure them.*

The lack of physicians and other healthcare workers is a large statewide problem that cannot be solved by the HIV programs in the state. However, the state of Nevada is aware of the problem and has been working to improve the situation. The state legislature approved funding for a second medical school which will be based in Las Vegas. RWPA and RWPB actively work to secure more providers each year. There also is a need for more medical providers that accept Medicaid, especially those enrolled in a Managed Care Health plan.

The Las Vegas TGA has consistently struggled with finding a provider that the Black/African-American population can identify with and feel comfortable frequenting. This has been a serious challenge since, in the Las Vegas TGA, the Black/African-American population is disproportionately impacted by HIV. In 2014, the Black/African-American population comprised 10% of the general population, but 26% of new HIV infections, 28% of new AIDS diagnoses, and 26% of PLWHA. Part A has worked diligently to encourage possible providers to apply to provide services, with little success. However, in the RFQ process in October 2015, a Black/African-American focused provider met the qualification criteria and applied to start service delivery in mental health, substance abuse, medical case management and psychosocial support services for GY2016-2017. Part A will work closely with the new provider to build a strong partnership in an effort to reduce health disparities in the Black/African-American community.

More syringe services programs are needed, particularly in the south and rural areas of the state. SNHD is in the process of piloting syringe service machines in Clark County. Access to PEP and PrEP also has been a challenge in Nevada. The integrated plan includes strategies to identify providers that provide PEP and PrEP and to explore other strategies related to expanding access to those services. Need for increased education about HIV and awareness of HIV resources was evident across the state, among community members, youth, PLWH, medical providers, and community organizations. The integrated plan includes various strategies that address this need.

D. ASSESSING NEEDS, GAPS, AND BARRIERS

NEEDS ASSESSMENT PROCESS

- a. Describe the process used to identify HIV prevention and care service needs of people at higher risk for HIV and PLWH (diagnosed and undiagnosed); this process description should include how various strategies were used to target, recruit, and retain participants in the HIV planning process that represent the myriad of HIV-infected populations and persons at higher risk for HIV infection, other key stakeholders in HIV prevention, care, and related services, and organizations that can best inform and support the development and implementation of the Integrated HIV Prevention and Care Plan.*

An extensive process of data collection, epidemiologic data review, community discussion and needs assessment was accomplished to derive data for the Nevada needs assessment. The Workgroup has met monthly and more frequently as needed to provide input and direction in assuring that the process of needs assessment and SCSN action plan setting was linked to unique needs and gaps in services. The planning councils and groups in the north and south—the Las Vegas TGA HIV/AIDS Planning Council, the Southern Nevada Regional HIV Community Planning Group, and the Northern Nevada HIV Prevention Planning Group—have been kept apprised of the needs assessment activities and have been involved in shaping and providing input to the plan throughout the process. Members of the planning groups and councils actively participated in the stakeholder meetings and in the needs assessment data collection efforts.

In April 2015, the first HIV engagement meetings for this integrated planning process were held in both

the north and the south to bring treatment and prevention stakeholders together to discuss HIV prevention and care unmet needs, challenges and gaps in Nevada. Stakeholders were also asked for their help in recruiting participants in the various planned needs assessment activities to be carried out over the next year. The 28 participants who attended these meetings represented 20 different organizations and providers from around the state.

Two needs assessments, one comprehensive and one targeted, and a customer satisfaction study from the Las Vegas TGA were conducted and used to inform this Statewide Coordinated Statement of Needs. Additional needs assessment activities were conducted between April 2015 and May 2016 to expand the assessment statewide and to address prevention needs. Across these needs assessment activities, seven different HIV client surveys (combined N=838) and one prevention community survey (N=1687) were administered in both online and pencil/paper formats. Client survey respondents were recruited in a variety of provider locations and community organizations through flyers, social media, and word of mouth. Respondents to the Las Vegas TGA client surveys received \$10 stipends or gift cards for their participation. The Las Vegas TGA comprehensive needs assessment included both consumer out of care surveys and in care surveys. The Las Vegas TGA targeted needs assessment included surveys for newly diagnosed PLWH, Ryan White clients who had recently moved to the Las Vegas TGA, and Ryan White Clients who had not received HIV care in the past for six months or more but who were currently in care. Survey respondents were diverse in their ethnic backgrounds, sexual orientation, age, and gender identity and generally representative of the demographics of PLWH in Nevada. Prevention community survey respondents were recruited through flyers, social media and in person at a variety of community locations, including places that people at higher risk of HIV infection may frequent.

Across both the Part A and statewide needs assessments, 26 focus groups were conducted with a total of 221 participants. Focus group participants were recruited with the help of a variety of community organizations, providers, and community members through flyers, social media, and word of mouth. Participants across the groups were diverse in their ethnic backgrounds, sexual orientation, age, and gender identity. Statewide focus group participants received \$25 gift cards for their time.

Two provider surveys (one Part A and one statewide) were administered online to a total of 43 individuals. The Part A provider survey was sent to all Part-A funded agencies. The statewide provider survey included respondents representing 13 different organizations/agencies, including both care and prevention-focused organizations.

In March 2016, a stakeholders meeting, in which preliminary data reports were presented and reviewed, was conducted to initiate the process of setting goals and objectives for the 2017 – 2021 SCSN and for brainstorming strategies and action plans for each objective. This meeting was attended by 41 participants, not including the facilitators, and represented a wide variety of participants including PLWH, and representatives from providers, prevention agencies, and other community-based organizations.

Once all the data were in, the Workgroup reviewed all reports and finalized the goals and objectives. They also discussed action strategies that emerged from objectives and would provide the course for HIV prevention, care and services 2017 – 2021.

HIV PREVENTION NEEDS AND GAPS

- b. *Describe the HIV prevention and care service needs of persons at risk for HIV and PLWH.*
- c. *Describe the service gaps (i.e., prevention, care and treatment, and necessary support services e.g. housing assistance and support) identified by and for persons at higher risk for HIV and PLWH.*

Through the needs assessment process, the needs, gaps in service and service barriers for PLWH and people at high risk for HIV in Nevada were identified. Service needs for persons at higher risk for HIV include education about the transmission of HIV and easily accessible testing services. Peer counselors and education can contribute to prevention and also early entry into care. During the community meetings and focus groups, participants discussed the importance of placing HIV prevention messages throughout the community and also on web sites where people tend to enter into risky behaviors. Focus group participants also mentioned the importance of discussions about HIV among friends, family members, in small groups, and between parents and youth.

Top HIV Prevention Service Needs

- Basic HIV prevention education
- HIV education for youth, African Americans and Latinos
- HIV education and awareness through social media, internet, and other media campaigns
- Reduction of stigma
- Free or low cost testing
- Access to rapid HIV testing
- Routine testing and sexual risk assessment by primary care providers
- Culturally and linguistically appropriate education
- Education and awareness of PEP and PrEP
- Access to PEP and PrEP
- Free or low cost access to condoms
- Education on harm reduction skills
- Syringe services programs

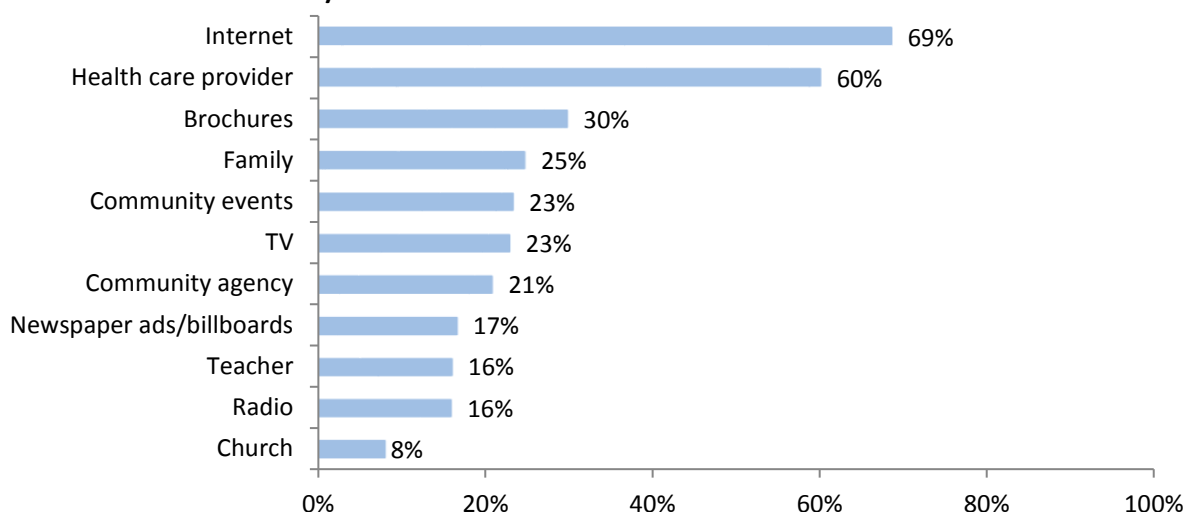
Service gaps in Nevada for persons at risk for HIV include education, peer support programs, and universal testing for HIV which may contribute to reducing risk and to getting people into care as soon as possible. The majority of community survey respondents (68%) felt there was not enough messaging/education about HIV/AIDS in their community and that access to free and low-cost testing for high risk populations could be increased. Culturally and linguistically appropriate HIV prevention materials were noted as lacking in the state. The lack of knowledge about HIV among youth was a noted concern. Both focus group and survey respondents emphasized the lack of comprehensive HIV prevention education in schools across the state. Another key gap is the limited availability of syringe services programs in the state, particularly in the southern and rural areas. Awareness of and access to PrEP and PEP were other noted gaps in prevention.

Top HIV Prevention Gaps

- Consistent comprehensive HIV prevention education in schools statewide
- Culturally and linguistically appropriate HIV prevention materials
- Awareness of HIV prevention resources in community
- Access to community-based testing for high risk populations
- Universal testing in medical settings
- Ongoing stigma and fear related to HIV and HIV testing
- Availability of syringe services programs
- Usage of condoms in high risk populations
- Testing among high risk populations
- Knowledge and awareness of PrEP and PEP
- Access to PrEP and PEP

The HIV Community Survey asked respondents to indicate the ways in which they preferred to receive information about HIV/AIDS. The most preferred methods were through the internet (69%), health care provider (60%), brochures (30%), or from family (25%; Figure 26). Some differences in preferred methods were found based on type of respondent. While the internet was the most preferred way for IDU to receive HIV/AIDS information, only 47% of IDU chose that way compared to 69% of the total sample. Only 37% of IDU indicated that they preferred to receive HIV/AIDS information from a health care provider, compared to 60% of the total sample. These results suggest the need for further exploration to discover other ways to better reach the IDU population with HIV/AIDS information. MSM respondents most preferred the internet as a way to receive HIV/AIDS information (72%). About half of MSM respondents (51%) indicated that they liked receiving HIV/AIDS information from a health care provider. Higher percentages of MSM respondents compared to the total sample liked receiving HIV/AIDS information from television (32%), community agencies (30%), community events (28%), radio (26%), and newspaper ads/billboards (16%).

Figure 26. Community Survey Respondents' Preferred Ways to Receive HIV/AIDS information



HIV CARE SERVICE NEEDS AND GAPS

Surveys and focus groups of PLWH revealed the most needed services including medical, dental, and vision care, food assistance, medication, transportation and case management. Providers' assessment of client needs included many of the same care services, but additionally they indicated the importance of legal services, substance abuse help, early intervention services, HIV and health classes, and outreach.

Top HIV Care Service Needs for PLWH in Nevada

- Medical care
- Dental care
- Vision care
- Food assistance
- Medication
- Transportation
- Case management
- Nutrition services
- Mental health care
- Specialty care
- Referrals for health care/supportive services
- Treatment adherence counseling
- Support groups
- Health insurance assistance
- Emergency financial assistance
- Housing services
- Legal services
- Substance abuse help
- Early intervention services
- HIV and health classes
- Outreach

The needs assessment process also revealed some gaps in care for PLWH. Some focus group participants acknowledged that it could be confusing or difficult at times to access services, particularly when first diagnosed with HIV. Some commonly mentioned issues included the burden and duplication of paperwork for eligibility for the different services; lack of one-stop shops for needed services (in southern Nevada); transportation issues; customer service at some locations; needing more HIV providers and specialists; and more dentists to serve PLWH. Top HIV care gaps from client and provider surveys included vision care, dental care, specialty doctors, mental health and substance abuse services, and referrals to health care and other supportive services. Transportation was a challenge for many clients, as was housing, financial assistance and food assistance. The need for additional assistance navigating the system was also noted by clients and providers.

Top HIV Care Gaps

- Vision care
- Dental care
- Financial assistance
- Transportation
- Specialty doctors
- Nutrition help
- Housing services
- Referrals to health care and other supportive services
- Mental health services
- Food assistance
- Peer advocates
- HIV and health classes
- Substance abuse services
- Legal assistance
- Culturally competent providers
- Providers knowledgeable about HIV
- Providers willing to accept Medicaid

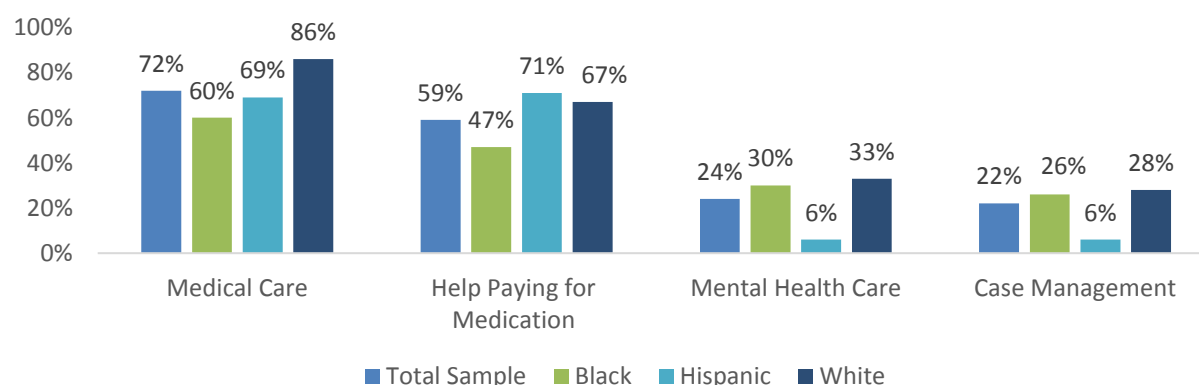
The Las Vegas TGA “Pathways to Care” Targeted Needs Assessment gathered information about perceived service needs and gaps for the newly diagnosed PLWH that had recently relocated to the Las Vegas TGA and out of care/returned to care populations. The newly diagnosed indicated dental care, medical transportation, medical care, and vision care as difficult to access. For the recently located, dental care, mental health care, and HIV medications were difficult to access (Table 14). Those who were out of care or returned to care found dental care, medical transportation, emergency financial assistance, housing assistance and food bank/vouchers difficult to access.

Table 14. Services Difficult to Access for PLWH who are Newly Diagnosed, Recently Relocated and Out of Care/Returned to Care

	Newly Diagnosed N=89	Recently Relocated N=53	Out of Care/Returned to Care N=61
Dental care	13%	15%	31%
Medical transportation	9%	10%	16%
Medical care	9%	10%	3%
Vision care	9%	5%	6%
Housing assistance	8%	0%	13%
Specialty medical care	8%	5%	0%
Mental health care	6%	15%	9%
HIV medications	5%	15%	3%
Emergency financial assistance	6%	0%	16%
Food bank/vouchers	6%	0%	13%
Substance abuse treatment	0%	0%	9%

Among statewide client survey respondents, some disparities were found in client usage by ethnicity (Figure 27). Fewer black clients were accessing medical care and help paying for medications than clients of other ethnic backgrounds. Fewer Hispanic clients were using mental health care and case management services compared to other clients.

Figure 27. Client Service Use by Race/Ethnicity



BARRIERS TO HIV PREVENTION AND CARE SERVICES

- d. *Describe barriers to HIV prevention and care services, including,*
 - i. *Social and structural barriers (e.g., poverty, cultural barriers, stigma, etc.);*
 - ii. *Federal, state, or local legislative/policy barriers (e.g., the changing health care coverage landscape, policies on HIV testing or lab reporting, etc.);*
 - iii. *Health department barriers (e.g., political landscape, staff capacity, etc.);*
 - iv. *Program barriers (e.g., infrastructure capacity, access to data, data sharing, inadequate health information systems, availability of funding, etc.);*
 - v. *Service provider barriers. Discuss any stakeholder(s) that are not involved with planning for HIV services that need(s) to be involved in order to address gaps in components of HIV Prevention programming and/or along the HIV Care Continuum more effectively (e.g., lack of specialized resources or specialty care providers.);*
 - vi. *Client barriers (e.g., transportation, homelessness/housing instability, inability to navigate the system, poverty, stigma, comorbid conditions, etc.).*

A variety of barriers to HIV prevention and care services in Nevada were identified through the needs assessment process. Barriers to HIV prevention services in Nevada include limited funding for HIV prevention and lack of universal HIV testing. Barriers to HIV care services in Nevada include a lack of care providers, transportation issues, and eligibility issues.

The social barrier of stigma related to HIV impacts both prevention and care efforts as it can prevent individuals from getting tested, from participating in HIV education, and from accessing care after a diagnosis. Some statewide client survey respondents indicated that a barrier to them getting into a doctor's office after their HIV diagnosis was not wanting anyone to know they had HIV. Stigma against people with HIV, against lesbian, gay, bisexual, transgender, and questioning (LGBTQ) individuals, and against injection drug users are present in Nevada. In communities of color, the stigma can be even more pronounced, often discouraging individuals from knowing their status and seeking treatment.

A structural barrier in the south is the distance between service providers in the Las Vegas area. The sprawl of the city can make it difficult for clients to easily access services, particularly for individuals who rely on public transportation. Another barrier is high transiency in Nevada, with people frequently moving in and out of state, as well as to other locations within cities and within the state, which can make it difficult to get HIV test results to people, to link individuals who test positive to care, and to retain PLWH in care.

At the time data were collected for this integrated plan, Nevada only required CD4 values with counts below 500 per ml³ of blood and a detectable viral load (>200 copies/ml) to be reported to the health authority. This barrier has impacted the quality of the data available for understanding Nevada's continuum of care. Reporting of viral load and CD4 lab tests is lacking for individuals receiving medical care outside of the Ryan White care system. Therefore, a large number of labs were unreported which results in and underestimation of retention in care and virally suppression. While this barrier impacted data for the current integrated plan, a change in policy at the state level that requires reporting of all levels will help improve Nevada's continuum of care data going forward.

The lack of health departments in many counties in Nevada limits access to prevention and care services for individuals in those counties. The health departments that do exist in Nevada struggle with a lack of funding and personnel for HIV prevention and care. Their bureaucratic structure can reduce flexibility and increase the time it takes to implement changes in programs, policies and procedures. At times, they have struggled to obtain support from their administrations for HIV related campaigns and programs due to political issues and fear of the public perception of some HIV related materials. Another barrier relates to mistrust of government agencies which may prevent individuals from seeking HIV-related services at health departments.

At the program level, decreases in funding and restrictions on how funding can be used are challenges faced by the state HIV prevention program and the Ryan White Programs. Political issues related to public perception of HIV-related programs and campaigns can restrict implementation of some programs at the state level in some instances. Securing providers is a challenge due to the lack of providers in the state. Also securing providers to serve specific target populations has been challenging. For example, the Las Vegas TGA has struggled with finding sub-recipients that the Black/African American population can identify with and feel comfortable frequenting.

At the service provider level, there are barriers related to lack of HIV providers, lack of specialty care providers, lack of mental health workers, and lack of case workers. Providing culturally and linguistically appropriate services can be challenging for service providers. A lack of one-stop shops for HIV services, particularly in southern Nevada, can make it difficult for clients to access all the services they need.

Top client barriers noted by survey respondents and focus group participants included lack of available services, health literacy, poverty, time, transportation, and conflicting responsibilities. Nearly one quarter of statewide client survey respondents indicated that not knowing where to go to receive needed services was a main reason they weren't receiving those services. This theme was echoed in the other client surveys and focus groups, as well as from the clients who participated in the stakeholder meetings.

Newly diagnosed respondents to the Las Vegas TGA Pathways to Care Needs Assessment survey reported the following barriers to accessing services: confusion with the cumbersome process for accessing care; not knowing where to get services; lack of transportation or difficulty using the TGA's public transportation system; and, cost of vision and dental care. PLWH recently relocated to the Las Vegas TGA indicated that paperwork, long commutes and limited transportation options, insurance and Medicaid issues, and the overall process of accessing care made it difficult to access some services. Among the out of care/returned to care, transportation, navigating the system, and insurance problems were barriers to accessing care. Among HIV Community Survey respondents, 47% had ever been tested for HIV. Differences were found in levels of testing among types of respondents, however. Lower percentages of respondents who were 24 years of age and younger (28% tested), intravenous drug users (37%), Native American (37%), or Asian/Pacific Islander (39%) reported having been tested for HIV than other types of respondents. A higher percentage of MSM respondents (66% tested) reported having been tested for HIV compared to other respondents. A higher percentage of respondents who were intravenous drug users (45%) than other types of respondents (14%) reported cost as a reason for not getting tested for HIV.

Barriers to HIV Prevention and Care Services

Structural and Social Barriers

Stigma related to HIV
Fear of people knowing they have HIV
Sprawl of Las Vegas TGA/distance between services
Transiency

Health Department Barriers

Lack of funding
Lack of personnel
Client mistrust of government
Lack of flexibility within bureaucratic structure
Length of time to implement changes
Difficulties using volunteers due to policies
Difficulties providing incentives to clients
Lack of support for some programming due to political issues/public perception
Lack of Health Departments in many counties

Service Provider Barriers

Lack of HIV providers
Lack of specialty care providers
Lack of mental health providers
Long wait times
Lack of case workers
Lack of culturally and linguistically appropriate services
Lack of one-stop shops for HIV services

Legislative and Policy Barriers

No requirement to report CD4 values with counts below 500 per ml³ of blood and a detectable viral load (>200 copies/ml)
Lack of comprehensive sexual education in schools

Program Barriers

Complicated eligibility process
Decreases in funding
Restrictions on use of funding
Lack of support for some programming due to political issues/public perception
Securing community buy-in when programmatic changes occur at the federal level

Client Barriers

Lack of housing
Lack of food/nutrition
Mental health and substance abuse issues
Denial about having HIV
Not feeling sick
Lack of transportation
Lack of knowledge of where to go for services
Burden of paperwork
Difficulty accessing medications
Cost of services
Services not covered by insurance

E. DATA: ACCESS, SOURCES, AND SYSTEMS

- a. *Describe the main sources of data (e.g., RSR data, qualitative data, and surveillance data) and data systems (e.g., CAREWare, eHARS) used to conduct the needs assessment, including the development of the HIV Care Continuum.*

MAIN SOURCES OF DATA

The Epidemiological Overview used data from CAREWare, Ryan White Services Report, eHARS, STD*MIS, EvaluationWeb, the BRFSS, YRBS, and Nevada State Demographer vintage 2015 date. EvaluationWeb is an online data collection and reporting system for HIV testing and prevention activities. CAREWare is a software package from HRSA which Ryan White funded providers use to track client level data and submit required reports. CAREWare client data includes demographics, housing and poverty information, viral loads and CD4 counts and core and support services provided. The Ryan White Services (RSR) report is an annual client level data report that documents what services are provided to clients on an individual level.

Data on new HIV infections, new AIDS diagnoses, and persons living with HIV/AIDS were obtained from analyses of data extracted from Nevada's Enhanced HIV/AIDS Reporting System (eHARS). eHARS is a browser-based application provided by the Centers for Disease Control and Prevention (CDC). Nevada's HIV Surveillance Program uses eHARS to collect, manage and report Nevada's HIV/AIDS cases surveillance data to CDC. The data are population-based for ongoing surveillance. All information is entered and stored in eHARS (Enhanced HIV/AIDS Reporting System). All information obtained from reported cases is entered into a case report and this information is then entered into eHARS. The data have been collected in real-time. Data include laboratory information (CD4, viral load, etc.), demographics, and other variables of importance.

Sexually Transmitted Disease Management Information Systems (STD*MIS) is an application provided to state and local health departments upon request. The intent of this application is to address the most common data management issues facing an STD program in its efforts to utilize the data that it receives from labs, providers, clinics, disease intervention specialists (DIS), etc. Nevada's STD program uses STD MIS to collect, manage and report Nevada's STD cases (gonorrhea, chlamydia, syphilis) surveillance data to CDC. Data includes testing, demographics, treatment, and partner information.

Nevada State Demographer vintage 2015 data comes from the Nevada State Demographer's office which is funded by the Nevada Department of Taxation. This office is responsible for conducting annual population estimates for Nevada's counties, cities, and unincorporated towns and for estimating Nevada's county populations by age, sex, race, and Hispanic origin. Population projections are produced as well.

The Behavioral Risk Factor Surveillance System (BRFSS) is primarily funded by the Centers for Disease Control and Prevention (CDC). The Nevada BRFSS surveys adults eighteen years of age or older: in 2011 -

5,493 adults were surveyed; in 2012 - 4,846 adults were surveyed and; in 2013 - 5,102 were surveyed. The BRFSS contains core questions that are asked in all states and territories allowing for national as well as state-to-state comparisons. In addition, optional modules are also available and state-specific questions may be added to address state-specific needs. The BRFSS is used to assess risk for chronic disease, identify demographic differences in health-related behaviors, address emerging health issues, evaluate public health policies and programs, assess special populations, and measure progress toward achieving state and national health objectives.

The Youth Risk Behavior Survey (YRBS) is a survey of adolescent health behaviors and was designed by the Centers for Disease Control and Prevention (CDC) in cooperation with federal agencies and numerous state and local departments of education and health. In 2015, CDC selected 32 high schools for sampling in Nevada. However, to ensure more complete representation from all counties and accurate weighting at the regional level, the DPBH contracted with UNR to sample all school districts in Nevada (97 high schools and 5,108 students participated). YRBS data are routinely collected on high school students, but only a few states collect data on middle school students. In 2015, the DPBH contracted with UNR to sample middle school students from all school districts in Nevada (113 middle schools and 4,535 students participated).

Other sources of needs assessment data included the client and provider surveys and focus groups conducted in the Part A needs assessments and the client, provider and prevention community surveys and focus groups conducted in the statewide needs assessment. Table 15 lists the survey, focus group and stakeholder meeting data sources and the number of participants or respondents at each.

Table 15. HIV Needs Assessment Data Sources

Data Source	Number of respondents
A. Stakeholder meeting responses April 2015	Northern Nevada N=8 Southern Nevada N=20
B. Stakeholder meeting responses March 2016	N=41
C. Part A Provider Survey	N= 18
D. Statewide Provider Survey	N=25
E. Statewide Prevention Community Survey	N=1687
F. Statewide Client and Community Focus Groups	20 focus groups N=191 participants
G. Part A Client Focus Groups	6 focus groups N=30 participants
H. Part A In-Care Client Survey	N= 273
I. Part A Out-of-Care Survey	N= 51
J. Part B Client Survey	N=177
K. Part A Newly Diagnosed Client Survey	N=89
L. Part A Recently Relocated Client Survey	N=55
M. Part A Returned to Care Client Survey	N=61
N. Part A Consumer Satisfaction Survey	N=132

DATA POLICIES

- b. Describe any data policies that facilitated and/or served as barriers to the conduct of the needs assessment, including the development of the HIV Care Continuum.*

Although it was not in effect in time to provide additional CD4 and viral load data for this current integrated plan, a new data policy regarding reporting of all levels of CD4 and viral loads was put into effect in September 2015 that will improve the accuracy of HIV data in Nevada for future reports and plans. The Nevada State Board of Health implemented changes to Nevada Administrative Code (NAC) 441A.235. The new regulations state that laboratories shall report the results of any test of any specimen derived from the human body to the health authority if a) the test results confirm the presence of HIV; or b) the test was conducted to monitor the progression of HIV, including, without limitation, all levels of CD4, and both detectable and undetectable viral loads.

Data collection is a significant barrier to developing a care continuum for the Las Vegas TGA. Both the Ryan White Part A services data and HIV surveillance data have significant limitations. One of the major limitations of the Ryan White Part A services data is that many clients do not receive medical care through a Ryan White provider due to the implementation of the Affordable Care Act, so their medical visit, prescription, and lab information are not documented in CAREWare.

Las Vegas is also a very transient area, so both the Ryan White and Surveillance program face a great challenge in determining if people truly missed their medical appointments or they have moved out of the area. To address these challenges, the Ryan White Part A program has instituted eligible scope reporting as of CY 2015, and the Nevada Division of Public and Behavioral Health successfully worked to revise the state administrative code to require mandatory reporting of all CD4 and viral load results to the health authority. These actions will improve the accuracy of the continuum of care measures and result in more effective use of the Care Continuum model in the Part A program. Until 2015, service data have been reported under the funded scope guidelines. This has resulted in large gaps in service and lab data, making it difficult to create an accurate continuum.

A challenge is also created due to CDC and HRSA not aligning on the definitions of each stage of the continuum. This creates confusion, and extra time is needed to clarify which description of numerator/denominator is being used. This also creates issues when utilizing the care continuum for other grant related projects, especially when collaborating with other grantees, such as the Integrated HIV Prevention and Care Plan Guidance. Nevada HIV surveillance does not utilize the HRSA definitions and have already built reports according to the CDC definitions.

DESIRED DATA AND INFORMATION

- c. *Describe any data and/or information that the planning group would like to have used in conducting the needs assessment including developing the HIV Care Continuum and the plan, but that was unavailable.*

Data is lacking on PLWH's use of dental, mental health, and substance abuse services when they access it from non-Ryan White funded providers. Other gaps in information relate to where people are initially diagnosed. Information on people leaving the area is also needed as they may not be actually out of care and the state is unable to determine their care status. Complete CD4 viral load data was not available for PLWH at the time this plan was written, however, as described above in Section I.E.b., it will be available for future plans.

SECTION II: INTEGRATED HIV PREVENTION AND CARE PLAN

A. INTEGRATED HIV PREVENTION AND CARE PLAN

- a. *Identify at least two objectives (using the SMART format – specific, measurable, achievable, realistic, and time-phased) that correspond to each NHAS goal.*
- b. *For each objective, describe at least three strategies that correspond to each objective.*
- c. *For each strategy, describe the activities/interventions, targeted populations, responsible parties, and time-phased, resources needed to implement the activity. Identify any activities specifically aimed at addressing gaps along the HIV Care Continuum.*
- d. *Describe the metrics (e.g., number of HIV tests performed, medical visits, mental health screenings, HIV positivity rate, etc.) that will be used to monitor progress in achieving each goal outlined in the plan. Metrics should be consistent with the most current HHS Core Indicators and the NHAS Indicators.*
- e. *Describe any anticipated challenges or barriers in implementing the plan.*

OVERVIEW OF NEVADA'S GOALS, OBJECTIVES, AND STRATEGIES FOR 2017-2021

Nevada's Goals and Objectives align with the National HIV/AIDS Strategy goals. From two to five objectives were developed for each goal along with three strategies for each objective. Tables in this section of the plan detail the timelines, responsible parties, activities/interventions, target populations, resources needed and metrics.

Goal 1: Reducing new HIV infections

Objective 1a. By 2021, 90% of people living with HIV will know their serostatus.

O1a. Strategy 1: Increase number of high risk people tested in Nevada, based on data

O1a. Strategy 2: Increase community awareness of the importance of HIV testing, including awareness of testing sites

O1a. Strategy 3: Increase the number of rapid HIV testing locations available in Nevada

Objective 1b. By 2021, reduce by 25% the number of new HIV diagnoses.

O1b. Strategy 1: Increase education and access to PrEP and PEP

O1b. Strategy 2: Increase community education of HIV/AIDS through comprehensive sexual health education

O1b. Strategy 3: Provide community-wide harm reduction strategies, including condoms and other harm reduction materials availability and utilization

Goal 2: Increasing access to care and improving health outcomes for PLWH

Objective 2a. By 2021, increase to 85% the percentage of people newly diagnosed with HIV who have been linked to a provider within the first 30 days.

O2a. Strategy 1: Improved communication between organizations

O2a Strategy 2: Link hard-to reach populations to providers to provide continuity of care for PLWH

O2a Strategy 3: Facilitate patient readiness to participate in their care and management of HIV

Objective 2b. By 2021, increase by 20% the percentage of clients in care needing mental and/or behavioral health services who went to their first appointment.

O2b. Strategy 1: Improve communication among organizations and between clients and organizations

O2b. Strategy 2: Recruit more mental/behavioral health providers

O2b. Strategy 3: Professional Development activities

Objective 2c. By 2021, 80% of people diagnosed with HIV, who have had a medical visit each year for the past two years, will be virally suppressed (VL <200)

O2c. Strategy 1: Address treatment adherence of PLWH through educational strategies and evaluation

O2c. Strategy 2: Provide education and information regarding uninterrupted access to and proper use of medication

O2c. Strategy 3: Educate both client and provider stakeholders regarding the importance of routine viral load testing and tracking of viral load data

Objective 2d. By 2021, reduce to 20% the incidence of STIs in HIV infected persons in care.

O2d. Strategy 1: Conduct provider education and disseminate recommendations regarding routine screenings for STIs

O2d. Strategy 2: Conduct public and individual education for PLWH and newly diagnosed regarding STI s

O2d. Strategy 3: Develop quality control measures to improve clinical care and outcomes

Objective 2e. By 2021, increase number of clinics screening for HIV associated comorbidities by 20%.

O2e. Strategy 1: Conduct provider education and recommendations regarding routine screenings for comorbidities

- O2e. Strategy 2: Conduct public and individual education for PLWH and newly diagnosed regarding common HIV comorbidities
- O2e. Strategy 3: Develop quality control measures to improve clinical care and outcomes

Goal 3: Reducing HIV related disparities and health inequities

Objective 3a. By 2021, reduce disparities in the rate of new diagnoses by at least 15 percent among Nevada's priority populations.

- O3a. Strategy 1: Engage the community in order to find out how to best reach priority populations
- O3a. Strategy 2: Implement HIV prevention public education through media campaigns and social network strategies to target populations
- O3a. Strategy 3: Increase provider and organization capacity to test at sites in their communities

Objective 3b. By 2021, increase to 85% the percentage of newly diagnosed with HIV among Nevada's priority populations who have been linked to a provider within the first 30 days.

