Nevada Integrated HIV Prevention and Care Plan 2017-2021
Interim Monitoring Program Report

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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. This report outlines progress made on the Plan activities and interventions through June 2017. Activities with a 2017 timeframe in the Plan are included in this interim report. The annual report will be completed in January 2018 and will include updates on progress towards the Plan goals and objectives and activities, as well as recommendations for the next year. Review of Plan activity progress to date revealed many activities in progress with some activities already completed and a few not yet started.

Key:

Green:
Activity completed.

Yellow light:
Activity in process, ongoing.

Red:
Activity not started.

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.

In 2016, the SNHD collaborated with AIDS Healthcare Foundation to bring an additional mobile testing van to Las Vegas. The additional testing services offered with the van aim to reach high risk clients who might not otherwise seek out screening services. The State of Nevada's HIV Prevention Program worked with WCHD to increase client notification of testing results from 76% to 91%. Prevention also reported that 96.6% of clients were informed of their test results within 7 days. According the Part B annual report, there were 22, 298 HIV test completed in GY16. Of that, 190 were newly diagnosed as positive. The State program also worked with SNHD to implement priority system for targeting infectious cases to reduce/prevent the acquisition of HIV. To continue progress on reducing new HIV infections, Northern Nevada continues to meet with a workgroup. Southern Nevada's and statewide workgroups are in discussion.

Status of Planned 2017-2018 Activities

Develop statewide targeted testing workgroup

Review available HIV testing data (where testing is conducted and where the positives are being found)

Recruit substance abuse and mental health representatives to workgroup

Establish baseline for testing among priority populations

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

To increase knowledge on HIV testing locations, a new website is expected to roll out on July 31, 2017. Other community awareness events, such as LV Urban League's World AIDS day event with approx. 70 participants, have taken place to spread awareness.

Status of Planned 2017-2018 Activities

- Collect data from the population on baseline knowledge of importance and availability of HIV testing

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

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, AIDS Healthcare Foundation, and Avella Specialty Pharmacy. SNHD has also worked with Disease Investigation Specialist (DIS) Sexual Health Clinic clinicians on rapid testing. This change reduces time DIS spends in the clinic and allows them more time to follow up with newly diagnosed individuals/partner services. With the prevention program, there have been a total of 9,470 rapid HIV tests (8328 SNHD; 1142 WCHD).

Status of Planned 2017-2018 Activities

- Enhance, develop and evaluate state training and certification process for new testing sites
- Develop and administer train the trainer
- Promote rapid testing
- Put rapid testing locations on HIV websites

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

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

The State HIV Prevention Program has been working with SNHD to start a PrEP and Pep program at the Sexual Health Clinic. The program is anticipated to start in November with the opening of the SNHD pharmacy. In addition, community partners have been working on a HIV prevention license plate with proceeds would go towards PrEP and PEP services. Currently, the Huntridge Family Clinic has two studies on PrEP and PEP. AETC's Transgender Health Conference on June 1, 2017 included a session on PrEP and Pep and the HIV summit at the Center in September or October also plans to address PrEP and PEP during the summit. SNHD is providing provider and community training on PrEP and PEP and will be offering a peer to peer education program on PrEP and PEP. The Wellness Center has peer to peer education on PrEP and PEP as well.

Status of Planned 2017-2018 Activities

- Obtain provider and community buy-in for education
- Identify other partners, agencies, and organizations that can
- Community education program on PrEP & PEP
- Peer to peer education on PrEP & PEP program

collaborate to fund and/or deliver trainings

Initiate provider and Community education and training on PrEP & PEP


Develop a resource list of pharmacies where PrEP is available

Training provider and staff on PrEP & PEP

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

AB348 to include comprehensive, medically accurate sexual health education in schools had some traction moving forward in the legislature; however, the bill was vetoed.

Status of Planned 2017-2018 Activities

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

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

In 2016, approximately 520,500 condoms were distributed throughout Nevada. 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. SNHD has a program with Walgreens to promote awareness among HIV positive clients of access to condoms through Medicaid.

