2022 - 2026 NEVADA HIV INTEGRATED PREVENTION AND CARE PLAN

Prepared by:

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for

Office of HIV
Community Health Services
Division of Public and Behavioral Health
State of Nevada Department of Health and Human Services

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Section 1: Executive Summary

Executive Summary of Integrated Plan, including the Statewide Coordinated Statement of Need (SCSN)

Community Engagement and Planning Process

The 2022 – 2026 Nevada HIV Integrated Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN), (referred to throughout as "Integrated Plan") was developed to describe the current state of HIV prevention, treatment, and ancillary care services in Nevada and to outline aggressive actions to reduce the burden of HIV in Nevada. Further, the Integrated Plan serves to align Nevada's efforts with national frameworks, including the strategies and activities outlined in the HIV National Strategic Plan.[1] Nevada utilized a collaborative and community-engaged process to develop this plan. Many programs, agencies, community-based organizations (CBOs), and service providers engaged in HIV prevention, treatment, and ancillary care services, as well as people living with HIV (PLWH), at-risk populations, people affected by HIV, community members, and other stakeholders participated in the development of this plan through various mechanisms, including participation in needs assessments, sharing personal experiences, and providing feedback on drafts of the plan through its development.

The development of the plan was led by the Larson Institute team within the School of Public Health at the University of Nevada, Reno (UNR) in collaboration with the Nevada Office of HIV. An Internal Workgroup, consisting of representatives from many traditional and non-traditional partners working in HIV prevention, treatment, and ancillary care services, was assembled in April 2022, and met bi-weekly to provide expertise, to review plan progress, and to assist in the development of plan sections. As sections of the plan were drafted, the Internal Workgroup, along with other HIV workgroups and stakeholders, provided feedback and recommendations for improvement. The final plan was produced in October 2022. Although no sections from other plans were directly included in the submission of the 2022 – 2026 Integrated Plan, the Internal Workgroup, wherever possible, sought to align initiatives of this plan with those outlined in the 2020 Nevada Ending the HIV Epidemic Plan.[2] A full summary of community engagement is provided in *Section 2: Community Engagement and Planning Process*.

Data: Epidemiologic Snapshot, Resource Inventory, and Needs Assessments

In 2021, there were 494 Nevadans newly diagnosed with HIV and nearly 13,000 Nevadans were currently living with HIV. Rates of new HIV diagnoses were highest for the following populations: young adults (ages 20 – 39), Black or African American males, Hispanic males, and persons living in Clark County (home to Las Vegas). The most common form of HIV transmission in Nevada was through male-to-male sexual contact (MSM). Of the 494 Nevadans diagnosed with HIV in 2021 who met follow-up criteria, 90% were linked to care and 38% were retained in care. Among those retained in care, 94% were virally suppressed, highlighting the importance of retaining PLWH in care. The proportion of those retained in care and virally

[1] U.S. Department of Health and Human Services. 2021. HIV National Strategic Plan for the United States: A Roadmap to End the Epidemic 2021–2025 (pp 2-3) Washington, DC. Accessed September 2022. https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf

[2] Nevada Ending the HIV Epidemic Plan: 2021 – 2026. 2020. Accessed June 2022. http://endhivnevada.org/wp-content/uploads/2021/01/Nevada-EHE-Plan-Final.pdf.

suppressed was lower for Black or African American persons and Hispanic persons compared to White persons.

Funding for HIV prevention, treatment, and ancillary care services in Nevada largely comes from three primary funders: the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), and the US Department of Housing and Urban Development (HUD). These funds are used to support the HIV prevention and surveillance programs at the state and local levels, the Ryan White HIV/AIDS Programs (RWHAP), including AIDS Drug Assistance Program, Housing Opportunities for Persons with AIDS (HOPWA) and initiatives and programs at CBOs. CDC funds are largely used for prevention and surveillance activities. HRSA funds are primarily used for HIV treatment and care, including access to medications. HUD funds are primarily used to provide housing support and assistance for PLWH.

Two needs assessments were conducted in late 2021 and early 2022 to understand the HIV prevention, treatment, and ancillary care services needs for persons at risk for HIV and PLWH. Over 1,500 Nevadans participated in the HIV prevention needs assessment and recruitment efforts focused heavily on priority populations, including sexually active young adults, men who have sex with men (MSM), people of color, and people who use substances. Findings from this assessment revealed several important priorities related to HIV prevention. One key theme that emerged from the needs assessment for HIV prevention was that many members of priority populations were not aware of existing resources and programs available in the state related to HIV testing, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), syringe service programs (SSPs), and condoms.[3] Another theme that continually emerged was regarding stigma associated with HIV testing and utilization of services, such as syringe SSPs and PrEP/PEP. A final theme worth noting was related to perception of risk for contracting HIV, as many participants in the needs assessment reported low levels of perceived risk for contracting HIV despite engaging in risky behaviors. Nearly 400 PLWH participated in a treatment and care needs assessment. Examples of key priorities and needs that emerged from the needs assessment among PLWH in Nevada include ensuring PLWH have access to quality case management services to reduce barriers to treatment and care, providing food-related resources for PLWH, strengthening patient support navigation services, improving housing assistance for PLWH, and improving continuity of services.[4] A full summary of the needs assessment findings are provided in *Section 3: Contributing Datasets and Assessments*.

Situational Analysis

A situational analysis was compiled by the Internal Workgroup to identify strengths, challenges, and needs related to HIV prevention, treatment, and ancillary care services within each of the four EHE pillars: *Diagnose, Treat, Prevent, Respond*, by synthesizing information presented in *Section 2: Community Engagement and Planning Process* and *Section 3: Contributing Datasets and Assessments* with experiences from those working in HIV prevention, treatment, and ancillary care services. Across all EHE pillars, many challenges and needs emerged related to knowledge, attitudes, and behaviors for high-risk populations. For example, there is a clear need for culturally competent and non-stigmatizing resources that can easily be accessed by priority populations. The situational analysis also includes several challenges and needs pertaining to service providers. For example, there is a need for more accessible training related to sexual

[3] Lensch T, Etiler N, Dermid G, Nguyen Tang P, Collins L. *2021 Nevada HIV Prevention Needs Assessment.* University of Nevada, Reno School of Public Health, Larson Institute for Health Impact and Equity. Nevada Office of HIV. 2022. Accessed June 2022.

[4] Daniel J, Rodriguez-Schucker T, Jackson D. *2022 Nevada HIV Statewide Needs Assessment.* Collaborative Research. 2022. Accessed July 2022.

health screening and PrEP, particularly for providers serving priority populations. A full summary of strengths, challenges, and needs related to HIV prevention, treatment, and ancillary care services is provided in *Section 4: Situational Analysis*.

Goals and Objectives

The goals, objectives, and activities presented in *Section 5: 2022 – 2026 Goals and Objectives* were initially developed by the Internal Workgroup and were revised several times over a two-month period based on feedback from key stakeholders, including the Northern and Southern Nevada HIV Prevention Planning Groups (HPPGs), local health authorities, CBOs, and service providers. The goals and objectives were framed within the four EHE pillars and are presented below. Specific activities for each objective are presented in in *Section 5: 2022 – 2026 Goals and Objectives*.

Diagnose

Goal 1: Diagnose all individuals with HIV as early as possible after infection.

Objectives:

1.1 By 2026, 20,000 federally funded HIV tests will be conducted annually within the state of Nevada.

1.2 By 2026, 90% of all persons testing negative for HIV will be informed of their test results within 90 days from report to health authority.

1.3 By 2026, reduce the number of new HIV stage 3 diagnoses by 10%.

1.4 By 2026, 95% of clients testing HIV-positive will be informed of their test result within 7 business days from report to health authority.

Treat

Goal 2: Treat people with HIV rapidly and effectively to reach sustained viral suppression.

Objectives:

Medical Visits

2.1 By 2026, 85% of newly diagnosed HIV-positive individuals will be linked to care and attend their first medical appointment with an HIV care provider within 30 days from HIV confirmatory test result(s).

2.2 For individuals engaged in the Rapid stART program, by 2026, 85% of newly diagnosed HIV-positive individuals, those new to care, and/or those out of care will be linked to HIV care within 7 days.

Antiretroviral Therapy (ART)

2.3 For individuals engaged in the Rapid stART program, by 2026, 85% of newly diagnosed HIV-positive individuals, persons new to care, and/or persons out of care will have initiated ART within 7 days.

Viral Suppression

2.4 By 2026, 85% of HIV-positive individuals enrolled in core medical and/or support services (medical/non-medical), will have achieved viral suppression (less than 200 copies/ml at last viral load).