- O3b. Strategy 1: Improve first contact and point of access to care for PLWH who experience multiple "layers" of stigma (e.g., HIV infected, gay, minority, female, transgender, IV drug user, etc.)
- O3b. Strategy 2: Improve the ability of PLWH in underserved or high risk groups to navigate the HIV system of care
- O3b. Strategy 3: Improve the accessibility of information for PLWH in underserved or high risk groups

GOAL 1: REDUCING NEW HIV INFECTIONS

Two objectives were created to address Goal 1 Reducing new HIV infections. Strategies for Objectives 1a. “By 2021, 90% of the people living with HIV will know their serostatus” focus on testing targeted to highest risk groups based on epidemiological data; launching campaigns to increase public awareness of the importance of HIV testing; and, increasing rapid HIV testing sites which will reduce the number of people tested who do not receive their results. Both focus group and survey respondents emphasized the role of stigma in preventing individuals from getting tested. Community survey respondents indicated that the internet and health care providers were the most preferred ways to receive information about HIV/AIDS. The proposed activities include plans for delivering messages through a variety of methods in order to reach the various priority populations. Increased messaging about the importance of HIV also may help to reduce stigma related to HIV testing.

Three strategies were created to achieve Objective 1b. “By 2021, reduce by 25% the number of new HIV diagnoses.” Strategy 1 relates to awareness and access to PrEP and PEP. Needs assessment results indicate low levels of awareness of PrEP and PEP both among HIV positive individuals and community members at higher risk for HIV infection. Access to PrEP and PEP has been limited in Nevada with few providers who offer it, lack of awareness of which providers offer it, challenges with insurance companies covering it, and the high cost associated with it. A common theme in focus group and survey responses was the importance of educating youth about basic HIV information. While sexual health education does occur in Nevada schools, the stakeholders involved in creating Nevada’s plan emphasized the need for more comprehensive sexual health programs in the schools. Finally, to reduce the spread of HIV in Nevada expanded harm reduction activities are planned, including condom distribution, syringe services programs and other strategies to reach individuals at higher risk of HIV infection.

Some anticipated challenges or barriers to implementing the plan for Goal 1 include the difficulties involved in changing state policy to require comprehensive sexual health education programs in schools and funding such programs if passed. Finding funding for syringe services programs can also be difficult. Addressing stigma that is a barrier to people to get tested for HIV is a large challenge that is not easily solved.

Objective 1a. By 2021, 90% of people living with HIV will know their serostatus

O1a. Strategy 1: Increase number of high risk people tested in Nevada, based on data

Timeframe	Responsible Parties	Activity/ Intervention	Target Population	Resources needed to implement activity	Metrics
2017	DPBH RWPA Planning Council HPPG	Develop statewide targeted testing workgroup	HPPGs Epi staff	HIV Testing Data Staff time Recruitment of volunteers	Workgroups formed to include members of HPPGs and Local Health Districts
2017	DPBH RWPA Planning Council HPPG	Recruit substance abuse and mental health representatives to workgroup	Substance abuse and mental health representatives	Contact information Staff time	# of representatives recruited
2017-2021	RWPA Planning Council HPPG Targeted Testing Workgroup	Review available HIV testing data (where testing is conducted and where the positives are being found)	HBGs Workgroup	Testing data Staff time	Statewide testing data compiled and analyzed
2017	RWPA Planning Council HPPG Targeted Testing Workgroup	Establish baseline for testing among priority populations	Priority populations	Baseline data Staff time	Baseline data compiled and analyzed
2018	RWPA Planning Council HPPG Targeted Testing Workgroup	Development of a targeted testing strategy based on data results	Priority populations MH & SA populations	Staff time	Nevada targeted testing strategy developed and adopted
2019-2020	DPBH RWPA Planning Council HPPG Local Health Districts CBOs	Targeted testing strategy implemented	NV residents Priority populations: MH & SA populations	Test kits Training resources Staff time	Testing among priority populations to increase 10% over baseline each year implemented
2021	DPBH RWPA Epi Staff	Strategy and testing campaign evaluated for effectiveness	NV residents Priority populations	Funding Staff Time	Summary report with numbers tested, numbers testing positive, and percentage receiving test results Distribution of report

O1a. Strategy 2: Increase community awareness of the importance of HIV testing, including awareness of testing sites

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017	HPPG Planning Councils	Collect data from the population on baseline knowledge of importance and availability of HIV testing	NV residents Priority populations	Data collection tools Staff Time Funding	Report of the results
2018	DPBH RWPA	Develop comprehensive statewide media and marketing campaign across multiple platforms	NV residents Priority populations HIV+ and partners	Funding Community Advisory Board to test market campaign materials to key populations	Campaign developed and approved by the CAB
2019-2020	DPBH RWPA	Media buys and placement across multiple platforms Website/phone app with updated testing information available	NV residents Priority populations	Funding Staff time	At least 5,000,000 duplicated impressions throughout the state of NV
2021	RWPA DPBH	Evaluate the effectiveness of the campaign to key populations	NV residents Priority populations	Data Collection Tools Staff Time Funding	Report of results

O1a. Strategy 3: Increase the number of rapid HIV testing locations available in Nevada

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017-2021	DPBH NVPHTC AETC	Enhance, develop and evaluate state training and certification process for new testing sites	CBOs Providers and health clinics	Staff time Funding for administration and management of training	State certification for HIV testing adopted
2017-2018	DPBH NVPHTC AETC	Develop and administer train the trainer	CBOs Providers and health clinics	Training materials Staff time	# trainers trained
2018-2019	DPBH NVPHTC AETC	Certify and train location staff to provide rapid testing to high risk populations	CBOs Providers and health clinics	Staff time Funding for administration and management of training	At least 10 new rapid testing locations certified
2018-2021	CBOs Providers and health clinics	Increase number of rapid tests conducted in Nevada by certified agencies	Priority populations	Tests Kits Staff Time Funding	Increase number of rapid tests performed in the state by 10% above baseline each year
2017-2021	DPBH	Promote rapid testing	Priority populations	Promotional materials Staff time Funding	# rapid testing sites
2017-2021	DPBH RWPA	Put rapid testing locations on HIV websites	Priority populations	Staff time	Website statistics

Objective 1b. By 2021, reduce by 25% the number of new HIV diagnoses.

O1b. Strategy 1: Increase education and access to PrEP and PEP

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017	DPBH, RWPA Local health districts CBOs	Obtain provider and community buy-in for education	Providers CBOs	Curriculum Staff Time	# of providers # of partners
2017	DPBH, RWPA	Identify other partners, agencies, and organizations that can collaborate to fund and/or deliver trainings	Providers CBOs	Staff time	# agencies and partners
2017-2018	DPBH, RWPA	Initiate provider and Community education and training on PrEP & PEP	Providers CBOs	Curriculum Staff time	# trainings
2017-2018	DPBH, RWPA Local health districts CBOs	Training provider and staff on PrEP & PEP	Providers CBOs	Curriculum Staff time	# providers and staff trained
2017-2018	DPBH, RWPA Local health districts CBOs	Community education program on PrEP & PEP	Priority populations	Curriculum Staff time	# programs implemented
2017-2018	DPBH, RWPA Local health districts CBOs	Peer to peer education on PrEP & PEP program	Priority populations	Curriculum Staff time Peer educators	# of targeted community members trained
2018-2019	DPBH, RWPA Local health districts CBOs	Implement pilot project for PrEP	Priority populations	PrEP providers Staff time	Pilot project implemented
2019-2020	DPBH, RWPA Local health districts CBOs	Develop process for developing a PrEP clinic	Providers CBOs	Staff time	Process developed
2018-2021	DPBH, RWPA Local health districts CBOs	Evaluate of the pilot project	Providers CBOs Priority populations	Evaluation tools Staff time	Evaluation report
2018-2019	DPBH, RWPA Local health districts Providers	Enhance and support clinics to offer PrEP	Providers CBOs	Staff time	# of clinics providing PrEP # of clinics supported
2017-2021	DPBH, RWPA	Develop a resource list of pharmacies where PrEP is available	Priority populations	Staff time	Resource list

O1b Strategy 2: Increase community education of HIV/AIDS through comprehensive sexual health education

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017-2018	HPPGs Planning Councils CBOs NPHF	Develop a workgroup for policy development and lobbying policy change for comprehensive, medically accurate sexual health education in schools Include recommended best practices/curricula in the policy Write in Opt-out policy into bill	State legislature School Districts	Staff time Policy development training	Legislative bill outcome
2019-2021	State Board of Education Local School Districts	Collaborate with State Board of Education and local school districts to implement Comprehensive SH education in schools	Youth	Staff time recommended Curriculum and best practices	# of students receiving comprehensive SH education
2019- 2020	DPBH, RWPA Local Health districts HPPGs Planning Council Local School Districts CBOs Providers	Explore the development of school-based clinics	Youth	Staff time	Findings of the exploration
2019-2020	DPBH, RWPA Local Health districts	Develop a standardized curriculum for HIV/STD 101	Community members and Providers	Curriculum development resources Staff time	Curriculum developed
2019-2020	DPBH, RWPA Local Health districts	Make curriculum available to community partners statewide online	Community members and Providers	Training resources RWPB and RWPA training Staff time	# of trainers trained # of providers trained # of people educated
2019-2020	DPBH, RWPA Local Health districts	Evaluate curriculum	Community members and Providers	Staff time Evaluation tools	Evaluation report

O1b Strategy 3: Provide community-wide harm reduction strategies, including condoms and other harm reduction materials availability and utilization

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017-2021	DPBH Local Health Districts	Explore condom need in community for priority populations	Priority populations	Condoms Community partners for distribution	# and locations distributed
2017-2021	DPBH Local Health Districts CBOs	Identify places where free condoms are most needed	Priority populations	Staff time Community partners, businesses	# and locations distributed
2017-2018	DPBH Local Health Districts CBOs	Identify where people can buy condoms	Priority populations	Staff time Website	Resource guide posted on website
2017-2019	DPBH Local Health Districts CBOs	Explore different pathways to acquiring condoms (i.e. working with manufacturers to get cheaper condoms for people to buy)	Condom manufacturers Priority populations	Staff time Collaborators	Pathways noted
2017-2021	DPBH Local Health Districts CBOs	Awareness campaign about ability to get condoms through Medicaid	Medicaid clients	Materials Staff time	Distribution information regarding reach of campaign
2017-2018	DPBH Local Health Districts	Increase accessibility by creating an online application to map free and purchased condom locations in Nevada	Priority populations	App developer	App created # of app users
2017-2018	DPBH Local Health Districts	Provide capacity building assistance for the implementation of syringe services programs (SSP)	IDU	Staff time	# of CBOs trained; SSP launched in Southern Nevada
2018-2019	DPBH Local Health Districts	Pilot of syringe exchange machines in Southern Nevada	IDU	Funding Syringe exchange machines	# of machines placed # of syringes exchanged
2018-2020	DPBH Local Health Districts	Develop buy-in from community organizations and businesses that would be impacted by the SSP	CBOs and businesses	Staff time	# of community organizations and businesses reached
2020-2021	DPBH Local Health Districts	Expand syringe services to centers for harm reduction, syringe exchange, wound care,	IDU	Staff time Funding	# of centers established # of IDU served

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2021	DPBH Local Health Districts	Analyze data from SSP to evaluate best practices moving forward	IDU	Staff time	Evaluation report

GOAL 2: INCREASING ACCESS TO CARE AND IMPROVING HEALTH OUTCOMES FOR PLWH

Objective 2a. By 2021, increase to 85% the percentage of people newly diagnosed with HIV who have been linked to a provider within the first 30 days.

Increasing access to care in this case means ensuring that people testing positive for HIV are immediately linked to an HIV care provider. Subsequent to receiving an HIV+ diagnosis, patients must be linked with HIV care providers in order to obtain antiretroviral therapy, and ultimately, to reduce viral loads to maintain health and reduce the risk of viral transmission. Achieving this objective requires the health care system to collaborate and assist clients in finding resources from a range of providers and organizations. The need to improve access to care was highlighted during the needs assessment process, which included a variety of client and provider surveys and focus groups around the state. Data from the statewide needs assessment indicated many pertinent barriers to care after diagnosis. These included clients not knowing where to go for care, transportation problems, and denial and stigma. Through the same needs assessment process, a range of solutions were presented and discussed. The strategies incorporated in this document reflect widely supported approaches.

The strategies and activities to improve the goal of access to care through linkage to care includes improved communication between organizations, linking hard to reach populations with providers (parolees, clients with mental and behavioral health issues, substance users, and homeless), and facilitating patient readiness to participate in the care and management of their HIV disease. To improve communication between organizations, activities include developing a resource map of services for the newly-diagnosed, which would be of use to clients and providers alike. Second, developing a referral network on CAREWare to coordinate and track patient referrals between organizations and to share providers would help clients make and keep appointments. Third, maintaining monthly service delivery meetings to bring together organizations and case management personnel across organizations, primarily in Las Vegas, to maintain clarity regarding client referrals and point of contact for each organization. Last, the provision of a Ryan White provider conference in the state would present fiscal and quality management discussions and various trainings and certifications for Ryan White administrators and providers. This gathering would promote open communication and collaboration between organizations.

To address the strategy of linking hard to reach populations, activities will include development of a connection between the Nevada Department of Corrections and local HIV service organizations and case managers and similar linkages for mental health and substance using clients to improve linkage to care and enhance retention in care. Last, develop point people at AIDS service organizations to work with

homeless and refugee clients to provide continuity of care for those special populations. Strategy three focuses on facilitating patient readiness for care upon diagnosis. Activities to support this strategy include providing peer-to-peer advocates at every Part B site, developing peer volunteer networks specifically to work with the newly-diagnosed client, and the provision of a six-week positive management program to HIV+ clients.

O2a. Strategy 1: Improved communication between organizations

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017-2021	RWPA RWPB RWPC RWPD	Develop regional flow chart (resource map) of services/ activities for the newly-diagnosed and for providers. Includes steps for the patient re: where to go and what to do next. Post online, share with ASOs and testing organizations. Update	Newly-diagnosed	Staff time Web application Materials for distribution	Completion of flow chart (resource map) Maintained/updates of flow chart # hits to website # of flyers handed to clients at testing sites
2017-2021	RWPA RWPB RWPC RWPD Sub-recipients	Utilize CAREWare referral system to coordinate new patient intakes between organizations. utilize to schedule out different organizational staff at other clinics/facilities, such as case managers where there are none	Newly-diagnosed	Coordination between all organizations	# of referrals being scheduled via this system Is it manageable? Does it work? # of referrals lost to follow-up
2017-2021	RWPA RWPB RWPC RWPD	Regional service delivery meetings monthly: interactions between organizations to provide clarity regarding point people for each service. Maintain updated records re: service providers in the area	CBOs Providers	Meeting space Materials	Meeting minutes
2017-2021	RWPA RWPB RWPC RWPD	Inter-agency case management team building/training. To reduce competition, understand roles	Medical case managers	Training materials Funding for trainers	training occurrence, communications between case managers, # patients seen/ transferred
2017-2021	RWPA RWPB	Annual Ryan White provider conference with training, RW updates on initiatives, basic fiscal and quality management, advanced training/certifications, strategies	RW providers	Training materials Evaluation tools	# of attendees Conference evaluation report

O2a Strategy 2: Link hard-to reach populations to providers to provide continuity of care for PLWH

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017-2019	RWPA RWPB Local Health districts NDOC County and city correctional facilities	Linking NDOC parolees and re-entry populations with local clinics to provide continuity of care for those patients Identify a point organization for parolee case management in each North and South. NDOC would connect HIV+ patients to the case management team initially, who would manage their care, set them up for services, referrals, eligibility	HIV+ inmates/parolees from NDOC and jails	Staff time Buy-in from NDOC and jails, point organization from each North and South	# HIV+ parolees, #making connections with point organizations # first visits
2017-2019	RWPA RWPB DPBH Mental Health & substance abuse providers	Link HIV+ mental health & substance abuse clients with local clinics to provide continuity of care. Identify point organizations and providers.	HIV+ mental health and substance abuse clients	Staff time Buy-in from MH and SA providers and point organizations	# of MH & SA clients linked # first visits
2018-2021	RWPA RWPB CBOs	Link HIV+ homeless clients with local clinics to provide continuity of care. Identify point organizations and providers.	HIV+ homeless clients	Staff time Buy-in from point organizations	# of homeless clients linked # first visits
2019-2021	RWPA RWPB CBOs	Link HIV+ individuals from refugee populations with local clinics to provide continuity of care. Identify point organizations and providers	HIV+ refugee clients	Staff time Buy-in from point organizations	# of refugee clients linked # first visits

O2a Strategy 3: Facilitate patient readiness to participate in their care and management of HIV

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017-2018	RWPA RWPB	Expand Peer to peer advocate to every Part A and Part B site	Newly-diagnosed	Peer advocates Training materials	# of site with peer advocate
2019-2020	RWPA RWPB	Evaluate peer advocate program	Peer advocate program	Evaluation tools	Evaluation report
2018-2019	RWPA RWPB	Develop peer (HIV+) volunteer support system to meet individually with newly diagnosed, based at case management organizations.	Newly-diagnosed	Funding support for organization to oversee/manage volunteer network	# of clients participating
2017-2021	RWPA RWPB	Delivery of 6-week Positive management program to HIV+ clients and chronic disease management	Newly-diagnosed	Meeting Space Training Materials Agencies and Trainers	# of clients participating
2018-2019	RWPA RWPB	Explore the requirements to have peer advocates become CHW through the certification program	Peer advocates	Staff time	# of peer advocates certified

Objective 2b. By 2021, increase by 20% the percentage of clients in care needing mental and/or behavioral health services who went to their first appointment.

Based on input from both providers and clients during the needs assessment process, mental health and substance abuse treatment are challenging for clients to access. Given the high risk for HIV infection and low retention rates among these groups, specific objectives have been drafted to target these populations. The strategies included in this objective focus on increasing the number of mental health and substance abuse providers and improving communication between organizations in order to reduce barriers to care and improve access and linkages to care for clients with mental and behavioral health and substance use problems.

Improving communication among organizations includes developing a regional resource map of all HIV/AIDS service organizations, including mental and behavioral health and substance use treatment organizations. This map will include navigation tips for clients in seeking services, as well as for organizations to share and refer clients. Part of this strategy includes a mechanism for regular updates to this resource guide, as well as posting it online for easy accessibility. Additional strategies here include a referral tracking system and a consumer forum to further clarify client barriers to care.

Strategy two is the focus of this objective. Ultimately, increasing the number of available mental health and substance abuse providers is key in addressing the needs of clients struggling with mental and behavioral health and substance abuse problems. Linking the HIV community to larger provider groups such as Southern Nevada Adult Mental Health Services, Northern Nevada Adult Mental Health Services, WestCare, and Salvation Army is the first step. Subsequent to recruitment will be a move to foster

collaboration between entities to provide services at partner organizations with the goal of increasing access to these services. Last, strategy three addresses the need for professional development. Providers must remain up-to-date on the continuum of care, the intersection between HIV/AIDS and mental health and substance abuse problems, and the community resources (within Ryan White and outside) available to their clients. Providers must also be made aware of the resource map which is a focus of goal two.

O2b. Strategy 1: Improve communication among organizations and between clients and organizations

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017-2021	RWPA RWPB RWPC	(See 2a) Develop regional flow chart (resource map) of services/activities for all HIV+ patients, including mental/behavioral/substance use resources. Includes steps for the patient re: where to go and what to do next. Post online and share with ASOs and mental/behavioral health organizations. For both organizations and clients	Mental health/ behavioral health/ substance using HIV+	Central responsible party. Part A in LV, Part B for North and rest of state. This is part of 2a.	Completion of flow chart (resource map) Maintenance/updates # hits to website # of flyers handed to clients at testing sites
2017-2021	RWPA RWPB	Update resource guide regularly.	MH/ BH/ substance using HIV+	Staff time Website	# of website hits on resource guide # of updates
2017-2018	RWPA RWPB	Part A and B having the same internal referral process to easily track referrals made and completed	MH/ BH/ substance using HIV+	Staff time Revised forms, materials, procedures	Documentation of referral process
2018-2019	RWPA RWPB	Needs assessment ; consumer forum to find out what is needed from a client perspective to get them to appointments	MH/ BH/ substance using HIV+	Staff time Needs assessment tools	Needs assessment report
2018-2020	RWPA RWPB	Increase communication regarding point of entry, eligibility, and services provided and requirements between managed care health plans and Ryan White and other health plans	Providers	Staff time Materials	Communication plan
2019-2021	RWPA RWPB	Conduct evaluation of communication including perspectives from impacted stakeholders	Clients Providers	Staff time Evaluation tools	Evaluation plan Evaluation report

O2b. Strategy 2: Recruit more mental/behavioral health providers

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017-2019	RWPA RWPB RWPC DPBH	Collaborate mental/behavioral health providers	Mental health/ behavioral health/ substance using HIV+	Entity to connect/recruit Staff time	# of providers, # of appts referred, # visits
2018-2021	RWPA RWPB RWPC DPBH	Foster collaboration between the agencies to cross provide services at other locations to make services more readily available	MH/ BH/ substance using HIV+	Staff time	# of collaborations # of clients served
2018-2021	RWPA RWPB RWPC DPBH	Collaborate with CBOs who have added some MH providers	MH/ BH/ substance using HIV+	Staff time	# of collaborations with CBOs # of clients receiving MH services

O2b. Strategy 3: Professional Development activities

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017-2021	RWPA RWPB	RW funded agencies participate annual Summer Institutes focuses on the continuum of care between MH, SA and HIV	HIV providers MH & SA providers	Funding for providers to attend the professional development	# attendees, program outcomes
2017-2018	RWPA RWPB DPBH	Explore methods to educate MH and SA providers about HIV integration within their existing roles (CEU's) tie this to HIV 101 mentioned previously Deliver HIV/STD 101 MH & SA providers	MH & SA providers	Curriculum Staff time	# of providers trained
2017-2021	RWPA RWPB	More education for providers about the resources available in the community including outside of Ryan White	HIV providers MH & SA providers	Resource guide	# of providers educated
2017-2018	RWPA RWPB DPBH Center of Excellence	(See 2a) Develop regional flow chart (resource map) of services/activities for all HIV+ patients, including mental/behavioral/substance use resources. Includes steps for the patient re: where to go and what to do next. Post online and share with ASOs and mental/behavioral health organizations.	HIV providers MH & SA providers PLWH	Staff time	# of flow charts distributed or accessed through website

Objective 2c. By 2021, 80% of people diagnosed with HIV, who have had a medical visit each year for the past two years, will be virally suppressed (VL <200)

This objective addresses patients who have been linked to care and who have received any care in the past two years. Data from the laboratories in the state that are required to report viral load and CD4 data will contribute to identifying these individuals. Achieving the objective requires PLWA to move along the continuum and to be guided through the remaining three steps: being retained in care, receiving ART, and through ongoing use of medications and rapport with the medical system, becoming virally suppressed.

Data from the Part B client survey indicated that the longer an individual has been diagnosed with HIV the greater the need for services. PLWH delineated problems receiving care; one reason being health insurance. Thirty percent (30%) of the individuals who are receiving care indicated having a break in taking medication and attributed this to issues of insurance and the cost of medications. The provider survey confirmed issues of significant medication breaks due to changing insurances and new formulary rules. This was true for newly enrolled Medicaid patients but Ryan White participants were much less likely to experience any disturbance in medication availability.

Various focus groups generated highlights such as the need for a useful flow chart of service options. Counseling and peer support positions were recommended and the ongoing issue of easing the burden of eligibility paperwork was raised. Talk of a service hub where eligibility is determined, and even a central data bank for patient prescription information could provide an infrastructure where issues such as an emergency need to cover medications could be easily coordinated and accomplished.

The Stakeholder meeting gave PLWH and agency representatives across Nevada a chance to sit down to review the preliminary needs assessment findings and contribute ideas for goals and objectives. The group which addressed Goal 2 (to increase access to care and improve health outcomes) engaged in an extensive discussion on the need for counseling, peer supports, ways to eliminate gaps in treatment and medications, and contributed many ideas to the development of strategies.

Challenges to this goal include the difficulty of navigating through insurance details to ensure medication acquisition, establishing a new partnership with the Pharmacy Board, finding sufficient number of peers who can and want to be trained and identifying payment sources for peer educator services.

Strategies and activities to support and approach the goal of viral suppression include supportive services to assure that individuals understand HIV, how it is managed, the nuances of medications, and approaches to the prevention of HIV transmission. Strategies in the realm of pharmacy issues range from assuring a consistent supply of the proper medication to pharmacist education and insurance company policy to prevent disruption in receiving medication. A strategy in the area of prevention will encourage people who are positive to understand how maintaining a suppressed viral load can prevent transmission.

O2c. Strategy 1 Address treatment adherence of PLWH through educational strategies and evaluation

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017-2018	RWPA RWPB RWPC RWD	Create a series of support, education and training options for group of patients in care	PLWH	Training materials Staff time	# options available
2017-2018	RWPA RWPB RWPC RWD	Ensure that patient education programs are language and literacy ability appropriate	PLWH	Staff time Materials Literacy	Assessment of how language and literacy appropriate materials and programs are
2017-2021	RWPA RWPB RWPC RWD	Deliver medication adherence sessions on a continual basis to provide education and support	PLWH	Staff time Training materials	# sessions provided
2017-2021	RWPA RWPB RWPC RWD Planning Councils	Evaluate the continuum of care on a regular basis to understand status; establish baseline and semi-annual update on continuum of care looking at viral suppression; identify patterns of viral load suppression and match to exams attended, services accessed, etc.	PLWH	Viral load data Continuum of care update Clinic records	Continuum of care # PLWH in care # of virally suppressed PLWH in care

O2c. Strategy 2 Provide education and information regarding uninterrupted access to and proper use of medication

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017-2018	RWPA RWPB RWPC RWD	Ensure clinical programs include medication management materials, support, educational programs and counseling for all patients	PLWH	Educational materials and programs	# programs providing medication adherence materials and education to clients
2017-2021	RWPA RWPB DPBH Center of Excellence	Provide education to pharmacists on HIV medication adherence	Pharmacists	Educational materials Staff time	# pharmacists receiving education
2017-2021	RWPA RWPB	Encourage pharmacists that work with HIV clinics	Pharmacists	Materials to disseminate Staff time	# pharmacists with HIV specialty

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
		to get certified in HIV care (AAHIVM certification)			
2017-2021	RWPA RWPB	Disseminate information about policies to clients regarding emergency medication access	PLWH	Materials to disseminate	# clients receiving materials

O2c. Strategy 3 Educate both client and provider stakeholders regarding the importance of routine viral load testing and tracking of viral load data

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017-2021	RWPA RWPB RWPC RWPB	Educate clients about the importance of obtaining and maintaining an undetectable viral load and the importance of individual viral load in regards to community viral load	PLWH	Educational materials	# clients educated
2017-2021	RWPA RWPB	Create data sharing agreements between CAREWare and labs	Lab staff	Agreements	# agreements
2017-2021	RWPA RWPB	Educate clinicians to do at least 2 viral load tests per year	Clinicians	Educational Materials	# of clinicians educated
2017-2021	RWPA RWPB Planning Councils	Educate the community about community viral load data	Community	Educational Materials	# of materials, campaigns, events

Objective 2d. By 2021, reduce to 20% the incidence of STIs in HIV infected persons in care.

This objective addresses patients who are linked to care and who may therefore be amenable to education, support and services that will help them understand how comorbidities like sexually transmitted infections will affect their health and how they may be prevented. The presence of STI in HIV infected persons indicates that prevention messages about safe sex are not being followed and infer risk for HIV transmission. Providers will have an education mandate but case managers, program navigators and others on the clinic team can support the prevention message. A broad approach to public education is also needed.

Data from the routinely reported STIs will contribute to identifying these patients. The State database will have information regarding who is providing care to patients with HIV and other STIs. Clinics will need materials and information for patients and education for providers regarding the state epidemiologic profile and ways to work with patients to increase better prevention practices. Encouraging all clinics to

conduct screening for STIs and HIV for all clients on an annual or as needed basis would assist in understanding the scope of the problems and would help direct resources where they may be needed for care and prevention.

Achieving this objective requires PLWH to receive an educational message from disease investigation staff, provider or clinic staff that helps them to understand the risk of STIs and to possess and implement tools for prevention. Peer advocates can be helpful in getting the message out about safer sex practices. Disease Syringe services programs provide important education and services, and public service messages can contribute to increased awareness about risks associated with certain sexual behaviors.

The client survey informs us that 69% of PLWH did not have any problem getting into medical care shortly after their diagnosis. This is an important time to assess risks and screen for STIs. Only 24% of clients noted using free condoms and 22% indicated that they appreciated and used services that helped them understand their medications and how to take them. It is a large estimate, but taking the leap from the findings, approximately 75% of PLWH may benefit from more extensive messaging and programming regarding the prevention of STIs. Clients suggested that services could be provided with more educational /informational seminars and more public service announcements/messages that target STI information. Providers dealing with ongoing syphilis infections in their patients agreed that standardization of screening would be very helpful.

Stakeholders at the goals and objectives planning meeting discussed the importance of including safe sex messages on internet sites. They also focused on the importance of routine STI testing, broader efforts at education and general prevention activities. Challenges to achieving this goal include lack of access to clinical care to screen and treat for STIs, lack of interest among clinicians to routinely screen for and discuss STIs, and concern about lack of confidentiality with mandated reporting to Health Department. Strategies and activities to support and approach the goal of increasing the identification of STIs in patients with HIV are in the areas of routine screening, education and prevention.

O2d. Strategy 1 Conduct provider education and disseminate recommendations regarding routine screenings for STIs

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017	RWPA RWPB	Recommend that HIV care clinics have plans in place for routine sexual history and screening for STIs	HIV Care Clinics PLWH	Policies Educational Materials	# clinics implementing
2018	RWPA RWPB	Develop resource guide for providers. (Health departments, providers who specialize in STI's including email for consults and referral)	HIV Care Clinics PLWH	Data on resources available	# Resource guides accessed
2017-2021	RWPA RWPB	Develop and maintain accurate list of who is seeing patients with HIV	PLWH	Data on providers	Provider list
2018-2020	RWPA RWPB NBPH Center for Excellence	Provide outreach to all providers (including private) re routine screening and education for STI's,	HIV Care Clinics PLWH	Partner with AETC to provide education	# providers reached

O2d. Strategy 2 Conduct public and individual education for PLWH and newly diagnosed regarding STIs

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017-2018	RWPA RWPB	Prevention with positives programs integrated into clinical care	PLWH	Education and implementation assistance to integrate into clinical care	# programs implemented # clients educated
2017-2018	RWPA RWPB	Recommend that EHR in all clinics includes sexual history and STI screenings	Clinics	IT support to update EHR programs (may be costly)	# clinics implementing
2017-2021	RWPA RWPB	Expand risk reduction and health education for clients to include STIs and importance of screenings and when to get tested	PLWH	Educational materials such as posters; training of clinic personnel to help with risk reduction topics; general educational events	# clients educated

O2d. Strategy 3 Develop quality control measures to improve clinical care and outcomes

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2018-2019	RWPA RWPB	Develop standardized assessment forms for all providers for all the assessments	Providers	Staff time Assessment forms	Assessment forms
2019	RWPA RWPB	Use Quality management team to develop and train on use of forms	Providers	Staff time Training materials	# providers trained
2019-2021	RWPA RWPB	Establish baseline data and report on data annually	Clinics	Quality control data	Annual Report
2019-2021	RWPA RWPB Planning Councils	Disseminate the findings on a regular basis	Providers and clinics	Routine communication	# of providers receiving findings
2020-2021	RWPA RWPB Planning Councils	Develop Quality improvement plans	Providers and clinics	Staff time	QI plans

Objective 2e. By 2021, increase number of clinics screening for HIV associated comorbidities by 20%.

This objective addresses patients who are linked to care and who may therefore be amenable to education, support and services that will help them understand how common comorbidities will affect their health. Providers will have an education mandate but case managers, program navigators and others on the clinic team can support the use of evidence based treatment strategies and preventive actions. Routine screening for common comorbidities is defined and supported by the US Preventative Services Task Force for all ages and should be incorporated in all primary care and addressed in all HIV infected persons. A broad approach to public education is also needed to support the understanding and acceptance of routine screening.

Providers and clinics will need materials and information for patients and education for providers regarding the state's disease epidemiology and ways to work with patients to increase knowledge and acceptance of screening and prevention practices. Encouraging all clinics to conduct recommended screening for mental health, substance use, and chronic disease for all clients on an annual basis would assist in understanding the scope of the problems with co-morbidities and would help direct resources where they may be needed for care and prevention. Achieving this objective requires PLWA to receive an educational message from their provider, to understand the need for screening, accept screening and to possess and implement tools for management. Peer advocates can be helpful in getting the message out about their experiences with conditions identified. Public service messages can contribute to increased awareness about common co-morbidities that impact all populations but cause increased problems in HIV infected individuals.

The client survey informs us that 69% of PLWH did not have any problem getting into medical care shortly after their diagnosis. This would be a key time for clinical providers and for case managers to initiate discussions about conditions and diseases associated with HIV. Behavioral health issues are common and many clients have determined that they have unaddressed needs. Routine screening for mental health issues is critical to improving their outcomes. Clients suggested that services could be provided with more educational /informational seminars and more public service announcements/messages.

The provider survey also uncovered some needs that include lack of access to behavioral health services. Stakeholders at the goal and objective planning meeting discussed the importance of addressing the “whole patient” during clinic encounters. They felt that screenings should be explained and offered routinely. Although substance abuse concerns may be difficult to admit, stakeholders felt it was very important for providers to ask. In addition, they felt that resources needed to be offered in conjunction with the screenings. Challenges include inadequate behavioral health and substance abuse resources to address findings of routine screenings (suicide excepted), patient concerns of finding out they have a chronic disease, and stigmatization of having chronic diseases. Strategies and activities to support and approach the goal of increasing the identification of comorbidities in patients with HIV are in the areas of routine screening, education and quality improvement activities.

