Nevada Integrated HIV Prevention and Care Plan 2017-2021

Mid-Year Monitoring Report

September 2018

Prepared by
HIV Prevention and Care Plan Monitoring Team
Center for Program Evaluation,
School of Community Health Sciences and School of Medicine
University of Nevada, Reno

Prepared for
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

Table of Contents

Acknowledgements

The **HIV Prevention and Care Plan Monitoring Team** at the University of Nevada, Reno

Elizabeth Christiansen, PhD
Director, Center for Program Evaluation (CPE), School of Community Health Sciences (SCHS)

Kelly Morning, MPH
Coordinator, CPE, SCHS

Jennifer Bennett, PhD, MPH
Director, Nevada AIDS Education & Training Center (NAETC), University of Nevada, Reno School of Medicine (UNR Med)

Mary Karls, MPH
Program Manager, NAETC, UNR Med

Barb Scott, RD, MPH
Nutrition Specialist, NAETC, UNR Med

Trudy Larson, MD
Dean, SCHS

Thank you to the **Nevada Integrated HIV Prevention and Care Plan Monitoring Workgroup** members. We appreciate the time they have taken to keep the monitoring team apprised of activities related to the Integrated Plan and to guide the monitoring process.

Tory Johnson, MMgt
HIV/AIDS Program Manager
Office of HIV/AIDS, Nevada Division of Public and Behavioral Health (DPBH)

Lyell Collins, MBA
HIV Prevention Program Manager
Office of HIV/AIDS, DPBH

M. Thomas Blissett
ADAP and Health Systems Coordinator
Office of HIV/AIDS, DPBH

Samantha Penn, MBA
Quality Assurance & Evaluation Analyst
Office of HIV/AIDS, DPBH

Preston Nguyen Tang
Health Program Specialist I
Office of HIV/AIDS, DPBH

Irene Rose, MPH
Ryan White Program Coordinator
Northern Nevada HOPES

Alisha Barrett
Grant Administrator, Ryan White Part A Program
Clark County Social Service

Marlo Tonge
Office of Epidemiology & Disease Surveillance Manager, Southern Nevada Health District (SNHD)

Cheryl Radeloff, PhD
Senior Health Educator, SNHD

Jennifer Howell, MPH
Sexual Health Program Coordinator, Community & Clinical Health Services, Washoe County Health District

Jan Richardson, RN
Manager
University Medical Center Wellness Center

Christine Baron
University Medical Center Wellness Center

Karen Gordon
Ryan White Part D Program
University of Nevada Las Vegas School of Medicine

Introduction

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) and submitted in September 2016. The UNR HIV Prevention and Care Plan Monitoring Team met with the Integrated HIV Prevention and Care Plan Monitoring Workgroup several times during 2017 and 2018 to track plan activities. Representatives from the Ryan White and Prevention Programs provided documents and data to the monitoring team for incorporation into the monitoring reports. This mid-year 2018 report describes progress made towards Nevada's Integrated Plan goals and objectives, including a review of the activities and interventions that were designated to start in 2017 and 2018.

Key:

Green: **Activity completed.**

Yellow: **Activity in process, ongoing.**

Red: **Activity not started.**

Gray rows indicate activities with a planned timeframe of 2019 or later.

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.

		Activity/Intervention	Status
	2017	Incorporate review of targeted testing data into the Community Planning Groups (CPGs) and include a representative from the Northern Nevada HIV Prevention Planning Group on the Southern Nevada HIV Prevention Planning Group and vice versa.	To continue progress on reducing new HIV infections, the two HIV Community Planning Groups (CPGs) serve as the targeted testing workgroups in the North and South.
	2017	Recruit substance abuse and mental health representatives to targeted testing workgroups.	Both CPGs have substance abuse and mental health representatives.

	2017-2021	Review available HIV testing data (where testing is conducted and where the positives are being found).	The CPGs review HIV testing data. The State of Nevada's HIV Prevention Program worked with SNHD to implement priority system for targeting infectious cases to reduce/prevent the acquisition of HIV.
	2017	Establish baseline for testing among priority populations	This data on priority populations needs to be submitted to the plan monitoring team.
	2018	Development of a targeted testing strategy based on data results	
	2019-2020	Targeted testing strategy implemented	
	2021	Strategy and testing campaign evaluated for effectiveness	

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

		Activity/Intervention	**Status**
	2017	Collect data from the population on baseline knowledge of importance and availability of HIV testing	
	2018	Develop comprehensive statewide media and marketing campaign across multiple platforms	To increase knowledge on HIV testing locations, information will be included in the new website in 2018.
	2019-2020	Media buys and placement across multiple platforms. Website/phone app with updated testing information available	
	2021	Evaluate the effectiveness of the campaign to key populations	

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

		Activity/Intervention	Status
✓	2017-2021	Enhance, develop and evaluate state training and certification process for new testing sites	In 2017, SNHD trained 13 additional community partner/sites in HIV counseling and rapid HIV testing. Rapid testing is now available at Aid for AIDS of Nevada (AFAN), AHF, and Avella Specialty Pharmacy. SNHD has also worked with Disease Investigation Specialist (DIS) Sexual Health Clinic clinicians on rapid testing.
✓	2017-2018	Develop and administer train the trainer	SNHD has provided the training.
✓	2018-2019	Certify and train location staff to provide rapid testing to high risk populations	SNHD provides rapid HIV testing and counseling training and certification on a regular basis.
✓	2018-2021	Increase number of rapid tests conducted in Nevada by certified agencies	SAPTA funding has increased the number of HIV rapid tests provided to substance users.
✓	2017-2021	Promote rapid testing	Through the HIV Prevention program, the number of rapid HIV tests increased from 7,239 in 2015 to 9,470 in 2016. The number of rapid testing sites has increased, particularly in Southern Nevada.
→	2017-2021	Put rapid testing locations on HIV websites	There is a link to the federal hiv.gov testing locator site on the state HIV prevention/RW Part B website and the RW Part A website. SNHD has an updated calendar with rapid testing dates and sites on its website. The HOPES website provides information about rapid testing it provides. The WCHD website provides testing information.