2.5 For individuals engaged in the Rapid stART program, by 2026, 85% of HIV newly diagnosed HIV-positive individuals, those new to care, and/or those out of care will have achieved viral suppression by 60 days after initiation of ART.

Retention and Reengagement into Case Management and Care

2.6 By 2026, 85% of HIV-positive individuals living in Nevada who are lost to care within the past 3 years will be reengaged into case management and/or medical care.

2.7 For individuals engaged in the Rapid stART program, by 2026, 85% of newly diagnosed HIV-positive individuals, persons new to care, and/or persons out of care who initiated ART will have at least 1 medical visit in each six-month period at least 90 days apart, annually.

2.8 A quality improvement evaluation and assessment process will be initiated on HIV case management with recommendations for implementation by 2026.

Prevent

Goal 3: Prevent new HIV transmissions by using proven interventions, including condom use, post-exposure prophylaxis (PEP), pre-exposure prophylaxis (PrEP), and syringe services programs (SSPs).

Objectives:

3.1 By 2026, reduce by 10% the rate of new HIV diagnoses.

3.2 By 2026, increase the number of providers receiving PrEP and PEP training, annually.

3.3 By 2026, increase the number of syringes distributed through syringe service programs (SSPs) by 10%.

3.4 By 2026, increase the number of syringes collected through syringe service programs (SSPs) by 10%.

3.5 By 2026, increase the number of condoms distributed in Nevada by 10%.

Respond

Goal 4: Respond quickly to potential HIV outbreaks to get necessary prevention and treatment services to people who need them.

Objectives:

4.1 By January 31, 2023, local and state health authorities and community stakeholders will develop and implement an HIV Outbreak Response Plan and by 2026, Outbreak Response Plans will be reviewed and updated quarterly, as necessary.

4.2 By 2026, increase capacity for cluster detection at state and local health departments.

4.3 By 2026, perform monthly analysis of case surveillance data to identify transmission clusters.

A full summary of all goals, objectives, activities, and specific outcomes measures is provided in *Section 5: 2022 – 2026 Goals and Objectives*.

Plan Implementation, Monitoring, and Jurisdictional Follow-Up

The Integrated Plan, including the SCSN, is meant to be a living document that will be continuously revised and improved. Across the plan period (2022 – 2026), the Internal Workgroup will meet quarterly, and the Northern and Southern Nevada HPPGs and Ryan White Strategic Planning Council will be engaged a minimum of two times per year to review progress on goals, objectives, and activities using evaluation data. These groups will provide suggestions for improvement and will have an opportunity to amend components of the plan, as needed. Proposed updates to the Integrated Plan will be presented to the stakeholders and community members with opportunity for feedback. All updates to the plan will be carefully tracked. A full description of all related implementation, monitoring, and follow-up activities is presented in *Section 6: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow-Up*.

Section 2: Community Engagement and Planning Process

Jurisdiction Planning Process

The jurisdictional planning process began in 2021 and included a variety of activities described below. In general, a comprehensive, community-oriented approach was utilized to engage key state and local stakeholders, CBOs, local health authorities, service providers and other treatment and care facilitators involved in HIV prevention, treatment, and ancillary care services, as well as PLWH and people at-risk for contracting HIV. Detailed descriptions of key planning activities, including the core planning team meetings, needs assessments, and development of goals and objectives, are outlined below.

Needs Assessments

Prior to the formation of the core planning team (referred to as "Internal Workgroup"), two needs assessments were conducted in late 2021 and early 2022 to understand needs and priorities for HIV prevention, treatment, and ancillary care services in the state. The Office of HIV, housed within the Nevada Division of Public and Behavioral Health (NV DPBH) contracted with Larson Institute/UNR School of Public Health team to conduct an HIV prevention needs assessment that included a community survey completed by nearly than 1,500 community members and a series of focus groups that included more than 60 individuals from priority populations, including PLWH, people of color, people who use substances, and young adults, across the state.

Further, a targeted needs assessment for PLWH was conducted in early 2022 by Collaborative Research in partnership with the State of Nevada, RWHAP parts, the Las Vegas Transitional Grant Area (TGA), and Clark County Ending the HIV Epidemic. These RWHAP parts, along with representatives from over 20 state and local health departments, CBOs, and service providers, offered guidance on survey development and dissemination and assisted with participant recruitment. Nearly 400 PLWH completed the assessment and provided valuable information about experiences with treatment and care in the state. The findings from these two needs assessments provided the Internal Workgroup with a detailed and nuanced understanding of the needs and priorities for PLWH and at-risk populations in Nevada. These assessments were used to complete the situational analysis and to develop goals and objectives. Additional details and key findings from both needs assessments are described in *Section 3: Contributing Datasets and Assessments*.

Core Planning Team: Internal Workgroup

The formal planning process and plan development for the Integrated Plan began in March 2022 after the completion of statewide needs assessments for HIV prevention, treatment, and ancillary care services. The planning coordinator from the Larson Institute/UNR School of Public Health team collaborated with the Nevada Office of HIV, and the RWHAP parts to develop an Internal Workgroup to facilitate planning and development of the Integrated Plan. More than 30 individuals representing over 15 programs, agencies, and CBOs working in HIV prevent, treatment, and care across the state were invited to join the Internal Workgroup meetings (see Table 1 below). The Internal Workgroup held a kick-off meeting in April 2022 and met for one to two hours every two weeks through October 2022. During Internal Workgroup meetings, the Larson Institute/UNR School of Public Health team engaged with the members to review project progress, to review findings and outline priorities arising from the needs assessments,

epidemiologic snapshot, and resource inventory, and to guide the development and goals and objectives. The Internal Workgroup also provided feedback on drafts of all sections of the Integrated Plan throughout the development process.

Table 1. List of individuals and organizations invited to attend Integrated Plan Internal Workgroup meetings.

Name	Organization	Region
Sarah Cowan	Nevada Office of HIV (AIDS Drug Assistance Program)	Southern
Victoria Young	AIDS Education Training Center (RWHAP Part F)	Statewide
Elaine Bergenheier	Carson City Health and Human Services	Quad Counties
Heather Shoop	Clark County Social Services (RWHAP Part A)	Southern
Tiffany Evans	Clark County Social Services (RWHAP Part A)	Southern
Vanessa Cruz	Clark County Social Services (RWHAP Part A)	Southern
Christina Boyles	Division of Public and Behavioral Health Tribal Liaison	Statewide
David Olsen	Nevada Division of Health Care Financing and Policy	Statewide
Marques Thompson	Nevada Office of HIV (RWHAP Part B)	Statewide
Tory Johnson	Nevada Office of HIV (RWHAP Part B)	Statewide
Gus Marquez	Northern Nevada HOPES (RWHAP Part C and Part D)	Northern
Ivy Spadone	Northern Nevada HOPES/UNR School of Medicine	Northern
Amy Lucas	Nevada Office of Analytics	Statewide
Ted Artiaga	Nevada Office of Analytics	Statewide
Caress Baltimore	Nevada Office of HIV (Surveillance)	Statewide
Lyell Collins	Nevada Office of HIV (Prevention & Surveillance)	Statewide
Preston Nguyen Tang	Nevada Office of HIV (Prevention)	Statewide
Cheryl Radeloff	Southern Nevada Health District	Southern
Victoria Burris	Southern Nevada Health District	Southern
Ben Trevino	Substance Abuse Prevention and Treatment Agency	Statewide
Tracy Palmer	Substance Abuse Prevention and Treatment Agency	Statewide
Mona Lisa Paulo	The LGBTQ Center of Southern Nevada	Southern
Amy Runge	University Medical Center (UMC) Wellness (RWHAP Part C)	Southern
Cathleen Danheiser	University of Nevada – Las Vegas (UNLV) School of Medicine (RWHAP Part D)	Southern
Karen Gordon	UNLV Medicine (RWHAP Part D)	Southern
Gerold Dermid	Larson Institute/UNR School of Public Health	Northern
Nilay Etiler	Larson Institute/UNR School of Public Health	Northern
Veronika Scavacini	Larson Institute/UNR School of Public Health	Northern
Kimberly Jacques	Veterans Administration	Statewide
Selena Pham	Veterans Administration	Statewide
Jen Howell	Washoe County Health District	Northern
Jessica Conner	Washoe County Health District	Northern

Supplemental Engagement

The Northern and Southern Nevada HIV Prevention Planning Groups (HPPGs) were also involved in the development of the Integrated Plan. The existing planning groups include representatives from a diverse range of health departments, CBOs, and service providers involved in HIV prevention, treatment, and

ancillary care services. The prevention planning groups also engage members of priority populations, including people with HIV, people of color, young adults, and people who use substances and are open to the public. These groups were heavily involved in the development and dissemination of the prevention, care, and treatment needs assessments and provided feedback on drafts of the plan, including the goals and objectives. The Larson Institute/UNR School of Public Health team attended HPPG meetings on several occasions to provide a summary of needs assessment findings and provide updates on plan development. As drafts of the Integrated Plan sections were developed, the HPPG chairs distributed the drafts through email listservs to allow stakeholders and community members to provide feedback. The Larson Institute/UNR School of Public Health team also shared updates on plan development with the Nevada EHE Workgroup. A full draft of the Integrated Plan was shared with the Nevada EHE Workgroup membership to provide an opportunity for feedback from their membership.