O2e. Strategy 1 Conduct Provider education and recommendations regarding routine screenings for comorbidities

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017-2018	RWPA RWPB	Gather baseline data from HIV care clinics regarding current practices for MH, SA and chronic disease screenings	HIV Care Clinics	Survey, interview protocol	# of clinics with screening practices
2018	RWPA RWPB	Recommend that HIV care clinics have plans in place for routine MH and SA assessments with HIV clients	HIV Care Clinics PLWH	Policies Educational Materials	# clinics implementing
2018	RWPA RWPB	Recommend that HIV care clinics have plans in place for routine assessments for chronic disease with HIV clients	HIV Care Clinics PLWH	Policies Educational Materials	# clinics implementing
2018-2019	RWPA RWPB	Develop resource guide for providers. (providers who specialize in chronic disease, mental health, and substance abuse including email for consults and referral)	HIV Care Clinics PLWH	Data on resources available	# Resource guides accessed
2109-2020	RWPA RWPB NDBPH Center for Excellence	Provide outreach to all providers (including private) re routine screening and education for chronic disease, mental health, and substance abuse and specific concerns as co-morbidities with HIV	HIV Care Clinics PLWH	Staff time	# providers reached

O2e. Strategy 2 Conduct Public and individual education for PLWH and newly diagnosed regarding common HIV comorbidities

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2019	RWPA RWPB	Recommend that EHR in all clinics includes routine screening and MH, SA and chronic disease assessments	Clinics	Reprogramming of EHRs	# clinics implementing
2019-2021	RWPA RWPB	Expand health education for clients to include different comorbidities and importance of routine screenings	PLWH	Health Educator/ materials	# clients educated
2019-2021	NAETC	Provide education for providers to assist them in providing good individual or group education	Clinics/providers	materials	# providers educated

O2e. Strategy 3 Develop quality control measures to improve clinical care and outcomes

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2018-2019	RWPA RWPB	Develop standardized assessment forms for all providers for all the assessments	Providers	Staff time Assessment forms	Assessment forms
2019	RWPA RWPB	Use Quality management team to develop and train on use of forms	Providers	Staff time Training materials	# providers trained
2019-2021	RWPA RWPB	Establish baseline data and report on data annually		Quality control data	Annual Report
2019-2021	RWPA RWPB Planning Councils	Disseminate the findings on a regular basis	Providers	Routine communication	# of providers receiving findings
2020-2021	RWPA RWPB Planning Councils	Develop Quality improvement plans	Providers	Staff time	QI plans

GOAL 3: REDUCING HIV RELATED DISPARITIES AND HEALTH INEQUITIES

Objective 3a. By 2021, reduce disparities in the rate of new diagnoses by at least 15 percent among Nevada's priority populations.

This objective addresses the need to provide targeted HIV prevention information to Nevada's priority populations to reduce new HIV infections in communities and groups experiencing the highest rates of new HIV infections. Information provided at the Stakeholder meeting indicated that higher rates of new infections may be due to a lack of basic knowledge about how HIV is transmitted, who is at risk, and how to prevent getting infected. The Stakeholders stressed the need to provide group specific messages tailored to make the information culturally relevant and readily available. Suggestions included being sure to provide information in Spanish and be proactive in taking education out to communities. Proactive "listening sessions" where public health workers go out to the communities will be used to find out what people know or believe about HIV, what they know about testing, about barriers to testing, and about motivators to get tested, etc. The listening session method may be more effective with individuals from communities or groups that experience stigma, prejudice and health disparities. It is done with humility and does not rely on individuals to come to a focus group or public meeting, and it should therefore provide rich information to use for tailoring educational messages. The public health "listeners" will need training in this method to be able to present themselves in a way that people will trust them and feel comfortable talking with them. They will need to learn to be excellent listeners so that they can truly capture the essence of what people are saying. Listening sessions will be conducted to help guide content and gather information about locations, methods, spokespersons, format, etc. for delivering messages. It is probable that multiple different messages will need to be crafted and that there won't be a "one size fits all" HIV prevention message for different communities, different genders, and different ethnic groups.

The strategies for this objective also recognize that much may already have been learned by other public health programs that could be helpful in delivering educational messages to priority groups. Therefore, efforts will be made to search the literature to see what may be adapted for this purpose. The educational outreach efforts will require expertise public health, HIV prevention, cultural competency, health literacy, advertising, and media. The support of respected community organizations in the priority population communities will also be essential. As with any educational effort, it will need to be evaluated. Evaluation strategies will include a second round of listening sessions to see if the messages were noticed, heard, understood, and if they resulted in any behavioral changes. Messages or delivery methods or locations that were not effective will need to be retooled. Ultimately, the effectiveness of the messages will be evaluated by comparing the percent change in number of new HIV infections from baseline in each of the priority populations.

Objective 3a. By 2021, reduce disparities in the rate of new diagnoses by at least 15 percent among Nevada’s priority populations.

O3a. Strategy 1: Engage the community in order to find out how to best reach priority populations

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017	DPBH RWPB RWPA Planning Council HPPG	Conduct listening sessions* with individuals from groups experiencing disparities to identify any gaps in knowledge or incorrect beliefs about HIV. *Listening sessions are one-on-one. A public health person goes to the community, poses open ended questions, and listens to people’s responses. These are more practical than focus groups as they are done where people live and at a time that is good for them. The sessions are informal, flexible, friendly (not intimidating).	priority populations	Listening session topics/questions. Partnerships with trusted organizations, community leaders, and agencies serving priority groups to identify individuals’ willing to participate in listening sessions; etc.) Trained listeners (staff) in different communities throughout the state.	Number of individuals “heard”; number of persons from each target group that participate.
2017	DPBH RWPB RWPA Planning Council HPPG	Identify successful group-specific disease prevention campaigns and strategies that can be adapted to HIV prevention.	priority populations	Staff time to do the literature review. Expertise to adapt findings from research in other diseases to the HIV community.	Identification of proven strategies.

O3a. Strategy 2: Implement HIV prevention public education through media campaigns and social network strategies to target populations.

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2018	DPBH RWPB RWPA Planning Council HPPG	Using information from listening sessions and components from other successful programs, identify the best locations, events, social media and other media strategies, etc. to reach target groups	priority populations	Staff time to synthesize the information from the listening sessions and develop list of most promising placements for media in different communities Persons who are familiar with target group neighborhoods and communities	# locations and platforms identified for each target group in each community

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
				throughout the state Change in policies to allow funding for advertising	
2018	DPBH RWPB RWPA Planning Council HPPG Local Health Districts CBOs	Using information from listening sessions and components from other successful programs, develop and implement group specific HIV 101 media and social media campaigns that 1) provide education about how to prevent HIV; 2) motivate people to get tested; and 3) empower HIV+ people to get into care	priority populations	Persons with expertise in media (all types including social media), health literacy, cultural competency, and public health outreach. Funding for media specialist, Spanish language translation, production of videos, radio and TV spots, posters, etc.	# educational efforts completed for each target group in each community Change from baseline in percent of PLWH linked to care
2018-2021	DPBH RWPB RWPA Planning Council HPPG	Evaluate social network strategies	priority populations	Staff time	Evaluation report
2019-2021	DPBH RWPB RWPA Planning Council HPPG Local Health Districts CBOs	Evaluate effectiveness and reach of education provided: Compare baseline data (prior to 2017) on new infections per 100,000 population to levels in each target group	priority populations	Annual data on new infections by white and by target groups.	# new infections per 100,000 population, target groups vs white % change in number of new infections in target groups from year to year
2019-2021	DPBH RWPB RWPA Planning Council	Conduct listening sessions with individuals from target groups experiencing disparities to find out if they are familiar with any of the educational	Black (male, female, youth); Hispanic;	Listening session topics/questions. Partnerships with trusted	Number of individuals "heard"; number of persons

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
	HPPG	efforts, and to find out what they know/believe about HIV.	Asian/PI	organizations, community leaders, and agencies serving priority groups to identify individuals' willing to participate in listening sessions; etc.) Trained listeners Funding to provide incentives for participants	from each target group that participate.
2020-2021	DPBH RWPB RWPA Planning Council HPPG Local Health Districts CBOs	Using information from listening sessions, identify the methods, messages, locations, radio or TV stations, bus routes, events, etc. that were most likely to reach target groups Using information from listening sessions, identify any new methods, messages, locations, radio or TV stations, bus routes, events, etc. that will be likely to reach target groups Discontinue unsuccessful methods, continue successful one, and implement new methods, messages, locations.	Black (male, female, youth); Hispanic; Asian/PI	Staff time to synthesize the information from the listening sessions and develop list of most successful placements and new placements for media in different communities. Persons who are familiar with target group neighborhoods and communities throughout the state.	# locations and platforms identified for each target group in each community Change from baseline in percent of PLWH linked to care

O3a. Strategy 3: Increase provider and organization capacity to test at sites in their communities

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017-2019	DPBH, RWPB RWPA Local Health Districts	Training CBOs and communities with high risk to provide on-site testing	CBOs and providers	Training materials Staff time	# of providers/ CPO staff trained
2017-2020	DPBH, RWPB RWPA Local Health Districts	Identify and recruit additional providers and CBOs to have testing at their sites	CBOs and providers Priority populations	Staff time	# of providers and CBOs recruited # of tests
2020-2021	DPBH, RWPB RWPA Local Health Districts	Evaluate CBO on-site testing programs	CBOs and providers Priority populations	Staff time	Evaluation report

Objective 3b. By 2021, increase to 85% the percentage of newly diagnosed with HIV among Nevada's priority populations who have been linked to a provider within the first 30 days.

Information from the Stakeholder meeting was also extremely helpful in crafting the strategies for accomplishing this objective to increase the percent of newly diagnosed individuals in priority populations who are linked to care within the first 30 days. Improvement in the point(s) of first contact, proactive assistance in navigating the complex system of care, and increasing accessibility of HIV care and treatment information were the three overarching areas of need identified.

Many HIV infected individuals in priority populations experience multiple layers of stigma, and some may have had negative experiences or poor treatment from workers in the HIV or other social service care system that they attribute to this stigma. Such first-hand experiences or even just hearing second-hand about the experiences of others may cause people to avoid seeking services and getting into and staying in care. This is especially true when there is a bad experience at the very first point of contact into care. Strategies under this objective aim to use the listening session format discussed above to find out more about the experiences of HIV positive individuals in priority populations. There will be questions about their first contacts with the system, what stories they have heard from others about their experiences, what fears or frustrations they have or perceive that prevent them from seeking care or that make it less likely that they will access care. Listeners will ask about ideas for what a "good" system would look like, what things would make it better, and what it would take for individuals to get back into care if they have had bad experiences or begin care if they are very fearful about how it will be.

Ongoing training for personnel in HIV health and social service agencies will be needed to improve interactions with persons seeking care from priority populations to reduce the burden of stigma and reduce health disparities. Humans all have prejudices, many we are not even aware of, so training will help sensitize workers to identify their own biases and improve their interactions with persons from all communities. Follow up after trainings will be conducted with workers and clients to see what changes were made and sustained, and systems of rewards and incentives will be implemented to help sustain those improvements.

For most HIV positive individuals, whether they are a member of a priority population or not, navigating the system of care can be complicated, confusing, and frustrating. Adding layers of stigma, poor treatment, prejudice, lack of understanding, poor explanations, low cultural competency, low health literacy, etc. to this already daunting system deters individuals from seeking and staying in care, resulting in the current disparities this objective seeks to address.

Therefore, this objective includes strategies for addressing how individuals get information about the system of care and for helping them learn to navigate it. Multiple systems are needed to disseminate information about the system of care (access, eligibility, cost, hours, locations, etc.) to all HIV positive individuals, but intensified outreach efforts are needed for individuals in priority populations. Intensified outreach may include outreach efforts "on the ground" at community events, in popular "hang outs", and in neighborhoods. It also includes the development of a strong peer navigator program where a person from the same priority population group who is knowledgeable about the care system literally walks with a person to take them through the system, help with things like filling out forms, problem solving, coaching on dealing with different personalities, handling frustrating situations, knowing where to go to get more answers, etc. Peer navigators will be trained to guide new clients from their first experiences to becoming self-sufficient care consumers. One strategy also provides for the replication of the "Living Room", a current successful model of entry into care. This is more of a drop in site as opposed to an agency or clinic

that is relaxed and friendly where newly diagnosed people or their friends and family can get information about getting tested and/or getting into care.

The effects of low health literacy on the health care system in general have been well documented. (It is perhaps more accurate to identify the real problem as being the materials and information that are too complex for most people.) The system of HIV care is very complex, and as such, it requires extra efforts to ensure that all of the materials (forms, flyers, enrollment information, eligibility guidelines, directions to services, maps to find services or bus routes, etc.) meet health literacy standards. For many individuals in Nevada's priority populations, this includes having the information in Spanish. Therefore, strategies under this objective also include reviewing and revising as needed all of the patient materials to meet basic health literacy standards, and assessing the strengths and weaknesses in the system for having materials and services provided in Spanish.

O3b. Strategy 1: Improve first contact and point of access to care for PLWH who experience multiple “layers” of stigma (eg: HIV infected, gay, minority, female, transgender, IV drug user, etc.)

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017	RWPA RWPB Planning Council	Conduct listening sessions with individuals from PLWH in underserved populations and high risk groups to 1) learn about their first contact experiences with HIV agencies; 2) find out if negative experiences in first or early contact prevented them from continuing or pursuing HIV care and/or accessing services; and 3) get ideas and suggestions for ways to make improvements	PLWH in underserved populations and high-risk groups	Listening session topics/questions Partnerships with trusted organizations, community leaders, and agencies serving priority groups to identify individuals' willing to participate in listening sessions; etc.) Trained listeners Funding to provide incentives for participants	Total number of individuals “heard” # of persons from each underserved or high risk group that participate
2018	RWPA RWPB Planning Council	Review information gathered in listening sessions Develop new strategies for improving first contacts	Employees and volunteers in HIV care and service organizations	Staff (or possibly graduate students) time to synthesize the information from the listening sessions and develop list of suggestions	# of HIV care and service organization employees and volunteers who receive information on how to improve first contact experiences
2017-2021	RWPA RWPB	Provide experiential training to employees and volunteers in HIV care and	Employees and volunteers in	Trainers, training facilities, time off	# of employees and

	Planning Council AETC in partnership with HIV care and service providers	service organizations about how personal bias and stigma can prevent PLWH in underserved populations and high-risk groups from accessing and staying in care Conduct brainstorming sessions on how to improve first access and point of contact Recognize persons and agencies that PLWH deem most welcoming Follow up with trainees at 3 and 9 months post training to determine what changes or improvements were made and sustained	HIV care and service organizations	for employees to attend training Group and community-specific data on percent of PLWH in underserved and high risk groups that are retained in care Method to reward and recognize persons and agencies that improve	volunteers trained # of trainees who report making and sustaining improvements Change from baseline in percent of PLWH who are retained in care and who are virally suppressed
2020-2021	RWPA RWPB Planning Council	Repeat listening sessions with individuals from PLWH in underserved populations and high risk groups to see if there have been improvements in their first contact experiences with HIV agencies and get additional ideas and suggestions for ways to make improvements	PLWH in underserved populations and high-risk groups	Listening session topics/questions Partnerships with trusted organizations, community leaders, and agencies serving priority groups to identify individuals' willing to participate in listening sessions; etc.) Trained listeners (staff or students) in different communities throughout the state May need funding to provide incentives for participants	Total number of individuals "heard" # of persons from each underserved or high risk group that participate Change from baseline in percent of PLWH who are retained in care and who are virally suppressed

O3b. Strategy 2: Improve the ability of PLWH in underserved or high risk groups to navigate the HIV system of care.

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2017	RWPA RWPB Planning Council	Develop HIV community-specific websites that are updated monthly to list available services, who is eligible to access the services, cost for services, who to call, how to access, locations, hours, etc.	HIV care and service “navigators” and PLWH	Website that is constantly updated as services, providers, rules, phone numbers, etc. change	Accuracy and timeliness of information # “hits” on the website Change from baseline in percent of PLWH who are linked to care, retained in care, and who are virally suppressed
2018	RWPA RWPB Planning Council	Hold a yearly provider showcase for all parts, where all services provided will be discussed and case studies will be reviewed in an effort to enhance service delivery between agencies to PLWH.	Providers	Staff time Location	# providers participating
2018	RWPA RWPB Planning Council HIV care and service providers	Implement “peer navigator” program. Role of peer navigators is to mentor newly diagnosed people, “hold their hand” early in the process of accessing services (help them fill out forms, go to agencies, get labs done, etc.), know when to reapply, and help them become self-sufficient over time	PLWH in underserved populations and high-risk groups	Funding, training, and transportation for peer navigators Staged system of assistance from dependency to self-sufficiency	# of PLWH assisted by peer navigators # who report feeling self-sufficient with regard to navigating the system within 6 months Change from baseline in percent of PLWH who are linked to care, retained in care, and who are virally suppressed

O3b. Strategy 3: Improve the accessibility of information for PLWH in underserved or high risk groups.

Timeframe	Responsible Parties	Activity/Intervention	Target Population	Resources needed to implement activity	Metrics
2018	RWPA RWPB Planning Council HIV care and service providers	Review all current patient materials (enrollment, list of services, patient responsibilities, timelines, payment, etc.) for health literacy criteria Revise materials as needed to be at 6 th grade reading level	PLWH in underserved populations and high-risk groups	Training for staff in health literacy (what it is, why it matters, how to adapt materials) Staff time to review and revise materials Training for staff in providing clear oral and written information for clients (using “living room language”, providing examples, checking in to ensure understanding, etc.)	% of written materials meeting health literacy standards #of staff trained in health literacy # of staff reporting making changes in how they communicate with clients. Change from baseline in percent of PLWH who are linked to care, retained in care, and who are virally suppressed
2017	RWPA RWPB Planning Council HIV care and service providers	Assess staffing to identify strengths and weaknesses in meeting language needs (oral and written) for Spanish speaking clients Determine the need for translation in other languages besides Spanish Hire bi-lingual staff who are fluent in differences in Spanish across varied Hispanic cultures	PLWH in underserved populations and high-risk groups	Hiring or reassignment of bilingual staff to ensure readily accessible translation services for Spanish-speaking clients. Purchase or translation time for having all materials in English and Spanish	%of Spanish speaking clients who report easy access to translators Change from baseline in percent of PLWH who are linked to care, retained in care, and who are virally suppressed
2019	RWPA RWPB Planning Council HIV care and service providers	Replicate the “Living Room” program in different communities, at different “user friendly locations”, different times and days. (The Living Room program is a welcoming, relaxed, friendly place where	PLWH in underserved populations and high-risk groups	Funding for staffing Identification of key locations for “Living Rooms” to attract underserved and high risk individuals	# of Living Room programs conducted # of persons coming to the Living Rooms # of PLWH who report accessing services as a result of attending Living Room

		newly diagnosed people and their family and friends can drop in to learn about what to expect from different agencies, how to access services, how to stay healthy, etc.)			Change from baseline in percent of PLWH who are linked to care, retained in care, and who are virally suppressed
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Goal 3 anticipated challenges or barriers in implementing the plan: Achieving this goal will require additional funding and potentially a change in funding guidelines to allow for expanded outreach including use of different media platforms, development of web-based information systems, training and re-training of staff, hiring new staff who are bilingual, who work on inter-agency outreach teams, and who serve as patient navigators for the hardest to reach clients. It will also require, or at least be more likely to be achieved, with better interagency cooperation and communication that can be fostered by more coherent funding strategies and incentives. Over time, cost savings can be realized as more PLWH enter and stay in care and achieve viral suppression.

B. COLLABORATIONS, PARTNERSHIPS, AND STAKEHOLDER INVOLVEMENT

CONTRIBUTIONS OF STAKEHOLDERS AND KEY PARTNERS

a. Describe the specific contributions of stakeholders and key partners to the development of the plan

The needs assessment and SCSN planning process was initiated in late 2014 as the administrators of Parts A, B and Prevention agreed to collaborate to create one needs assessment and care plan for Nevada. This made great sense to the planning bodies and to the clinical community as treatment and prevention represent two sides of the same coin and both are of equal importance in achieving better outcomes at the various points of the cascade. Under the leadership of the State Office of HIV/AIDS and the Ryan White Part A program, the HIV Prevention and Care Integrated Plan Internal Workgroup was formed to guide the plan development process. The internal workgroup included representatives from RWPB, the HIV Prevention, RWPA, SNHD, and WCHD. RWPB, HIV Prevention and RWPA contracted with the School of Community Health Sciences (SCHS) at UNR to conduct the needs assessment and write the state plan in collaboration with the internal workgroup and other stakeholders.

As described previously, stakeholders were invited to participate in meetings related to the plan development in April 2015 and March 2016. Stakeholders included PLWH and representatives from a variety of agencies, organizations, and providers around the state. Furthermore, providers and representatives from other agencies and organizations related to HIV prevention and care were invited to complete a statewide provider/organization survey and Part A providers completed surveys for the Part A Comprehensive Needs Assessment.

Community members and people at higher risk for infection contributed to the development of the plan through participation in the Community Survey and a variety of focus groups. PLWH contributed to plan development through their participation in the Part A needs assessment and customer satisfaction surveys and focus groups and statewide/part B client survey and focus groups. Furthermore, PLWH, community members, providers, and community based organizations are represented in the membership of the planning groups in the north and south and in the Part A planning council. The planning group and council members were involved in the needs assessment activities, large stakeholder meetings, development of plan objectives and strategies, and review of the plan drafts.

b. Describe stakeholders and partners not involved in the planning process, but who are needed to more effectively improve outcomes along the HIV Care Continuum

While a wide variety of stakeholders were involved in Nevada's integrated process, it would have been helpful to have some additional partners at the table. Representatives from churches, schools, other healthcare providers, mental health providers, dentists, additional community groups, cultural groups, substance abuse providers, and political groups are examples of potential partners to involve more in the planning process. This integrated plan includes strategies to involve other community partners and

stakeholders in the HIV Prevention and Care efforts in the next five years.

- c. *Provide a letter of concurrence to the goals and objectives of the Integrated HIV Prevention and Care Plan from the co-chairs of the planning body and the health department representatives*

Letters of Concurrence from the planning bodies are found in Appendix M.



C. PEOPLE LIVING WITH HIV (PLWH) AND COMMUNITY ENGAGEMENT

- a. *Describe how the people involved in developing the Integrated HIV Prevention and Care Plan are reflective of the epidemic in the jurisdiction.*
- b. *Describe how the inclusion of PLWH contributed to the plan development.*
- c. *Describe the methods used to engage communities, people living with HIV, those at substantial risk of acquiring HIV infection and other impacted population groups to ensure that HIV prevention and care activities are responsive to their needs in the service area.*
- d. *Describe how impacted communities are engaged in the planning process to provide critical insight into developing solutions to health problems to assure the availability of necessary resources.*

People involved in developing the Integrated HIV Prevention and Care Plan are reflective of the epidemic in Nevada in a variety of ways. People from all areas of the state were invited to participate in meetings, focus groups, paper surveys, and online surveys. PLWH and people at risk for HIV infection were included in all stages of the needs assessment and plan development. Participants in the needs assessment were diverse and represented the Nevada population of people PLWH and at risk for HIV very well. As shown in Figure 27, PLWH who participated in the HIV positive focus groups matched the sex and gender identity percentages of PLWH in Nevada—with nearly identical percentages of female, male and transgender participants. Client survey participants closely matched PLWH in Nevada with a slight overrepresentation of females and slight underrepresentation of males among the survey respondents. Participants in the client survey and HIV positive focus groups were also fairly representative of PLWH in Nevada with respect to ethnicity (Figure 28). Hispanic were underrepresented in the survey and focus groups; however, multi-race respondents were overrepresented which could account for some of the disparity. Several focus groups were held in Spanish and the survey was available in both Spanish and English. Blacks were also overrepresented in the survey and focus group samples; however, with the disproportionate burden of

HIV among blacks in Nevada, it was a high priority group to include in data collection efforts.

Figure 27. PLWH Survey and Focus Group Participants by Sex and Gender Identity

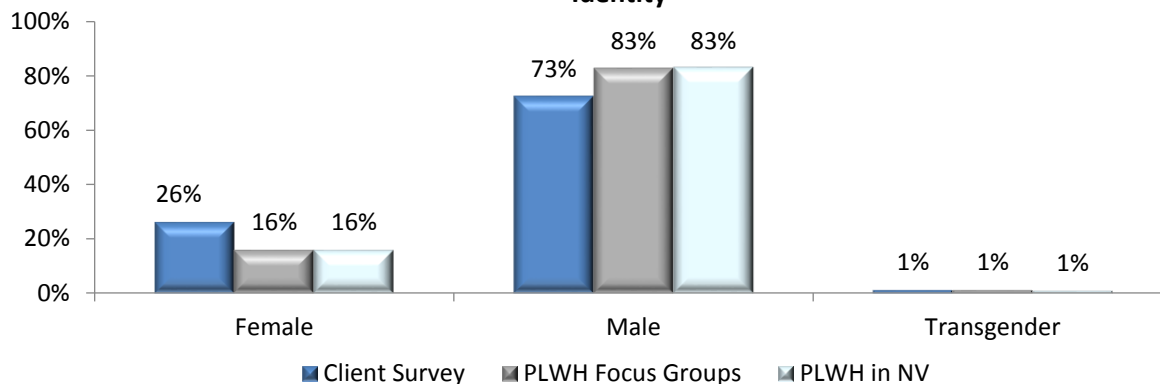
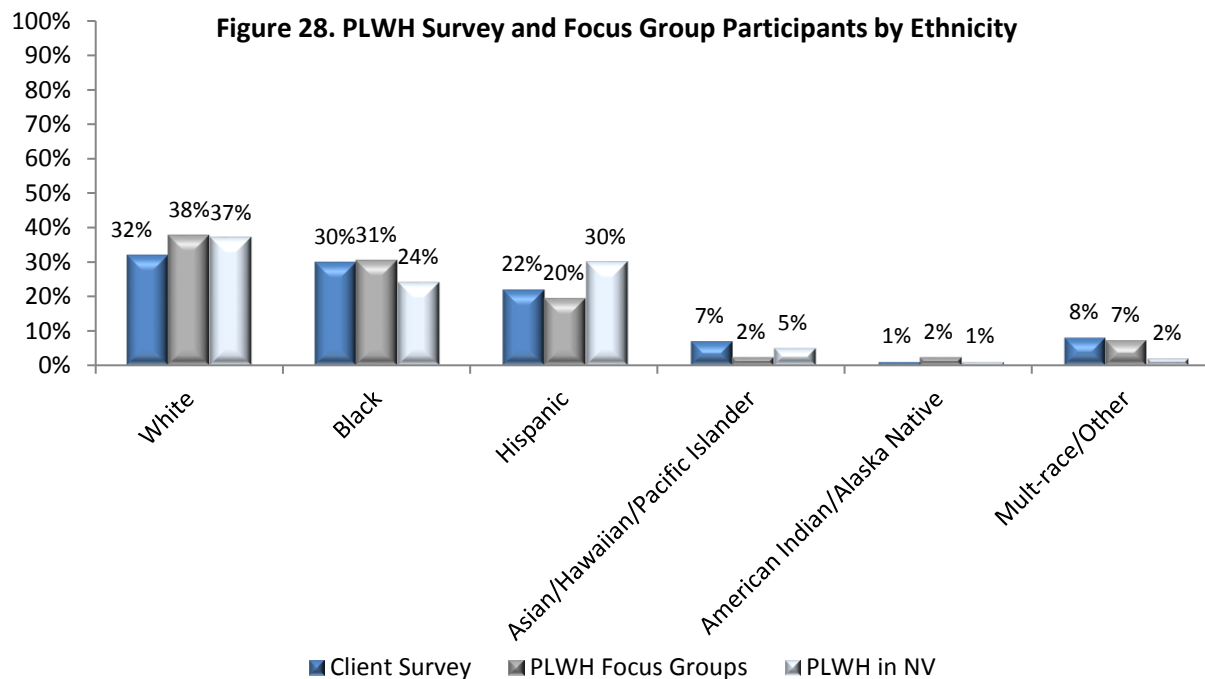


Figure 28. PLWH Survey and Focus Group Participants by Ethnicity



PLWH were included in plan development in a variety of ways. PLWH are members of the planning groups in the north and south as well as the Part A Planning Council. The Part A Planning Council is comprised of 48% PLWH, of which 39% are non-aligned consumers (i.e. a non-aligned consumer receives Part A or MAI-funded HIV-related services but is not an officer, employee or representative of, or consultant to, any agency receiving Part A or MAI funds). The planning groups and council were actively involved in the stakeholder meetings; and they reviewed the integrated plan drafts and provided feedback to the plan development workgroup. PLWH also contributed to plan development through their participation in the needs assessment focus groups, client surveys, and community surveys. Focus groups conducted for the statewide needs assessment included 43% of participants who had tested positive for HIV (some focus groups were specifically for HIV clients, while others were for community members/people at risk for HIV).

Focus groups conducted for the Part A needs assessments included all PLWH as that was the focus population. The inclusion of PLWH was extremely valuable to the development of the plan. Their voices were key to determining the needs of PLWH and to generate ideas for improving HIV prevention and care in the state of Nevada.

A variety of methods were used to engage communities, people living with HIV, those at substantial risk of acquiring HIV infection and other impacted groups to ensure that HIV prevention and care activities were responsive to their needs in the service area. As described previously, community members and people at risk for HIV infection were sought out to complete the community survey and to participate in focus groups. The community survey was administered in paper and online in many different settings to engage a diverse group of people in the state. Focus groups were held in diverse locations. The needs of PLWH were assessed through client needs assessment surveys and client satisfaction surveys at different times, locations, and modes. Furthermore, client focus groups were used to further understand the needs of PLWH. Finally, in the stakeholder meetings, planning group and planning council meetings, and through review of the plan drafts, PLWH and community members had further opportunities to have their voices heard in the process. The stakeholder meetings and planning groups and councils proved to be valuable means for generating ideas and solutions to challenges in the HIV prevention and care system. Attendees participated actively in these meetings and were fully engaged in the process.

SECTION III: MONITORING AND IMPROVEMENT

- a. Describe the process for regularly updating planning bodies and stakeholders on the progress of plan implementation, soliciting feedback, and using the feedback from stakeholders for plan improvements.*
- b. Describe the plan to monitor and evaluate implementation of the goals and SMART objectives from Section II: Integrated HIV Prevention and Care Plan.*
- c. Describe the strategy to utilize surveillance and program data to assess and improve health outcomes along the HIV Care Continuum, which will be used to impact the quality of the HIV service delivery system, including strategic long-range planning.*

The HIV Prevention and Care Integrated Plan Internal Workgroup will meet every six months to review progress on plan implementation. At the regularly scheduled meetings following the six-month review, representatives to the planning groups and council will update those bodies on plan progress and use that opportunity to solicit feedback from the planning groups which can be built back into the plan for improvements.

The Part A, Part B and Prevention programs have contracted the School of Community Health Sciences (SCHS) at the University of Nevada, Reno to oversee the evaluation and monitoring of the plan. SCHS will collaborate with the workgroup and planning bodies throughout the evaluation and monitoring process. An evaluation report will be produced annually to document the implementation process as well as progress towards the plan goals and objectives. The report will be shared with the workgroup and planning bodies. Also on an annual basis, current epidemiology data will be reviewed in relation to the goals and objectives and will be used to make adjustments to the plan as needed.

Surveillance and program data will continue to be used regularly to improve service delivery. The Integrated plan incorporates use of data in multiple strategies such as targeted HIV testing, prevention and resource/service awareness campaigns to maximize resources and impact of programs and services. QM data is used regularly to make improvements in service delivery and to revise plans. To ensure stakeholder involvement in quality management activities and processes, the Ryan White Part A and B programs jointly implemented a Ryan White Part A, B, C, D, F and prevention Cross-Part Collaborative Quality Management team in March 2013. The purpose of the team is to provide a mechanism for the objective review, evaluation and continuing improvement of the quality management system. It is also responsible for guiding the direction of quality improvement projects, forming quality improvement committees when necessary, documenting improvements and results, and guiding the implementation of successful practices statewide. A statewide QM Plan has been developed and will be reviewed and updated regularly. Monthly QM Committee meetings via teleconference provide a statewide communication vehicle to discuss projects, performance measures, standards and activities or events that may affect program quality management initiatives. Part A and Part B are working on data sharing agreements that will include surveillance in order to have a more comprehensive reporting of viral loads.

APPENDICES

APPENDIX A: LIST OF ACRONYMS AND DEFINITIONS

Definitions and Terminology

All other counties

The category *all other counties* includes all counties in Nevada other than Clark and Washoe counties. This includes Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine Counties.

Age at diagnosis

Age at diagnosis is the age of the individual at the time he/she was diagnosed with HIV and/or HIV stage 3 (AIDS).

Age at end of year

Age at end of year is calculated based on a person's date of birth, and is the person's age at the end of the report year. If the date of birth is incomplete or unknown, age at end of year cannot be calculated.

Cumulative deaths

The total number of deaths from the beginning of the epidemic through the end of the report year.

Deaths among persons living with HIV

Deaths among persons living with HIV (all stages), including HIV stage 3 (AIDS), may or may not have been due to HIV or HIV stage 3 (AIDS). Deaths are counted for those persons whose current residence was Nevada at the end of the report year; therefore, cases that have died out of state may not be reflected in this data.

eHARS

Enhanced HIV/AIDS Reporting System; a document based data management system for tracking surveillance of HIV all stages, including HIV stage 3 (AIDS).

HIV/ HIV Stage 3 (AIDS) surveillance

The systematic collection, analysis, interpretation, dissemination, and evaluation of population-based information about persons with a diagnosis of HIV infection and persons with a diagnosis of HIV stage 3 (AIDS).

Morbidity

The occurrence of an illness, disease, or injury.

New HIV infections/ New HIV Diagnoses

The category *new HIV infections* includes persons newly diagnosed with HIV infection in Nevada (both

living and deceased) and excludes persons who were diagnosed in another state but who currently live in Nevada. This category also includes persons who were newly diagnosed with HIV and HIV stage 3 (AIDS) in the same year. Thus, the categories *new HIV infections* and *new HIV stage 3 (AIDS) diagnoses* will duplicate case counts for the same report year and cannot be combined.

In addition, the category new HIV infections is based on diagnoses of HIV infection and does not include every person who has been infected with HIV. Many people do not get tested for HIV and cannot be included in surveillance statistics. Furthermore, a recent diagnosis may not reflect a new infection; an individual may be diagnosed with HIV many years after he/she was first infected.