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

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

		Activity/Intervention	Status
→	2017	Obtain provider and community buy-in for education	AETC's Transgender Health Conference on June 1, 2017 included a session on PrEP and PEP and the HIV summit at the Center in addressed PrEP and PEP. Huntridge Family Clinic has two studies on PrEP and PEP. SNHD is providing provider training on PrEP and PEP. The Association of Nurses and

			AIDS Care included PrEP and PEP a topic at 2018 conference.
→	2017	Identify other partners, agencies, and organizations that can collaborate to fund and/or deliver trainings	AETC's Transgender Health Conference on June 1, 2017 included a session on PrEP and PEP and the HIV summit at the Center in addressed PrEP and PEP. Huntridge Family Clinic has two studies on PrEP and PEP. SNHD is providing provider training on PrEP and PEP. The Association of Nurses and AIDS Care included PrEP and PEP a topic at 2018 conference.
→	2017-2018	Training provider and staff on PrEP & PEP	SNHD is providing provider training on PrEP and PEP. The Association of Nurses and AIDS Care included PrEP and PEP a topic at 2018 conference.
→	2017-2018	Community education program on PrEP & PEP	SNHD is providing community training on PrEP and PEP.
→	2017-2018	Peer to peer education on PrEP & PEP program	SNHD is offering a peer-to-peer education program on PrEP and PEP.
→	2017-2019	Implement pilot project for PrEP	The State HIV Prevention Program has been working with SNHD to start a PrEP and PEP program at the Sexual Health Clinic. The program started in November with the opening of the SNHD pharmacy. COMC has a PrEP program. WCHD currently makes referrals to PrEP providers and has plans to expand to provide PEP and PrEP services through WCHD's Sexual Health Clinic.
✗	2018-2021	Evaluate of the pilot project	
✗	2018-2019	Enhance and support clinics to offer PrEP	
✗	2017-2021	Develop a resource list of pharmacies where PrEP is available	
	2019-2020	Develop process for developing a PrEP clinic	

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

		Activity/Intervention	Status
→	2017-2018	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	In the 2017, Nevada Legislative Session, AB348 to include comprehensive, medically accurate sexual health education in schools had some traction moving forward in the legislature; however, the bill was vetoed. Members of the northern Nevada HIV Prevention Planning Group identified legislation supporting the update of sexual health education in schools to be comprehensive, medically accurate and inclusive as one of the priorities to address in advocacy efforts for the upcoming 2019 Nevada Legislative Session. It will be necessary to identify, engage, and request support from elected representatives to sponsor bill requests and take the responsibility of moving the efforts forward through the legislative process.
	2019-2021	Collaborate with State Board of Education and local school districts to implement Comprehensive SH education in schools	
	2019-2020	Explore the development of school-based clinics	
	2019-2020	Develop a standardized curriculum for HIV/STD 101	
	2019-2020	Make curriculum available to community partners statewide online	
	2019-2020	Evaluate curriculum	

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

		Activity/Intervention	Status
→	2017-2021	Explore condom need in community for priority populations	The Center's Pharmacy Project has distributed over 50,000 condoms to HIV positive individuals through pharmacies and other community support groups. SNHD has taken over the program resulting

			in positive impact. To increase condom distribution, subcontracts in Las Vegas were required to attend a Social Network Recruitment training. In addition to condom distribution, organizations have continued to promote general HIV education strategies.
	2017-2021	Identify places where free condoms are most needed	
	2017-2018	Identify where people can buy condoms	
	2017-2019	Explore different pathways to acquiring condoms (i.e. working with manufacturers to get cheaper condoms for people to buy)	
	2017-2021	Awareness campaign about ability to get condoms through Medicaid	SNHD has a program with Walgreens to promote awareness among HIV positive clients of access to condoms through Medicaid.
	2017-2018	Increase accessibility by creating an online application to map free and purchased condom locations in Nevada	
	2017-2018	Provide capacity building assistance for the implementation of syringe services programs (SSP)	
	2018-2019	Pilot of syringe exchange machines in Southern Nevada	SNHD has been operating three syringe exchange machines in Las Vegas.
	2018-2019	Develop buy-in from community organizations and businesses that would be impacted by the SSP	
	2020-2021	Expand syringe services to centers for harm reduction, syringe exchange, wound care,	