Impact of the COVID-19 Pandemic

The COVID-19 pandemic posed significant challenges related to community engagement, particularly with respect to in-person meetings and events. For example, during the data collection periods for the needs assessments in fall/winter of 2021 – 2022, elevated daily COVID-19 case counts caused many state and local health departments and CBOs to cease in-person meetings and events. Despite challenges associated with in-person meetings and events, there was significant and meaningful participation in the state health needs assessments, particularly from priority populations, that was made possible by collaborative efforts, creative engagement strategies, and significant support from community partners. For example, focus groups for the HIV prevention needs assessment were primarily held in-person in large rooms where participants were socially distanced and masked.

Summary

Representatives from a diverse variety of state and local HIV prevention programs, all RWHAP parts, local health authorities, CBOs, universities (e.g., Schools of Public Health, Medicine, and Dentistry), federally qualified health centers (FQHCs), service providers, PLWH, people at-risk for HIV, people affected by HIV, and the general community were involved across various stages of the planning process. Participation was solicited through the Internal Workgroup, Northern and Southern Nevada HPPGs, the Nevada EHE Workgroup, and participation in needs assessments, data sharing, and resource inventory documentation.

Role of Planning Bodies and Other Entities

As drafts were produced, the Northern and Southern Nevada HPPGs were involved in the planning process and provided feedback on survey instruments used in the needs assessments, assisted with needs assessment data collection, and provided feedback on all sections of the Integrated Plan. Members of the Northern and Southern Nevada HPPGs were also included on the Integrated Plan Internal Workgroup and were heavily involved during regular planning and development. The Nevada EHE Workgroup was also provided with updates on the progress of plan development and were given an opportunity to review a full draft of the plan and offer feedback. Members of the Nevada EHE Workgroup were also part of the Internal Workgroup.

Collaboration with RWHAP Parts

All RWHAP parts were included as key stakeholders throughout the entirety of the plan development. RWHAP Part A and RWHAP Part B were heavily involved in the development of the treatment and care needs assessment for PLWH. Further, representatives from each RWHAP parts were included on the Internal Workgroup.

Engagement of People with HIV and Other Priority Populations

PLWH contributed to plan development through participation in the prevention and treatment and care needs assessments, including both surveys and focus groups, through participation in planning group meetings, and through opportunities to provide feedback provided on drafts of the Integrated Plan. Across all surveys and focus groups conducted as part of the needs assessment process, there was participation from over 450 PLWH in Nevada. See *Section 3: Contributing Datasets and Assessments* for specific details regarding participation from PLWH in the needs assessments. In addition to PLWH, the Northern and Southern Nevada HPPGs identified the following groups as priority populations for HIV prevention efforts in Nevada: MSM, people who are sexually active, people who use substances, youth and young adults, and communities of color. These priority populations were specifically recruited during the HIV needs assessment process to ensure the needs and priorities for HIV prevention, treatment, and ancillary care services were representative of these target populations.

Identified Priorities

Several priorities emerged from the planning and community engagement process and are outlined below.

Measurable Goals and Objectives

One of the priorities that emerged from the planning and community engagement process was related to the development of goals and objectives for the Integrated Plan. To minimize challenges in future monitoring and evaluation of the plan, key stakeholders on the Internal Workgroup emphasized the importance of developing measurable goals and objectives that leverage existing performance indicators. In doing so, Nevada is set-up to monitor and evaluate ongoing efforts outlined the *Section 5: 2022 – 2026 Goals and Objectives*.

Health Equity

The plan aims to prioritize health equity by focusing efforts on identified priority populations who are most at-risk and are disproportionately impacted by HIV in Nevada. According to CDC, health equity is something that is achieved when every person has an opportunity to attain their full health potential without any disadvantages stemming from social position or other socially determined circumstances.[5] The plan aligns with the CDC Division of HIV Prevention's Health Equity Plan, which is guided by the following principles: reduce disparities in HIV incidence, viral suppression, and PrEP access; address social and structural barriers to prevention, treatment, and care; measure data and monitor progress; engage

[5] CDC. Health Equity. Accessed at: https://www.cdc.gov/chronicdisease/healthequity/index.htm.

communities for insight; ensure diverse and representative leadership.[6] More broadly, this aligns with one of the overarching goals of *Healthy People 2030*: To eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.[7]

Plan Improvement and Continued Engagement

As described in *Section 6: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow-Up*, plan improvement will be prioritized throughout the monitoring and evaluation period. The Integrated Plan is meant to be a living document that will be updated as goals and objectives are met, and when programmatic, legislative, and other important changes are made. Further, evaluation and monitoring reports will be made available twice per year and will be disseminated to stakeholders throughout the state via distribution of reports and presentations at planning group and other community meetings. Stakeholders and community members will be given opportunities to share feedback about the Integrated Plan across the monitoring and evaluation period. Engagement efforts will be pursued through presentations at workgroup and community meetings and events and through continued engagement with the Internal Workgroup.

Section 3: Contributing Datasets and Assessments

Data Sharing and Use

Data included in *Section 3: Contributing Data Sets and Assessments* come from a variety of sources and include primary/secondary surveillance data, individual agency and program data, and qualitative and quantitative data from statewide needs assessments. The epidemiologic snapshot contains data from several sources including the enhanced HIV/AIDS reporting system (eHARS), the Youth Risk Behavior Surveillance System (YRBSS), the Ryan White HIV/AIDS Program (RWHAP) Annual Client-Level Data Report, and the National Electronic Disease Surveillance System (NEDSS) Base System (NBS).

For all tables and figures, the most recent available data were utilized. When examining trends over time, the five most recent years' worth of data were used. Data for the prevention, care, and treatment resource inventory were reported by staff from agencies receiving HIV funding. Further, two needs assessments, one for HIV prevention and one for HIV care and treatment, were conducted to understand gaps and barriers to HIV-related services in Nevada. The HIV prevention needs assessment was conducted by the UNR School of Public Health in partnership with the Nevada Division of Public and Behavioral Health and the Nevada Office of HIV between August and December 2021. The prevention needs assessment consisted of a community survey and a series of focus groups with priority populations across the state. The HIV care and treatment needs assessment was conducted by Collaborative Research in partnership with the State of Nevada, the Las Vegas TGA, RWHAP parts, and Clark County Ending the HIV Epidemic (EHE). The needs assessment consisted of a survey among PLWH in Nevada. Data from these sources are presented in the following subsections and were used by the Internal Planning Group to develop *Section 4: Situational Analysis* and *Section 5: 2022 – 2026 Goals and Objectives*.

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[6] CDC. Division of HIV Prevention Equity Plan: Advancing Equity in DHP Workforce, Programs, and Science. Accessed at: https://www.cdc.gov/hiv/pdf/policies/strategic-priorities/cdc-hiv-dhp-equity-plan.pdf.

[7] Health People 2030. Health Equity in Healthy People 2030. Accessed at: https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030.

Epidemiologic Snapshot

Characteristics of persons diagnosed with HIV, HIV stage 3, and persons living with HIV in Nevada

Table 2 shows characteristics of new HIV diagnoses in Nevada in 2021. In 2021, there were 494 new HIV diagnoses in the state and 430 (87%) of these diagnoses were among males. Males had a significantly higher rate of new HIV diagnoses (26.8 per 100,000 population) compared to females (4.0 per 100,000 population). Nearly 90% of new diagnoses in 2021 were from Clark County, 7.7% were from Washoe County, and 3.0% were from all other counties. Further, the rate of new HIV diagnoses in Clark County (18.5 per 100,000 population) was more than two times higher than the rate in Washoe County (7.9 per 100,000 population) and more than four times higher than the rate in all other counties (4.2 per 100,000 population). Nearly two-thirds (64.3%) of new HIV diagnoses occurred among those aged 20-39 with the highest rate of new HIV diagnoses among those aged 30-34 (45.8 per 100,000 population). Non-Hispanic Black males and females accounted for the highest rates of new HIV diagnoses in Nevada in 2021 (81.5 per 100,0000 population and 20.1 per 100,0000 population, respectively). Male-to-male sexual contact (MSM) accounted for 52.2% of all new HIV diagnoses in 2021. As of 2019, an estimated 81% of Nevada living with HIV were aware of their serostatus, compared to 87% of those in the United States.[8]

[8] America's HIV Epidemic Analysis Dashboard (AHEAD). Indicator Data for Nevada. Accessed at: https://ahead.hiv.gov/locations/nevada.