New HIV Stage 3 (AIDS) diagnoses

The category *New HIV stage 3 (AIDS) Diagnoses* includes persons newly diagnosed with HIV stage 3 (AIDS) in Nevada (both living and deceased) and excludes persons who were diagnosed in another state but who currently live in Nevada. This category also includes persons who were newly diagnosed with HIV stage 3 (AIDS) and HIV in the same year. Thus, the categories *new HIV stage 3 (AIDS) diagnoses* and *new HIV infections/diagnoses* will duplicate case counts for the same report year and cannot be combined.

The criteria for an HIV stage 3 (AIDS) diagnosis are: (1) a confirmed HIV infection and (2) either an HIV stage 3 (AIDS)-defining opportunistic infection or a CD4+ T-lymphocyte count of less than 200 cells/ μ L or percentage of less than 14 if no CD4+ T-lymphocyte count is present.

Persons living with HIV (not HIV Stage 3 (AIDS))

This category includes persons currently living with HIV (not HIV stage 3 (AIDS) in Nevada, based on the most current address in eHARS. These persons may or may not have been diagnosed with HIV in Nevada.

Persons living with HIV Stage 3 (AIDS)

This category includes persons currently living with HIV stage 3 (AIDS) in Nevada based on the most current address in eHARS. These persons may or may not have been diagnosed with HIV or HIV stage 3 (AIDS) in Nevada.

Persons living with HIV

This category includes the total number of persons currently living with HIV, including HIV stage 3 (AIDS), in Nevada, based on the most current address in eHARS. These persons may or may not have been diagnosed with HIV, including HIV stage 3 (AIDS), in Nevada. The categories *persons living with HIV (not HIV stage 3 (AIDS))* and *persons living with HIV stage 3 (AIDS)*, are mutually exclusive and can be combined to calculate the total number of persons living with HIV.

Race/Ethnicity

The collection of race/ethnicity data in HIV surveillance follows the guidelines set forth by the Office of Management and Budget (OMB) in 1997.

Ethnicity: There are two ethnicity categories: Hispanic/Latino and not Hispanic/Latino. All persons who identified as Hispanic/Latino are classified as Hispanic/Latino regardless of their racial identification.

Race: There are four race categories: White, Black/African American, Asian/Native Hawaiian/Pacific Islander (API), and American Indian/Alaska Native (AI/AN). The categories Asian, Native Hawaiian, and Pacific Islander were combined into the single category API due to their small population size in Nevada. Persons categorized by race were not Hispanic/Latino.

Rate

The rapidity at which a health event occurs as indicated by the number of cases per number of people during a specific time period. In this report, rates were calculated for the 12-month period per 100,000 population using population estimates from the Nevada State Demographer's Office. Rates in the tables calculated using counts under 12 have been suppressed due to a relative standard error greater than 30% denoted by ~.

Transgender

Persons whose gender identity, expression or behaviors are different from those typically associated with their assigned sex at birth. HIV surveillance programs use two variables, *sex at birth* and *current gender identity*, to identify transgender individuals and commonly use the following gender categories:

Male to Female (MTF): An individual who was born as a male but currently identifies as a female.

Female to Male (FTM): An individual who was born as a female but currently identifies as a male.

Additional gender identity: Gender identities other than male, female, MTF, and FTM. For example, genderqueer, gender fluid, and bi-gender.

Transmission Category

The risk behavior associated with HIV transmission. A single person may have multiple exposures, so a hierarchy is used to select the risk factor that was most likely to cause HIV transmission. However, male-to-male sexual contact and injection drug use are equally likely to cause transmission, so males who report both of these behaviors are classified into a combined category. The primary transmission categories that have been identified are:

Male-to-male sexual contact (MSM): includes males with reported sexual contact with another male.

Injection drug use (IDU): includes persons who took non-prescribed drugs by injection, intravenously, intramuscularly or subcutaneously.

Male-to-male sexual contact and injection drug use (MSM+IDU): includes males who reported both male-to-male sexual contact and injection drug use.

Heterosexual contact: includes persons who had heterosexual contact with an HIV-infected person, an injection drug user, or a person who has received blood products. For females only, history of heterosexual sex with a bisexual male constitutes a transmission category of heterosexual contact.

Perinatal transmission: includes infants who were infected during gestation, birth, or postpartum through breastfeeding to an HIV-infected mother.

Transfusion/Hemophilia: includes hemophilia and receipt of transfusions or transplants.

No Identified Risk / No Risk Reported (NIR/NRR): Persons who have no risk information reported by the provider or no risk factor was identified during an expanded investigation.

Abbreviations

ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AIDS	Acquired Immunodeficiency Syndrome, also referred to as HIV stage 3 (AIDS).
AI/AN	American Indian/Alaskan Native
API	Asian/Hawaiian/Pacific Islander
ART	Antiretroviral Therapy
CBO	Community Based Organization
CCHHS	Carson City Health and Human Services
CDC	Centers for Disease Control and Prevention
CPG	Community Planning Group
CRCS	Comprehensive Risk Counseling Services
DPBH	Division of Public and Behavioral Health
eHARS	enhanced HIV/AIDS Reporting System
EIIHA	Early Identification of Individuals with HIV/AIDS
EPI	Epidemiology
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
HOPWA	Housing Opportunities for Persons with AIDS
IDU	Injection drug use or injection drug user
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex
MSM	Male-to-male sexual contact or men who have sex with men
MSM+IDU	Male-to-male sexual contact and injection drug use or men who have sex with men and use injection drugs
MTF	Male to female
FTM	Female to male
NHAS	National HIV/AIDS Strategy
NIR	No identified risk

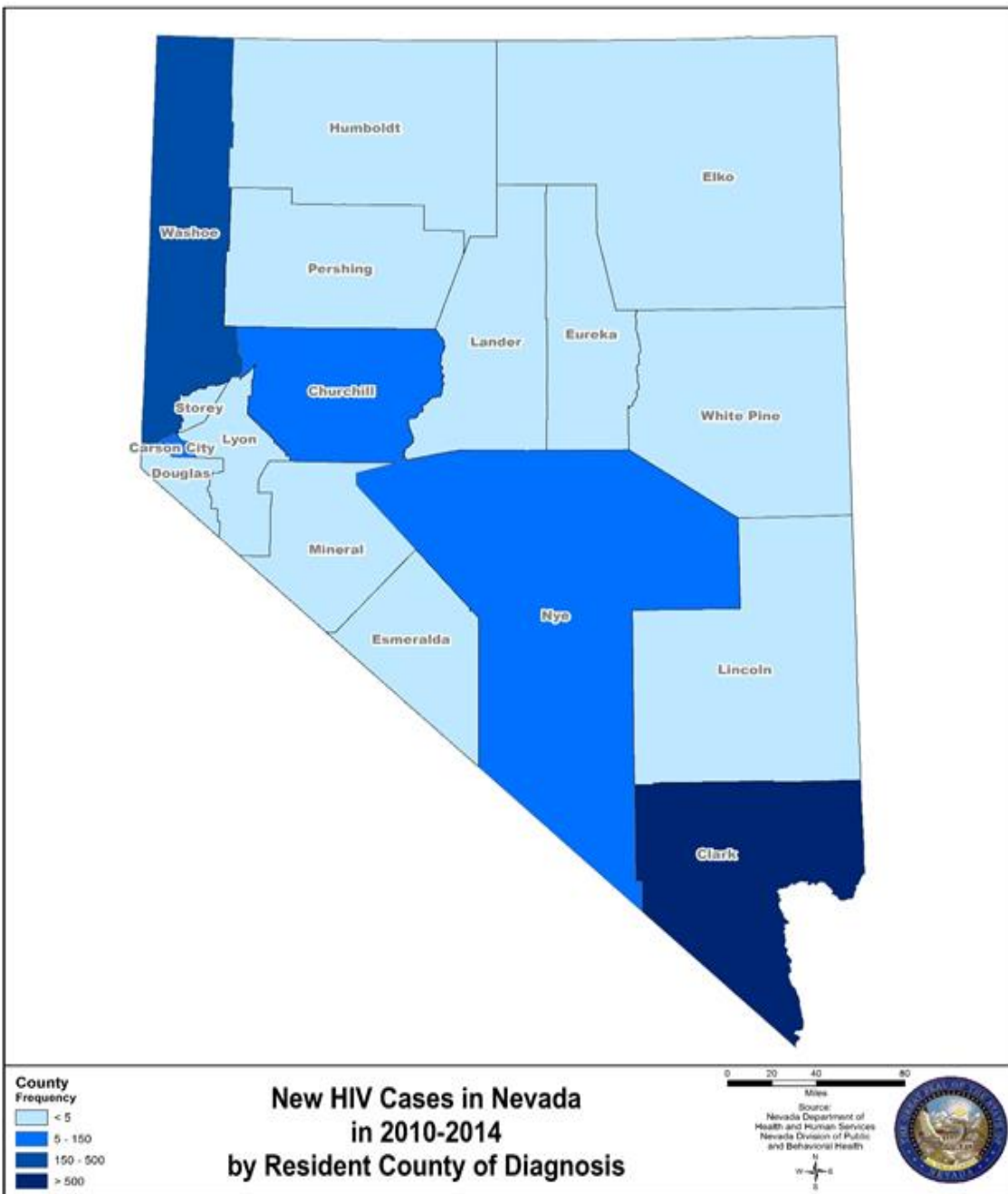
NRR	No reported risk
PEP	Post Exposure Prophylaxis
PLWH	Persons Living with HIV
PrEP	Pre-Exposure Prophylaxis
RWPA	Ryan White HIV/AIDS Part A Program
RWPB	Ryan White HIV/AIDS Part B Program
SAPTA	Substance Abuse Prevention and Treatment Agency
SCHS	School of Community Health Sciences, University of Nevada, Reno
SNHD	Southern Nevada Health District
STD/I	Sexually Transmitted Disease/Infection
TGA	Transitional Grant Area
UNLV	University of Nevada, Las Vegas
UNR	University of Nevada, Reno
UNSOM	University of Nevada School of Medicine
WCHD	Washoe County Health District

APPENDIX B ADDITIONAL EPIDEMIOLOGICAL PROFILE TABLES AND GRAPHS

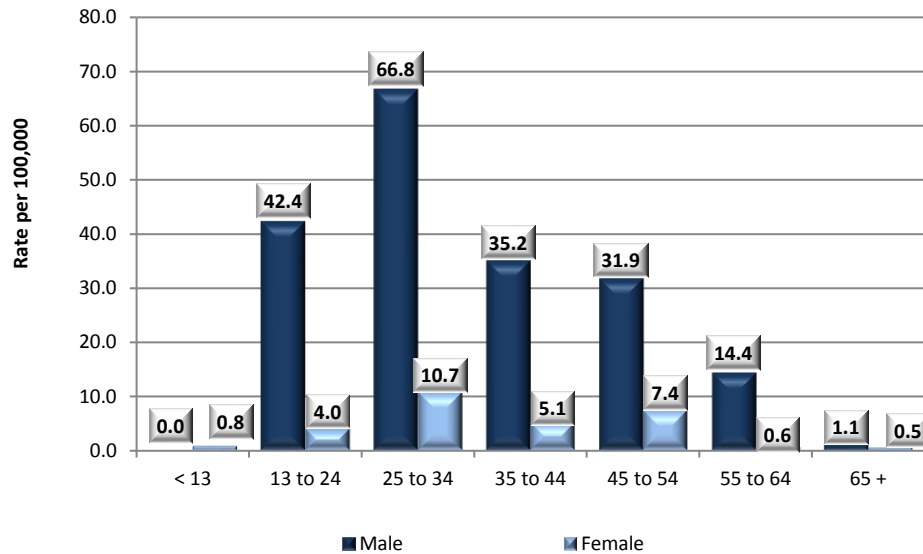
Behavioral Risk Factor Surveillance Survey—Risky Behaviors, 2011-2012

	Risky Behaviors	
	BRFSS Yes	CI*
Sex at Birth		
Male	4.6	(3.5-5.6)
Female	3.7	(2.9-4.6)
Race/Ethnicity		
White, non-Hispanic	3.5	(2.7-4.2)
Black, non-Hispanic	6.0	(2.7-9.2)
Hispanic	4.9	(3.4-6.4)
Multi-race /All-Other/Unknown	5.2	(2.6-7.8)
Age		
18 - 24	14.2	(10.6-17.9)
25 - 34	7.0	(5.1-8.9)
35 - 44	3.8	(2.2-5.4)
45 - 54	1.8	(0.9-2.6)
55 - 64	0.5	(0.2-0.8)
65+	0.4	(0.1-0.7)
Education		
Less than H.S.	4.3	(2.4-6.1)
H.S. or G.E.D.	4.6	(3.4-5.9)
Some Post H.S.	4.8	(3.5-6.0)
College Graduate	2.4	(1.4-3.4)
Income		
< 15,000	6.5	(4.1-8.8)
\$15,000 to \$24,999	6.0	(4.0-8.0)
\$25,000 to \$34,999	3.6	(1.6-5.7)
\$35,000 to \$49,999	4.0	(2.3-5.7)
\$50,000 to \$74,999	3.2	(1.9-4.5)
\$75,000+	2.8	(1.6-4.0)
Insurance		
Yes	3.4	(2.7-4.1)
No	6.2	(4.7-7.8)
Total	4.2	(3.5-4.8)

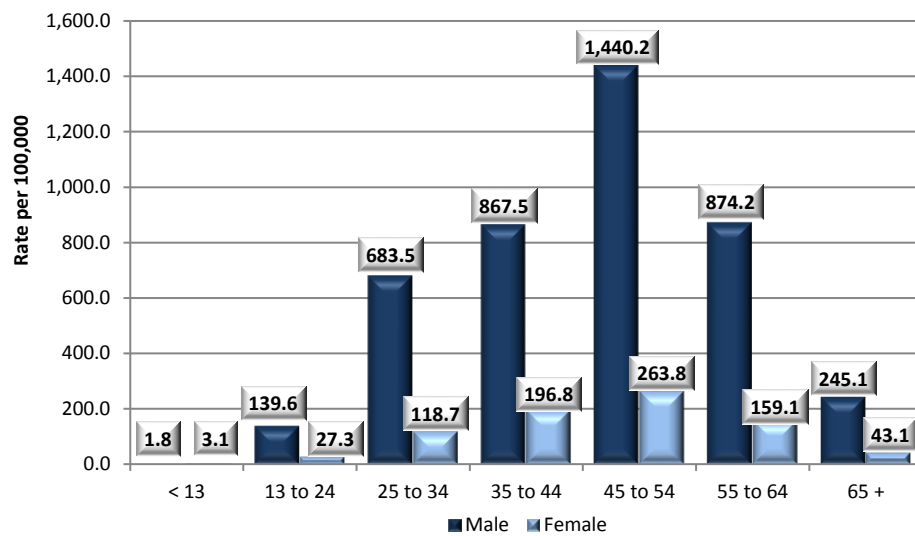
New HIV Diagnoses by County of Residence in Nevada, 2010-2014



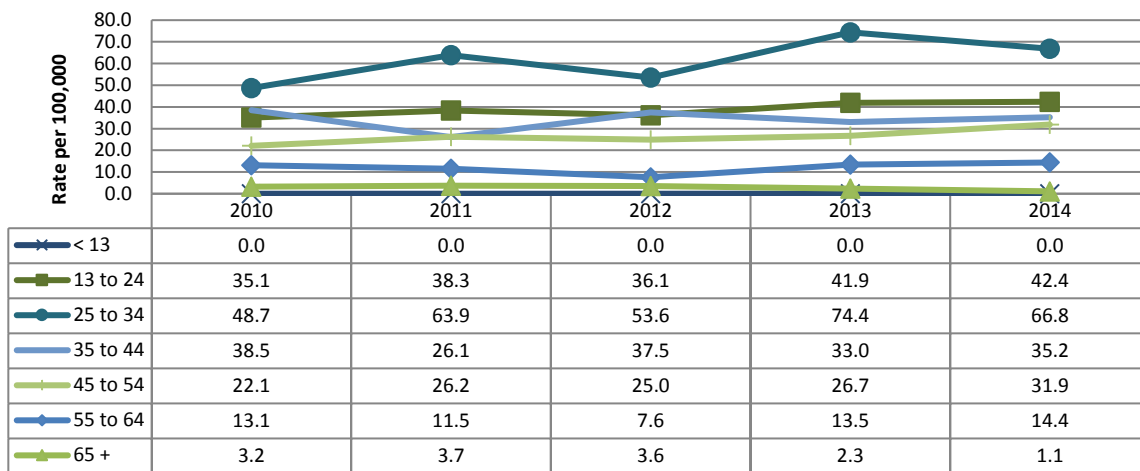
Annual Rate of New HIV Diagnoses in Nevada by Sex and Age, 2014



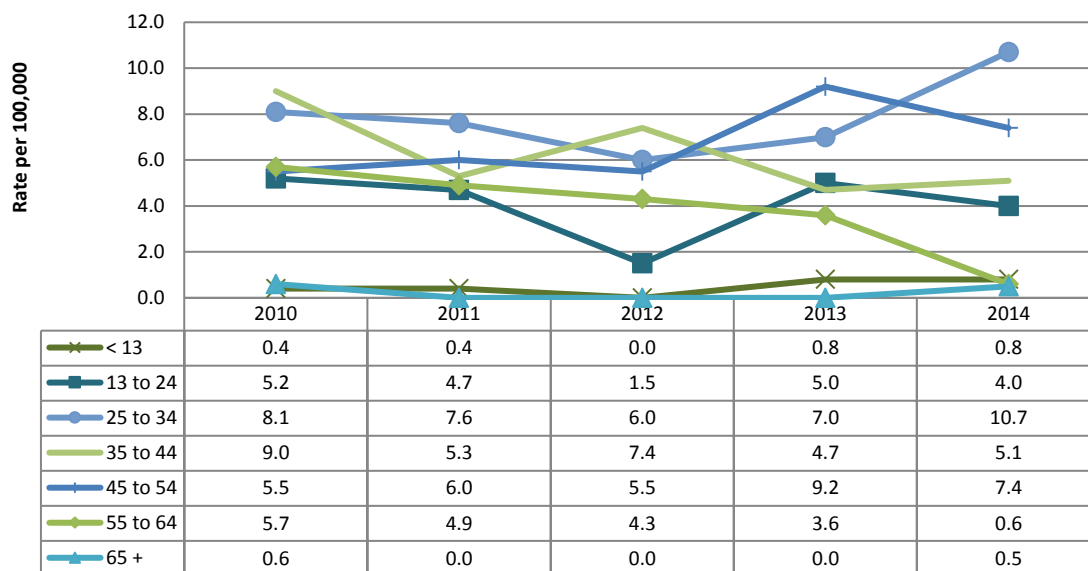
Annual Rate of Persons Living with HIV in Nevada by Sex and Age, 2014



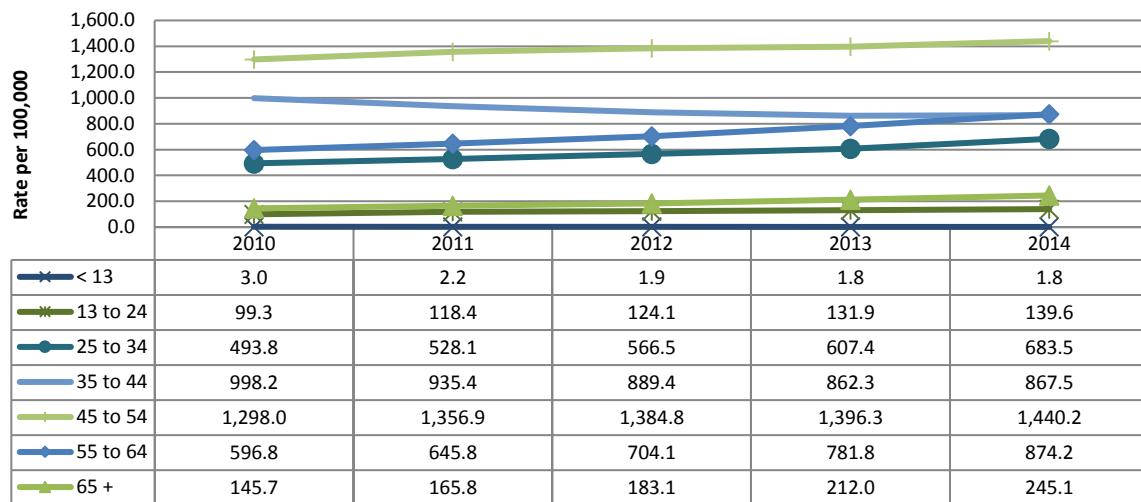
Annual Rate of New HIV Diagnoses among Males in Nevada by Age at Diagnosis, 2010 – 2014



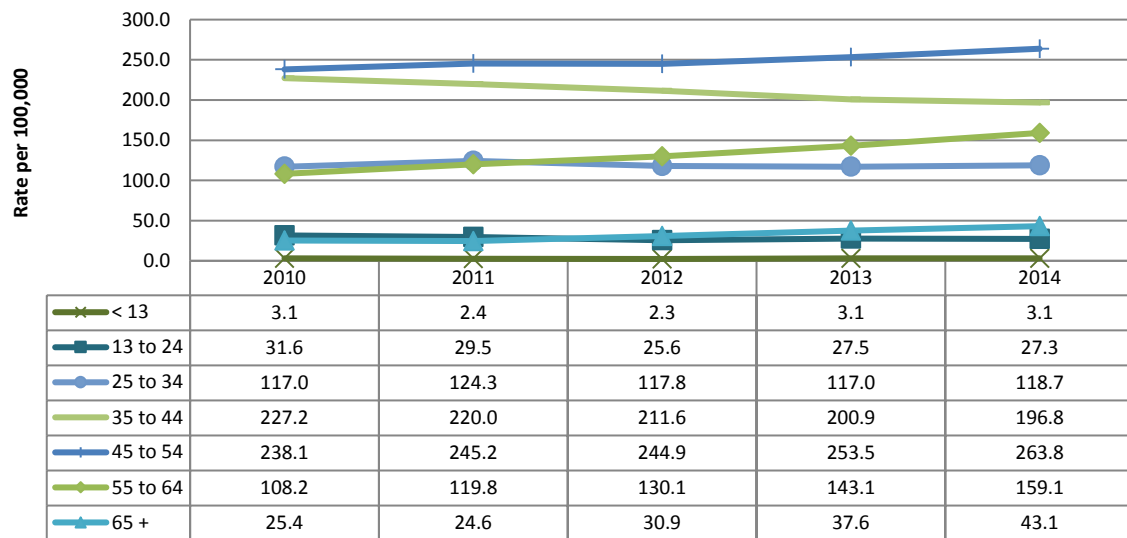
Annual Rate of New HIV Diagnoses among Females in Nevada by Age at Diagnosis, 2010 – 2014



Annual Rate of Males Living with HIV by Age at End of Year, 2010– 2014



Annual Rate of Females Living with HIV by Age at End of Year, 2010– 2014



Expanded Risk Categories by Sex for New HIV Diagnoses, 2010 - 2014

Expanded Risk	2010		2011		2012		2013		2014	
	N	%	N	%	N	%	N	%	N	%
Males										
MSM only	18 6	60%	19 8	61%	19 3	61%	23 2	62%	23 8	62%
MSM and heterosexual contact	71	23%	75	23%	54	17%	56	15%	46	12%
IDU only	0	0%	2	1%	2	1%	0	0%	0	0%
IDU and heterosexual contact only	15	5%	12	4%	10	3%	13	3%	13	3%
IDU and MSM	9	3%	11	3%	11	3%	19	5%	21	5%
IDU, MSM, and heterosexual contact	10	3%	7	2%	9	3%	11	3%	5	1%
Heterosexual contact with IDU female	0	0%	0	0%	4	1%	6	2%	3	1%
Heterosexual contact with HIV+ female	5	2%	9	3%	4	1%	11	3%	9	2%
Heterosexual contact only (no other risk identified)	14	5%	11	3%	31	10%	27	7%	41	11%
Perinatal exposure, HIV diagnosed at age 13 years or older	0	0%	1	0%	0	0%	0	0%	0	0%
No Risks Reported (NIR/NRR)	0	0%	1	0%	0	0%	2	1%	6	2%
Total	31 0	100 %	32 7	100 %	31 8	100 %	37 7	100 %	38 2	100 %
Females										
Heterosexual contact with MSM	3	5%	3	6%	5	11%	5	9%	2	4%
Heterosexual contact with IDU male	6	10%	1	2%	2	4%	3	5%	3	5%
Heterosexual contact with MSM+IDU male	2	3%	1	2%	0	0%	1	2%	1	2%
Heterosexual contact with HIV+ male	39	62%	23	43%	13	29%	23	40%	14	25%
Heterosexual contact (no other risk identified)	7	11%	18	34%	20	44%	17	30%	28	50%
IDU only	0	0%	1	2%	1	2%	0	0%	0	0%
IDU and heterosexual contact	3	5%	2	4%	3	7%	1	2%	1	2%
IDU and heterosexual contact with IDU male	1	2%	2	4%	1	2%	3	5%	2	4%
IDU and heterosexual contact with MSM+IDU male	1	2%	0	0%	0	0%	1	2%	2	4%
Perinatal exposure	1	2%	0	0%	0	0%	2	4%	1	2%
Perinatal exposure, HIV diagnosed at age 13 years or older	0	0%	2	4%	0	0%	1	2%	1	2%
No Risks Reported (NIR/NRR)	0	0%	0	0%	0	0%	0	0%	1	2%
Total	63 56	100 %	53 53	100 %	45 45	100 %	57 57	100 %	56 56	100 %

Source: Nevada State Health Division HIV/AIDS Reporting System (eHARS), (March 2016)

Facility of New HIV Diagnosis, 2014

Facility Type	Nevada		Clark County		Washoe County		All Other Counties**	
	N	%	n	%	n	%	n	%
Facility of Diagnosis								
HIV Counseling and Testing Site	129	29%	124	32%	5	13%	0	0%
Private Physician's Office	140	32%	132	34%	7	18%	1	8%
Inpatient Facility/Hospital	72	16%	61	16%	9	23%	2	17%
Outpatient Facility (unspecified)	14	3%	6	2%	6	15%	2	17%
Adult HIV Clinic	9	2%	1	0%	7	18%	1	8%
Correctional Facility	13	3%	13	3%	0	0%	0	0%
STD Clinic	15	3%	14	4%	0	0%	1	8%
Blood Bank or Plasma Center	17	4%	15	4%	2	5%	0	0%
Emergency Room	0	0%	0	0%	0	0%	0	0%
Tuberculosis Clinic	4	1%	4	1%	0	0%	0	0%
Obstetrics and Gynecology Clinic	2	0%	0	0%	2	5%	0	0%
Facility/Other/Unknown	23	5%	16	4%	2	5%	5	42%
Total	438	100%	386	100%	40	100%	12	100%

The majority of people who were diagnosed with HIV in 2014 were diagnosed at a Private Physician's Office (32%) or and HIV counseling and testing site (29%). HIV Counseling and Testing Sites are located at community centers serving populations at high risk for HIV, and testing is conducted by local health department staff. This high proportion indicates the importance of these efforts in identifying individuals who are HIV-positive. Sixteen percent of persons were diagnosed at an inpatient facility/hospital, meaning they were admitted to a medical facility. This suggests they were fairly ill at the time of diagnosis and could have tested earlier.

Facility of HIV Stage 3 (AIDS) Diagnosis, 2014

Facility Type	Nevada		Clark County		Washoe County		All Other Counties**	
	N	%	n	%	n	%	n	%
Facility of Diagnosis								
HIV Counseling and Testing Site	48	22%	48	26%	0	0%	0	0%
Private Physician's Office	42	20%	39	21%	2	10%	1	10%
Inpatient Facility/Hospital	86	40%	71	39%	11	52%	4	40%
Outpatient Facility (unspecified)	1	0%	0	0%	0	0%	1	10%
Adult HIV Clinic	27	13%	20	11%	6	29%	1	10%
Correctional Facility	7	3%	5	3%	1	5%	1	10%
STD Clinic	0	0%	0	0%	0	0%	0	0%
Blood Bank or Plasma Center	0	0%	0	0%	0	0%	0	0%
Emergency Room	0	0%	0	0%	0	0%	0	0%
Tuberculosis Clinic	0	0%	0	0%	0	0%	0	0%
Obstetrics and Gynecology Clinic	0	0%	0	0%	0	0%	0	0%
Facility/Other/Unknown	4	2%	1	1%	1	5%	2	20%
Total	215	100%	184	100%	21	100%	10	100%

Source: Nevada State Health Division HIV/AIDS Reporting System (eHARS), (March 2016)

New HIV Diagnoses are counted in eHARS surveillance statistics and include HIV cases diagnosed in Nevada, both living and deceased. The surveillance data excludes HIV cases diagnosed in other states, but who currently live in Nevada. HIV Diagnoses may duplicate case counts if the person was diagnosed with both HIV and HIV stage 3 (AIDS) in 2014.

The majority of people who were diagnosed with HIV stage 3 (AIDS) in 2014 were diagnosed at an inpatient facility/hospital (40%) or an HIV counseling and testing site (22%), which raises several concerns. Being diagnosed with HIV stage 3 (AIDS) at an inpatient facility/hospital suggests that the individual was either diagnosed with HIV late during the course of the infection or was not receiving routine care and became very ill.

Time from HIV Infection to AIDS Diagnosis

HIV Stage 3 (AIDS) diagnosis within 12 Months of HIV diagnosis among Persons Diagnosed with HIV Diagnoses in Nevada, 2010 vs. 2014*

	2010			2014			Difference in proportion diagnosed < 12 months*
	HIV Stage 3 (AIDS) Diagnosis <12 months n	Total HIV Diagnoses N	% of Total Diagnoses %	HIV Stage 3 (AIDS) <12 months n	Total HIV Diagnoses N	% of Total Diagnoses %	
Residence at Diagnosis							
Clark County	122	338	36%	102	378	27%	-9%
Washoe County	7	25	28%	14	40	35%	7%
All Other Counties**	3	5	60%	2	4	50%	-10%
Total	132	368	36%	118	422	28%	-8%
Sex at Birth							
Male	110	307	36%	102	368	28%	-8%
Female	22	61	36%	16	54	30%	-6%
Total	132	368	36%	118	422	28%	-8%
Race/Ethnicity							
White, non-Hispanic	45	136	33%	53	153	35%	2%
Black, non-Hispanic	26	100	26%	23	101	23%	-3%
Hispanic	48	102	47%	31	133	23%	-24%
Asian/Hawaiian/Pacific Islander	10	22	45%	11	22	50%	5%
American Indian/Alaska Native	0	1	0%	0	3	0%	0%
Multi-race/other/unknown	3	7	43%	0	10	0%	-43%
Total	132	368	36%	118	422	28%	-8%
Age at Diagnosis							
< 13	0	0	0%	0	0	0%	0%
13 to 24	13	80	16%	12	97	12%	-4%
25 to 34	27	108	25%	28	146	19%	-6%
35 to 44	43	93	46%	33	80	41%	-5%
45 to 54	27	52	52%	34	73	47%	-5%
55 to 64	16	29	55%	9	23	39%	-16%
65 +	6	6	100%	2	3	67%	-33%
Total	132	368	36%	118	422	28%	-8%
Transmission Category							
Male							
MSM	91	255	36%	73	274	27%	-9%
IDU	3	14	21%	5	13	38%	17%
MSM+IDU	6	19	32%	5	25	20%	-12%
Heterosexual contact	3	5	60%	2	12	17%	-43%
Perinatal exposure	0	0	0%	0	0	0%	0%
Transfusion/Hemophilia	0	0	0%	0	0	0%	0%
NIR/NRR	7	14	50%	17	44	39%	-11%
Subtotal	110	307	36%	102	368	28%	-8%
Female							
IDU	1	5	20%	0	5	0%	-20%
Heterosexual contact	19	49	39%	3	20	15%	-24%
Perinatal exposure	0	0	0%	0	1	0%	0%
Transfusion/Hemophilia	0	0	0%	0	0	0%	0%
NIR/NRR	2	7	29%	13	28	46%	18%
Subtotal	22	61	36%	16	54	30%	-6%
Total	132	368	36%	118	422	28%	-8%

Only persons who were informed of their HIV infection were included in this table.

*Difference in proportion was calculated as the proportion of persons in 2010 with a diagnosis of HIV Stage 3 (AIDS) within 12 months of their HIV diagnosis subtracted from the proportion of persons in 2014 with a diagnosis of HIV Stage 3 (AIDS) within 12 months of their HIV diagnosis.

Having a diagnosis of HIV and HIV stage 3 (AIDS) within a 12-month period is commonly considered to be a marker for a late HIV diagnosis and late HIV testing. However, recent research suggests that using this measurement alone may misclassify individuals as late testers.¹⁸ Thus, when reviewing these data, it is important to consider the full range of factors that could cause a short time interval from HIV to HIV stage 3 (AIDS) diagnosis.

In this analysis, only individuals who were diagnosed with HIV in Nevada and informed of their HIV status were included. Based on CD4 lab data from eHARS (HIV stage 3 (AIDS) is typically diagnosed when an HIV-positive individual's CD4 count is less than 200 cells/ μ L of blood or CD4 percent is less than 14), HIV stage 3 (AIDS) diagnosis information was complete for a majority of these individuals. In 2014, 96% of persons had a CD4 lab within 12 months of their HIV diagnosis, and in 2010, 99% of persons had a CD4 lab within 12 months of their HIV diagnosis. However, CD4 counts greater than 500 cells/ μ L of blood do not have to be reported, so some lab results may have been missing.

In 2014, of the 422 individuals who were newly diagnosed with HIV and had been informed of their status, 28% were diagnosed with HIV stage 3 (AIDS) within 12 months of their HIV Diagnosis. From 2010 to 2014, there was a decrease of 8 percentage points in the proportion of late diagnoses.

The all other counties region had the highest proportion of persons with a late diagnosis (50%) in 2014, and this proportion has decreased by 10 percentage points since 2010. In 2014, Clark County had the lowest proportion of late diagnoses (27%), and this proportion decreased by 9 percentage points from 2010 to 2014.

In 2014, a greater proportion of females had a late diagnosis compared to males (30% vs. 28%). From 2010 to 2014, the proportion of late diagnoses points among female's increased 6 percentage points whereas males decreased 8 percentage points.

In terms of race/ethnicity, the highest proportion of late diagnoses occurred among persons who identified as API (50%), White (35%), Hispanic (23%) and Black (23%) in 2014. Hispanics were the only race/ethnicity group to experience a large decrease. The proportion of late diagnoses among Hispanics decreased by 24 percentage points from 2010 to 2014.