	2021	Analyze data from SSP to evaluate best practices moving forward

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

		Activity/Intervention	Status
✓	2017-2021	Develop regional flow chart (resource map) of services/ activities for the newly-diagnosed and for providers and update it regularly.	As of November 2017, a regional flow chart, that includes services and actives for HIV+ patients, is available online and in print.
→	2017-2021	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	Parts A, B, C, and D are working to map the systems to better utilize the CAREWare referral system to coordinate new patient intakes between organizations. AFAN utilizes CAREWare to submit necessary referrals to community partners for any services not offered at AFAN or at the client's request. AFAN care staff is also able to provide additional resources outside of Ryan White providers as needed. Moving forward, AFAN care staff will utilize CAREWare performance measures and custom reports to monitor clients who have not achieved viral suppression. Care staff will follow-up with those clients to discuss current barriers, provide intensive medical management, and work with each client to establish possible resolutions to alleviate those barriers preventing them from achieving viral suppression. Horizon Ridge Clinic, LLC (HRCL) has instituted a position for an intake coordinator who completes all initial eligibility for newly diagnosed clients and recertification for new clients to their agency. The coordinator assigns the client to a medical case manager for continuum of care, recertification and additional resources under RWPA and outside resources.

			AFAN staff recognize that some clients often experience difficulty expressing or sharing information regarding their current needs and/or barriers. Additionally, many clients may not completely understand the full scope of all programs and services available to them. With this in mind, adjustments were made to internal agency forms such as those included in AFAN's client confidential information (CCI) packet. A checklist citing all of the services available at AFAN and / or community partners was added to this packet. In addition to staff who complete Ryan White Eligibility, it allows other care staff to review clients' packet and take part in linking them to care. It also enables staff to link clients to care in a more efficient and timely manner. The Community Outreach Medical Center continues to work with our community partners to increase client admissions into medical care and medical case management. During the last quarter they admitted 26 new patients into medical care and 24 new patients into medical case management and they also had 6 Returning to medical case management. Northern Nevada HOPES has hired a Ryan White Program Coordinator who will assist in oversight of HOPES' RW Part B, C, and D programs. The HOPES Retention in Care program continues to coordinate efforts with CCHD during bi-weekly conference calls to review mutual clients who access HOPES as their medical home, but live in rural areas. This has proven to be effective in not duplicating services among agencies and supporting one another's work.
	2017-2021	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	Regional service delivery meetings have been occurring and include SPEC (Services, Planning, and Evaluation Collaborative), Northern Nevada HIV and Ryan White Providers, and Action Planning Group (APG). AHF reported that sharing QM data trends and information regarding effective strategies at the RW meeting has been helpful. AFAN would like to coordinate with community partners on ways to inform clients of the Hepatitis C screening locations and transportation options. UMC Wellness started coordinating with NARES to provider Uber transportation and bus passes to their clients. The Center in Las Vegas has hired a HIV Services Manager.

✓	2017-2021	Inter-agency case management team building/training. To reduce competition, understand roles	Part A has conducted an inter-agency case management team building training by Coldspring and plan to do it yearly. SNHD is doing a QM project to improve communication across the RW programs and with other district programs.
✓	2017-2021	Annual Ryan White provider conference with training, RW updates on initiatives, basic fiscal and quality management, advanced training/certifications, strategies	AETC hosted the 18th Annual Autumn Update, Networking for HIV Care conference in November 2017. A Ryan White provider conference was held in June 2018 and the Association of Nurses & AIDS Care (ANAC) conference was held in April 2018.

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

		Activity/Intervention	Status
→	2017-2019	Linking justice-involved individuals with local clinics to provide continuity of care for those patients. Identify a point organization for parolee case management in each North and South. Jails and prisons would connect HIV+ patients to the case management team initially, who would manage their care, set them up for services, referrals, eligibility	SNHD reports a recent influx of clients released from prison or jail. SNHD has a SPNS grant for re-entry populations. Transitional Care Coordination is designed for HIV positive clients who are incarcerated. This program works with clients to prepare them for discharge and link with services upon release. SNHD has a new subgrant that started October 1, 2017 with the pharmacy at SNHD and the jail. The RW clinic at SNHD tries to see Former inmates discharged from the correctional system when they walk-in even without appointments so care can be initiated. The RW Part A program, under EIS, started sending a Community Health Nurse (CHN) to Clark County Detention Center (CCDC) to work with the TCC team to minimize these disparities. So far, the CHN has developed an effective working relationship with the medical team in CCDC, facilitated the referral of prescriptions to the SNHD pharmacy for those who have a discharge date, and has provided an in-service on syphilis to the facility per their provider request. In Washoe County, an agreement has been reached so that HOPES can have a provider in the jail once a week and to facilitate re-entry.
→	2017-2019	Link HIV+ mental health & substance abuse clients with local clinics to provide continuity of care. Identify point	HIV testing has been integrated into the mental health system in the state. A position was created and filled to connect Nevada's HIV/AIDS Office and the Substance Abuse Prevention and Treatment Agency