Table 2. New HIV diagnoses in Nevada, 2021.

	Total			Males			Females		
	N	Column %	Rate*	N	Column %	Rate*	N	Column %	Rate*
County of Diagnosis									
Clark	441	89.3%	18.5	384	89.3%	32.3	57	89.1%	4.8
Washoe	38	7.7%	7.9	35	8.1%	14.5	3	4.6%	1.2
All Other Counties**	15	3.0%	4.2	11	2.6%	6.2	4	6.3%	2.3
Total	494	100.0%	15.4	430	100.0%	26.8	64	100.0%	4.0
Race/Ethnicity									
White, non-Hispanic	134	27.1%	8.5	119	27.7%	15.0	15	23.4%	1.9
Black, non-Hispanic	148	30.0%	51.0	119	27.7%	81.5	29	45.3%	20.1
Hispanic	174	35.2%	17.6	159	37.0%	31.9	15	23.4%	3.1
Asian/Hawaiian/Pacific Islander	29	5.9%	8.9	27	6.3%	18.0	2	3.1%	1.1
American Indian/Alaska Native	4	0.8%	11.1	4	0.9%	22.7	0	0.0%	0.0
Multi-race/other	5	1.0%	-	2	0.5%	-	3	4.7%	-
Total	**494**	**100.0%**	**15.4**	**430**	**100.0%**	**26.8**	**64**	**100.0%**	**4.0**
Age Group at Diagnosis									
< 13	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
13 to 14	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
15 to 19	12	2.4%	5.4	11	2.6%	9.7	1	1.6%	0.9
20 to 24	62	12.6%	28.8	56	13.0%	50.3	6	9.4%	5.8
25 to 29	85	17.2%	36.7	74	17.2%	62.7	11	17.2%	9.7
30 to 34	104	21.1%	45.8	97	22.6%	83.5	7	10.9%	6.3
35 to 39	66	13.4%	31.5	56	13.0%	53.2	10	15.6%	9.6
40 to 44	46	9.3%	21.2	39	9.1%	35.7	7	10.9%	6.5
45 to 54	68	13.8%	16.6	55	12.8%	26.4	13	20.3%	6.4
55 to 64	40	8.1%	10.4	32	7.4%	16.8	8	12.5%	4.2
65 +	11	2.2%	2.3	10	2.3%	4.5	1	1.6%	0.4
Total	**494**	**100.0**	**15.4**	**430**	**100.0%**	**26.8**	**64**	**100.0%**	**4.0**
Transmission Category									
Male-to-male sexual contact (MSM)	258	52.2%	8.0	258	60.0%	16.1	0	0.0%	0.0
Injection drug use (IDU)	27	5.5%	0.8	18	4.2%	1.1	9	14.1%	0.6
MSM+IDU	26	5.3%	0.8	26	6.0%	1.6	0	0.0%	0.0
Heterosexual contact	9	1.8%	0.3	5	1.2%	0.3	4	6.3%	0.2
Perinatal exposure	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
Transfusion/Hemophilia	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
No identified risk (NIR)	174	35.2%	5.4	123	28.6%	7.7	51	79.7%	3.2
Total	**494**	**100.0%**	**15.4**	**430**	**100.0%**	**26.8**	**64**	**100.0%**	**4.0**

Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), (March 2022).

** Rates per 100,000 population were calculated using 2021 population projections from the Nevada State Demographer vintage 2020 data.*

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

Table 3 shows the characteristics of PLWH in Nevada. As of 2021, there were 12,866 PLWH in Nevada. In 2021, the rate of PLWH in Clark County (467.9 per 100,000 population) was nearly double the rate in Washoe County (242.5 per 100,000 population) and nearly triple the rate in all other counties (160.0 per 100,000 population). Regarding race and ethnicity, the rate of PLWH was highest for non-Hispanic Black persons (1,271.9 per 100,000 population), followed Hispanic persons (335.8 per 100,000 population), and non-Hispanic White persons (318.2 per 100,000 population). Regarding age, rates of PLWH generally increased with age, with a notable exception being among those aged 65 and older.

Table 3. Persons living with HIV in Nevada, 2021.

	Total			Males			Females		
	N	Column %	Rate*	N	Column %	Rate*	N	Column %	Rate*
County of Diagnosis									
Clark	11,132	86.5%	467.9	9,431	86.5%	794.4	1,701	86.9%	142.7
Washoe	1,169	9.1%	242.5	1.023	9.4%	422.7	146	7.5%	60.8
All Other Counties**	565	4.4%	160.0	455	4.2%	256.4	110	5.6%	62.6
Total	**12,866**	**100.0%**	**400.3**	**10,909**	**100.0%**	**678.9**	**1,957**	**100.0%**	**121.7**
Race/Ethnicity									
White, non-Hispanic	5,014	39.0%	318.2	4,424	40.6%	556.6	590	30.1%	75.5
Black, non-Hispanic	3,690	28.7%	1,271.9	2,763	25.3%	1,892.1	927	47.4%	643.3
Hispanic	3,313	25.8%	335.8	3,001	27.5%	602.2	312	15.9%	63.9
Asian/Hawaiian/Pacific Islander	523	4.1%	160.6	444	4.1%	296.1	79	4.0%	45.0
American Indian/Alaska Native	78	0.6%	216.0	61	0.6%	364.2	17	0.9%	91.9
Multi-race/other	246	1.9%	-	215	2.0%	-	31	1.6%	-
Unknown	2	0.0%	-	1	0.0%	-	1	0.1%	-
Total	**12,866**	**100.0%**	**400.3**	**10,909**	**100.0%**	**678.9**	**1,957**	**100.0%**	**121.7**
Age Group at Diagnosis									
< 13	5	0.0%	1.0	1	0.0%	0.4	4	0.2%	1.6
13 to 14	3	0.0%	3.3	1	0.0%	2.2	2	0.1%	4.5
15 to 19	33	0.3%	15.0	21	0.2%	18.6	12	0.6%	11.2
20 to 24	263	2.0%	122.0	224	2.1%	201.1	39	2.0%	37.4
25 to 29	902	7.0%	389.2	813	7.5%	688.7	89	4.5%	78.3
30 to 34	1,508	11.7%	663.7	1,362	12.5%	1,172.5	146	7.5%	131.5
35 to 39	1,548	12.0%	740.0	1,350	12.4%	1,282.6	198	10.1%	190.5
40 to 44	1,347	10.5%	619.7	1,128	10.3%	1,033.0	219	11.2%	202.5
45 to 54	2,880	22.4%	701.3	2,343	21.5%	1,125.7	537	27.4%	265.1
55 to 64	3,053	23.7%	793.9	2,571	23.6%	1,346.0	482	24.6%	249.0
65 +	1,324	10.3%	272.1	1,095	10.0%	493.7	229	11.7%	86.5
Total	**12,866**	**100.0%**	**400.3**	**10,909**	**100.0%**	**678.9**	**1,957**	**100.0%**	**121.7**

Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), (March 2022).
**Rates per 100,000 population were calculated using 2021 population projections from the Nevada State Demographer vintage 2020 data.*
***All other counties include Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine Counties.*

Table 4 shows the facility of diagnosis for new HIV diagnoses in Nevada in 2021. Statewide, the most common facility of diagnosis was private physician's offices (25.1%), followed by HIV counseling and testing sites (11.1%), inpatient facilities and hospitals (8.7%), STD clinics (8.3%), and unspecified outpatient facilities (8.1%). Private physician's offices represented a larger percentage of new diagnoses in Clark County compared to Washoe County (27.4% vs. 7.9%), while inpatient facilities and hospitals represented a larger percentage of new diagnoses in Washoe County compared to Clark County (26.3% vs. 6.6%).