With regard to age, the proportion of late diagnoses was much higher in older age groups, with the highest proportions among those over 65 years of age (67%) and 45 to 54 year olds (47%). From 2010 to 2014, all groups had a percentage decrease of those converting to stage 3 (AIDS) within 12 months. Those over 65 years of age experienced the greatest decrease in proportion of late diagnoses, from 100% in 2010 to 67% in 2014.

Among males, individuals with a transmission category of NIR/NRR had the highest proportion of late diagnoses (39%) followed by IDU (38%). The proportion of NIR/NRR who had a late diagnosis decreased 11 percentage points from 2010 to 2014. IDU is the only transmission category to have an increase from 21% in 2010 to 38% in 2014. Males who had a transmission category of Heterosexual contact had the lowest proportion for a reported transmission category of late diagnoses (17%), and there was a 43 percentage point decrease in this proportion from 2010 to 2014.

Among females, individuals with a transmission category of NIR/NRR had the highest proportion of late diagnoses (46%), followed by individuals who had Heterosexual contact (15%).

Survival for more than 12, 24, and 36 months after a diagnosis of HIV Stage 3 (AIDS) in Nevada during 2008-2012 by selected characteristics

	Number of Persons	Proportion Survived (in months)		
		>12	>24	>36
Residence at AIDS Diagnosis				
Clark County	1,044	87%	84%	82%
Washoe County	92	77%	77%	76%
All Other counties*	38	89%	87%	87%
Total	1,174	86%	83%	81%
Sex at Birth				
Male	973	87%	84%	82%
Female	201	86%	81%	79%
Total	1,174	86%	83%	81%
Race/Ethnicity				
White, non-Hispanic	458	86%	82%	81%
Black, non-Hispanic	324	87%	84%	81%
Hispanic	312	87%	85%	83%
Asian/Hawaiian/Pacific Islander	51	84%	84%	84%
American Indian/Alaska Native	10	80%	80%	80%
Multi-race/Other	19	84%	79%	74%
Total	1,174	86%	83%	81%
Age at AIDS Diagnosis				
< 13	0	0%	0%	0%
13 to 24	92	97%	95%	93%
25 to 34	286	91%	90%	88%
35 to 44	359	86%	85%	83%
45 to 54	303	87%	82%	80%
55 to 64	111	74%	66%	61%
65 +	23	52%	48%	43%
Total	1,174	86%	83%	81%
Transmission Category				
Male				
MSM	736	86%	84%	81%
IDU	67	88%	85%	84%
MSM+IDU	63	90%	87%	84%
Heterosexual Contact	40	90%	88%	85%
Perinatal Exposure	6	0%	0%	0%
Hemophilia/Blood Transfusion	1	0%	0%	0%
NIR/NRR	60	78%	78%	78%
Subtotal	973	87%	84%	82%
Female				
IDU	33	82%	79%	76%
Heterosexual Contact	128	88%	83%	81%
Perinatal Exposure	3	0%	0%	0%
Hemophilia/Blood Transfusion	0	0%	0%	0%
NIR/NRR	37	78%	73%	73%
Subtotal	201	86%	81%	79%
Year of AIDS Diagnosis				
2008	280	85%	83%	81%
2009	228	89%	86%	82%
2010	226	85%	82%	81%
2011	225	87%	84%	82%
2012	215	85%	82%	81%
Total	1,174	86%	83%	81%

In this analysis of survival after an HIV stage 3 (AIDS) diagnosis, only persons who were diagnosed with HIV stage 3 (AIDS) in Nevada in 2008-2012 and had a current Nevada residence as of March 2016 were included.

Overall, 86% of persons living with HIV stage 3 (AIDS) in Nevada survived more than 12 months after their HIV stage 3 (AIDS) diagnosis. The proportion surviving more than 36 months was 81%, only 5% less than the proportion surviving more than 12 months.

From 2008 to 2012, there was little change in survival for more than 12, 24, and 36 months.

Between Clark, Washoe, and all other counties, differences in the proportion surviving were very small. The all other counties region had the greatest proportion of persons surviving 36 months or more (87%).

In Nevada as a whole, the proportion of males surviving more than 36 months was similar to that of females. Gender differences were small with regard to survival for more than 12 months and more than 24 months.

AI/AN had the lowest proportion of persons surviving more than 12 months after an HIV stage 3 (AIDS) diagnosis (80%), followed by API (84%). Hispanics had the highest proportion surviving more than 12 months (87%) followed by Blacks (87%).

As age increased, the proportion of persons surviving more than 12 months decreased. Persons 55 to 64 years old and persons 65 had the lowest proportions of persons surviving more than 12 months (74% and 52%, respectively).

Among males, persons with a transmission category of injection drug use NIR/NRR had the lowest proportion of persons surviving more than 12 months (78%).

Among females, persons with a transmission category of Heterosexual contact had the highest proportion surviving more than 12 months (88%). However, the overall proportion of females surviving more than 36 months was only 79%.

APPENDIX C: JURISDICTIONAL HIV RESOURCES INVENTORY

Jurisdictional HIV Resources Inventory

Funding source	Funding Amount FY16	Funded Service Provider Agencies	Services Delivered	Which HIV Care Continuum Step(s) or Component(s) of HIV Prevention Impacted
Ryan White Part A (Las Vegas/Clark County TGA)	\$4,727,707.65			
	\$612,108.31	Aid for AIDS of Nevada (AFAN)	Medical case management, emergency financial assistance, medical nutrition therapy	Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$305,348.20	AIDS Healthcare Foundation	Medical case management, outpatient/ambulatory medical care, early intervention services	HIV-Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$341,047.84	Community Counseling Center	Medical case management, substance abuse and mental health services	Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$30,000.00	Clark County Social Service	Health Insurance Continuation Program (Co-pays for Physician and Lab visits)	Retained in Care; Viral Load Suppression
	\$391,611.80	Community Outreach Medical Center	Medical case management; outpatient/ambulatory medical care; emergency financial assistance; medical nutrition therapy; medical transportation; food bank/home delivered meals; health education/risk reduction; psychosocial support services	HIV-Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$35,000.00	Firstmed Health and Wellness	Outpatient & ambulatory health	HIV-Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$180,939.53	Golden Rainbow	Emergency financial assistance; housing assistance	Retained in Care;
	\$116,777.08	Horizon Ridge Clinic	Medical case management; mental health; substance abuse outpatient; psychosocial support services	Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression

Funding source	Funding Amount FY16	Funded Service Provider Agencies	Services Delivered	Which HIV Care Continuum Step(s) or Component(s) of HIV Prevention Impacted
	\$188,000.00	North Country Health Center	Outpatient ambulatory medical care; oral healthcare; health insurance continuation program; mental health; medical nutrition therapy; medical case management; emergency financial assistance; food bank/home delivered meals; medical transportation; psychosocial support services	HIV-Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$119,277.08	Nye County Health and Human Services	Medical case management; medical transportation assistance; food bank/home delivered meals; emergency financial assistance	Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$1,360,000.00	Southern Nevada Health District Sexual Health Clinic	Medical case management; outpatient/ambulatory medical care; early intervention services; substance abuse; emergency financial assistance	HIV-Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$892,212.43	UMC Wellness Center	Medical case management; outpatient/ambulatory medical care; oral health care; mental health	HIV-Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$155,385.38	UNLV School of Dental Medicine	Oral healthcare	Retained in Care;
Ryan White Part B (Nevada Department of Health and Human Services)	\$4,847,857.00			
	\$78,208.00	Access for Community & Cultural Education Programs & Training (ACCEPT)	Health Education/Risk Reduction	Linkage to Care; Retained in Care
	\$1,670,956.00	Access to Healthcare	Health Ins Premium Cost Sharing; Oral Health Care;	HIV-Diagnosed; Linkage to Care; Retained in Care;

Funding source	Funding Amount FY16	Funded Service Provider Agencies	Services Delivered	Which HIV Care Continuum Step(s) or Component(s) of HIV Prevention Impacted
		Network (AHN)	Medical Transportation; Referral Healthcare	Antiretroviral Use; Viral Load Suppression
	\$149,796.00	Aid for AIDS of Nevada (AFAN)	Referral Healthcare; Health Education/Risk Reduction	Linked to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$279,857.00	CARE Coalition	Non-medical Case Management	Linkage to Care; Retained in Care
	\$124,694.00	Community Counseling Center (CCC)	Health Education/Risk Reduction	HIV-Diagnosed; Linked to Care; Retained in Care
	\$104,821.00	Carson City Health & Human Services (CCHHS)	Health Education/Risk Reduction	HIV-Diagnosed; Linked to Care; Retained in Care
	\$146,930.00	Community Outreach Medical Center (COMC)	Outpatient & ambulatory health	HIV-Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$140,333.00	Dignity Health	Health Education/Risk Reduction	HIV-Diagnosed; Linked to Care; Retained in Care
	\$270,503.00	Las Vegas Urban League (LVUL)	Early Intervention Services	HIV-Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$128,920.00	Southern Nevada AIDS Research & Education Society (NARES)	Medical Case Management; Medical Nutrition	Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$80,780.00	Nevada Legal Services	Legal Services	Linkage to Care; Retained in Care
	\$585,250.00	Northern Nevada HOPES	Mental Health; Medical Case Management; Substance Abuse; Non-Medical Case Management; Housing; Medical Transportation; Psychosocial; Referral	Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$39,634.00	Ridge House	Substance Abuse	Linkage to Care; Retained in Care; Antiretroviral

Funding source	Funding Amount FY16	Funded Service Provider Agencies	Services Delivered	Which HIV Care Continuum Step(s) or Component(s) of HIV Prevention Impacted
				Use; Viral Load Suppression
	\$675,840.00	Southern Nevada Health District	Early Intervention Services; Medical Case Management; Referral Healthcare	HIV-Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$120,105.00	The Center	Health Education/Risk Reduction	HIV-Diagnosed; Linked to Care; Retained in Care
	\$143,902.00	University Medical Center (UMC)	Mental Health	Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$107,328.00	Washoe County Health District	Early Intervention Services	HIV-Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
Ryan White Part C: Community-Based Early Intervention	\$669,117.00	Northern Nevada HOPES	outpatient/ambulatory medical care; dental care; vision care; psychiatric care; specialty referrals	HIV-Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$875,172.00	University Medical Center of Southern Nevada	outpatient/ambulatory medical care; dental care; vision care; psychiatric care; specialty referrals	HIV-Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
Ryan White Part D: Women, Infants, Children, Youth	\$429,900.00	Northern Nevada HOPES	HIV/AIDS medical care, pediatric services birth-21 years old; HIV/AIDS services for women including pregnancy consultations, prenatal care, specialty referrals	Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
	\$210,993.00	University Nevada Reno, School of Medicine	HIV/AIDS medical care, pediatric services birth-21 years old; HIV/AIDS services for women including pregnancy consultations, prenatal care, specialty referrals	Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
Ryan White Part F: AIDS Education & Training Centers (AETC)	\$185,045.00	Nevada AETC, University of Nevada School of Medicine	Practice Transformation, education and support services regarding HIV clinical care to providers in Nevada	Testing, linkage to care, retention in care

Funding source	Funding Amount FY16	Funded Service Provider Agencies	Services Delivered	Which HIV Care Continuum Step(s) or Component(s) of HIV Prevention Impacted
CDC HIV Prevention & Surveillance Programs	\$1,645,582.00	Southern Nevada Health District; Washoe County Health District; Carson City Health & Human Services	Counseling, testing & referral; health communication & public information; Individual level intervention; partner services	HIV Testing; Effective Behavioral Interventions; comprehensive risk counseling & services; condom distribution; comprehensive programs; prevention with persons with HIV; HIV Diagnosed; Linked to Care
Minority AIDS Initiative (MAI)				
MAI Part A	\$115,651.80	AIDS Healthcare Foundation	Outpatient Ambulatory medical care; medical case management	HIV-Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
MAI Part A	\$276,388.20	Community Outreach Medical Center	Outpatient Ambulatory medical care; medical case management	HIV-Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression
SAMHSA	\$850,000.00	Substance Abuse Providers	Early Intervention Services	HIV-Diagnosed; Linkage to Care; Retained in Care
HUD/HOPWA NN	\$253,362.00	Northern Nevada HOPES	Housing Assistance; Access to Healthcare	Linkage to Care; Retained in Care
HUD/HOPWA SNV	\$1,139,472.00			
	\$608,671.00	AFAN	STRMU, TBRA, Supp. Svcs., Housing, Permanent Housing Placement	Retained in Care
	\$200,000.00	Golden Rainbow	Supp. Svcs., Housing, Permanent Housing Placement.	Retained in Care
	\$50,000.00	Community Counseling	Supportive Svcs. (Counseling)	Retained in Care
	\$151,307.00	Women's Dev. Center	Supp. Svcs. Housing (rental assistance)	Retained in Care
Medicaid	\$31,400,847.13	This represents the net cost to the state for all Fee For Service claims after all adjustments and third party liability (TPL) for everyone diagnosed with 042 or V08 in the 10/1/2014-9/30/2015 time period.		HIV-Diagnosed; Linkage to Care; Retained in Care; Antiretroviral Use; Viral Load Suppression

APPENDIX D: STAKEHOLDER MEETING REPRESENTATIVES

HIV PREVENTION/RYAN WHITE PROVIDER ENGAGEMENT MEETING April 1, 2015 Reno
Agencies Represented
Northern NV HIV Prevention Planning Group
Carson City Health & Human Services
University of Nevada- Reno School of Community Health Sciences
Carson City Health & Human Services
Washoe County Health District
Access to Healthcare Network
Northern Nevada Hopes
Nevada AIDS Education and Training Center (AETC)

HIV PREVENTION/RYAN WHITE CARE PROVIDER ENGAGEMENT MEETING April 3, 2015 Las Vegas
Agencies Represented
Clark County Social Services- Ryan White Part A Program
Aid For AIDS of Nevada (AFAN)
Vanatter Consulting
Horizon Ridge Mental Health
Southern Nevada Health District (SNHD)
WISH
Golden Rainbow
Member of HIV Prevention Planning Group of Southern NV
The Gay and Lesbian Center of Las Vegas
RAGE
Planned Parenthood Rocky Mountains (PPRM)
University of Nevada- Las Vegas
UMC of SO NV – Wellness
HIV Prevention Planning Group of Northern Nevada
University of Nevada- Reno School of Community Health Sciences
Nevada AIDS Education and Training Center (AETC)

HIV PREVENTION/RYAN WHITE CARE STAKEHOLDER MEETING March 11, 2016 Las Vegas	
Agencies Represented	
Access to Healthcare Network	
Aid For AIDS of Nevada (AFAN)	
AIDS Healthcare Foundation	
CARE Coalition	
Community Counseling Center of Southern Nevada	
Community Outreach Medical Center	
FirstMed Health & Wellness Center	
HIV/AIDS Office Division of Public and Behavioral Health	
Horizon Ridge Clinic LLC	
Las Vegas Urban League	
Nevada AIDS Education and Training Center (AETC)	
Nevada AIDS Research and Education Society (NARES)	
Northern Nevada HIV Prevention Planning Group	
Northern Nevada HOPES	
Nye County Health & Human Services	
Persons Living With HIV	
Planned Parenthood of Southern Nevada	
Ryan White HIV/AIDS Part A Program	
Ryan White Part A Planning Council	
School of Community Health Sciences, University of Nevada, Reno	
Southern Nevada Health District	
Southern Nevada Regional HIV Community Planning Group	
The Gay & Lesbian Center	
UMC Wellness Center	

APPENDIX E: LAS VEGAS TGA NEEDS ASSESSMENT AND CUSTOMER SATISFACTION REPORTS

The reports for the Las Vegas TGA Ryan White Part A HIV/AIDS Program needs assessments and consumer satisfaction project that are referred to in this document can be accessed at the following links.

Comprehensive HIV/AIDS Needs Assessment 2014, Las Vegas TGA Ryan White Part A HIV/AIDS Program
<http://www.lasvegasema.org/assets/lvtgarwpartacomprehensiveneedsassessment2014.pdf>

Ryan White Consumer Satisfaction Project Grant Year 2014-2015, Las Vegas TGA Ryan White Part A HIV/AIDS Program
<http://lasvegasema.org/assets/consumer-satisfaction-survey-report-2014-2015.pdf>

Targeted Needs Assessment Pathways to Care, Ryan White Part A HIV/AIDS Program of the Las Vegas TGA Grant Year 2014-2015
<http://lasvegasema.org/assets/targeted-needs-assessment-report-2015.pdf>

APPENDIX F: CLIENT SURVEY

HIV SERVICES CLIENT SURVEY 2016

If you are HIV positive, we need your help! Thank you for filling out this survey that will help improve HIV care and prevention in Nevada.
(The survey is also online <https://www.surveymonkey.com/s/NVHIVclient15> or scan the QR code.)



1. How old were you when you were diagnosed with HIV? ____ years (If you are not HIV positive, please stop taking the survey.)
2. After you were diagnosed with HIV, how long did it take before you first saw a doctor? (Check one answer)

☐ I got into care immediately	☐ 4-6 months	☐ I have not seen a doctor since my diagnosis
☐ Less than a month	☐ More than 6 months	☐ Don't remember
☐ 1-3 months		
3. What problems did you have getting into a doctor's office after your diagnosis? (Check all that apply)

☐ I didn't have any problems	☐ I didn't feel sick
☐ I didn't know where to go	☐ I didn't have child care
☐ The wait time was too long	☐ I didn't want to go alone
☐ I couldn't get an appointment	☐ I didn't want to think about having HIV
☐ They didn't have a time that worked with my schedule	☐ I was too nervous to see a doctor
☐ I didn't have a way to get to the appointment	☐ I didn't want anyone to know I have HIV
☐ I didn't want to see a doctor right away	☐ Other (please specify): _____
4. Please check all the services you are using now or have used this year:

☐ Medical care	☐ Transportation	☐ Child care
☐ Help paying for medicines	☐ Mental health care	☐ Case Management
☐ Help understanding medicines and how to take them	☐ Help filling out forms	☐ HIV and health classes
☐ Help getting food	☐ Specialty doctors	☐ Free condoms
☐ Dental care	☐ Therapy (occupational, speech, physical)	☐ Home health care
☐ Help getting health insurance	☐ Nutrition help	☐ Legal help
☐ Vision care	☐ Referrals to get other health care or services	☐ Support groups
☐ Financial help	☐ Interpretation or translation into my language	☐ Other (please specify): _____
	☐ Help getting off drugs or alcohol	
5. What services do you need that you don't get? (Check all that apply)

☐ Medical care	☐ Transportation	☐ Child care
☐ Help paying for medicines	☐ Mental health care	☐ Case Management
☐ Help understanding medicines and how to take them	☐ Help filling out forms	☐ HIV and health classes
☐ Help getting food	☐ Specialty doctors	☐ Free condoms
☐ Dental care	☐ Therapy (occupational, speech, physical)	☐ Home health care
☐ Help getting health insurance	☐ Nutrition help	☐ Legal help
☐ Vision care	☐ Referrals to get other health care or services	☐ Support groups
☐ Financial help	☐ Interpretation or translation into my language	☐ Other (please specify): _____
	☐ Help getting off drugs or alcohol	
6. Why don't you get them? (Check all that apply)

☐ I don't know where to go	☐ I have other things on my mind
☐ I can't get an appointment	☐ Services not available
☐ I don't have transportation	☐ Services not available near me
☐ I don't have child care	☐ Services not available in my language
☐ Services cost too much	☐ Providers did not respect me
☐ Services not covered by insurance	☐ Long wait lists
☐ It takes too much time	☐ I didn't want anyone to know I was HIV positive
☐ I don't qualify for the services	☐ Does not apply/I get all the services I need
☐ Eligibility process is too hard	☐ Other (please describe): _____

Continue survey on other side →

7. Have you ever stopped taking your HIV medicines in the last two years?

- ☐ I don't take HIV meds
☐ No
☐ Yes ↓

8. If yes, why did you stop taking them? (check all that apply)

- | | |
|--|---|
| ☐ Couldn't afford them | ☐ I was on a break from taking HIV meds, directed by my doctor |
| ☐ They made me feel really bad | ☐ I was on a break from taking HIV meds, decided by myself |
| ☐ Insurance stopped covering it | ☐ Other (please describe): _____ |
| ☐ Lost my insurance | |
| ☐ Changed my insurance | |
| ☐ I missed a doctor's visit | |
| ☐ I felt healthy | |

9. What do you do to prevent your sex partner(s) from getting HIV? (Check all that apply).

- ☐ Use condoms
☐ Take my HIV medicines regularly
☐ Partner takes PrEP (Pre-exposure prophylaxis/HIV prevention medication)
☐ (If inject drugs), I do not share needles, syringes or other drug equipment with partner
☐ My partner is HIV positive
☐ Does not apply—I do not have sexual partners.
☐ Other (please describe): _____

10. How many people do you know who are HIV+ and not using any HIV services? _____

11. Why do you think they aren't using any services?

12. How could HIV/AIDS care services be improved in Nevada?

13. Please tell us a little bit about yourself.

Gender:

- ☐ Female
☐ Male
☐ Transgender

How old are you?

_____ years

Which race/ethnicity best describes you? (check all that apply)

- ☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino/a
☐ Native Hawaiian or Pacific Islander
☐ White or Caucasian
☐ Other (please specify) _____

Sexual Orientation:

- ☐ Gay/homosexual
☐ Lesbian/homosexual
☐ Bisexual
☐ Straight/heterosexual
☐ Other (please specify) _____

Zip code where you live:

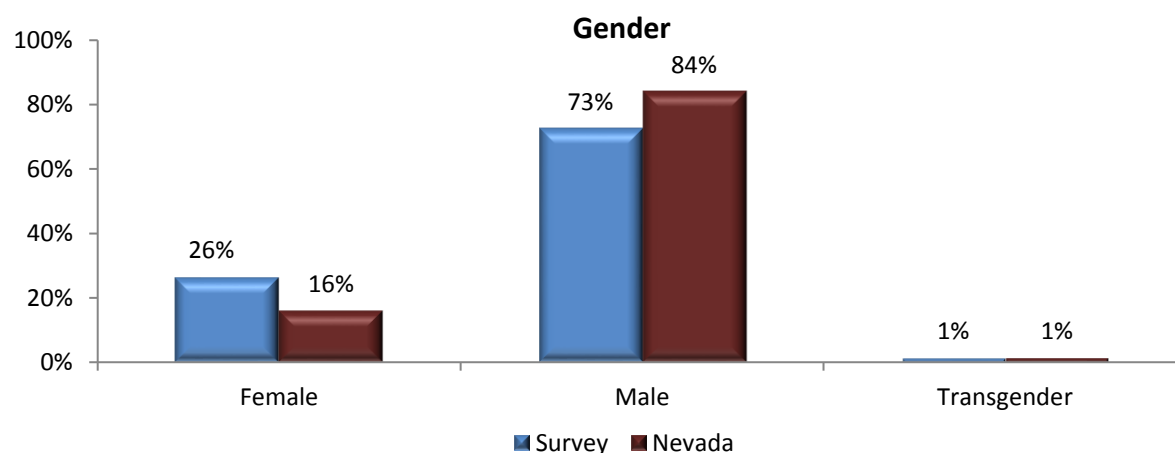
Thank you very much for your time!

APPENDIX G: SUMMARY OF CLIENT SURVEY RESULTS

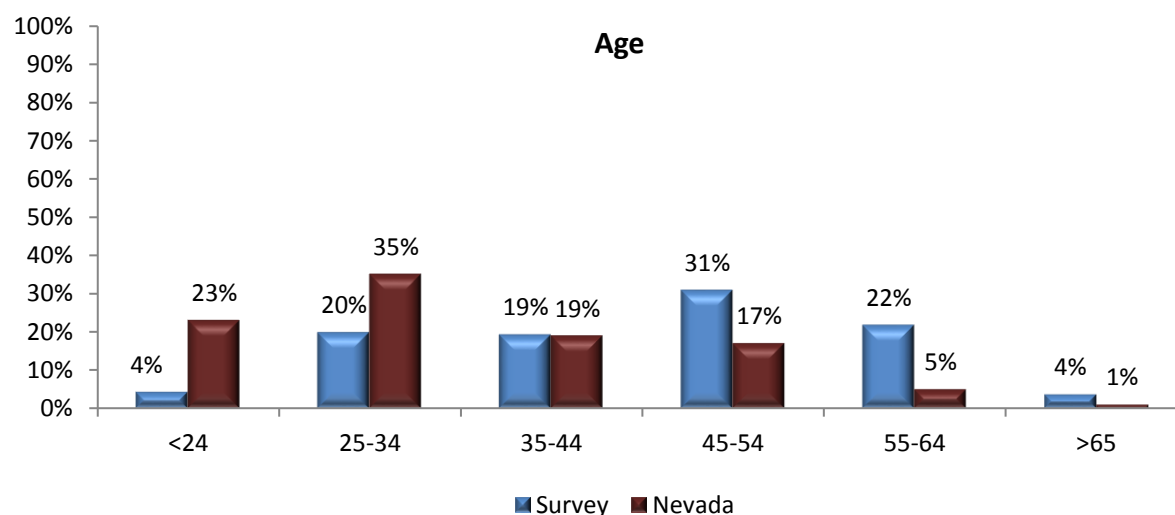
Summary of SCSN Client Survey Results (2015-2016)

The SCSN Client Survey was completed by 177 PLWH between January and March 2016. While the survey was available online, most respondents completed the survey on paper at a service provider site. The survey was available in both English and Spanish.

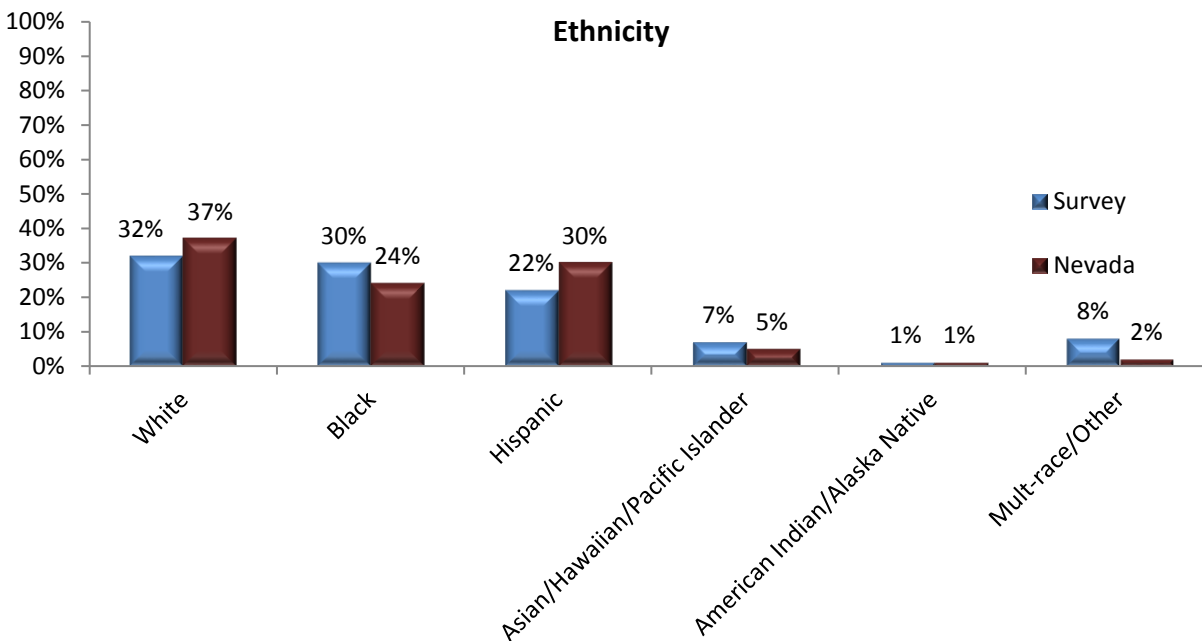
Demographic characteristics of the SCSN Client Survey are compared to the 2014 Nevada HIV/AIDS Surveillance data for PLWH. The majority of client survey respondents were male, as is the case in Nevada PLWH. However, the survey had slightly higher representation of females than found in Nevada.



The mean age of survey respondents was 45 years. The survey sample was somewhat older than PLWH in Nevada. Higher percentages of survey respondents were 45 years and older and fewer were under 35 years, compared to Nevada statistics.

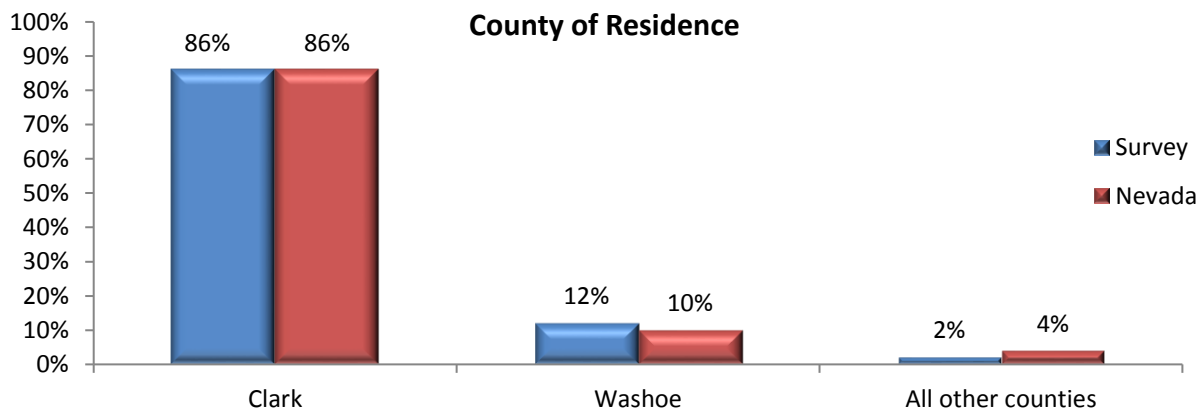


Client survey respondents were generally representative of PLWH in Nevada; however, Hispanics were underrepresented in the sample (sample = 22%; Nevada = 30%), while multi-race and blacks were slightly overrepresented.



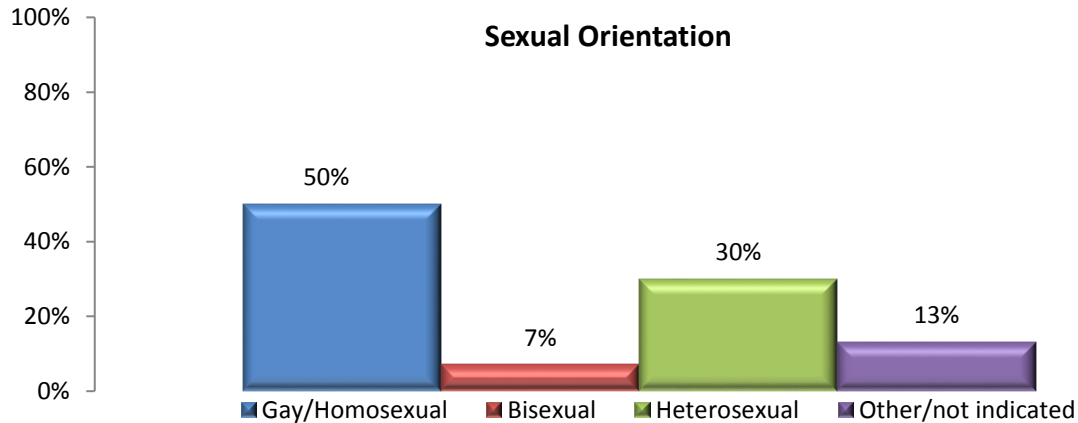
Residence

Respondents were asked to provide their zip code of residence which was then coded into Clark County, Washoe County and all other Nevada counties. The distribution of the survey respondents closely matches the Nevada statistics for PLWH, with most respondents residing in Clark County (86%). The number of respondents from all other counties was very low.



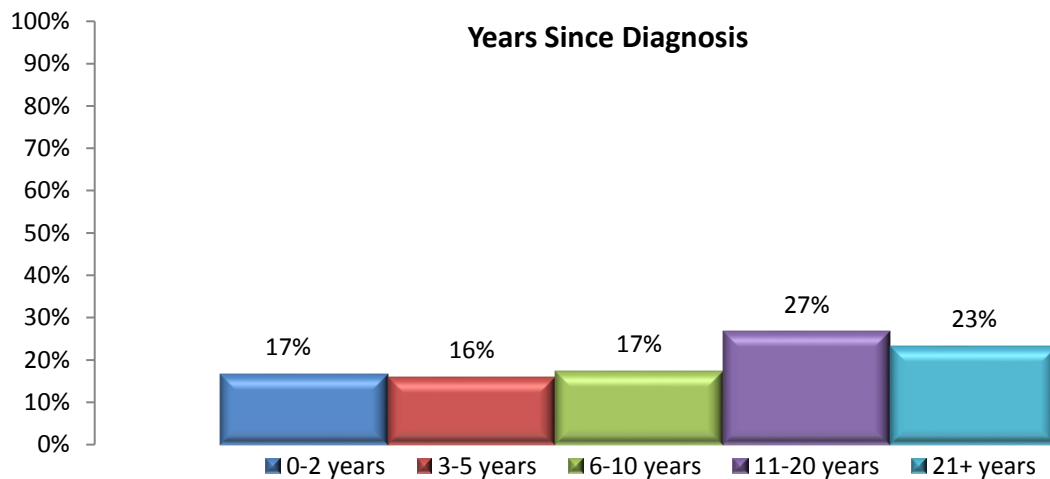
Sexual Orientation

Half the sample identified as gay/homosexual; 30% heterosexual; 7% bisexual and the remaining 13% as other or they did not indicate sexual orientation.