		organizations and providers.	(SAPTA). The state is talking with Caliente to possibly test youth in detention every six weeks. University Medical Center provided 123 clients with mental health screenings in the 16/17 grant year. UMC also liked clients with psychiatric care and decreased wait time to see a provider. Part A has added several new mental health providers. Horizon works directly with the SNHD on-site with the newly diagnosed and others in need of accessing mental health and substance abuse services. In a therapeutic setting we navigate individuals through mental health challenges that impede they ability to focus on their medication regiments. Our therapeutic team with include treatment goals to assist clients with medication management and adherence when the client exhibit limitations to manage taking medications due to mental health challenges. AFAN Mental Health Services worked with 22 clients in the 2016-2017 grant year. The program was able to offer clients services to keep them moving to self-sufficiency. The Mental Health program at HOPES served 215 unduplicated clients in the GY. A client satisfaction survey reported 93% of clients being satisfied with behavioral health services. Ridge House also provided nine clients with comprehensive care.
	2018-2021	Link HIV+ homeless clients with local clinics to provide continuity of care. Identify point organizations and providers.	HELP of Southern Nevada is an organization that has been working with homeless individuals. SNHD and Part A have been collaborating with HELP for outreach. HRCL notes that they are also seeing many clients who are homeless or on the edge of homelessness, without income. Some of these clients also have substance abuse issues and/or mental health challenges. Many agencies will not work with them until they have been clean for 40 to 90 days. AFAN has noted an increase of homeless clients that are not eligible for Ryan White services due to not having an acceptable form of ID. This issue becomes more difficult to resolve when those clients do not have a certified birth record in their possession as well. Many of these clients were born out of state and most applications for a certified birth record require a copy of the person's ID and / or a notarized attachment. In rare cases, AFAN care staff are able to come up with a resolution for some individuals who have allowable family members that can request the client's birth record in the their behalf.

	2019-2021	Link HIV+ individuals from refugee populations with local clinics to provide continuity of care. Identify point organizations and providers	SNHD has had an influx of clients who are refugees. They are coordinating with other SNHD programs (TB clinic, refugee health, sexual health clinic) and with community refugee agencies to improve communication and decrease duplication.

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

		Activity/Intervention	**Status**
	2017-2018	Expand Peer-to-peer advocate to every Part A and Part B site	Expansion of peer-to-peer advocates to all sites is in progress at Part A and Part B. Part B is funding the Center to provide the Stanford Positive Management Program to HIV+ clients. Part A funded Dignity Health to provide the training. Since October 1, 2017, Part B has had a Community Health Worker based at SNHD. This is a demonstration site project with Boston University. There are also two peer navigators. Three agencies have site-based peer advocates. UMC could benefit from a peer navigator.
	2019-2020	Evaluate peer advocate program	
	2018-2019	Develop peer (HIV+) volunteer support system to meet individually with newly diagnosed, based at case management organizations.	All clients at the Community Counseling Center review their labs every six months with a MCM. They are the mental/psycho-social link for partnering agencies. CCC has become part of the plan to insure clients are virally suppressed. CCC has support groups and activities, all geared to health and wellness. This includes 2 peer advocates, reaching out to active and non-active clients. CCC has increased CCC activities and now has a support group Monday and Wednesday night, an educational/social activity every Thursday, an intro to HIV/our agency/or Las Vegas every Tuesday. CCC also collaborates with Golden Rainbow for wellness workshops every Tuesday night. Peer support groups led by HOPES continue to be a safe space for clients to express concerns and share resources. To date, there is no waitlist for PSS services and clients can access PSS groups immediately. The Mental Health Services program has worked in collaboration with the PSS program to be able to provide referrals to clients who may be interested in speaking with other individuals/peers who have similar experiences.

	2017-2021	Delivery of 6-week Positive management program to HIV+ clients and chronic disease management	The Las Vegas TGA reports that when a newly diagnosed client comes in for their first Sexual Health Clinic visit to receive the confirmatory test, the client is enrolled in the Anti-Retroviral Treatment and Access to Services (ARTAS) program. ARTAS is an individual-level, multi-session intervention for people who are recently diagnosed with HIV. ARTAS operates on a case management strengths-based approach, helping the client realize strengths they already possess and utilizing those strengths to make the linkage to medical care. The most important goal of the ARTAS program is linkage to medical care. Results data from grant year 2016-2017 show 435 individuals enrolled in the ARTAS program. Of the total number of clients,186 were newly diagnosed and 249 were previously diagnosed but re-engaging in medical care from jails/prison, out of care or out of state. The Las Vegas TGA also provided health education/risk reduction (HERR) classes to 215 HIV positive individuals (1,060 classes) to encourage healthy behavior and positive health outcomes. Dignity Health is expanding Stanford Chronic Disease Self-Management Program and Positive Self-Management Program in Southern Nevada and sent two staff members to train as Master Trainers for both programs.
	2018-2019	Explore the requirements to have peer advocates become CHW through the certification program	

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

	Activity/Intervention	Status
	2017-2019	Collaborate with mental/behavioral health providers	Las Vegas TGA has been successful in recruiting several more mental health providers.

			Since the beginning of 2018 HOPES has allocated 1 FTE to specifically serve Ryan White patients who requested and/or were referred to their behavioral health services. This has allowed them to eliminate the previously experienced waitlist for Ryan White consumers. They also have developed processes for their internal behavioral health referrals to be able to be triaged and overseen by the Behavioral Health Liaison who assists the Specialists in monitoring the referral list and scheduling clients for appointments. This process has proven to be extremely efficient and has maximized the resources we currently have available. HOPES is currently expanding services in the coming months, to include increased capacity to the entire Behavioral Health department.
	2018-2021	Foster collaboration between the agencies to cross provide services at other locations to make services more readily available	Las Vegas TGA reports that there had historically been issues of medical case managers not working together between agencies and medical case managers with different education and life experience backgrounds not able to reconcile differences with one another. They worked with Coldspring Center for Social and Health Innovation to provide an HIV Medical Case Management Certificate training program. Once all medical case managers completed the online trainings, there was in-person two day training focusing on a system of care with a common language focus, which can facilitate long-term change and improved quality of services.
	2018-2021	Collaborate with CBOs who have added some MH providers	