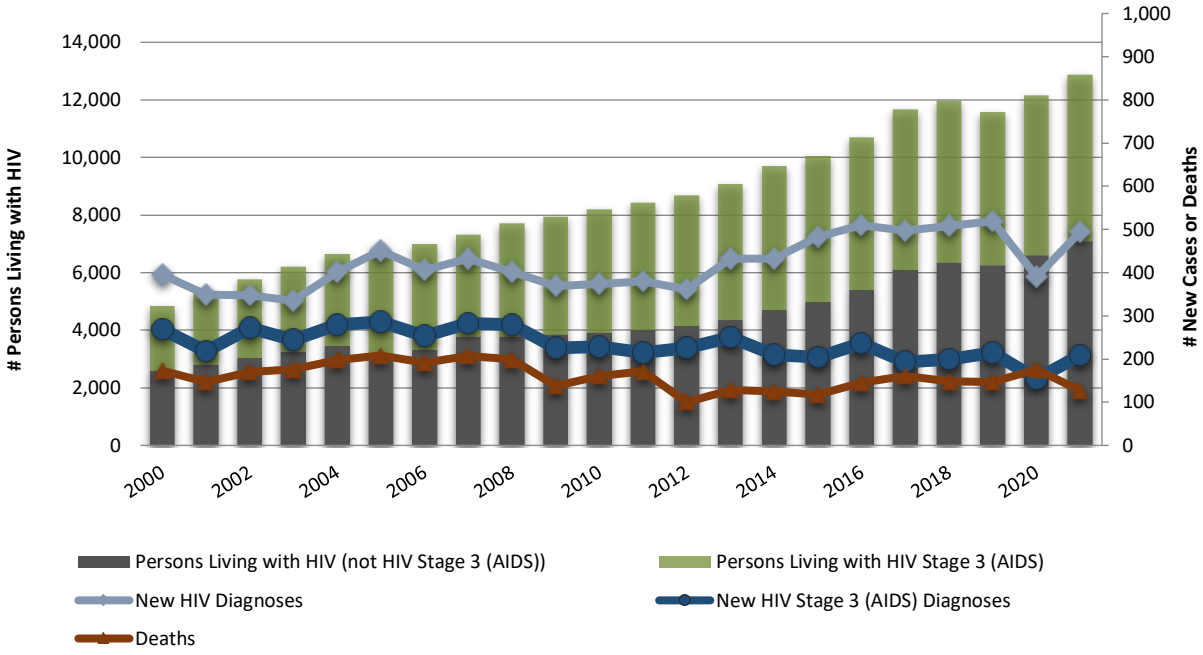
Table 4. Facility of diagnosis for new HIV diagnoses in Nevada, 2021.

	Nevada		Clark County		Washoe County		All Other Counties*	
	N	Column %	N	Column %	N	Column %	N	Column %
Facility of Diagnosis								
HIV Counseling and Testing Site	55	11.1%	49	11.1%	6	15.8%	0	0.0%
Private Physician's Office	124	25.1%	121	27.4%	3	7.9%	0	0.0%
Inpatient Facility/Hospital	43	8.7%	29	6.6%	10	26.3%	4	26.7%
Outpatient Facility (unspecified)	40	8.1%	38	8.6%	1	2.6%	1	6.7%
Adult HIV Clinic	10	2.0%	5	1.1%	4	10.5%	1	6.7%
Correctional Facility	18	3.6%	18	4.1%	0	0.0%	0	0.0%
STD Clinic	41	8.3%	41	9.3%	0	0.0%	0	0.0%
Blood Bank or Plasma Center	21	4.3%	21	4.8%	0	0.0%	0	0.0%
Emergency Room	20	4.0%	17	3.9%	2	5.3%	1	6.7%
Tuberculosis Clinic	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Drug Treatment Center	1	0.2%	1	0.2%	0	0.0%	0	0.0%
Obstetrics and Gynecology Clinic	1	0.2%	0	0.0%	1	2.6%	0	0.0%
Community Health Center	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Facility/Other/Unknown	120	24.3%	101	22.9%	11	28.9%	8	53.3%
Total	**494**	**100.0%**	**441**	**100.0%**	**38**	**100.0%**	**15**	**100.0%**

Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), (March 2022).
**All other counties include Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine Counties.*

Figure 1 shows the number of persons living with HIV and HIV stage 3 in Nevada, the number of new HIV and HIV stage 3 diagnoses in Nevada, and the number of deaths among PLWH in Nevada between 2000 and 2021. Between 2000 and 2012, the annual number of new HIV diagnoses fluctuated between 335 and 451 new diagnoses each year. Between 2013 and 2019, there was a slight, but steady increase in the number of new HIV diagnoses with 433 new diagnoses in 2013 and 519 new diagnoses in 2019. In 2020, there was a sharp decline in the number of new HIV diagnoses (519 new diagnoses in 2019 and 391 new diagnoses in 2020). Some of this decrease can likely be attributed to factors associated with the COVID-19 pandemic, such as decreased testing, stay-at-home orders, and limited public health and health care staffing. New HIV diagnoses increased between 2020 and 2021 (391 new diagnoses in 2020 and 494 diagnoses in 2021) but remained lower than the number of new HIV diagnoses reported in 2019. Advances and improvements in HIV testing and treatment and care for PLWH has likely resulted in fewer annual deaths among PLWH between 2011 and 2021 compared to the period between 2000 and 2010.

Figure 1. Persons living with HIV/HIV Stage 3, new HIV infections, new HIV Stage 3 diagnoses, and deaths in Nevada, 2000 – 2021.

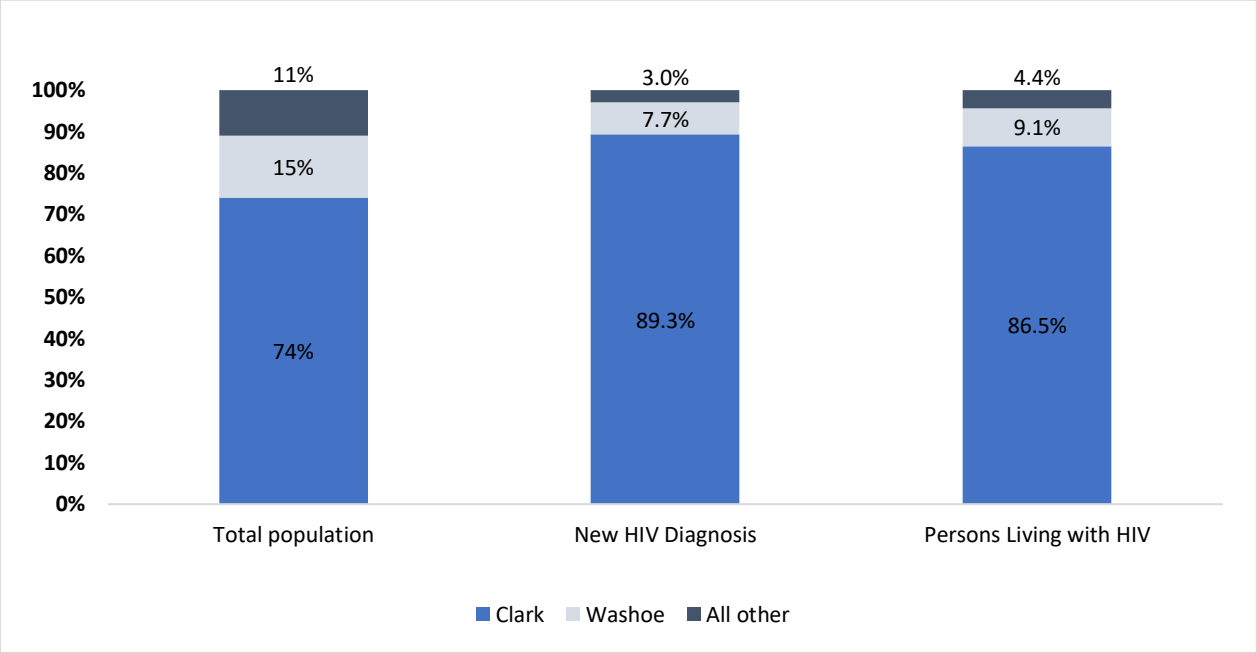


Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), (June 2022).

Geography

In general, the burden of HIV in Nevada is greatest in Clark County. Figure 2 shows the percentage of total population in Nevada, percentage of new HIV diagnoses in Nevada, and percentage of persons living with HIV in Nevada, by county in 2021. Clark County, home to Las Vegas, has historically faced a disproportionate burden of HIV compared to other counties in Nevada. In 2021 for example, despite being home to 74.0% of Nevada's total population, 89.3% of new HIV diagnoses in Nevada and 86.5% of PLWH in Nevada were in Clark County. Conversely, Washoe County, home to Reno, represents 15.0% of the total population, but only 7.7% of new HIV diagnoses in Nevada and 9.1% of PLWH in Nevada were in Washoe County. Similarly, all other counties in Nevada represent 11.0% of the total population, but only 3.0% of new HIV diagnoses and 4.4% of PLWH in Nevada.

Figure 2. Total population, new HIV diagnoses, and persons living with HIV in Nevada, 2021.