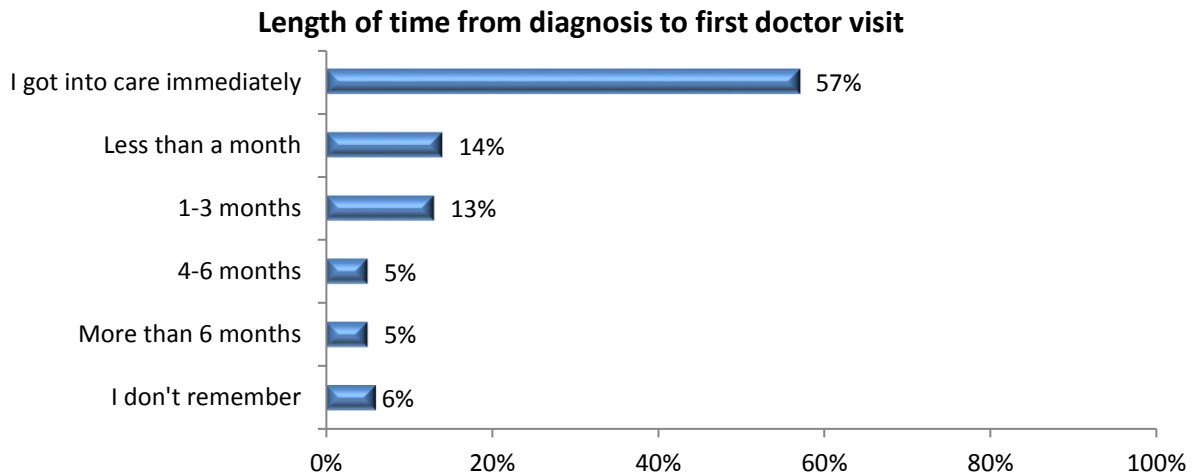
Years since diagnosis

The mean age survey respondents were diagnosed with HIV was 31 years. The majority of respondents had received their diagnosis more than six years ago (67%); 16% received their diagnosis from 3-5 years ago; while 17% had received it within the past two years.



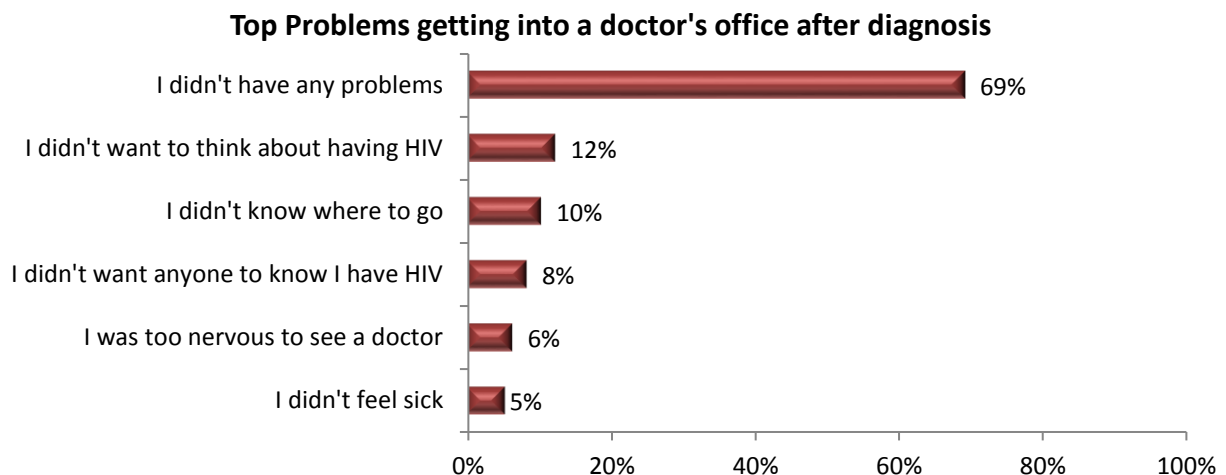
Length of time from diagnosis to first doctor visit

The majority of clients indicated that they had gotten into care immediately following their diagnosis with HIV (57%); and another 14% indicated that they had seen a doctor less than a month after diagnosis. Five percent of respondents indicated it took more than six months until their first doctor visit. There were no differences in the amount of time by ethnicity or county.



Barriers to Getting Into Care after Diagnosis

The majority of client respondents indicated they didn't have any problems getting into a doctor's office after diagnosis. The top problems reported by respondents included not wanting to think about having HIV, not knowing where to go, and not wanting anyone to know they had HIV.

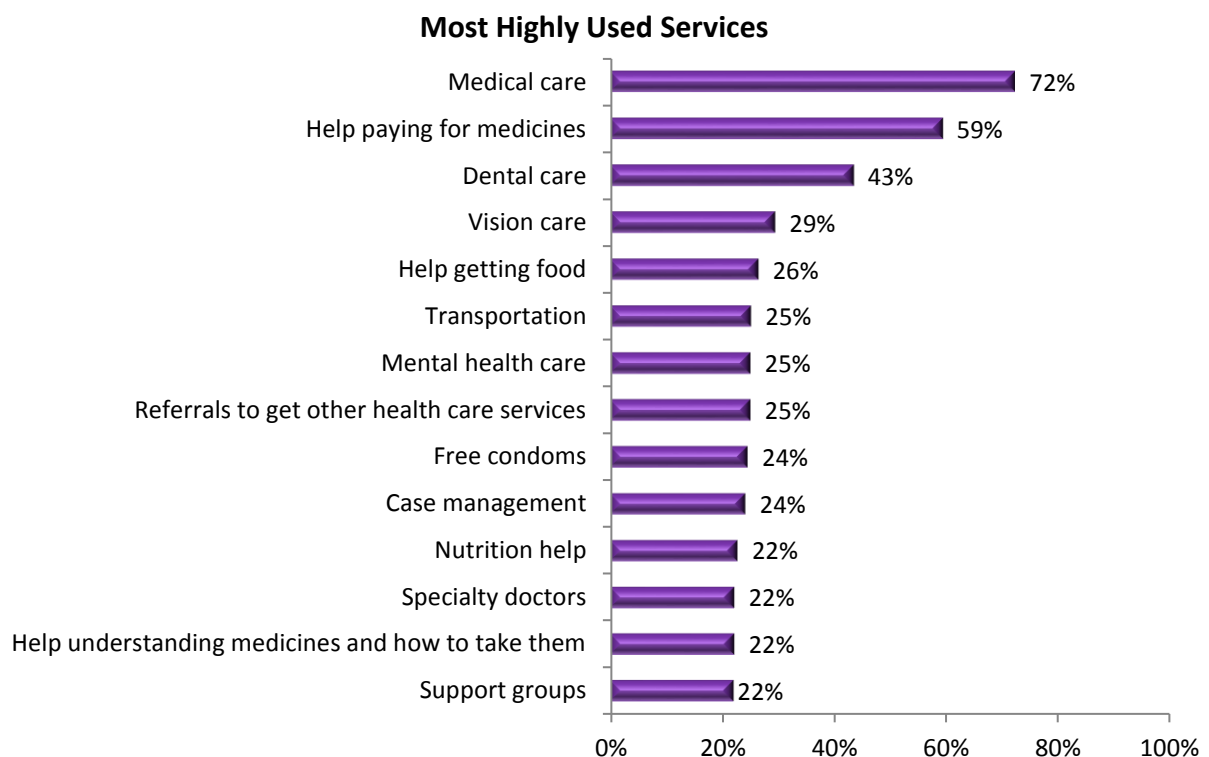


Differences in Barriers to getting care after diagnosis by Ethnicity

- Hispanic clients were more likely than clients of other ethnicities to indicate that they didn't feel sick
- Hispanic clients were more likely than clients of other ethnicities to indicate that they were too nervous to see a doctor

Most Highly Used Services

Respondents reported using from 0 to 18 services, with a mean of five services used. Medical care was the most frequently used service, followed by help paying for medicines, and dental care. Other frequently used services included vision care, help getting food, transportation, mental health care, and referrals to get other health care services. Differences were not found between clients in Clark and Washoe counties with respect to types of services used. Some differences in types of services used were found among different ethnicities.



Differences in Types of Services Used by Ethnicity

	Total Sample	Black	Hispanic	White	Multi-race/Other
Medical care	72%	60%	69%	86%	76%
Help paying for medicines	59%	47%	71%	67%	72%
Help understanding medicines and how to take them	21%	26%	20%	13%	43%
Mental health care	24%	30%	6%	33%	36%
Help filling out forms	7%	4%	17%	4%	8%
Specialty doctors	21%	26%	11%	23%	44%
Referrals to get other health care or services	24%	26%	23%	17%	52%
Case management	22%	26%	6%	28%	44%

Orange highlighted cells indicates ethnicity had lower usage

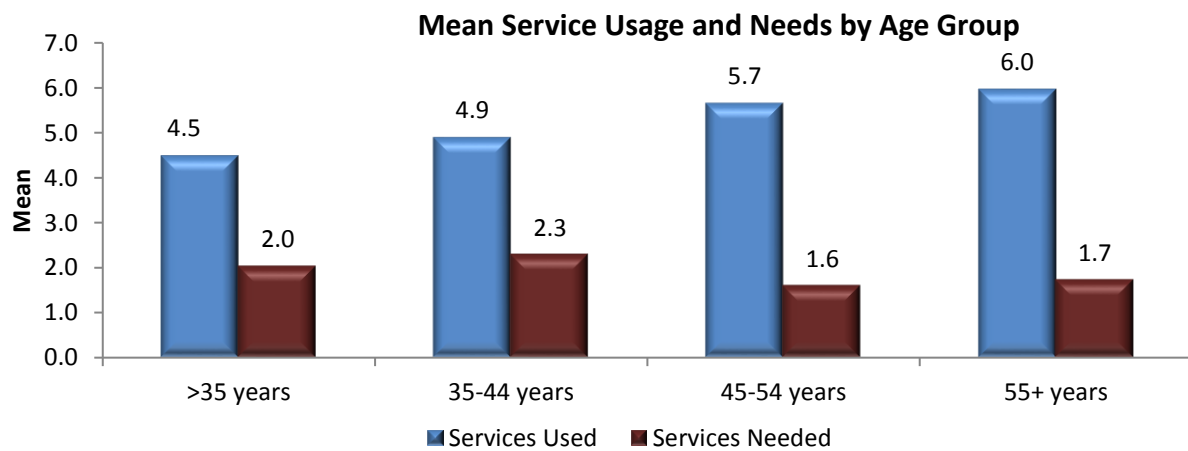
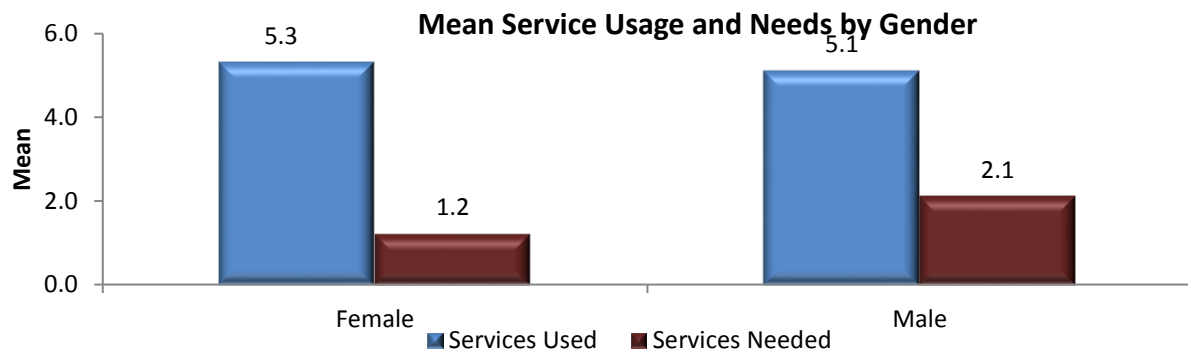
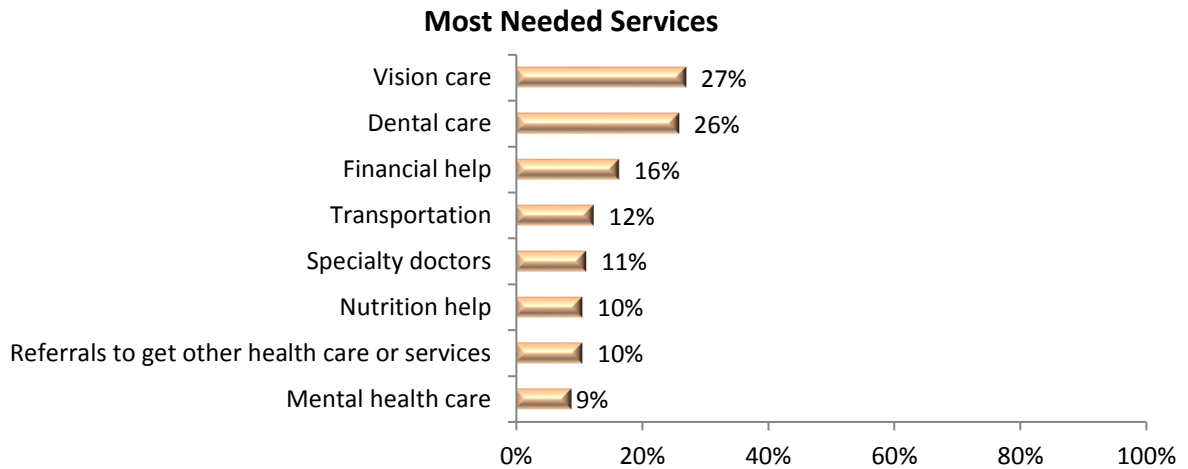
Green highlighted cells indicate ethnicity had higher usage

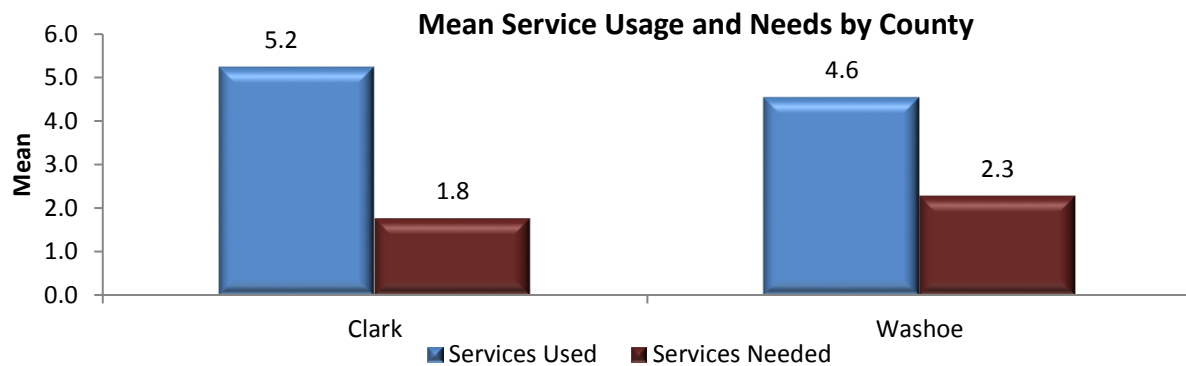
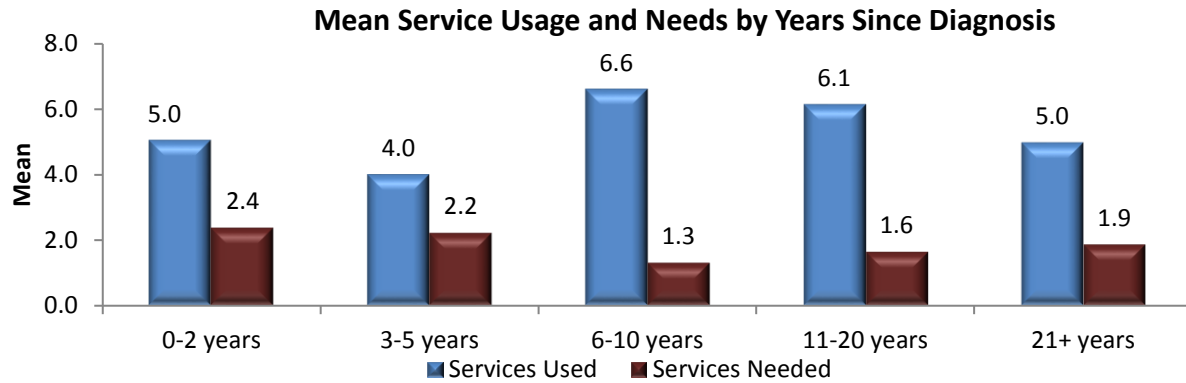
- Fewer black clients than white clients were using medical care
- Fewer black clients than were using help paying for medicines
- More multi-racial/other ethnicity clients were using help understanding medicines and how to take them.
- Fewer Hispanic clients were using mental health care
- More Hispanic clients were using help filling out forms
- More multi-racial/other ethnicity clients were using specialty doctors
- More multi-racial/other ethnicity clients were using referrals to get other health care or services
- Fewer Hispanic clients were using case management services

Most Needed Services

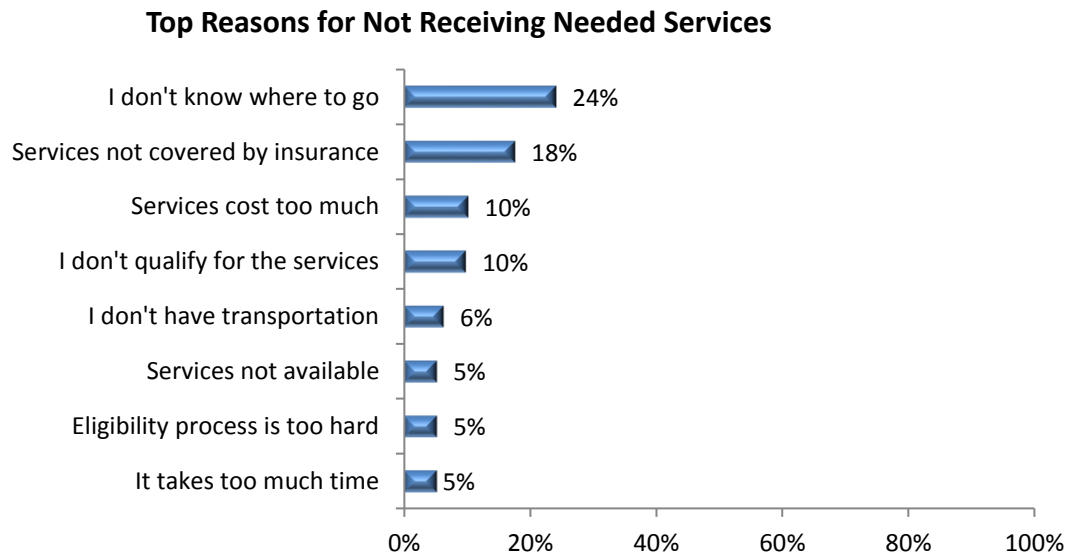
The most needed services that clients were not receiving included vision care, dental care, financial help and transportation. A higher percentage of clients in Washoe County reported needing medical care than those in Clark County. There were no differences in types of services clients indicated needing by ethnicity.

The mean number of services clients reporting needing but not receiving was two with a range from 0 to 16 services needed. Male respondents reported needing more services ($M=2.1$) than female respondents ($M=1.2$). The mean number of services used rose among clients along with age; however, younger clients reported lacking slightly more services than older clients. Respondents in Clark County reported the highest usage of services, while Washoe County respondents reported slightly higher needs than Clark County. Clients who had been diagnosed in the past five years had the highest number of needed services, while clients who had been diagnosed between 6 and 20 years had the highest usage of services. Mean usage of services and number of needed services was similar across ethnicities.

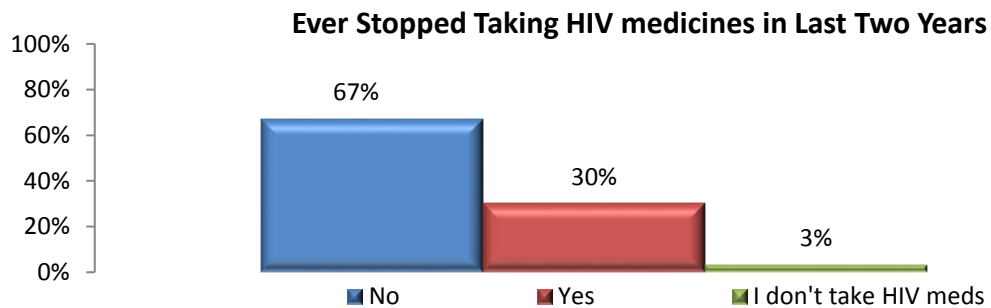




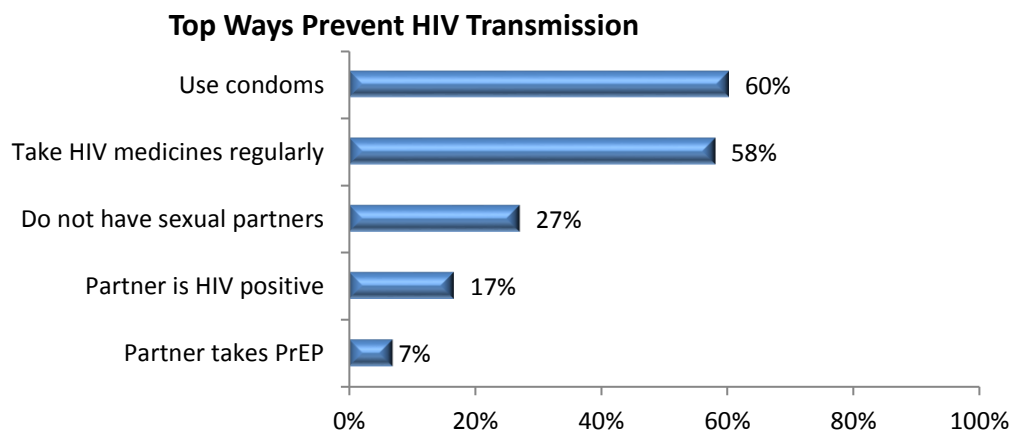
The most frequently mentioned reasons for clients not receiving services they need included not knowing where to go, services not covered by insurance, services cost too much, and not qualifying for services. There were no differences in reasons by county or ethnicity.



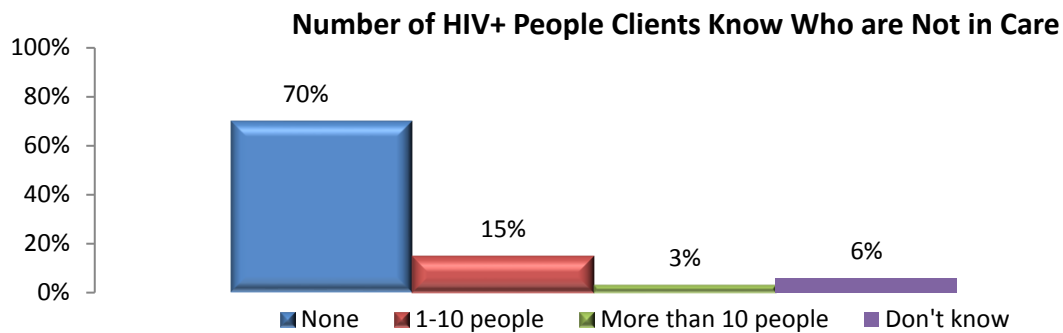
The majority of clients (67%) had not stopped taking their HIV medicines in the last two years for any reason. Of the 30% who had stopped their HIV medicines, the most frequently mentioned reasons for stopping included being on a break from taking HIV medicines (decided by themselves) (24%), insurance stopped covering it (20%), and lost insurance (18%). There were no differences in reasons by county or ethnicity.



Respondents were asked what they did to prevent their sexual partners from contracting HIV. The most frequently mentioned preventive measures were using condoms (60%) and taking HIV medicines regularly (58%). More than one quarter of respondents (27%) reported not having any sexual partners. Compared to black, white, and Hispanic clients, a higher percentage of multi-racial/other ethnicities reported not having sexual partners.



Knowing HIV+ People not in care and not accessing HIV services



Respondents were asked to estimate how many people they knew were HIV positive and not using any HIV services. While the most frequent response was “none” (70%), 15% reporting knowing from 1 to 10 people and 8% reported knowing more than 10 people. The most frequently mentioned reasons why some people were not in care included not knowing where to get resources or what resources were available to them; active substance abuse problems; fear/stigma associated with HIV; and difficulty accessing resources.

Summary of Reasons why PLWH may not use services N=45

- Too many places to get all the services and approvals
- Fear
- Lack of knowledge of how to get services
- Denial
- Substance abuse
- Lack of transportation
- Apathy
- Don't want help
- Overwhelmed

Ideas for Improving HIV/AIDS Services in Nevada

Some of the frequently mentioned ideas for improving HIV/AIDS services in Nevada included having all services located in one place; increasing awareness of available services and assistance with navigating services; and increasing housing assistance.

How could HIV/AIDS care services be improved in Nevada? (N=91)

23 of 91 who commented had positive comments about the services in Nevada (25%)

- Have all the services in one place; one stop
- ADAP services could be made easier to get
- Increase awareness about available services and where to get services

- Decrease red tape/eligibility requirements
- Easier testing
- Allow everyone with HIV/AIDS to receive the same services;
- Eye care
- Insurance
- Job referral services; workforce preparation classes
- Provide food at classes
- Have more people with HIV/AIDS working with people with HIV/AIDS
- Increased housing; help people get off the streets; transitional housing
- Have health navigators at all agencies
- Allow HIV MDs to be primary care MDs
- Mental health care
- More doctors
- More informational seminars
- More public service announcements on radio and TV
- Opening an office in Henderson and west Nevada
- Lower costs for medicines
- Increased outreach to those who need care but are afraid
- Vision
- Bring back gift cards
- Train case manager; improved empathy from case managers

APPENDIX H: COMMUNITY HIV PREVENTION SURVEY

Nevada HIV Community Planning Survey 2015

Thank you for agreeing to participate in this survey. Your answers to this survey will be used to improve HIV services in Nevada. Please **DO NOT** put your name on this form. Your answers to these questions are anonymous. This means your name is not anywhere on this form and we will not match your answers with your name or try to identify you in any way. Please answer each question accurately and honestly. Please give the survey back to the person that gave it to you. If you received this by email, you can email it back to: elizabethc@unr.edu. We will not keep your email address. This survey can also be found at this link <https://www.surveymonkey.com/s/NVHIV15LV> or by scanning the QR code. Please only complete the survey one time—either on paper or online.



Thank you for giving us information that will help us make better programs to prevent HIV!

What is your zip code? _____

1. Location of Survey (CHECK ONE ONLY):

- ☐ HIV Clinic - Please specify: _____
- ☐ Community Agency - Please specify: _____
- ☐ Health department - Please specify: _____
- ☐ Outreach - Please specify: _____
- ☐ Business - Please specify: _____
- ☐ Email/Online - Please specify: _____
- ☐ Other - Please specify: _____

2. Gender (CHECK ONE ONLY):

- ☐ Male ☐ Female ☐ Transgender Male to Female
- ☐ Transgender Female to Male

3. Age (CHECK ONE ONLY):

- ☐ 0-12 years ☐ 18-24 years ☐ 45-64 years
- ☐ 13-17 years ☐ 24-44 years ☐ 65+ years

4. Race/Ethnicity (CHECK ONE ONLY):

- ☐ Black/African American ☐ Hispanic/Latino
- ☐ Asian/Pacific Islander ☐ Native American/Alaskan Native
- ☐ White/Caucasian
- ☐ Other (please specify): _____

5. What is your relationship status? (CHECK ONE ONLY)

- ☐ Single ☐ In a committed relationship (1 sexual partner)
- ☐ Married ☐ In an open relationship (more than 1 sexual partner)
- ☐ Separated/Divorced
- ☐ Widowed
- ☐ Other (Please specify): _____

6. What is the highest grade of school or year of college you have completed? (CHECK ONE ONLY)

- ☐ None ☐ Undergraduate Degree
- ☐ Elementary School (grades 1-8) ☐ Associate's Degree
- ☐ Some High School (grades 9-11) ☐ Some Post-Graduate work
- ☐ High School Graduate/GED ☐ Graduate Degree or higher
- ☐ Some College work

7. Which of the following best describes where you live right now? (CHECK ONE ONLY)

- ☐ Rent/Lease
- ☐ Own
- ☐ Live with friends or family without paying rent
- ☐ Homeless
- ☐ Weekly motels
- ☐ Other-Please specify: _____

8. During the past 12 months, who were your sexual partners? (CHECK ONE ONLY)

- ☐ Only males
- ☐ Only females
- ☐ Both males and females
- ☐ I have not had sex within the last 12 months
- ☐ Do not know
- ☐ Prefer not to answer

9. How many sexual partners (vaginal, oral, anal) have you had in the past 12 months? (CHECK ONE ONLY)

- ☐ None ☐ 2-4 ☐ 8-10
- ☐ 1 ☐ 5-7 ☐ 11 or more

10. Have you done any of the following in the past 12 months? (CHECK ALL THAT APPLY)

- ☐ Unprotected oral sex
- ☐ Unprotected vaginal sex
- ☐ Unprotected anal sex
- ☐ None of the above

11. How often have you used condoms in the past 12 months when you had sex (oral, vaginal or anal)? (CHECK ONE ONLY)

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Seldom
- ☐ Never

Please continue survey on the next page

→ 1

12. What may prevent you from using condoms? (CHECK ALL THAT APPLY)

- ☐ I only have sex with one person who I believe doesn't have sex with anyone else (i.e., I'm married or in a committed relationship)
- ☐ The person(s) I will be having sex with refuses to use them.
- ☐ I can't afford condoms
- ☐ Too uncomfortable to talk about with sex partner(s)
- ☐ I don't like the feeling
- ☐ They ruin the moment/inconvenient
- ☐ I have not had sex within the past 12 months
- ☐ Other – please specify: _____

13. Have you injected drugs in the past 12 months ?

- ☐ Yes ↓ ☐ No

If Yes, have you done any of the following in the past 12 months? (CHECK ALL THAT APPLY)

- ☐ Shared needles/works without bleaching
- ☐ Shared needles for tattoos/piercing with someone who I believe injects drugs
- ☐ Shared a cooker, cotton, or rinse water
- ☐ None of the above

14. Have you ever been tested for HIV (even if you did not get the results)?

- ☐ Yes ☐ No ↓

15. If no to #14 (the last question), why haven't you tested for HIV? (CHECK ALL THAT APPLY)

- ☐ I have not been exposed to HIV
- ☐ I was afraid of finding out I am HIV positive
- ☐ I thought I was HIV negative
- ☐ I did not know where to get tested in this area
- ☐ I was worried my name would be reported to the government if I test positive
- ☐ Inconvenient location
- ☐ Takes too much time
- ☐ Cost
- ☐ I never really thought about getting tested
- ☐ Is there any other reason why you did not get an HIV test? Please specify: _____

16. If you had a question about HIV/AIDS, where would you go for information? (CHECK ALL THAT APPLY)

- ☐ Internet
- ☐ Teacher
- ☐ Health department
- ☐ Family
- ☐ Friends
- ☐ Church
- ☐ Sexual Partner(s)
- ☐ Health care provider
- ☐ Community agency
- ☐ Other, please specify: _____

17. How would you like to get information about HIV/AIDS?

- ☐ Internet
- ☐ TV
- ☐ Radio
- ☐ Newspaper ads/Billboards
- ☐ Brochures
- ☐ Community events
- ☐ Teacher
- ☐ Family/Friends/Partners
- ☐ Church
- ☐ Health care provider
- ☐ Community agency
- ☐ Other, please specify: _____

18. What else is needed in your community to address HIV/AIDS?

Please continue survey on the next page



19. For the following statements, please mark how you agree or disagree with the statement.

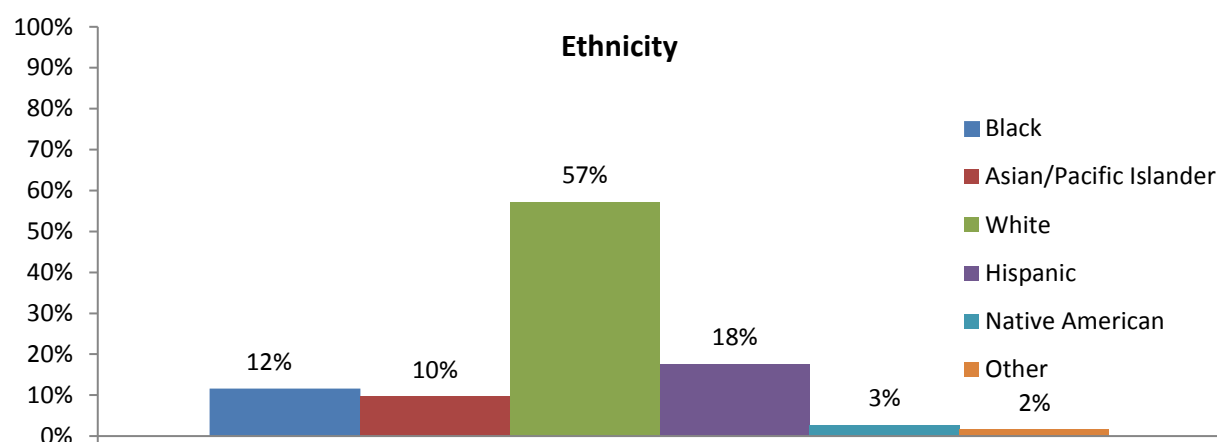
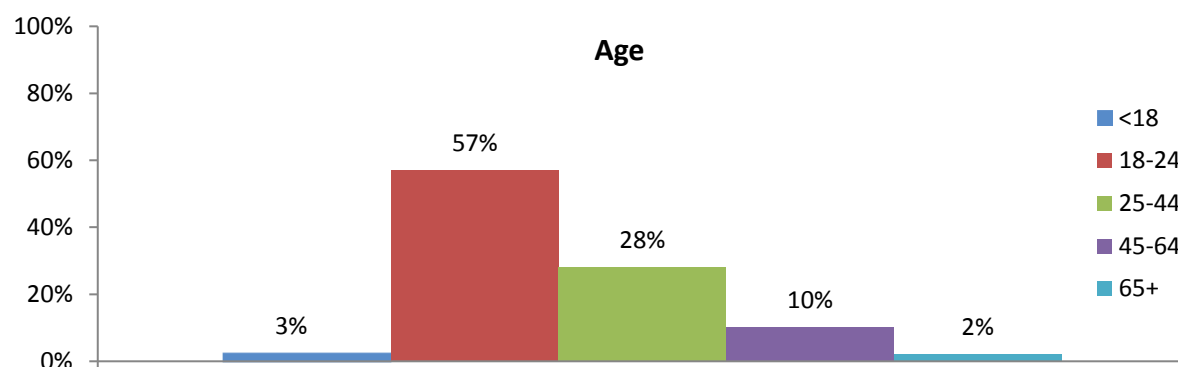
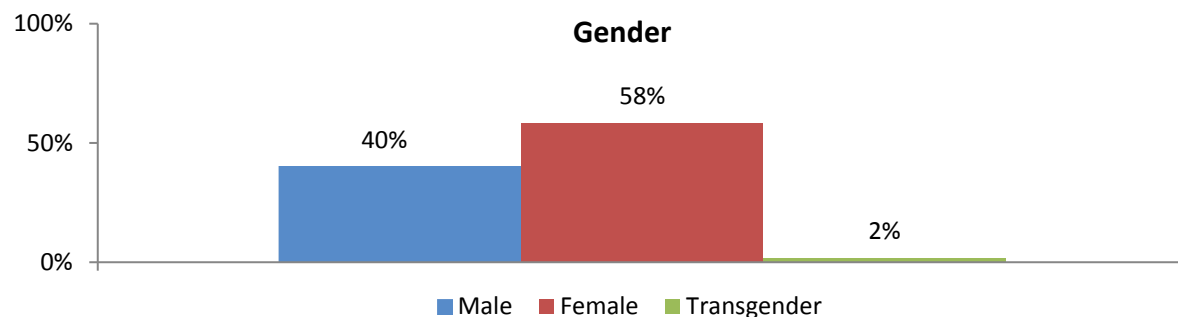
	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
a. Medical care can help a person live longer and stay healthier if he/she has HIV/AIDS.	1	2	3	4
b. My sexual partners and/or needle sharing partners are genuinely concerned with whether I have had an HIV/AIDS test and what the results were.	1	2	3	4
c. I see HIV/AIDS as a manageable/treatable disease and am not as concerned about getting it.	1	2	3	4
d. Taking HIV/AIDS drugs decreases the chances that someone with HIV/AIDS will infect their partner(s).	1	2	3	4
e. Oral sex without a condom is safe if there is no ejaculation (cum).	1	2	3	4
f. Anal sex without a condom is safe if there is no ejaculation (cum).	1	2	3	4
g. Sometimes I do not use condoms because they require too much effort.	1	2	3	4
h. I feel that people who were infected with HIV/AIDS through sex or drug use got what they deserved.	1	2	3	4
i. I feel comfortable being around someone with HIV/AIDS.	1	2	3	4
j. I feel that there is enough messaging/education about HIV/AIDS in my community.	1	2	3	4
k. I would date someone who is infected with HIV/AIDS.	1	2	3	4
l. HIV/AIDS affects my life.	1	2	3	4
m. I am concerned about getting HIV/AIDS.	1	2	3	4
n. I know where to get an HIV/AIDS test.	1	2	3	4

Thank you for taking the time to do this survey! We appreciate it!