O2b. Strategy 3: Professional Development activities

		Activity/Intervention	**Status**
	2017-2021	RW funded agencies to participate in annual Summer Institutes which focus on the continuum of care between MH, SA and HIV	Part B is now allowing out of state travel and funded scholarships for the HIV community to go to the US Conference on AIDS in 2017. AETC worked closely with the Nevada Office of AIDS to provide the HIV summer conference in June 2018 for all RW funded agencies to participate.
	2017-2018	Explore methods to educate MH and SA providers about HIV integration within their existing roles (CEU's)	SNHD has delivered statewide HIV 101 and 201 and Hepatitis C professional development to mental health providers and SAPTA. A webinar is in development.

		tie this to HIV 101 mentioned previously	The WCHD HIV staff participated in HIV stigma training.
		Deliver HIV/STD 101 MH & SA providers	Dignity Health has been successful at running webinars and trainings on a wide variety of HIV topics
	2017-2021	More education for providers about the resources available in the community including outside of Ryan White	There is a statewide Hospital Discharge Planning summit and quarterly meetings to improve discharge practices with providers. Agenda for the summit and meetings include educating providers about available resources.
	2017-2018	(See 2a) Develop regional flow chart (resource map) of services/activities for all HIV+ patients, including mental/behavioral/substance use resources and update it regularly.	As of November 2017, a regional flow chart, that includes services and actives for HIV+ patients, is available online and in print.

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.

		Activity/Intervention	**Status**
	2017-2018	Create a series of support, education and training options for group of patients in care	The Las Vegas TGA provided a variety of services to Ryan White Clients to help improve treatment adherence: emergency financial assistance for food, housing, utilities and medication; food bank/home delivered meal services to improve health and maintain adherence to primary medical care; medical transportation services in the form of a bus pass or van transportation for access to medically necessary appointments and services; housing assistance to ensure access and maintenance to health care and supportive services; and psychosocial support services. The Las Vegas TGA has an Out of Care (OOC) program to actively monitor the service utilization of the HIV continuum of care and compares the unduplicated clients against the officially reported cases of HIV and AIDS. The OOC program continuously tracks unduplicated clients accessing

			services to see if any gap in medical care occurs. If a client's treatment statistics show that the client may have fallen out of care, a disease investigator goes into the field to find the client and encourage their re-entry into the care system. This directly triggers the ARTAS program with the main goal of linking the individual into care through the assistance of a Linkage Coordinator. UMC Wellness is doing a QM project to track no-show rates before and after implementing a reminder system using Google text messaging system with clients. AFAN continues to maintain support and educational programs such as the Mothers, Sisters, Daughter (MSD) support group, nutrition lunch & learn, external corporate hosted presentations. AFAN also creates and provide a monthly community calendar for clients as well as community partners listing most events taking place within the community. HOPES focuses on ensuring that clients stay current with their RW status via reminder phone calls for clients who have upcoming expiration dates and/or who have already expired. During these patient contacts, the RCHSS staff are also able to link clients to schedule any needed medical appointments, labs, housing, and/or other case management needs. Part B has a series of support, education and training options for patients in care. The new Part B website will include a calendar of support groups and other education options. Part B reports that, of the 109 clients with labs, 89 (82%) have viral loads of less than 200 copies/Ml. Part B reports that 74 clients were receiving treatment adherence counseling; and, 90% of clients were adherent with clinic appointments. WCHD linked 75% of OOC cases back to HIV care.
	2017-2018	Ensure that patient education programs are language and literacy ability appropriate	Evidence needed.
	2017-2021	Deliver medication adherence sessions on a continual basis to provide education and support	UMC medical providers ensure that our clients get their antiretrovirals and provide all clients adherence counseling at initial visit. Patients are navigated to the pharmacy of their choice to obtain ART once they are seen at UMC Wellness Center. Staff makes sure that clients have insurance (private or public) to be able to get their ARTs, otherwise,

			they will be seen by our Ryan White Eligibility Specialist on site to get RW Part B/ADAP. Medical case management providers are required to provide education on medication adherence. If supplemental funding is received, SNHD will be doing medical adherence counseling at their pharmacy.
	2017-2021	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.	The first lab exchange between Part A and Part B has occurred and will occur on an annual basis. In Clark County, 10 of 16 providers have been trained on pulling their own viral suppression by service category. Nye County is using the Performance Measure Worksheet to monitor viral loads, 90% of clients are virally suppressed. Recommends being tested every 3 to 6 months and tells client to ask doctor about changing medications. SNHD continues to utilize the **Find, Assess, Stabilize, Treat (FAST)** model through collaborative activities between Office of Epidemiology and Disease Surveillance (OEDS) and Clinical Services. With great technical assistance from RW Part A grantee office, AFAN is now able to monitor performance measures and track individual clients who have not achieved viral suppression. As of 12/31/17, 78% of active clients had labs documented in CAREWare in year 2017. When generating the amount of clients not virally suppressed, CAREWare also includes those clients that do not have labs entered during the time span being measured. Therefore, almost 70% of active client were reported as virally suppressed in year 2017 according to CAREWare. At Huntridge, rapid ART initiation is on the same day of HIV diagnosis as a strategy to increase engagement in care and increase the proportion of individuals who achieve and maintain ART viral suppression.