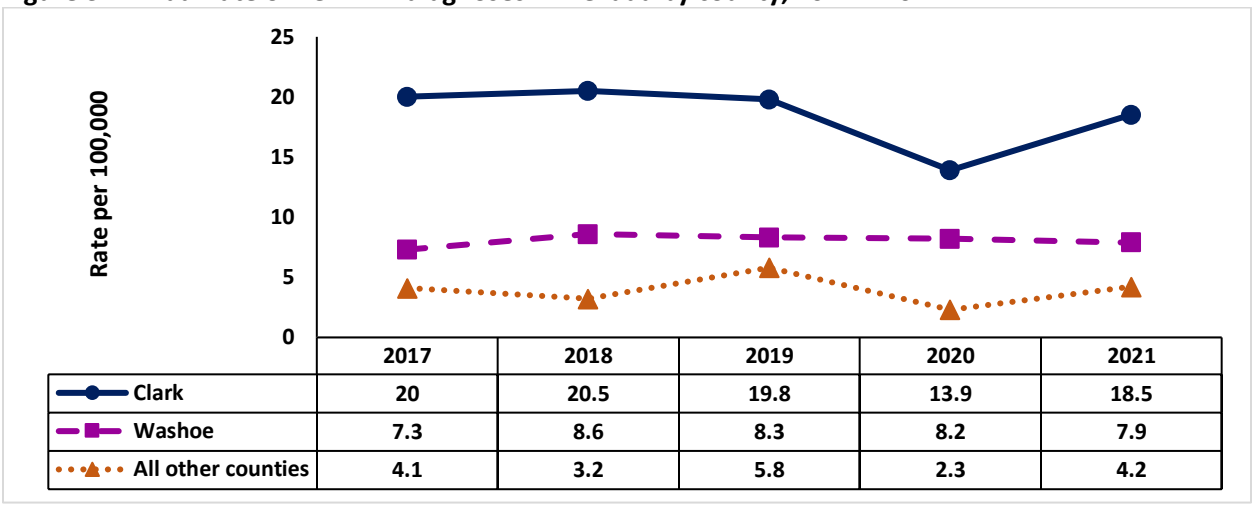


Source: US Census Bureau; Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), June 2022.

In 2017, Clark County (20 per 100,000 population) had a rate of new HIV diagnoses that was more than twice that of Washoe County (7.3 per 100,000 population). This difference persisted until 2020 when Clark County's rate of new diagnoses dropped substantially, potentially due to the COVID-19 pandemic and reduced access to testing and disruption of other HIV-related services. Conversely, between 2017 and 2021, the rate of new diagnoses in Washoe County remained constant, averaging at 8.1 new diagnoses per 100,000 population across the 2017 – 2021 period. As for all other counties in Nevada, the rate of new diagnoses increased in 2019 followed by a decrease in 2020.

In 2021, Clark County had the highest rate of new HIV diagnoses (18.5 per 100,000 population) with Washoe County and all other counties following far behind at 7.9 new diagnoses per 100,000 and 4.2 new diagnoses per 100,000 population, respectively.

Figure 3. Annual rate of new HIV diagnoses in Nevada by county, 2017 – 2021.

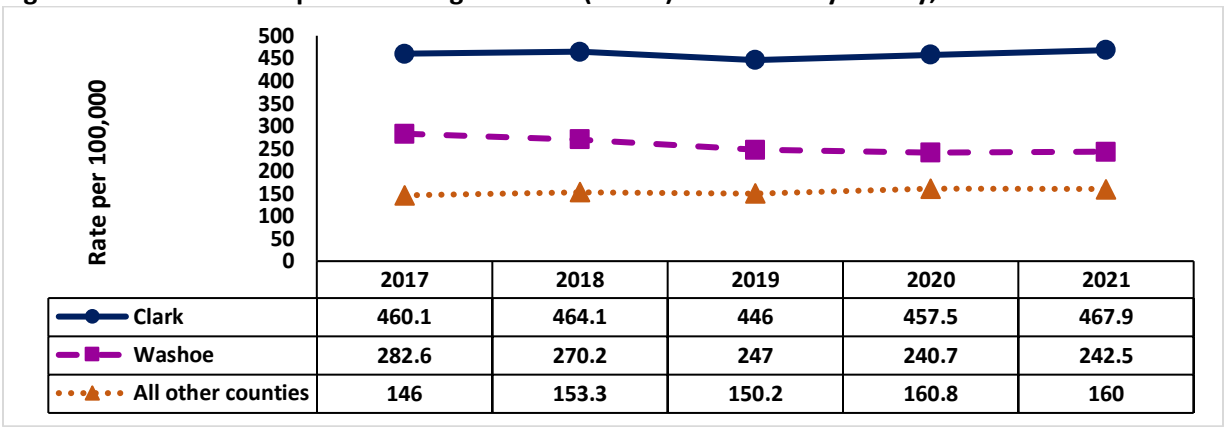


	2017	2018	2019	2020	2021
Clark	20	20.5	19.8	13.9	18.5
Washoe	7.3	8.6	8.3	8.2	7.9
All other counties	4.1	3.2	5.8	2.3	4.2

Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

Between 2017 to 2021, the rate of PLWH was consistent in Clark County, decreased in Washoe County, and slightly increased in all other counties. In 2021, the rate of PLWH in Clark County (467.9 per 100,000 population) was nearly twice the rate of that in Washoe County (242.5 per 100,000 population) and nearly three times the rate of that in all other counties (160.0 per 100,000 population).

Figure 4. Annual rate of persons living with HIV (PLWH) in Nevada by county, 2017 – 2021.



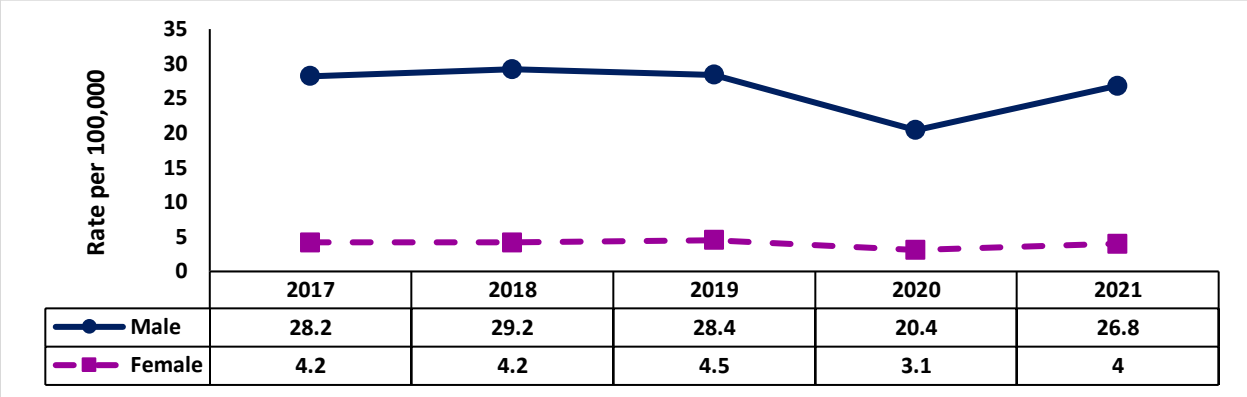
	2017	2018	2019	2020	2021
Clark	460.1	464.1	446	457.5	467.9
Washoe	282.6	270.2	247	240.7	242.5
All other counties	146	153.3	150.2	160.8	160

Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

Sex at Birth

From 2017 to 2021, males had a significantly higher rate of new HIV diagnoses compared to females (Figure 5). On average, the annual rate of new HIV diagnoses for males has been nearly seven times the rate for females between 2017 and 2021. While the rate of new HIV diagnoses has remained stable among females over the past 5 years, there was a sizable decrease in 2020 among males. Unlike previous years where the rate changed minimally (around 1 diagnosis per 100,000 population), there was a decrease of 8 diagnoses per 100,000 population in 2020. Again, some of this decrease may be due to factors associated with the COVID-19 pandemic, including stay-at-home orders and reduced access to testing and other relevant services. In 2021, the rate of new HIV diagnoses for males increased sharply from 20.4 diagnoses to 26.8 diagnoses per 100,000 population.

Figure 5. Annual rate of new HIV diagnoses in Nevada by sex at birth, 2017 – 2021.