Status of Planned 2017-2018 Activities

Explore condom need in community for priority populations

Awareness campaign about ability to get condoms through Medicaid


Identify places where free condoms are most needed


Increase accessibility by creating an online application to map free and purchased condom locations in Nevada


Identify where people can buy condoms


Provide capacity building assistance for the implementation of syringe services programs (SSP)


Explore different pathways to acquiring condoms (i.e. working with manufacturers to get cheaper condoms for people to buy)

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

SNHD is doing a QM project to improve communication across the RW programs and with other district programs. They have also had an influx of clients who are refugees, and 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. HRCL has instituted a new position for an intake coordinator who completes all initial eligibility for newly diagnosed clients and recertification for new clients to our agency. The coordinator assigns the client to a medical case manager for continuum of care, recertification and additional resources under RWPA and outside resources. AHF reported that sharing QM data trends and info 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 Hep C screening locations and transportation options. UMC Wellness started coordinating with NARES to provider UBER transportation and bus passes to their clients.

The Las Vegas TGA includes three counties, Clark County and Nye County in Nevada and Mohave County in Arizona, and they report working together to collaborate and provide comprehensive care to people living with HIV and individuals at risk for infection. They have expanded their collaboration on a broader scale by having a joint Integrated HIV Prevention and Care Plan for Nevada Part A, B and Prevention. The Las Vegas TGA Part A program collaborated with Arizona Part A, B and Prevention programs in relation to Mohave County, Arizona, to provide input on Arizona's Integrated HIV Prevention and Care Plan. The collaboration includes an ongoing workgroup to monitor the progress of the Integrated Plan and forward steps made to reduce new HIV infections. Almost all agencies reported some difficulties with new CAREWare systems, with some specific needs. Many reported successful technical assistance received such as for running reports.

Part B is working on developing a resource guide of services and activities for the newly diagnosed. 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. 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). Part A has conducted an inter-agency case management team building training by Cold Spring and plan to do it yearly. An annual Ryan White provider conference is currently not possible due to budget constraints, however, a series of webinars could be feasible to accomplish the same objectives.

Status of Planned 2017-2018 Activities

- 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,
- Inter-agency case management team building/training. To reduce competition, understand roles

share with ASOs and testing organizations. Update

- 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
- 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
- Annual Ryan White provider conference with training, RW updates on initiatives, basic fiscal and quality management, advanced training/certifications, strategies

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

SNDH reports recent influx of client released from prison or jail. SNHD has a SPINs grant for re-entry populations. Transitional Care Coordination is designed for HIV positive clients who incarcerated. This program works with clients to prepare them for discharge and link with services upon release. 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.

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 won't work with them until they have been clean for 40 to 90 days. HIV testing has been integrated into the mental health system in the state. Part A has added several new mental health providers. HELP is an organization that has been working with homeless individuals and SNHD and Part A have been collaborating with them for outreach.

SNHD has a team of nurse case managers that are alerted per Nevada Revised Statute when a woman seeks pre-natal care and the HIV test is positive. A nurse case manager contacts the pregnant woman and explains the importance of treatment adherence for herself and her fetus. The nurse case manager attends medical appointments if required, provides high acuity care and arranges for post-partum care through a partnership with the Part D program in the TGA. The Part D program meets with the pregnant women in their final trimester of pregnancy and discusses medical care for the soon-to-arrive baby. Together Part D and SNHD follow the newborn's medical care until an HIV status may be confirmed. SNHD's nurse case management program medically case managed 40 pregnant HIV positive females in the 2016-2017 grant year and zero babies seroconverted to HIV. Additionally, staff and clients at HOPES worked to spread the word about onsite eligibility services.

Status of Planned 2017-2018 Activities

- 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
- Link HIV+ mental health & substance abuse clients with local clinics to provide continuity of care. Identify point organizations and providers.

initially, who would manage their care, set them up for services, referrals, eligibility

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

Program staff at SNHD have morning meetings to discuss the appointments for the day in order to: (1) decrease the number of appointments and locations a client has to attend (try to have them see as many providers as they need and want that same day); (2) increase client engagement in their care (presumably by having them select or agree to who they want to see); (3) allow for early initiation of ART meds; and (4) allow for better and earlier referrals.

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. This approach allows the client to guide the process helping them see their own strengths and building upon them. The data also shows that individuals are more likely to stay in care when they meet the goals they set for themselves. At both sub-recipient locations, a certain number of medical appointments are set aside based on the number of individuals that test positive or have begun the linkage process. This enables the clients to be seen right away, reduces he potential for real and perceived barriers and provides the newly diagnosed individual assistance at the most critical time. Results data from grant year 2016-2017show 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 ARTAS program also tracks individual goals set in addition to Linkage to Medical Care. Personal goals included 1) Housing, 2) Job/Employment, 3) Disclose status; 4) Obtain insurance; and 5) Sobriety. Perceived barriers to accessing medical care are also collected upon entrance into ARTAS. The Las Vegas TGA also provided health education/risk reduction classes to 215 HIV positive individuals (1,060 classes) to encourage healthy behavior and positive health outcomes, and they provided substance abuse services to 81 clients.