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

	Activity/Intervention	Status
 2017-2018	Ensure clinical programs include medication management materials, support,	The Ryan White program is required to ensure clinical programs include medication management materials, support, and education programs/counseling for all clinical patients.

		educational programs and counseling for all patients	SNHD has added pharmacy services with a pharmacist available to counsel clients who are starting ART, to discuss adherence issues with clients, and to screen clients who have co-morbid conditions and medications. The SNHD pharmacy is preparing to offer PrEP in the fall. Patient counseling is included with ADAP. AHN staff continues to work very closely with the ADAP program to ensure that the consumers are prescribed and receiving their ART medication in a timely manner with no gaps. AHN staff follows up with both internal and external Community Partners to ensure service referrals have been made and or received. AHN staff review and explains the importance of consumers being adherence to their medication. A success seen in the HOPES Medical Case Management and Treatment Adherence (MCMTA) program is through an intensive medication management program provided to non-adherent patients and/or those who may need a higher level of care or contact. This program, HOPES' pill box program, provides the MCM/TA staff with the ability to dispense current medications to clients through weekly and/or monthly pill boxes. Clients are able to drop-in during clinic hours or are able to have their medication delivered to their residence by HOPES' MTS program. This program has provided an invaluable opportunity for the MCMTA staff to monitor client's medication adherence and provide medication counseling, as well as provide additional oversight for client's medical needs such as provider follow-up appointments, labs, and/or support services. One of the many successes in this program is the ability to work collaboratively among clients who are accessing Behavioral Health services. This has allowed for the provision of therapeutic opportunities to develop and identify strategies with clients to build upon self-sufficiency in medication management in the future.
	2017-2021	Provide education to pharmacists on HIV medication adherence	The SNHD pharmacy has increased the number of contracted third-party payers which has enhanced our capacity to ensure that patients leave the facility with their ART medications. Along with the other team members, the pharmacist provides adherence counseling, including use of pillbox and follow-up contacts with patients who are just starting their medications. The program provides patients with a list of specialty pharmacies in the community so they

			can make their choices based on pharmacy location, hours, etc. The HOPES Pharmacy works closely with the Medical Transportation Services (MTS) program and HIV RN to ensure clients who are able to access their medications from HOPES pharmacy are provided the option of local medication delivery.
	2017-2021	Encourage pharmacists that work with HIV clinics to get certified in HIV care (AAHIVM certification)	Currently, three pharmacists in RW Part B have AAHIVM certification to work in HIV care. The SNHD pharmacists are trained in HIV. Pharmacists at HOPES are trained in HIV. Huntridge encourages clients to use HIV specialty pharmacies for all their medications, as these locations are better suited to assess for adherence and possible drug interactions, which increase adherence, decrease barriers to care and help foster a more positive treatment related experience.
	2017-2021	Disseminate information about policies to clients regarding emergency medication access	A policy regarding emergency medication access is in place.

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

		Activity/Intervention	**Status**
	2017-2021	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	Educating 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 is part of the standards of care for Part A and Part B.
	2017-2021	Create data sharing agreements between CAREWare and labs	There have been some challenges with respect to creating data sharing agreements between CAREWare and the labs. Parts A and B have hired people to coordinate sharing agreements. In addition, they are working with the Office of Public Health Informatics and Epidemiology (OPHIE) on an agreement for viral loads and CD4.

			The first lab exchange between Part A and Part B has occurred and will occur on an annual basis. In collaboration between the Dignity Health- St. Rose Dominican Hospital's IT department and the Clark County IT, CAREWare was installed and is fully functioning in a Dignity Health desktop this quarter. Through multiple internal processes, a permanent solution was finally established.
✓	2017-2021	Educate clinicians to do at least 2 viral load tests per year	Ryan White requires clinicians to do at least one viral load test per year and plans to send out additional guidelines to education the community about viral load to all list-serve members.
✗	2017-2021	Educate the community about community 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

		Activity/Intervention	**Status**
✓	2017	Recommend that HIV care clinics have plans in place for routine sexual history and screening for STIs	Routine sexual history and screenings for STIs are incorporated into care in at least four of the Las Vegas clinics. SNHD is working with Clark County Detention Center to conduct STI screenings. During the GY, SNHD performed 896 Syphilis test, with 23 new positives. In addition, 2390 HIV test were conducted with 18 new positives. Within the last 3 months, AHF has hired a HCC Registered Nurse. This new role in the HCC has allowed more impact on capturing TB screening, Annual Pap smears, HEP B vaccines, etc. Routine sexual history and screenings for STIs are incorporated into care at HOPES in the north. HOPES reported that 89.8% of clients received HIV risk-reduction screening/ counseling; 36% were screened for TB; 40% screened for syphilis; 25% screened for Hepatitis B; and 11% screened for Hepatitis C.
✗	2018	Develop resource guide for providers. (Health departments, providers	

		who specialize in STI's including email for consults and referral)	
	2017-2021	Develop and maintain accurate list of who is seeing patients with HIV	An accurate list of who is seeing patients with HIV in Nevada is under development.
	2018-2020	Provide outreach to all providers (including private) re routine screening and education for STI's	