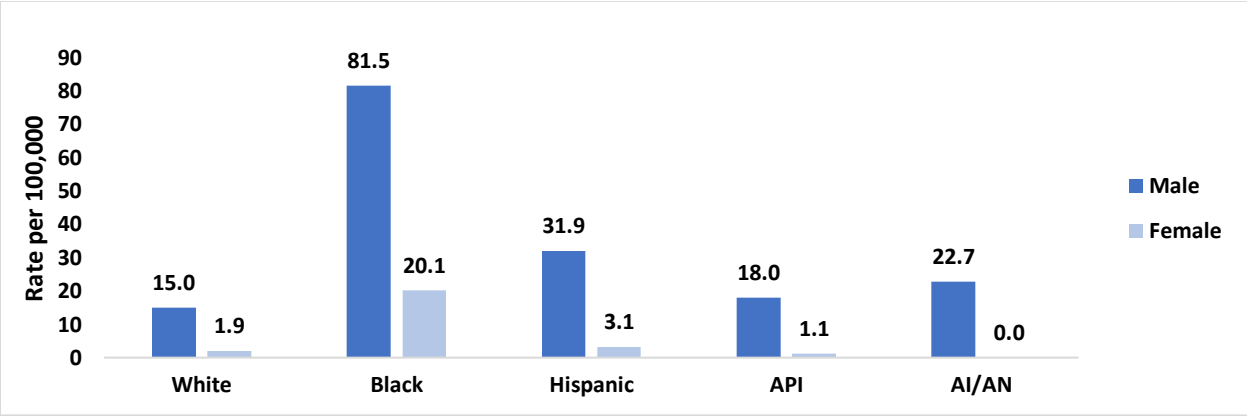


	2017	2018	2019	2020	2021
Male	28.2	29.2	28.4	20.4	26.8
Female	4.2	4.2	4.5	3.1	4

Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

Figure 6 shows the annual rate of new HIV diagnoses in 2021, by race and ethnicity. New HIV diagnoses among Black males (81.5 per 100,000 population) was twice that of the second-most afflicted race/ethnicity, Hispanic males (31.9 per 100,000 population). New HIV diagnoses among Black females (20.1 per 100,000 population) was six times that of the second-most afflicted race/ethnicity, Hispanic females (3.1 per 100,000 population). Among males, White males had the lowest rate of new diagnoses (15.0 per 100,000 population) and among females, American Indian/Alaska Native (AI/AN) females had the lowest rate of new diagnoses (0.0 per 100,000 population).

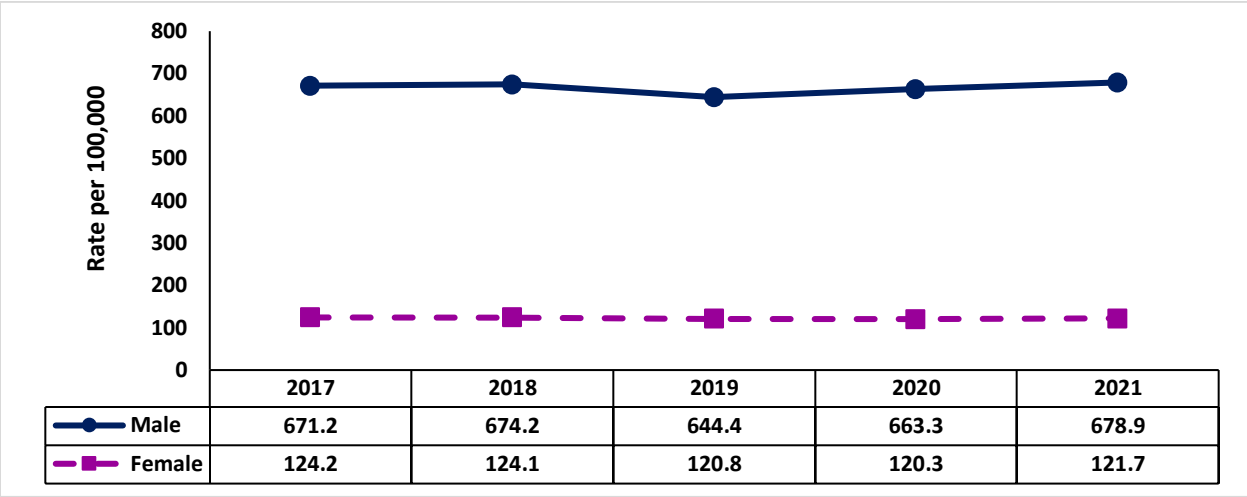
Figure 6. Annual rate of new HIV diagnoses in Nevada by sex at birth, and race/ethnicity, 2021.



Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

Figure 7 shows the rate of PLWH by sex at birth between 2017 and 2021 in Nevada. The rate of PLWH in Nevada is similarly reflective of the trends noted among new HIV diagnoses, with males disproportionately affected. Rates of PLWH among males have consistently been over five times higher than rates of PLWH among females. The rate of PLWH among males was highest in 2021 at 678.9 per 100,000 population.

Figure 7. Annual rate of people living with HIV (PLWH) in Nevada by sex at birth, 2017 – 2021.

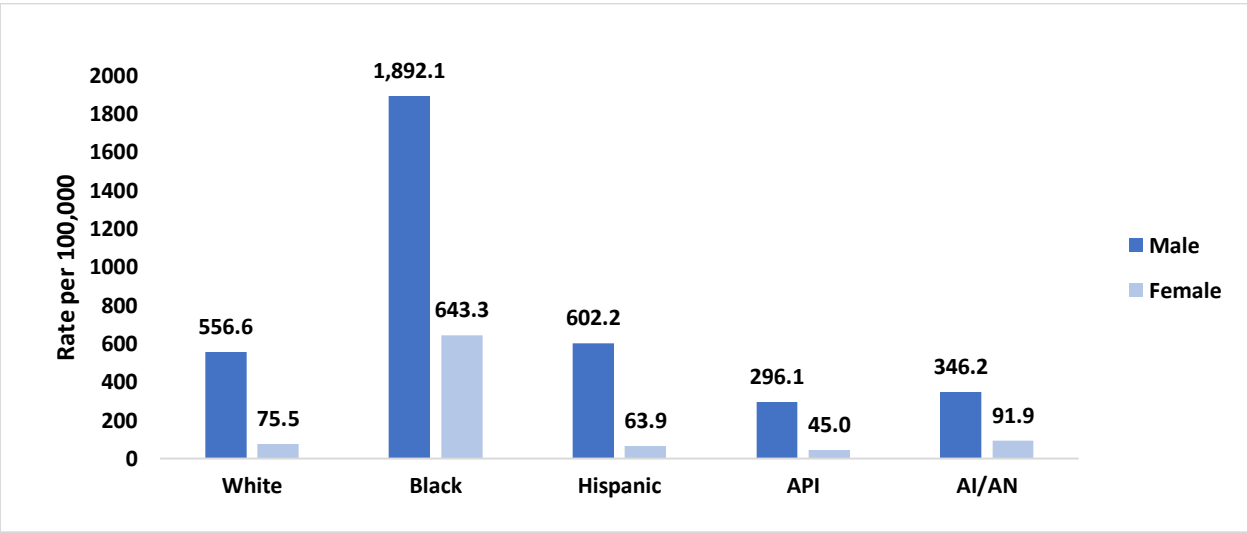


	2017	2018	2019	2020	2021
Male	671.2	674.2	644.4	663.3	678.9
Female	124.2	124.1	120.8	120.3	121.7

Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

Similar to the rate of new diagnoses in 2021, the rate of PLWH was highest among Black males (1,892.1 per 100,000), followed by Hispanic males (602.2 per 100,000 population), and White males (556.6 per 100,000 population). The rate of PLWH was highest among Black females (643.3 per 100,000), followed by AI/AN females (91.9 per 100,000 population) and White females (75.5 per 100,000 population). The lowest rates for PLWH for both males and females were among Asian/Pacific Islanders (API) (296.1 per 100,000 population for males and 45 per 100,000 population for females).

Figure 8. Annual rate of people living with HIV (PLWH) in Nevada by sex at birth, and race/ethnicity, 2021.



Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

Transmission Category

Table 5 shows the transmission categories of new HIV diagnoses in 2021 in Nevada. Male-to-male sexual contact (MSM) was the most common transmission category, representing 52.2% of all diagnoses in 2021. Further, injection drug use (IDU) alone represented 5.5% of all diagnoses in 2021 and MSM with IDU represented 5.3% of all 2021 diagnoses. For over one-third of all cases in Nevada (35.2%), there was no identified risk (NIR) ascertained from case interviews. It is important to note that NIR can also represent situations when individuals cannot be located for interview/investigation. For males, MSM was the most common transmission category (60.0% of all diagnoses), followed by MSM plus IDU (6.0% of all diagnoses) and heterosexual contact (1.6% of all diagnoses). For 28.6% of males diagnosed with HIV in 2021, NIR was ascertained. For females, IDU was the most common transmission category (14.1% of all cases) followed by heterosexual contact (6.3% of all cases). For 79.7% of female cases in 2021, NIR was ascertained.