Peer support groups lead by HOPES continue to be a safe space for clients to express concerns and share resources. 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.

Status of Planned 2017-2018 Activities

Expand Peer to peer advocate to every Part A and Part B site

Delivery of 6-week Positive management program to HIV+ clients and chronic disease management

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

Las Vegas TGA completed a targeted needs assessment focused on PLWH who accessed Ryan White Part A Mental Health and Substance Use services. The intent of this project was to gather information regarding the specific needs and barriers to care consumers face in the service categories of mental health and substance abuse in the Las Vegas TGA. This information will assist the Planning Council in funding priorities, service providers in service design and delivery and the Recipient staff in program structuring. A survey was designed to glean information on the unique needs of this population, which yielded 61 survey respondents. Results from the targeted needs assessment helped inform the Planning Council's FY 2017 Priority Setting and Resource Allocation process. The 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. University Medical Center provided 123 clients with mental health screenings in the 16/17 grant year. UMC also liked clients with psychiatric care and shorted wait time to see provider. The Mental Health program at HOPES served 215 unduplicated clients in the GY. A client satisfaction survey reported 80% of clients being satisfied with behavioral health services. Ridge House also provided 9 clients with comprehensive care.

Status of Planned 2017-2018 Activities

- (See 2a) Develop regional flow chart (resource map) of services/activities for all HIV+ patients, including mental/behavioral/substance use resources.

  For both organizations and clients

- Update resource guide regularly.

- Part A and B having the same internal referral process to easily track referrals made and completed

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

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. The program included an online portion teaching the foundations required in helping professions. 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. The in-person training builds on the content presented in the online training. Specifically reviewing motivational interviewing skills building, trauma informed medical case management and self-care. The evaluations after the training showed all participants gained a better understanding of medical case management techniques, especially self-care. Ninety-eight percent of participants listed they agreed or strongly agreed that new tools were learned and were committed to integrating some of what was

learned into work with clients. Las Vegas TGA was successful in recruiting several more mental health providers.

Status of Planned 2017-2018 Activities

Collaborate with mental/behavioral health providers

O2b. Strategy 3: Professional Development activities

The WCHD HIV staff participated in HIV stigma training. LV Urban League staff attended a number of trainings/ webinars on public health issues. Dignity Health expanding Stanford CDSMP and PSMP programs in Southern Nevada as well as sent two staff members to train as Master Trainers for both programs. Dignity Health has also been successful at running webinars and trainings on a wide variety of HIV topics. Part B is now allowing out of state travel now and funding scholarship for HIV community to go to the US conference on AIDS this year. Mary Karls from AETC was one of the recipients of this year's scholarship to attend the US conference on AIDS in September along with other individuals working in HIV and HIV positive clients.

Status of Planned 2017-2018 Activities

RW funded agencies participate annual Summer Institutes focuses on the continuum of care between MH, SA and HIV (Summer Institute not funded but travel to out-of-state conferences has been funded)

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

More education for providers about the resources available in the community including outside of Ryan White

(See 2a) Develop regional flow chart (resource map)

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.

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. The Las Vegas TGA provided the following services to Ryan White Clients to help improve treatment adherence: a) emergency financial assistance for food, housing, utilities and medication to 237 clients; b) food bank/home delivered meal services to 426 clients to improve health and maintain adherence to primary medical care; c) medical transportation services in the form of a bus pass or van transportation to 431 clients for access to medically necessary appointments and services; d) housing assistance to 21 clients to ensure access and maintenance to health care and supportive services; and e) psychosocial support services to 177 clients.

UNLV SDM uses reports to evaluate measures more frequently than quarterly, and they do an audit on any unmet measures to determine why they were not met. COMC reports that clients that were able to get insurance under the ACA no longer want to register for Ryan White support services. This has decreased the number of patients they have. COMC conducted chart audit that indicated that 80% of their patients have VL <20. (Their goal is 90%).

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 (i.e., a client has no recorded services system wide for more than 6 months or in a full year). 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. These reports are produced on a quarterly basis to track progress and identify trends or barriers. A variety of support groups and other opportunities are available in Southern Nevada through various sub-recipients.