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

	Activity/Intervention	Status
	2017-2018	Prevention with positives programs integrated into clinical care	Part B implemented 24 HIV Health Education Risk Reduction (HERR) sessions in the 2016-2017 grant year. In the sessions, 80% of participants reported an increase in knowledge about reducing HIV transmission. Part B has applied for a supplemental award, which would expand their ability to provide clinical care and ensure that the standards of care are up to date. Prevention with positives is part of the standard of care for Part A. They are able to monitor if STI testing occurred. ACCEPT has health education and risk reductions meetings twice per month.
	2017-2018	Recommend that EHR in all clinics includes sexual history and STI screenings	Evidence needed.
	2017-2021	Expand risk reduction and health education for clients to include STIs and importance of screenings and when to get tested	Evidence needed.

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

		Activity/Intervention	Status
✗	2018-2019	Develop standardized assessment forms for all providers for all the assessments	
	2019	Use Quality management team to develop and train on use of forms	
	2019-2021	Establish baseline data and report on data annually	
	2019-2021	Disseminate the findings on a regular basis	
	2020-2021	Develop Quality improvement plans	

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

		Activity/Intervention	Status
→	2017-2018	Gather baseline data from HIV care clinics regarding current practices for MH, SA and chronic disease screenings	Part B funded medical clinics are required to screen for mental health. If Part B receives the supplemental award they applied for, they will be able to expand the number of clients who could be served by Ryan White clinics. If a client does not receve services at a Ryan White clinic, receipt of mental health and substance abuse screening is not guaranteed. In Part A, mental health assessment and substance abuse screening is part of case management and is occurring in Part A clinics. Screening for chronic disease also is done but is a very broad category to monitor. Part A conducted a needs assessment on mental health and substance abuse last year. UMC Wellness and SNHD conduct substance abuse screening at visits.

			The Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening tool is done by HOPES at every client visit.
	2018	Recommend that HIV care clinics have plans in place for routine MH and SA assessments with HIV clients	Part B funded medical clinics are required to screen for mental health. In Part A, mental health assessment and substance abuse screening is part of case management and is occurring in Part A clinics. UMC Wellness and SNHD conduct substance abuse screening at visits. The Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening tool is done by HOPES at every client visit
	2018	Recommend that HIV care clinics have plans in place for routine assessments for chronic disease with HIV clients	Screening for chronic disease also is done in Part A but is a very broad category to monitor.
	2018-2019	Develop resource guide for providers. (providers who specialize in chronic disease, mental health, and substance abuse including email for consults and referral)	
	2019-2020	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	

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

	Activity/Intervention	Status
2019	Recommend that EHR in all clinics includes routine screening and MH, SA and chronic disease assessments	

	2019-2021	Expand health education for clients to include different comorbidities and importance of routine screenings
	2019-2021	Provide education for providers to assist them in providing good individual or group education

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

	Activity/Intervention	Status
	2018-2019	Develop standardized assessment forms for all providers for all the assessments
	2019	Use Quality management team to develop and train on use of forms
	2019-2021	Establish baseline data and report on data annually
	2019-2021	Disseminate the findings on a regular basis
	2020-2021	Develop Quality improvement 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.

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

	Activity/Intervention	Status
	2017	Conduct listening sessions with individuals from groups experiencing disparities to identify any gaps in knowledge or incorrect beliefs about HIV.	Part B staff members and Southern Nevada HPPG are planning to conduct listening sessions. Part B has a partnership with the Office of Minority Health for a community needs assessment related to faith-based organizations and minorities. Some Part A sub-recipients have gathered information from difficult to reach populations, including customer satisfaction surveys and gap analysis information.

			SNHD reported some issues faced by transgender clients and refugee clients.
✗	2017	Identify successful group-specific disease prevention campaigns and strategies that can be adapted to HIV prevention.	

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

		Activity/Intervention	Status
✗	2018-2021	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	
	2019-2021	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	
	2019-2021	Evaluate social network strategies	
	2020-2021	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	
	2019-2021	Conduct listening sessions with individuals from target groups experiencing disparities to find out if they are familiar with any of the educational efforts, and to find out what they know/believe about HIV.	

	2020-2021	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.	

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

		Activity/Intervention	Status
✓	2017-2019	Training CBOs and communities with high risk to provide on-site testing	In 2017, the state prevention program funded training for 89 participants and 26 agencies to provide their own HIV testing.
✓	2017-2020	Identify and recruit additional providers and CB0s to have testing at their sites	Prevention has had ongoing discussions with a variety of CBOs about offering their own testing. Two additional trainings to provide testing were held in August 2017.
	2020-2021	Evaluate CBO on-site testing programs	

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.)

		Activity/Intervention	Status
→	2017	Conduct listening sessions with individuals from PLWH in underserved populations and high risk groups to 1) learn about their	Part B staff members and Southern Nevada HPPG are planning to conduct listening sessions.