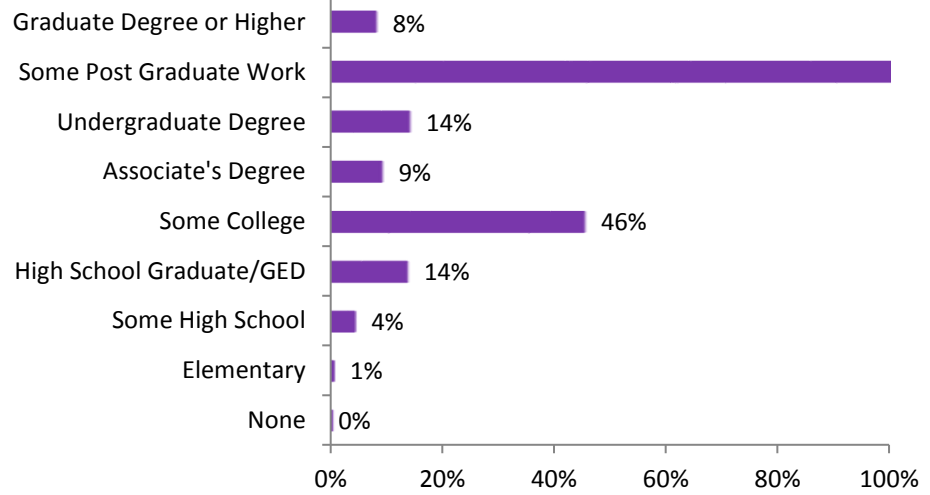
APPENDIX I: SUMMARY OF HIV PREVENTION COMMUNITY SURVEY RESULTS

Results Highlights from HIV Community (Prevention) Survey (April 2016)

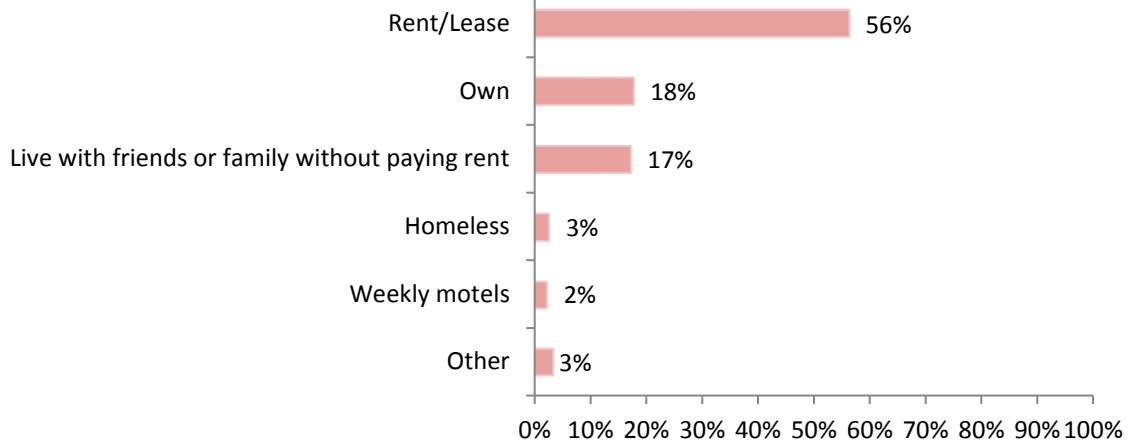
The HIV Community Survey was collected from 1687 respondents around the state from April 2015 to March 2016. The survey collected information regarding HIV risks, barriers to prevention and community needs.



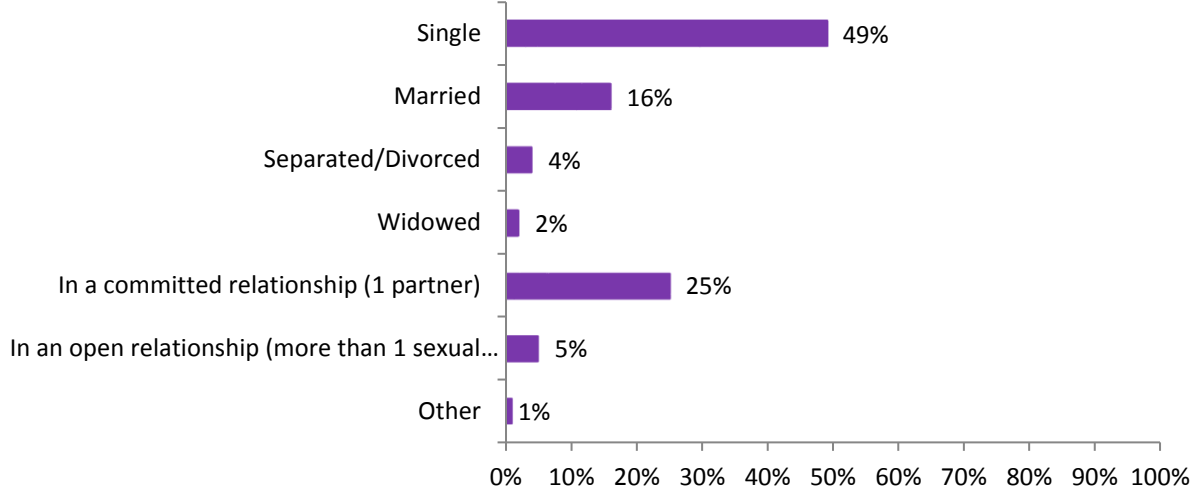
Education Level

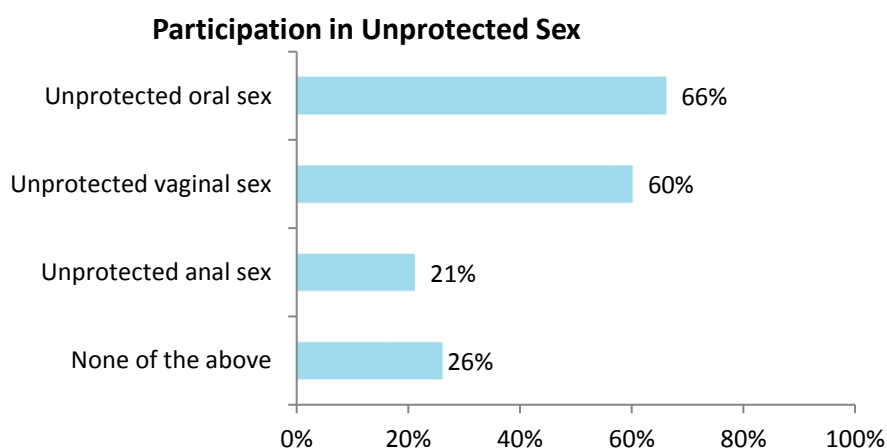
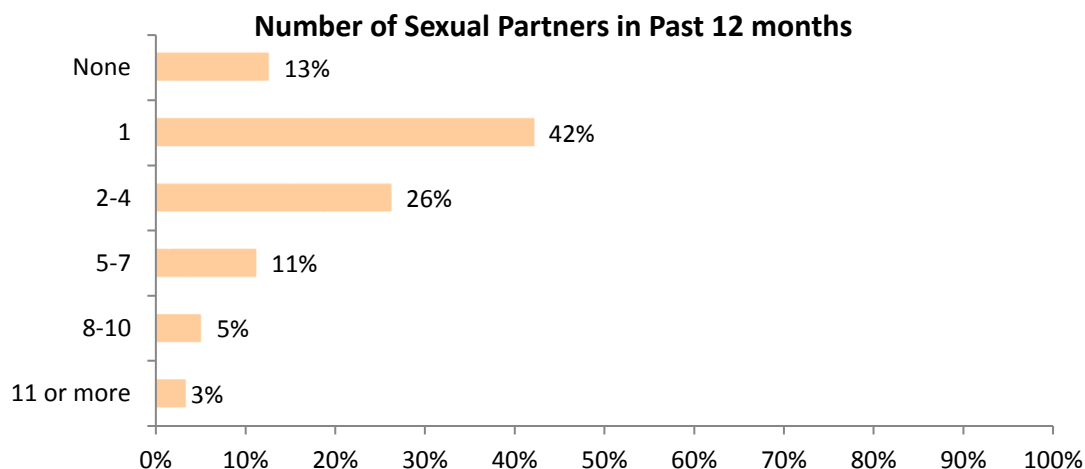


Housing



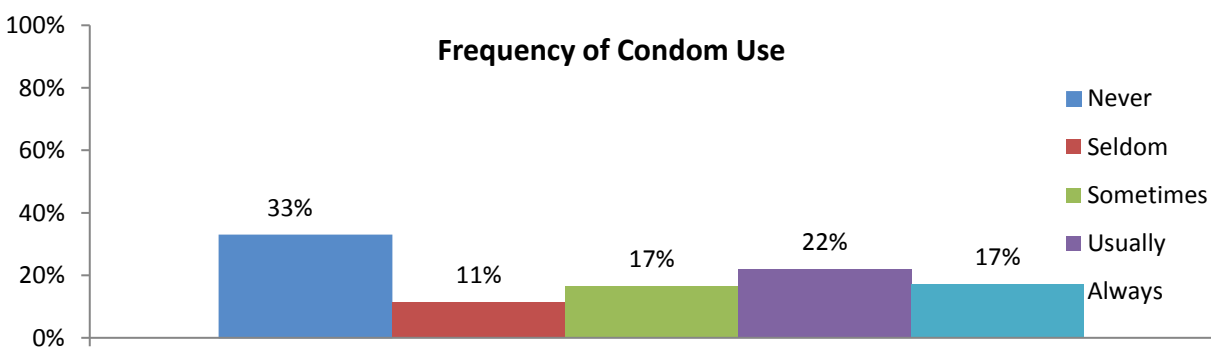
Relationship Status



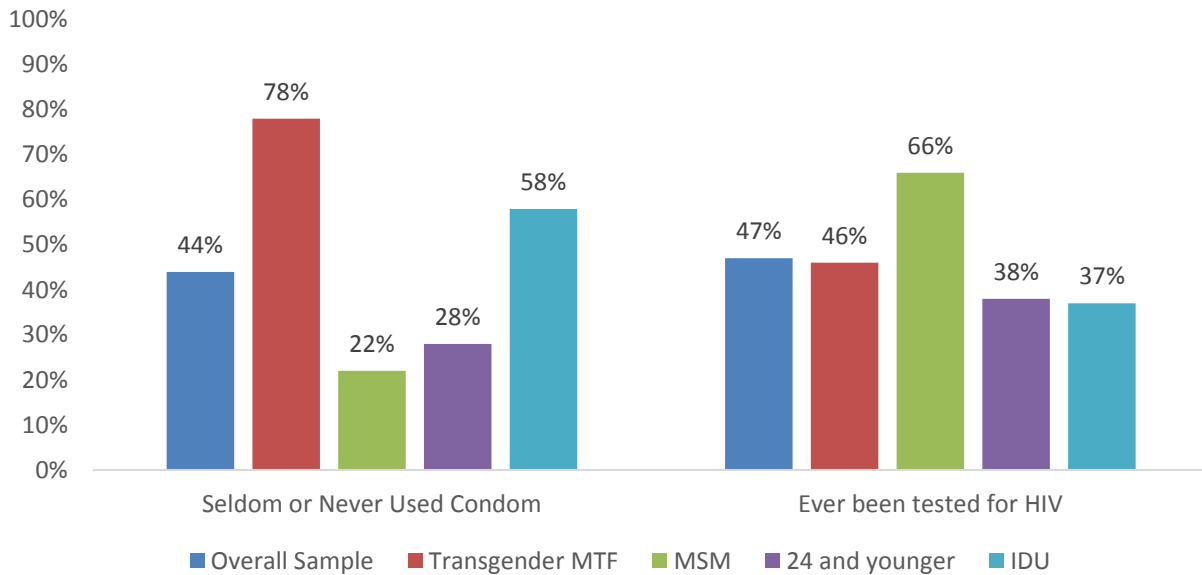


Of those who had more than 1 sexual partner in past 12 months (N=751):

- 78% unprotected oral sex
- 66% unprotected vaginal sex
- 28% unprotected anal sex
- 12% none of the above



Condom Use and HIV Testing



44% of respondent seldom or never use condoms.

Transgender M to F: 78% seldom or never use condoms (small sample size, n=13).

IDU: 58% seldom or never use condoms.

Of those who had more than 1 sexual partner in past 12 months, 27% seldom or never use condoms.

What prevents from using condoms

	Total sample	More than 1 sex partner
Only sex with one person	47%	27%
Don't like feeling	26%	39%
Ruin moment/inconvenient	24%	38%
Have not had sex within past 12 months	10%	2%
Person refuses to use	8%	13%
Can't afford	5%	8%
Uncomfortable to talk about	7%	12%

Can't afford

- 25% IDU
- 12% African American
- 10% Native American
- 10% MSM
-

Uncomfortable to talk about

- 23% IDU
- 23% Trans M to F

Don't like feeling

- 45% IDU
- 41% Heterosexual male

Frequently mentioned write in reasons:

- Always use condoms
- Birth control pill
- Didn't have one available
- Latex allergy

Have you injected drugs in the past 12 months?

6% of the sample was IDU (N=90)

Of IDU:

- 51% had shared needles/works without bleaching
- 40% had shared needles for tattoos/piercing with someone who I believe uses drugs
- 27% had shared a cooker, cotton or rinse water

HIV Testing

47% had ever been tested for HIV.

- 38% 24 years and under
- 37% IDU
- 66% MSM
- 39% API
- 37% Native American

Top reasons for not being tested

"I have not been exposed to HIV" 50%

"I never really thought about getting tested" 41%

"I was afraid of finding out I am HIV positive"

- MSM 32%
- Transgender M to F 43%

"I thought I was HIV Negative" 14%

Cost 13%

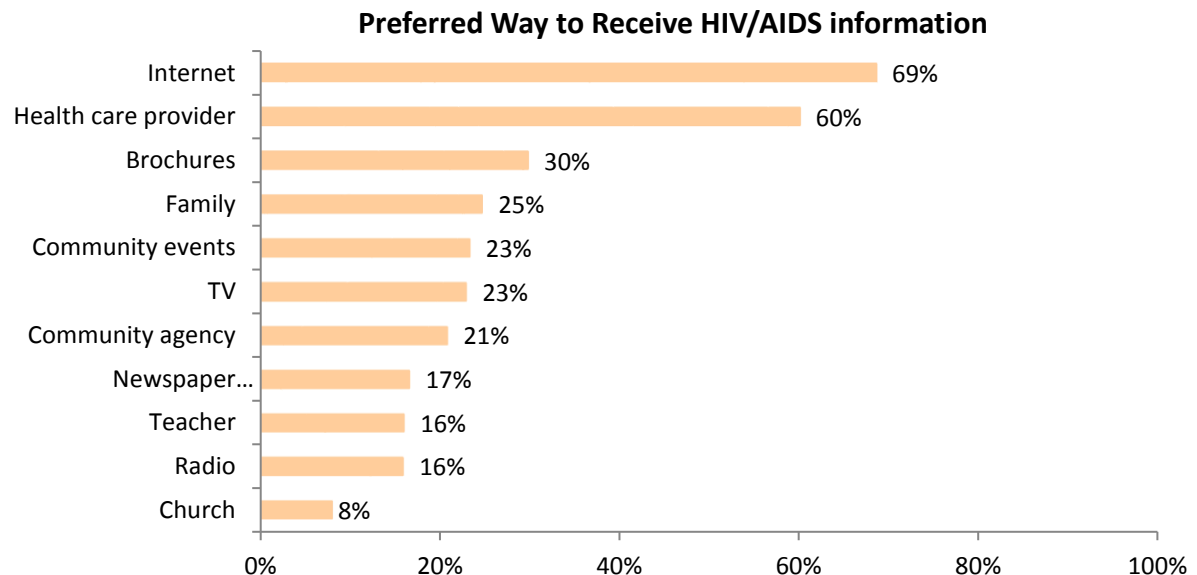
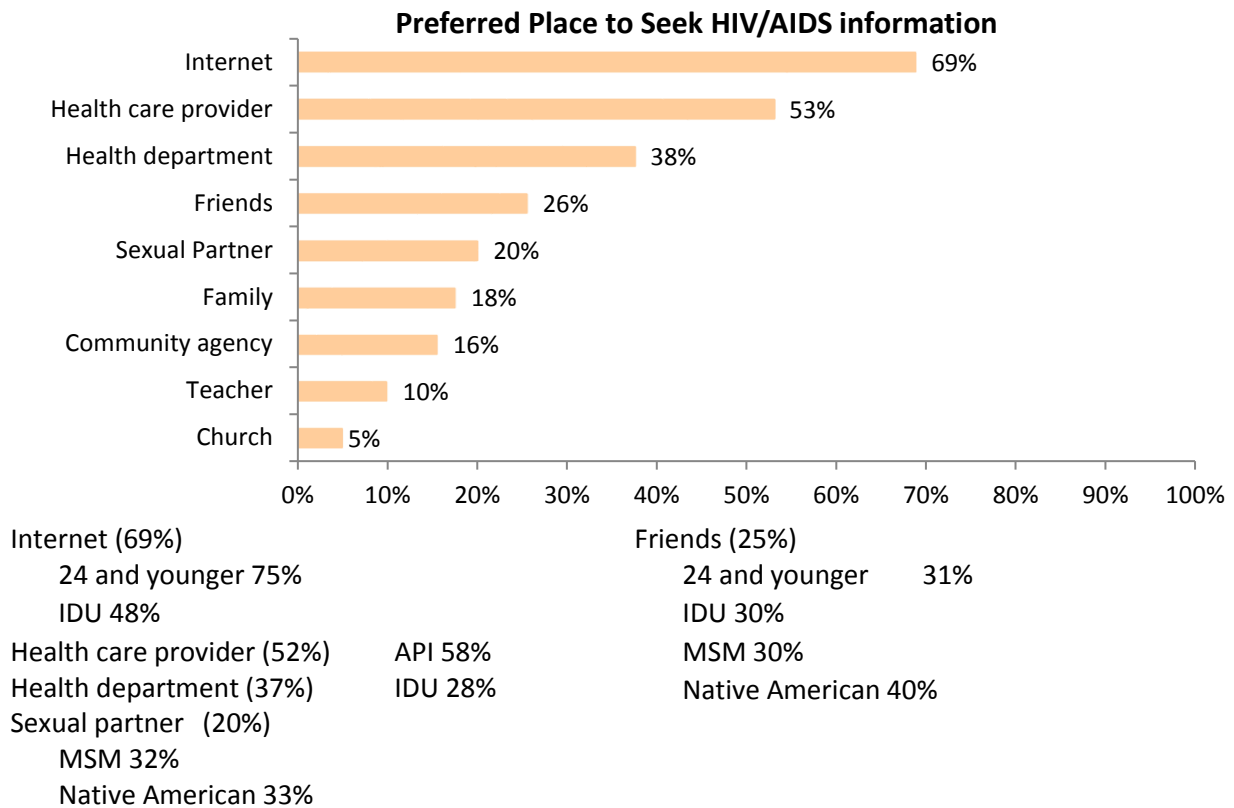
- IDU 45%
- MSM 27%
- AA 19%
- API 20%
- Native American 27%

Takes too much time 10%

- IDU 34%

- MSM 24%
- Native American 23%

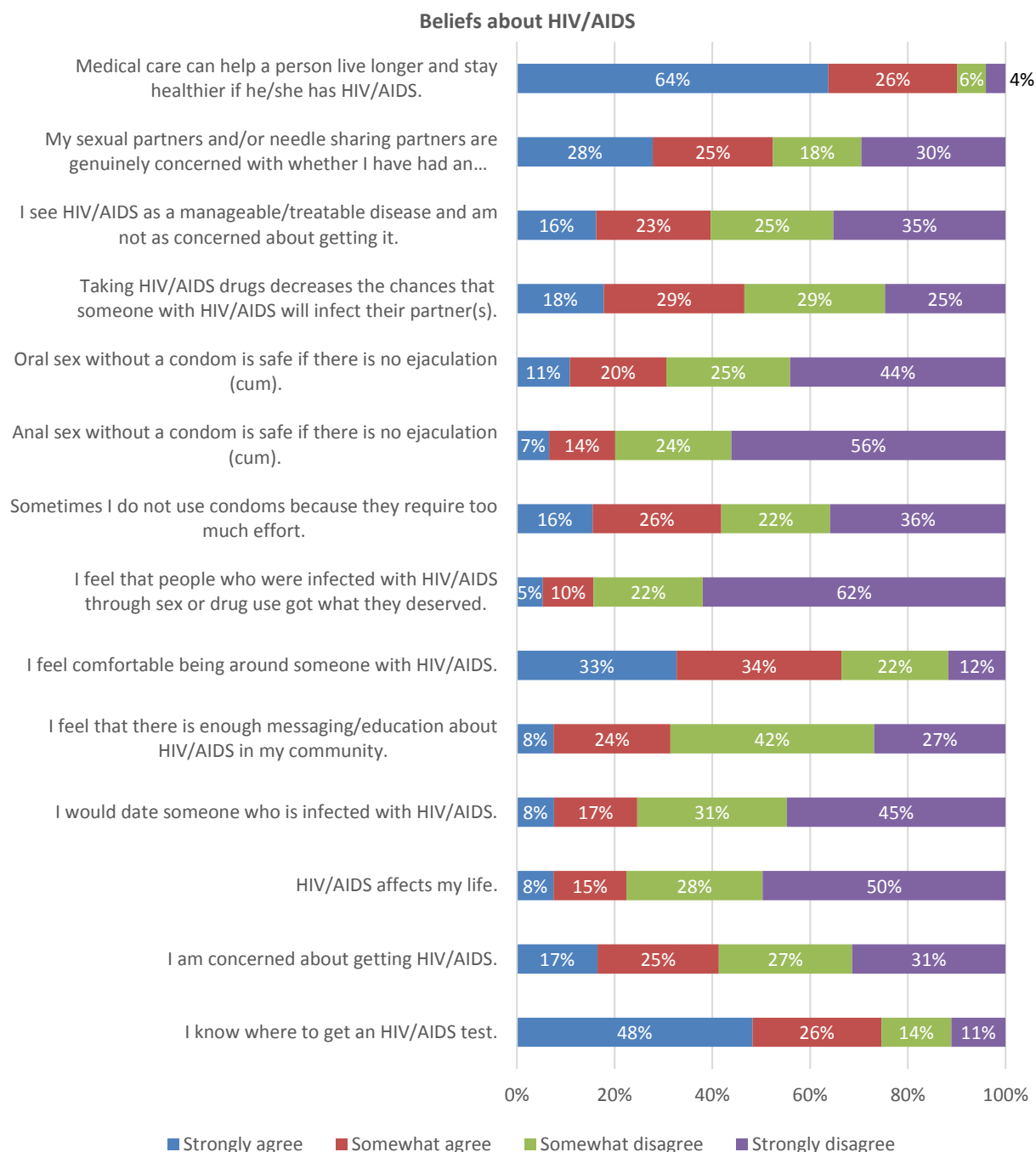
If had a question about HIV/AIDS, where would they go to seek HIV/AIDS information:



Internet (68%)	IDU 47%	MSM 72%	
Health care provider (60%)	IDU 37%	MSM 51%	
Brochures (29%)			
Family (24%)			Native American 32%
Community events (23%)		MSM 28%	Native Am 30%
TV (23%)		MSM 32%	Native American 32%
Community agency (20%)		MSM 30%	
Radio (16%)		MSM 26%	Hispanic 19% Native Am 20%
Newspaper ads/billboards (16%)		MSM 20%	Native American 20%
Teacher (16%)			Native American 25%
Church (8%)		Hispanic 9%	Native American 23%

What else is needed in your community to address HIV/AIDS?

- Education/ classes
- Access
 - testing
 - condoms
- Advertising
- Awareness
- Reduction in stigma/ discrimination
- Clean needle education/ exchange opportunities



I feel there is enough messaging/education about HIV/AIDS in my community

- 68% somewhat or strongly disagree
- 47% IDU somewhat or strongly disagree

I know where to get an HIV/AIDS test.

- 74% somewhat or strongly agree
- 68% African American somewhat or strongly agree

APPENDIX J: FOCUS GROUP QUESTIONS

HIV Community Planning Focus Group Pre-Survey

Thank you for participating in this focus group. Your participation will help improve HIV Prevention and Care services in Nevada. Please fill out this brief survey before the focus group starts. Do not put your name on the paper. Your responses will remain anonymous.

1. Gender ☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male

2. Age: _____ years 3. Are you a Veteran of the U.S. Armed Forces? ☐ Yes ☐ No

4. Zip code where you live: _____

5. Race/Ethnicity:

- | | |
|--|--|
| ☐ American Indian/Alaska Native | ☐ Hispanic/Latino |
| ☐ Asian/Pacific Islander | ☐ White/Caucasian |
| ☐ Black/African American | ☐ Other (please specify): _____ |

6. What is the highest grade of school or year of college you have completed? (Check ONE only)

- | | |
|---|---|
| ☐ None | ☐ Associate's Degree (2-year degree) |
| ☐ Elementary School (grades 1-8) | ☐ Bachelor's Degree (4-year degree) |
| ☐ Some High School (grades 9-11) | ☐ Some Post-Graduate work |
| ☐ High School Graduate/GED | ☐ Graduate Degree or higher |
| ☐ Some College | |

7. What is your annual household income from all sources? (Check ONE only)

- | | | |
|---|--|--|
| ☐ Less than \$10,000 | ☐ \$25,000 – 34,999 | ☐ \$75,000 – 99,999 |
| ☐ \$10,000 – 14,999 | ☐ \$35,000 – 49,999 | ☐ \$100,000 – 149,999 |
| ☐ \$15,000 – 24,999 | ☐ \$50,000 – 74,999 | ☐ \$150,000 or more |

8. What do you consider your sexual orientation? (Check ONE only)

- | | |
|--|--|
| ☐ Straight/Heterosexual | ☐ Bisexual |
| ☐ Gay/Homosexual | ☐ Other (please specify): _____ |

9. What is your relationship status? (Check ONE only)

- | | |
|---|---|
| ☐ Single | ☐ In a committed relationship (1 sexual partner) |
| ☐ Married | ☐ In an open relationship (more than 1 sexual partner) |
| ☐ Separated/Divorced | ☐ Other (please specify): _____ |
| ☐ Widowed | |

10. What is your HIV status?

- | | |
|--|---|
| ☐ Tested negative for HIV | ☐ Tested for HIV but did not receive results |
| ☐ Tested positive for HIV | ☐ Do not know/Have not been tested for HIV |

11. Do you use social media to find partners? ☐ No ☐ Yes → Which social media apps/sites do you use?

General HIV Prevention Focus Group Questions

Q1. Describe what HIV means to you and your peers (people like you). (Do people you know feel at risk for getting HIV? Are they concerned about getting HIV? How do they actively prevent the spread of HIV (or don't they)?)

Q2. What are some of the risky behaviors that your peers do that might put them at risk for getting (or spreading) HIV? (What keeps people from protecting themselves from HIV? Where do these risky behaviors happen?)

Q3. Where do your peers get services and information about preventing the spread of HIV? (By services, I mean HIV testing, condoms, educational materials, and other resources.) (What makes it easy to get these services and information? What makes it hard to get these services and information?)

Q4. What other services, resources, and information are needed to prevent the spread of HIV among your peers (people like you)?

Q5. What is the best way to educate your peers about preventing HIV? (What types of activities would be most effective? If you were to design a communications campaign for your peers, what would that look like? What would it say?; Where would you reach your peers who are at risk for getting HIV?; What social media websites/apps do you and your peers use *to find partners*?)

Q6. About one quarter of all people living with HIV do not know they are infected. What could we do to get more people in this community to test for HIV? (Time, locations, type of test?)

Q7. What do you know about PrEP (pre-exposure prophylaxis)? What do you know about the concept of treatment as prevention, as it relates to HIV?

HIV + Focus Group Questions

C1. What has it been like for you accessing HIV services? (What has made it easy or hard to get the services you need?)

C2. What are the most important services that help you manage your care? (What helps people living with HIV to stay in care? If you could change one thing in the HIV Care Network, what would it be?)

C3. What services do you need that you are not getting?

C4. Some people who are HIV+ are not using HIV services. Why do you think they are not using any services? (What would help people who recently found out their HIV+ status to get linked into care?)

C5. What is the best way to educate your peers (people like you) about preventing HIV? (What types of activities would be most effective? Where would you reach your peers who are at risk for getting HIV? What social media websites/apps do you and your peers use?)

Q7. What do you know about PrEP (pre-exposure prophylaxis)? (What do you know about the concept of treatment as prevention, as it relates to HIV?)

C6. Are there any other ideas about how HIV/AIDS care services could be improved in Nevada?