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. Spanish language support groups are available in Northern Nevada. 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. In addition, 27 PLWHA received at least one ARTAS session; and 86% of PLWHA had more than one lab during the funding period. Part B is working to obtain more reliable lab data and then it will be able to pull continuum of care data more frequently and share with Part A. Medical case management providers are required to education on medication adherence. If supplemental funding is received, SNHD will be doing medical adherence counseling at their pharmacy.

NNHOPES (Part C) reported that the percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year was 75%. 92% of patients were prescribed Art.

Status of Planned 2017-2018 Activities

- ✓ Create a series of support, education and training options for group of patients in care
- → Ensure that patient education programs are language and literacy ability appropriate
- ✓ Deliver medication adherence sessions on a continual basis to provide education and support
- → 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.

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

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. The SNHD pharmacists are trained in HIV. Patient counseling is included with ADAP. Pharmacists at NNHOPES are trained in HIV.

Status of Planned 2017-2018 Activities

- Ensure clinical programs include medication management materials, support, educational programs and counseling for all patients
- Encourage pharmacists that work with HIV clinics to get certified in HIV care (AAHIVM certification)
- Provide education to pharmacists on HIV medication adherence
- Disseminate information about policies to clients regarding emergency medication access

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

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. There have been some challenges with respect to creating data sharing agreements between CAREWare and the labs. The deputy attorney general for the health department and the national TA providers have different legal interpretations regarding data sharing.

Status of Planned 2017-2018 Activities

- 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
- Educate clinicians to do at least 2 viral load tests per year
- Create data sharing agreements between CAREWare and labs
- 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

Routine sexual history and screenings for STIs are incorporated into care in at least four of the Las Vegas clinics and at Northern Nevada Hopes in the north. 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. Northern Nevada Hopes (Part C) 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. Developing and maintaining an accurate list of who is seeing patients with HIV in Nevada is under development.

Status of Planned 2017-2018 Activities


Recommend that HIV care clinics have plans in place for routine sexual history and screening for STIs

Develop and maintain accurate list of who is seeing patients with HIV

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

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. Prevention with positives is part of the standard of care for Part A and they are able to monitor is STI testing occurred. 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. ACCEPT has health education and risk reductions meetings twice per month

Status of Planned 2017-2018 Activities

Prevention with positives programs integrated into clinical care

Expand risk reduction and health education for clients to include STIs and importance of screenings and when to get tested


Recommend that EHR in all clinics includes sexual history and STI screenings

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

Status of Planned 2017-2018 Activities

None planned until 2018-2019

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

In Part A, mental health assessment and substance abuse screening is part of case management and is occurring in Part A clinics. Both Mental healt. 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. 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.

Status of Planned 2017-2018 Activities

Gather baseline data from HIV care clinics regarding current practices for MH, SA and chronic disease screenings

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

Status of Planned 2017-2018 Activities

None planned until 2018-2019

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

Status of Planned 2017-2018 Activities

None planned until 2018-2019

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

Some Part A sub-recipients have gathered information from difficult to reach populations. SNHD reported some issues faced by transgender clients including 1) those with unstable or no housing having difficulty getting in to shelters because the shelters are either for men or women; 2) having difficulty with housing assistance; 3) needing legal assistance when applying for new identification cards under a different gender. An issue faced by refugee clients is that the three month service period for ECDC isn't long enough for many of them to be able to get a job, find housing, etc. because of language and cultural "learning curve". In Nye County, they are having difficulty coordinating gas voucher program for very rural clients in area 51.They did a transportation survey with their clients that showed high need in this area. Some of their clients are "squatters" so they can't get the documentation they need to be able to get assistance at their "address". HRCL conducts random quality assurance phone checks with clients to see if the services they received were satisfactory.

Status of Planned 2017-2018 Activities

Conduct listening sessions with individuals from groups experiencing disparities to identify any gaps in knowledge or incorrect beliefs about HIV.

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.

Status of Planned 2017-2018 Activities

None planned until 2018-2019

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

For all of FY2016, the Las Vegas TGA utilized two separate sub-recipients providing linkage services. One sub-recipient is the Southern Nevada Health District, which is very well established and recognized in the community. The other sub-recipient is a non-profit organization, AIDS Healthcare Foundation. They are located in an underserved area and were able to connect with individuals frequenting their service delivery area or disenfranchised with the Health District. In order to maximize linkage services, the two sub-recipients worked closely together to understand what each other's strengths are and how best to meet the needs of the community.