		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	Some Part A sub-recipients have gathered information from difficult to reach populations, including customer satisfaction surveys and gap analysis information. SNHD reported some issues faced by transgender clients and refugee clients.
	2018	Review information gathered in listening sessions Develop new strategies for improving first contacts.	
	2017-2021	Provide experiential training to employees and volunteers in HIV care and 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	Part B was able to use rebate dollars to send 15 prevention and care providers to the U.S. Conference on AIDS in September. 90% of Part B's HIV Health Education Risk Reduction (HERR) program participants reported program was culturally competent and appropriate. The Aids Healthcare Foundation is increasing clients by assisting with transportation offered by the Linkage team. Linkage also offers incentive cards for food. In doing this our patients feel the HCC cares about their well-being. Just recently our HCC, Pharmacy, and case management have been approved to move forward with creating a Lyft account for any clients who are needing transportation assistance. Horizon has been working very diligently with contacting and encouraging clients to utilize services with the agency. In our effects to retain clients our case managers have been doing monthly contact with clients to see if they are in need of any services and to see if clients have any questions or concerns about medications and to determine if clients need any referrals for services that are offered at the agency or other service needs.
	2020-2021	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	

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

		Activity/Intervention	Status
	2017	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.	Part B and Prevention are working on a new HIV NV website and social media campaign which will be launched in 2018. The website will include lists of available services, eligibility information, costs, contacts, instructions on how to access services, locations, and hours of providers. The website will be updated on a regular basis. Part A also has a website that is updated regularly.
	2018	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.	
	2018	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	

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

	Activity/Intervention	Status
2017	Assess staffing to identify strengths and weaknesses in meeting language needs (oral and written) for Spanish speaking clients. Hire bi-lingual staff who are fluent in differences in Spanish across varied Hispanic cultures	Part A has resources available in Spanish and the website can be accessed in Spanish. Part A has Spanish-speaking providers at AFAN, AHF, CCC, COMC, Dignity Health, SNHD, and Huntridge Family Clinic. In addition, a partnership with University of Las Vegas Nevada has allowed AFAN to have a Master Practicum Student available to serve their Spanish-speaking clients with individual mental health therapy. AFAN finds there is a gap for their Spanish-speaking clients and it has been beneficial to have practicum students on sight. The new Part B website and campaign materials will be translated into Spanish. 90% of Part B's HIV Health Education Risk Reduction (HERR) program participants reported that the program was culturally competent and appropriate. HOPES has Spanish-speaking medical assistants, navigators, eligibility & intake specialists, case managers, a community health worker, and a pharmacy technician.
2017-18	Determine the need for translation in other languages besides Spanish	Part B has identified the primary language for most Ryan White clients in 2017. 72% are English speakers; 15% Spanish speakers; 12% primary language is unknown; and the remaining 1% spoke other languages.
2018	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 6th grade reading level	
2019	Implement welcoming drop-in programs in different communities, at different "user	AHN has been consistent with making daily reminder calls to ensure consumers attend their appointments. Consumers are scheduling appointments 6 months out and attending. Consumer

	friendly locations", different times and days. (These programs offer a welcoming, relaxed, friendly place where 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.	participation has increased in completing a satisfaction survey showing that they are engaged in care. AHN staff assist consumers in obtaining the proper, required documentation as well as referring the consumers to the proper agencies depending on their needs.

Conclusion

The review of Integrated Plan activity progress through July 2018 revealed many activities in progress with some activities already completed and some not yet started. The Integrated Plan Monitoring Workgroup will continue to meet to review the Plan objectives, strategies and activities to determine if any changes should be made to fit current priorities and resources available in the state. The Workgroup will be working on a revised process for tracking plan activities in the next year. A final 2018 progress report will be completed in March 2018.

Appendix A: List of Acronyms

AAHIVM	American Academy of HIV Medicine
ACA	Affordable Care Act
ACCEPT	Access for Community & Cultural Education Programs & Training
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AHF	AIDS Healthcare Foundation
AFAN	Aid for AIDS of Nevada
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
ARTAS	Anti-Retroviral Treatment and Access to Services program
CBO	Community Based Organization
CCC	Community Counseling Center
CCHHS	Carson City Health and Human Services
CDC	Centers for Disease Control and Prevention
COMC	Community Outreach Medical Center
CPG	Community Planning Group
CRCS	Comprehensive Risk Counseling Services
DIS	Disease Investigation Specialist
DPBH	Division of Public and Behavioral Health
eHARS	enhanced HIV/AIDS Reporting System
HER	Electronic Health Record
EIIHA	Early Identification of Individuals with HIV/AIDS
EPI	Epidemiology
GY	Grant Year
HELP	HELP of Southern Nevada
HERR	HIV Health Education Risk Reduction
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
HOPES	Northern Nevada HOPES
HOPWA	Housing Opportunities for Persons with AIDS
IDU	Injection drug use or injection drug user
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex
MH	Mental Health
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
NARES	Nevada AIDS Research and Education Society
NDOC	Nevada Department of Corrections
NHAS	National HIV/AIDS Strategy

NIR	No identified risk
NRR	No reported risk
OOC	Out of Care
OPHIE	Office of Public Health Informatics and Epidemiology
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
SA	Substance Abuse
SAPTA	Substance Abuse Prevention and Treatment Agency
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SCHS	School of Community Health Sciences, University of Nevada, Reno
SNHD	Southern Nevada Health District
STD/I	Sexually Transmitted Disease/Infection
SSP	Syringe Services Program
TGA	Transitional Grant Area
UMC	University Medical Center
UNLV	University of Nevada, Las Vegas
UNR	University of Nevada, Reno
UNR Med	University of Nevada, Reno School of Medicine
WCHD	Washoe County Health District