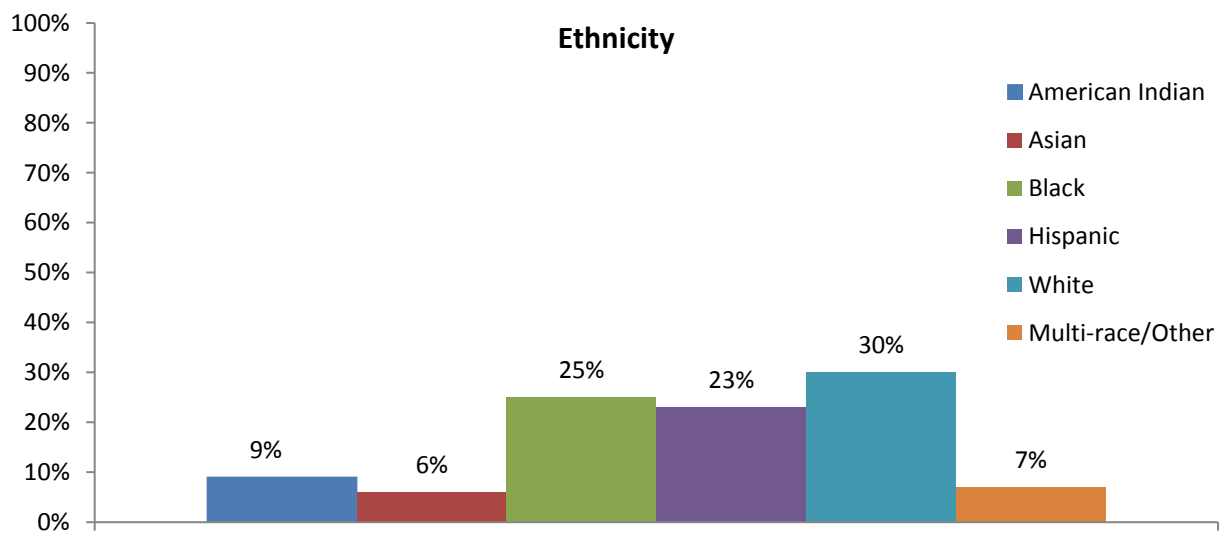
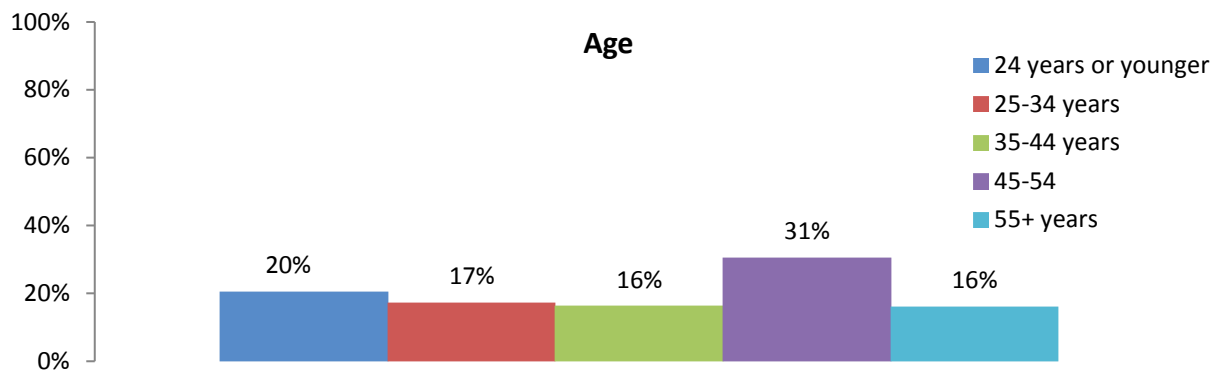
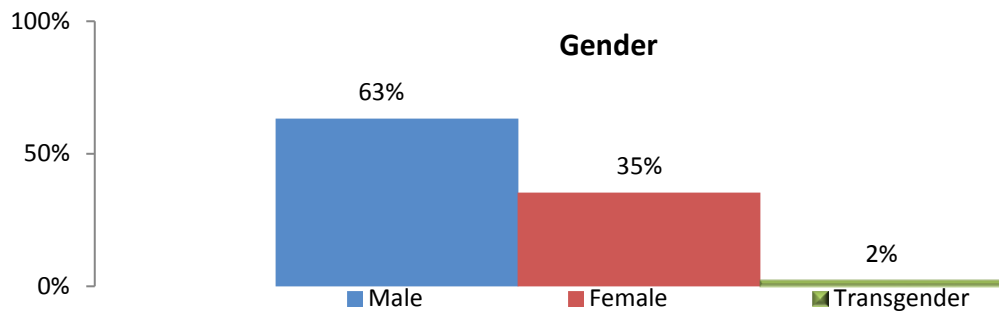
APPENDIX K: SUMMARY OF FOCUS GROUP RESULTS

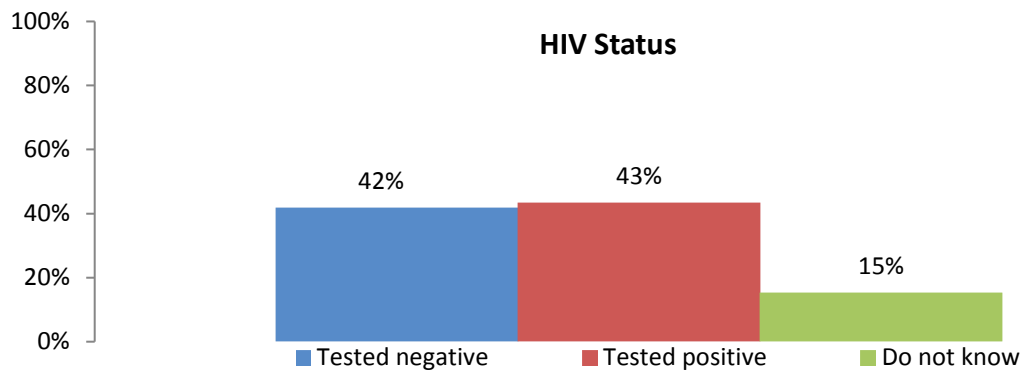
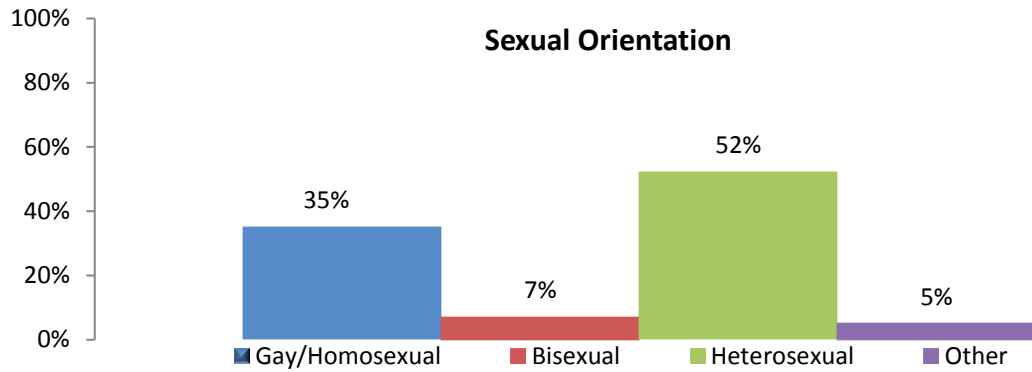
HIV Needs Assessment Focus Group Summary (Groups held August 2015-May2016)

Twenty HIV client and prevention focus groups were held in Northern and Southern Nevada between August 2015 and May 2016 with 191 people participating. Six groups were specifically for HIV positive individuals, while 14 groups had a prevention focus, but sometimes included PLWH. Focus group participants completed a brief demographic survey before the groups started. HIV positive individuals represented nearly half of the participants (43%). The majority of participants were male (63%) and residents of Southern Nevada (69%). Participants ranged in age from 11 to 83 years, with a mean age of 40 years. Participants were well distributed among various ethnic groups. Thirty percent of participants was white; 25% black; 23% Hispanic; 9% Native American; 6% Asian, and 7% multi-race or other. Half the participants (52%) indicated they were heterosexual; 35% homosexual; and, 7% bisexual.

Focus Group Participants

Focus	Population	# participants	Location
HIV Care	HIV positive; MSM	12	Las Vegas
HIV Care	HIV positive; MSM	13	Las Vegas
HIV Care	HIV positive (mostly women; majority African American)	10	Las Vegas
HIV Care	HIV positive; MSM	11	Pahrump
HIV Care	HIV positive (Includes some MSM)	18	Reno
HIV Care	HIV positive; Hispanic men (includes some MSM)	10	Reno
HIV Prevention	African American men; (Includes some MSM; some HIV+)	7	Las Vegas
HIV Prevention	African American women (Includes some HIV+)	20	Las Vegas
HIV Prevention	MSM youth/young adult (Includes some transgender)	11	Las Vegas
HIV Prevention	IDU/Substance abuse (includes some MSM; some HIV+)	11	Las Vegas
HIV Prevention	Hispanic women	9	Las Vegas
HIV Prevention	Hispanic men	8	Las Vegas
HIV Prevention	Hispanic men	7	Las Vegas
HIV Prevention	Native American	10	Reno
HIV Prevention	IDU/Substance abuse; some HIV+	9	Reno
HIV Prevention	Young adult	9	Reno
HIV Prevention	MSM	8	Reno
HIV Prevention	Native American	5	Las Vegas
HIV Prevention	Young adult female	4	Las Vegas
HIV Prevention	Asian/Pacific Islander	7	Las Vegas





26% use social media to find partners

Most frequently used social media apps

- Facebook
- Adam 4 Adam
- Growlr
- Grindr
- Scruff
- Bear 411
- Jack'd
- Craigslist
- Tinder

Summary of HIV Positive Group Responses

What has it been like for you accessing HIV services? (What has made it easy or hard to get the services you need?)

Many clients had found it generally easy to access services; however, some acknowledged it was sometimes confusing or difficult to access services, particularly at the beginning.

What are the most important services that help you manage your care?

What helps people living with HIV to stay in care?

Most important services that help HIV clients manage their care and stay in care

- Case Management
- Doctors specializing in HIV
- Transportation
- Knowledge of resources available and where to go
- Support groups
- Housing
- Help paying for medication and co-pays
- Food
- Mental Health care
- Dental work
- Eligibility
- Labwork

What helps people stay in care

- Desire to do so; positive attitude
- Taking medication regularly
- Lunch and learn (apparently has been discontinued)
- Social media groups
- housing

If you could change one thing in the HIV Care Network, what would it be?

- better communication between hospitals and primary care provider; improved coordination of care
- dental care available other than at the dental school
- improved pharmacy services; all in one pharmacy
- more funding and resources
- improved patient confidentiality
- improved handling of bills denied by Medicare; time consuming process to get denied services covered

- shouldn't have to fill out separate paperwork for all of the different Ryan White programs; streamline paperwork
- only UMC patients now qualify for Part C; should change that
- improvement in of organizations
- improvement of entire HIV system

What services do you need that you are not getting?

- Food vouchers; food cards; lunch
- Van service; transportation; bus passes
- 24-hour access to counseling services
- 24-hour access to nurse online
- Better dental care
- Better access to therapist/psychiatrist
- Better vision coverage
- Infectious disease specialist in Pahrump
- Housing
- Hygiene products
- Peer advocates
- Hotline; resource information online; increased awareness of available services
- Lunch and learn
- Compassion and empathy; improved cultural competence
- African American health professionals

Some people who are HIV+ are not using HIV services. Why do you think they are not using any services? (What would help people who recently found out their HIV+ status to get linked into care?)

- Have an addiction; drugs; alcohol; addiction taking all time and attention
- Don't want anyone to know are HIV+
- Stigma; discrimination; stereotypes
- Don't know where to go to get services; don't know system
- Don't care; apathy; give up
- Fear
- Too much work to get services, doctor, take medicines, etc.
- Language barrier

What would help people who recently found out their HIV+ status to get linked into care

- Health manager; case manager; someone to help get the services
- Person with HIV to explain about services and resources
- Resource guide with all the services

Prevention-focused Groups

What are some of the risky behaviors that your peers do that might put them at risk for getting (or spreading) HIV? (What keeps people from protecting themselves from HIV? Where do these risky behaviors happen?)

Top Risky Behaviors

- Unprotected sex; not using condom
- Using drugs or alcohol; drug addiction; alcohol addiction
- Multiple sex partners
- Sharing needles
- Sex with strangers; prostitution
- Barebacking
- Nondisclosure of status

Top Risky Behavior Locations

- Discos, bars, clubs, parties
- Bathhouses
- Online
- Schools
- The street

Top Barriers to testing

- Fear of finding out HIV+
- don't want anyone to know
- Stigma
- Lack of education
- Think they are not at risk

How to get people to test

- Offer incentives
- Normalize it so it's cool to test
- Celebrities
- Free testing
- Testers from the community
- Community events
- Word of mouth
- Variety of hours and places
- Judgment-free testing
- Make testing a fun event

Where to recruit people to test

- Social media, online ads
- mobile van ads
- doctor's office
- Parks
- school
- meetings at workplaces
- Billboards
- discos, clubs, bars
- newspaper ads

Top Prevention services needed

- Education; Increase awareness
- More mobile and rapid testing
- Programs in churches
- Ads; billboards; radio; newspaper; online
- Social media
- More information on the internet
- Health fairs
- Pharmacies
- Increase education of youth;
- Programs in schools
- Programs for parents to teach their children
- Normalizing sex
- Conversations among friends and families
- Small groups; classes
- Increased education for African Americans and Latinos

Top Prevention barriers

- Lack of education
- Drug addiction
- Lack of resources
- Fear
- Stigma
- False beliefs that it only affects gay people
- False beliefs that HIV is non-life threatening

APPENDIX L: PROVIDER SURVEY RESULTS

Which of the following best describes your agency or organization's focus with respect to HIV/AIDS care and prevention in the state of Nevada?

Answer Options	Response Percent	Response Count
HIV/AIDS Care and/or Support Services for people living with HIV/AIDS	24.0%	6
HIV/AIDS Prevention Education and Services	20.0%	5
Both HIV/AIDS Prevention and Care services	56.0%	14
answered question		25
skipped question		0

Please check all the services you find lacking for your HIV clients:

Answer Options	Response Percent	Response Count
Medical care	16.7%	3
Help paying for medicines	22.2%	4
Help understanding medicines and how to take them	22.2%	4
Help getting food	44.4%	8
Dental care	55.6%	10
Help getting health insurance	27.8%	5
Vision care	38.9%	7
Financial help	55.6%	10
Transportation	55.6%	10
Mental health care	50.0%	9
Help filling out forms	33.3%	6
Specialty doctors	22.2%	4
Therapy (occupational, speech, physical)	5.6%	1
Nutrition help	27.8%	5
Referrals to get other health care or services	16.7%	3
Interpretation or translation services	22.2%	4
Help getting off drugs or alcohol	38.9%	7
Child care	27.8%	5
Case Management	11.1%	2
HIV and health classes	22.2%	4
Free condoms	0.0%	0
Home health care	11.1%	2
Legal help	44.4%	8
Support groups	16.7%	3
Other (please specify)	27.8%	5
answered question		18
skipped question		7

Other (please specify)

- Continuous frustration with variations in eligibility. Emergency access for housing, food.
- Stable, long term housing options
- housing
- Shelter and affordable housing
- People who are infected or affected by HIV/AIDS are often not open to discussing their status outside of their communities. They feel stigmatized and that others do not understand their community. Support groups need to be designed for identified populations i.e. groups specifically designed for women (by race and ethnicity), gay men of color, heterosexual men of color, teens.

What do you feel are barriers to clients accessing any of the above needed services?

- Transportation
- Disparate and complicated system. Clients have to travel to many agencies sometimes physically located far apart to address their needs.
- All eligibility should be the same across all parts - this is very difficult for all clients needing different RW eligibility and also difficult for the staff.
- Agency resources/funding, barriers with insurance and providers for mental health and substance use treatment (not enough providers and cumbersome process when their needs are acute)
- Funding
- Transportation, education, stigma
- Funding
- Referral sources. Funding.
- Not enough funding for the services above
- Lack of available services in the above areas. Also, the lack of housing, food, or transportation affects all other access to needed services.
- Low or no income, no transportation, psychological stressors and mental illness, substance abuse.
- They do not know who can help them, programs and agencies. There are programs that they can be referred to however, someone needs to help them. Mental Health Services especially Psychiatrists who can prescribe. Counseling is also missing. Many clients are below or at poverty levels. They need assistance to fill out forms that they do not understand. Providers are limited and assistance for dental care services., They do not have transportation or funding for public transportation. Limited access to legal assistance and help to apply for Social Security Disability. People in poverty do not eat well and need to understand the importance of good Nutrition.
- Regarding Nutrition help there are many food pantries but many clients don't know how to cook or can't get groceries home. They could use restaurant vouchers such as McDonalds who post nutrition values.
- The health care system
- Apathy, lack of information about where to go (updated HIV/AIDS Resource Guide not updated), stigma, fear
- Funding

What are the unmet needs of your clients that are not listed above?

- none
- housing
- none
- Access to Hospice

- Shelter and affordable housing
- In our primary care facilities statewide and with Access To Healthcare many clients are lead to the help they need. Unfortunately some areas are not accessible especially in Mental Health Services. The primary care will help them with a nutritional chart and if they are a diabetic they can see a nutritionist. HIV and health classes are needed.
- Spiritual Counseling would help clients become aware of who they are and of the power they have within to become self-reliant and live a healthy existence.

What ideas do you have to improve HIV care services in your area?

- I would like to see additional dental providers and assist clients with glasses.
- More doctors and integration of services
- Have services more easily accessible and in one area vs. Across the city.
- Continue to ensure that processes are streamlined between agencies
- More services for pregnant women, and detox and housing services for opiate dependent pregnant women
- Increase funding for dental services. This is badly needed. Access to specialty care services is hard, but a lot of this is due to lack of providers and providers closing to Medicaid clients.
- More prevention. Mental Health Care providers are not proficient in prevention models of care. The field needs to stop discriminating against HIV- white gay males who want to help.
- More communication within service providers
- Consolidating Ryan White funded positions to create extra money to funnel into direct services.
- Better connection/networking of the different parts of the Ryan White Programs, HOPWA, Medicaid, Medicare and private insurance.
- I work with HIV/AIDS clients who are out of adherence. I do determine what they are in need of and where they can get the help they need. I would like to offer a support group and nutrition and health classes to the local clients.
- More awareness specifically of testing sites, service agencies, education and support.
- Place more service providers in minority areas
- Provide to clients that need it, a monthly buss pass
- No ideas

Have your patients had any issues (such as with medications) related to the Affordable Care Act (ACA) since its implementation ?		
Answer Options	Response Percent	Response Count
No	29.4%	5
Yes	52.9%	9
Does not apply	17.6%	3
answered question		17
skipped question		8

Please describe any issues your patients have experienced related to the Affordable Care Act (ACA).

- Backlog for Medicaid and if Medicaid administrator changes, clients find themselves in strange gap of coverage until change is in place.
- Newer medications prescribed are frequently denied, have to go through prior authorization, which can delay the medication being received by the client which can result in missed doses.
- Getting "kicked off" Medicaid, only to find it is a computer glitch. The process for clearing that up is stressful.
- Price of purchasing insurance has increased, co-pays, and specialty services have increased, services now have more limits than with just having Ryan White as a funding source
- Insurance companies are requiring patients change their medication regimen in order to pay for the meds, or there are long prior authorization processes.,
- Medications often need pre authorization or approval that often keep clients from starting or staying adherent to medications
- Difficulty navigating through the process, many organizations and service providers might not accept the insurance type, or service providers not being on insurance panels.
- Clients did not know how to go online and pick a plan. Others picked a plan that did not provide the formularies, and some could not afford the plans. Many people did not think they could keep their Ryan White coverage as a wrap around in case something happened to their Medicaid or if they lost their benefits. While others did have a job, did not qualify for Medicaid, and they lost their jobs putting them in crisis, or they got a job and lost their Medicaid benefits and would not qualify for insurance with their company until they were in their jobs 90 days.
- Primarily costs. They cannot afford the premiums and/or co-pays.

How many people do you know who are HIV-positive and not using any HIV services?

- 4
- 50%
- unknown number
- 3
- my clients are all accessing service
- ?
- 0
- Only a few. It is my job to get them into services and care.
- Difficult to know
- a large number
- few
- Many. I get calls regularly from people affected by friends who do not seek care.
- too many to mention
- 0
- Can't say unknown

Why do you think they aren't accessing any services?

- Transportation
- Our system is too complicated.
- They are insured and possibly don't know what the other services are.
- Stigma, lengthy and burdensome process (eligibility)
- They are homeless and dealing with addiction and/or mental health problems
- N/A

- ?
- Clients are tired of all the mountains of paperwork, they do not have the tools being knowledge or education to wade through the paths to get help. They are embarrassed and they are sick. They have to get help to even get a bus ticket then wait for a bus. One of the side effects is diarrhea and they are nauseous.
- Previous negative experiences with different service providers
- Barriers to services either psychosocial barriers or lack of food, shelter, and/or transportation often take precedent over staying in care or seeking out services
- Because although services are available, they are all too often not connected and the funding programs or insurance companies make it too complicated for individuals to understand.
- Fear. Scare of the unknown. Afraid of being stigmatized and unfairly judged.
- Apathy, lack of information about resources (HIV/AIDS Resource Guide out of date), Clients having to go to more than one organization for Ryan White assistance, no transportation, no assistance with obtaining paperwork needed to qualify, etc.
- N/A
- Fear, denial and lack of knowledge

What are the top HIV prevention services people at high risk for HIV need but are not able to get?

- Transportation, vision services
- Medication and mental health/substance abuse
- Connecting to all services
 - Case management
 - Mental health services
 - Substance Abuse services
 - Housing
 - Support groups in different places
 - transportation/bus passes/rides
 - providers that speak other languages
- PREP - some insurances won't approve.
- PrEP
 - Routine testing/sexual risk assessment by primary care providers
- Education and care coordination
- Education and harm reduction skills.
- Information. People typically find HIV prevention services, not the other way around.
- Targeted HIV Prevention Programs that match the attitude of the city which is "what happens in Vegas, stays in Vegas. No comprehensive effort to match that tone of the city has been executed
- Accurate and appropriate information regarding HIV prevention and testing. Many educational programs for HIV are based on grants with specific target populations
- Education, counseling, medications and med management.
- Education. We need more outreach
- Access to free or low cost testing
- Testing.
- Dental assistance, mental/behavioral health assistance
- Ongoing mental health counseling

What are the top barriers to people getting the HIV prevention services they need?

- Transportation
- Unaddressed mental health issues and social barriers (housing, food, etc)
- All of the above
- Insurance.
- Time needed to access services (they put it off until emergent or convenient)
- Process
- Lack of mental health services
- Not knowing about the resources
- Not getting help accessing resources
- Mental health and substance abuse issues
- Non-stigmatized points of service. i.e. not the health department, gay and lesbian center, etc.
- Information not available in their language or culturally appropriate
- Psychosocial barriers, especially HIV related stigma and, again, lack of basic needs being met (shelter, food, and transportation)
- Complicated system that creates barriers to treatment
- There's no monies to perform all of the outreach services we'd like
- Lack of knowledge around resources/services for education, testing and treatment
- Stigma of HIV in certain high risk minority groups i.e African American MSM
- Previously testing was only offered by the Health Department or private doctors. Many clients did not use private doctors out of fear of being stigmatized and family finding out. Nor do they want to go to SNHD because of the misconception that the health department is only interested in gay people.
- No transportation, having to go to more than one organization for Ryan White Assistance, no assistance with obtaining paperwork needed for eligibility
- Time, funding and awareness of self/others

What ideas do you have to improve HIV prevention services in your area?

- Integration of services. more true navigators through complicated system
- Coordinated efforts to increase access to services
- Coalitions meeting to make a difference not just to increase their income or look good
- ????
- Continuity and collaboration among existing and new partner agencies to decrease duplication of services and reach high-risk populations
- increase mental health services and expand housing programs to be more inclusive
- Better community outreach. We still don't talk about HIV and related care.
- ?
- Educating my fellow mental health clinicians.
- Increase funding and engage all providers in a coordinated effort. Develop an HIV outreach team that also has qualified Spanish Speaking members
- Offer HIV Prevention services to everyone (People living with HIV and those who are HIV negative) without targeting populations, which could completely overlook others outside of grant parameters. NORMALIZE HIV education and regular HIV testing city wide and state wide. We need billboards and HIV related public health information all over the Las Vegas valley--Billboards!
- Link all services and service providers, promote these services as a group-wide effort and not strictly as a "business" by agency to agency. Collaboration!!
- See above
- Work more within faith community to reduce stigma around HIV so more people get tested and know status. Work with multiple organizations in the community so that all can offer free to low cost testing.

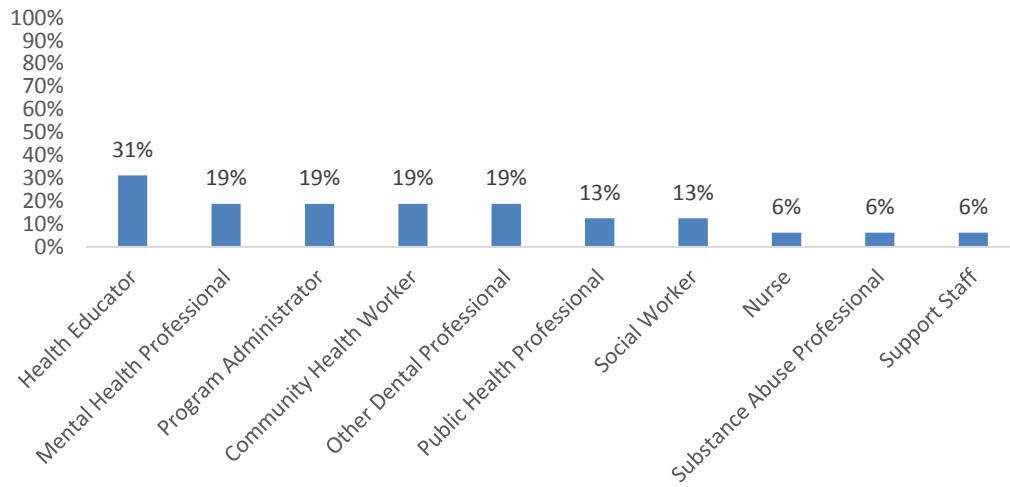
- One is the new legislation which allows Community based organizations to conduct testing on site. Hopefully in the future HIV testing will be handled just like flu vaccinations - at drug, grocery stores and malls.
- Make monthly bus passes available to clients, have case managers that will go the extra mile to assist clients in obtaining paperwork needed for eligibility,

Please provide any additional comments you have about HIV/AIDS prevention and care in Nevada:

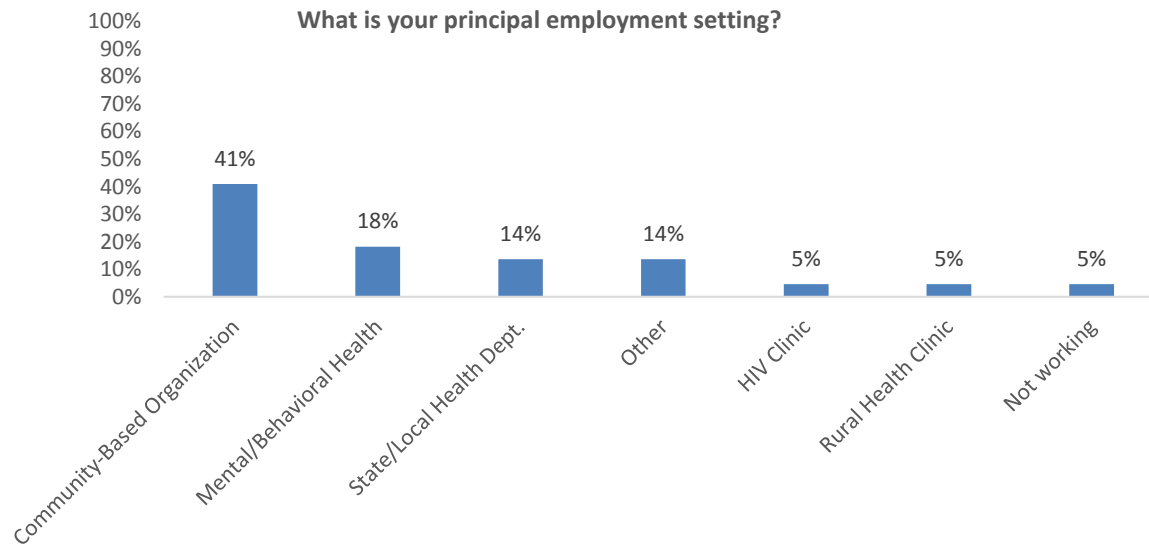
- Not as accessible as it should be
Not a concise go to place
agencies don't do enough outreach in the affected communities
Use of media in a larger scale to provide awareness reduce stigma and reiterate the services available
- In reference to Northern Nevada, providers work really well together and have fairly seamless service delivery.
- Refer to #12
- Although we are a little sluggish on outreach for prevention. We still do a reasonable job given our circumstances.
We are very good at HIV/AIDS care in the Northern Nevada area, and have made that relatively easy.
- The API community is underserved in HIV/AIDS prevention and care. We need to work more with groups and organizations that work in the API community. We should also be testing in senior living homes and communities as well as provide prevention education to them.
- Even though condom use is very important and should continue to be stressed we should also focus more on knowing who your partner is and educating the public on the ramifications behind risky behavior.

Which Nevada counties are served by your organization/agency? (Check all that apply.)		
Answer Options	Response Percent	Response Count
All Nevada counties	5.9%	1
Carson City	23.5%	4
Churchill County	11.8%	2
Clark County	64.7%	11
Douglas County	11.8%	2
Elko County	11.8%	2
Esmeralda County	11.8%	2
Eureka County	11.8%	2
Humboldt County	11.8%	2
Lander County	11.8%	2
Lincoln County	11.8%	2
Lyon County	23.5%	4
Mineral County	11.8%	2
Nye County	29.4%	5
Pershing County	5.9%	1
Storey County	17.6%	3
Washoe County	23.5%	4
White Pine County	11.8%	2
answered question		17
skipped question		8

What is your profession?



What is your principal employment setting?



APPENDIX M: LETTERS OF CONCURRENCE



Gary Costa and Kenneth Gary--Co-Chairs

September 21, 2016

Lennwood Green, MBA, MScM
Public Health Analyst/Project Officer DMHAP HAB
U.S. Department of Health and Human Services
Health Resources and Services Administration
5600 Fishers Lane
Parklawn 09W
Rockville, MD 20857

Dear Mr. Green:

The Las Vegas TGA Part A Planning Council concurs with the following submission by the Office of HIV/AIDS, State of Nevada Division of Public and Behavioral Health and the Las Vegas TGA Ryan White Part A HIV/AIDS Program 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 FOA PS 12-1201.

The Las Vegas TGA Part A Planning Council participated in the planning process through attendance at HIV stakeholder group meetings, participation in needs assessment surveys, focus groups, and other activities, reviewing and providing feedback on plan goals, objectives and strategies, and reviewing and providing feedback on the overall integrated plan document.

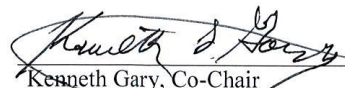
The Planning process in Nevada was a collaborative effort between the Ryan White Part B program, Las Vegas TGA Ryan White Part A program, the HIV/AIDS Prevention Program, the Northern Nevada HIV Prevention Planning Group, the Southern Nevada Regional HIV Community Planning Group, and the Las Vegas TGA Part A Planning Council.

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

Sincerely,


Gary Costa, Co-Chair

9/23/16
Date


Kenneth Gary, Co-Chair

9/23/16
Date



September 16, 2016

Kevin Ramos, MPH
Public Health Advisor
Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD and TB
Division of HIV/AIDS Prevention
8 Corporate Square Blvd, Room 3069
Mail Stop E-58
Atlanta, GA 30333

Dear Mr. Ramos:

The Southern Nevada HIV Prevention Planning Group concurs with the following submission by the Office of HIV/AIDS, State of Nevada Division of Public and Behavioral Health and the Las Vegas TGA Ryan White Part A HIV/AIDS Program 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.

The Southern Nevada HIV Prevention Planning Group 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 that bear the greatest burden of HIV disease. The planning body concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The Southern Nevada HIV Prevention Planning Group participated in the planning process through attendance at HIV stakeholder group meetings, participation in needs assessment surveys, focus groups, and other activities, reviewing and providing feedback on plan goals, objectives and strategies, and reviewing and providing feedback on the overall integrated plan document.

The Planning process in Nevada was a collaborative effort between the Ryan White Part B program, Las Vegas TGA Ryan White Part A program, the HIV Prevention Program, the Northern Nevada HIV Prevention Planning Group, the Southern Nevada HIV Prevention Planning Group, and the Las Vegas TGA Part A Planning Council.

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

Cheryl Radeloff, Ph.D.
Southern Nevada HIV Prevention Planning Group
Public Health Co-Chair

Bryan C. Heitz M.A.
Southern Nevada HIV Prevention Planning Group
Community Co-Chair



Northern Nevada HIV Prevention Planning Group

September 28, 2016

To Whom It May Concern:

The Northern Nevada HIV Prevention Planning Group (NNHPPG) concurs with the following submission by the Office of HIV/AIDS, State of Nevada Division of Public and Behavioral Health and the Las Vegas TGA Ryan White Part A HIV/AIDS Program 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.

The NNHPPG 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 that bear the greatest burden of HIV disease. The planning body concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The NNHPPG participated in the planning process through attendance at HIV stakeholder group meetings, participation in needs assessment surveys, focus groups, and other activities, reviewing and providing feedback on plan goals, objectives and strategies, and reviewing and providing feedback on the overall integrated plan document.

The Planning process in Nevada was a collaborative effort between the Ryan White Part B program, Las Vegas TGA Ryan White Part A program, the HIV/AIDS Prevention Program, the Northern Nevada HIV Prevention Planning Group, the Southern Nevada Regional HIV Community Planning Group, and the Las Vegas TGA Part A Planning Council.

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


Jennifer Howell, MPH
Public Health Co-Chair


Doug Hodges
PLWH Co-Chair

REFERENCES

- ¹ Rates were calculated using the Interim 2013 Population Estimates which are based on 2013 Population Estimates. Updated June 2013, by the Nevada State Health Division, Bureau of Health Planning and Statistics, based on the 2013 Total Population Estimates provided by the Nevada State Demographer, June 2013.
- ² U.S. Census Bureau: *2012 American Community Survey*. (2014, July). Retrieved from http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_12_1YR_NP01&prodType=narrative_profile
- ³ U.S. Census Bureau: *Community Facts*. (2014, July). Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/community_facts.xhtml
- ⁴ University of New Mexico: Bureau of Business & Economic Research: *Per capita personal income by state*. (2013, April). Retrieved from <http://bber.unm.edu/econ/us-pci.htm>
- ⁵ USDA Economic Research Service: *Percent of Total Population in Poverty, 2012 Nevada*. (2014, June). Retrieved from http://ers.usda.gov/data-products/county-level-data-sets/poverty.aspx?reportPath=/State_Fact_Sheets/PovertyReport&fips_st=32#.U7W_B_IdVHU
- ⁶ United Health Foundation: *America's health rankings Nevada*. (2014, July). Retrieved from <http://www.americahealthrankings.org/CustomReport>
- ⁷ The Henry J. Kaiser Family Foundation: *State Health Facts*. (2014, July). Retrieved from <http://kff.org/statedata/?state=NV>
- ⁸ U.S. Department of Health and Human Services: *Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations*. (2014, July). Retrieved from <http://hpsafind.hrsa.gov/>
- ⁹ Centers for Disease Control and Prevention. (2011). HIV among Transgender People: <http://www.cdc.gov/hiv/transgender/pdf/transgender.pdf>
- ¹⁰ Herbst, J.H. et al. (2008). Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. *AIDS Behavior* 12(1):1-17.
- ¹¹ Sausa LA, Sevelius J, Keatley J, Iñiguez JR, Reyes M. (2009). Policy recommendations for inclusive data collection of trans people in HIV prevention, care & services. Center of Excellence for Transgender HIV Prevention: University of California, San Francisco: <http://transhealth.ucsf.edu/pdf/data-recommendation.pdf>
- ¹² STD and HIV – CDC Fact Sheet Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance 2013*. Atlanta: U.S. Department of Health and Human Services; 2014. <http://www.cdc.gov/nchhstp/newsroom/docs/std-trends-508.pdf>
- ¹³ Nevada Department of Public and Behavioral Health (DPBH). Behavioral Risk Factor Surveillance System Survey Data, 2011-2012.
- ¹⁴ Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. 2015 Nevada High School Youth Risk Behavior Survey (YRBS)
- ¹⁵ Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online].

2015. [accessed Aug 11, 2016]. URL: <http://wwwdev.cdc.gov/brfss/brfssprevalence/>.

- ¹⁶ Packham, J., Griswold, T., Jorgensen, T., Etchegoyhen, L., and Marchand, C. (2016). Physician Workforce in Nevada – 2016 Edition. Reno, NV: Office of Statewide Initiatives, University of Nevada School of Medicine.
- ¹⁷ Marchand, C., Packham, J., Griswold, T., Etchegoyhen, L., and Jorgensen, T. (2016). Health Workforce Supply in Nevada – 2016 Edition. Reno, NV: Office of Statewide Initiatives, University of Nevada School of Medicine.
- ¹⁸ Schwarcz, S.K., Hsu, L., Chin, C.S., Richards, T.A., Frank, H., Wenzel, C., & Dilley, J. (2011). Do people who develop HIV stage 3 (AIDS) within 12 months of HIV diagnosis delay HIV testing? *Public Health Reports*, 126(4), 552-9.

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