In 2017, the state prevention program funded training for 89 participants and 26 agencies to provide their own HIV testing. Prevention has had ongoing discussions with a variety of CBOs about offering their own testing. Two additional trainings to provide testing will be held in August 2017.

Status of Planned 2017-2018 Activities

- Training CBOs and communities with high risk to provide on-site testing
- Identify and recruit additional providers and CB0s to have testing at their sites

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 (eg: HIV infected, gay, minority, female, transgender, IV drug user, etc.)

The Las Vegas TGA noted challenge related to this objective in that there was an increase in HIV and AIDS cases in all race/ethnic groups except white. African Americans comprise 27% of HIV and AIDS prevalence, followed by Hispanics who make up 24% of HIV prevalence and 23% of AIDS prevalence. A/PI now comprise 4% of HIV prevalence and 3% AIDS prevalence. New cases of HIV among A/PI increased from 4% to 8% from 2013 to 2015 (17 cases to 33 cases). HIV prevalence rates have increased overall by about 7% from 2013 to 2015, and AIDS prevalence has increase about 4% annually over that same period; however the increases have been greater in priority populations. New African American HIV cases increased 19%, and new Hispanic cases increased 17% over the last three years. Part A will be conducting a consumer survey in July which may provide some information regarding consumer experiences related to first contact and point of access to care. Many of the Part A agencies conduct client satisfaction surveys which could be used to gather this type of information and would be most helpful if race/ ethnicity and other key demographic items are collected to be able to review responses by different types of consumers. Part A has

been focused on trauma-informed care. Staff training on trauma-informed care was conducted at AFAN and AHF.

Part B is able to use rebate dollars to send 15 prevention and care providers to the U.S. Conference on AIDS in September. More than 30 people applied for the funding They will be sending five providers from south and three from north, two medical committee advisory members, and five consumers. Sending people to the conference is a way for Part B to provide ongoing TA for providers as well as the opportunity to network with others. During the last subgrant period, Part B encouraged providers to include out-of-state TA conferences in their budgets so they can learn about best practices and the latest information in the field and network across jurisdictions. 90% of Part B's HIV Health Education Risk Reduction (HERR) program participants reported program was culturally competent and appropriate.

Status of Planned 2017-2018 Activities

- 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

- 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

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

The Las Vegas TGA has selected three target populations, one of which is African Americans. These clients are enrolled in the ARTAS program which is designed to be tailored to the specific client's needs, whether the individual is in their early 20's, identifies as MSM or African American or some sort of combination. ARTAS operates on a strengths-based model. The linkage coordinator asks questions in a way that the client is able to pinpoint situations where he or she achieved a positive outcome and take those skills and apply them to their current situation. ARTAS also employs a 5 interaction system where the client has 5 meetings to meet their goals or make documentable progress. The program accepts that not all individuals are ready to be in-care or make big life decisions/changes. However, the program does provide the client with skills that when they are ready they can try again. It is also built into the program that if an individual is lost to care the case will be re-routed to a Disease Investigator that will attempt to reconnect with the individual and bring them back into the ARTAS program. The coordination between successfully completing the ARTAS program and transitioning to a long-term case manager based on the client's acuity has also made the program successful. Resources and partnerships used to implement the successful strategies include a sophisticated reporting

system required by Nevada Revised Statue when an individual receives a positive HIV test, an effective partner services program and long-standing partnerships with providers and community centers. Daily case conferencing between the different units in the Sexual Health Clinic, where most newly diagnosed individuals receive their first medical visit, includes a review of individuals that did not keep their appointment the day before and a review of the planned appointments for that day. In addition, there are weekly case conferencing between the largest medical team, the ARTAS linkage coordinators and medical case managers that provides essential communication and best practices of working with a client shared by all resources. Individuals who are not ready to meet the goals they have set and remain in care are a challenge for the individual and the program. In order to address this challenge the Linkage Coordinator provides the individual with as much information as possible, pointing out the positive steps accomplished to-date and contact information when the client is ready.

Part B and Prevention have a new HIV NV website and social media campaign which will be launched at the end of July 2017. 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.

Status of Planned 2017-2018 Activities

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.

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

Improvement has occurred with respect to accessibility of information for Spanish-speaking individuals. The Access to Healthcare Network is hiring a bilingual health insurance specialist. The new Part B website and campaign materials will all be translated into Spanish. 90% of Part B's HIV Health Education Risk Reduction (HERR) program participants reported program was culturally competent and appropriate. 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.

Status of Planned 2017-2018 Activities

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