Table 5. Transmission category of new HIV Infections and PLWH in Nevada by gender, 2021.

	Total			Males			Females		
	N	Column %	Rate*	N	Column %	Rate*	N	Column %	Rate*
New HIV infections									
Male-to-male sexual contact (MSM)	258	52.2%	8.0	258	60.0%	16.1	-	-	-
Injection drug use (IDU)	27	5.5%	0.8	18	4.2%	1.1	9	14.1%	0.6
MSM+IDU	26	5.3%	0.8	26	6.0%	1.6	-	-	-
Heterosexual contact	9	1.8%	0.3	5	1.2%	0.3	4	6.3%	0.2
Perinatal exposure	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
Transfusion/Hemophilia	0	0.0%	0.0	0	0.0%	0.0	0	0.0%	0.0
No identified risk (NIR)	174	35.2%	5.4	123	28.6%	7.7	51	79.7%	3.2
Total	**494**	**100.0%**	**15.4**	**430**	**100.0%**	**26.8**	**64**	**100.0%**	**4.0**
People living with HIV (PLWH)									
Male-to-male sexual contact (MSM)	8,256	64.2%	256.9	8,256	75.7%	513.8	0	0.0%	-
Injection drug use (IDU)	759	5.9%	23.6	485	4.4%	30.2	274	14.0%	17.0
MSM+IDU	762	5.9%	23.7	762	7.0%	47.4	0	0.0%	-
Heterosexual contact	1,386	10.8%	43.1	353	3.2%	22.0	1,033	52.8%	64.3
Perinatal exposure	87	0.7%	2.7	33	0.3%	2.1	54	2.8%	3.4
Transfusion/Hemophilia	6	0.0%	0.2	3	0.0%	0.2	3	0.2%	0.2
No identified risk (NIR)	1,610	12.5%	50.1	1,017	9.3%	63.3	593	30.3%	36.9
Total	**12,866**	**100.0%**	**400.3**	**10,909**	**100.0%**	**678.9**	**1,957**	**100.0%**	**121.7**

Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

Table 6 shows the transmission category of new HIV diagnoses in 2021, stratified by sex at birth and race/ethnicity. For males, MSM remained the highest transmission category for all races and ethnicities and was highest for Hispanic males (69% of diagnoses among Hispanic males), API males (59% of diagnoses among API males), and Black males (58% of diagnoses among Black males). For females, IDU was the most common transmission category, especially for White females (47% of diagnoses among White females). For most females, NIR was ascertained in 2021.

Table 6. New HIV Infections in Nevada by race/ethnicity and transmission category, 2021.

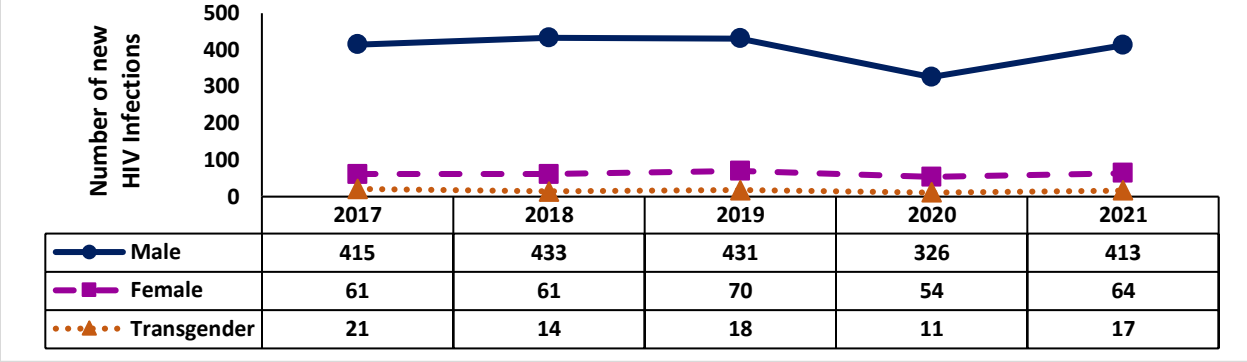
Transmission	White		Black		Hispanic		API		AIAN		Multi-Race/Other	
	N	%	N	%	N	%	N	%	N	%	N	%
Males												
MSM	61	51%	69	58%	110	69%	16	59%	2	50%	0	0%
IDU	9	8%	3	3%	4	3%	1	4%	0	0%	1	50%
MSM+IDU	16	13%	2	2%	6	4%	2	7%	0	0%	0	0%
Heterosexual contact	1	1%	3	3%	0	0%	0	0%	0	0%	1	50%
Perinatal exposure	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Transfusion	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
No identified risk (NIR)	32	27%	42	35%	39	25%	8	30%	2	50%	0	0%
Subtotal	**119**	**100%**	**119**	**100%**	**159**	**100%**	**27**	**100%**	**4**	**100%**	**2**	**100%**
Females												
IDU	7	47%	1	3%	1	7%	0	0%	0	0%	0	0%
Heterosexual contact	1	7%	1	3%	1	7%	1	50%	0	0%	0	0%
Perinatal exposure	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Transfusion	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
No identified risk (NIR)	7	47%	27	93%	13	87%	1	50%	0	0%	3	100%
Subtotal	**15**	**100%**	**29**	**100%**	**15**	**100%**	**2**	**100%**	**0**	**0%**	**3**	**100%**
Total	**134**		**148**		**174**		**29**		**4**		**5**	

Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

Gender Identity

Figure 9 shows the annual number of all new HIV diagnoses and new HIV Stage 3 diagnoses in Nevada between 2017 and 2021, by gender identity. The number of new HIV and HIV Stage 3 diagnoses was consistently highest for males, followed by females, and transgender persons across the five-year period.

Figure 9. Annual number of new HIV diagnoses in Nevada by gender identity, 2017 – 2021.



	2017	2018	2019	2020	2021
Male	415	433	431	326	413
Female	61	61	70	54	64
Transgender	21	14	18	11	17

Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

As shown in Table 7, most (220 out of 239 individuals, or 92.1%) transgender PLWH, including those diagnosed in Nevada and out of Nevada, are male-to-female (MTF), while only 7.9% (19 out of 239 individuals) are female-to-male (FTM). The most common transmission category for transgender persons in Nevada was sexual contact (79% of all transgender PLWH) followed by sexual contact and IDU (11% of all transgender PLWH).

Table 7. Transgender persons living with HIV and HIV Stage 3 in Nevada, 2021.

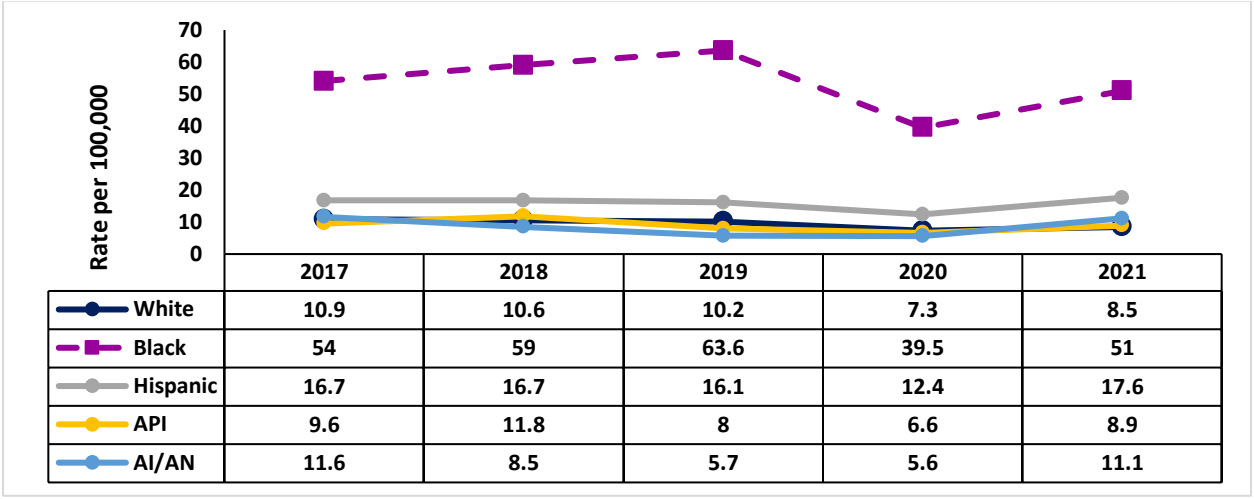
	Total		Male to Female (MTF)		Female to Male (FTM)	
	N	%	N	%	N	%
Residence at Diagnosis						
Nevada	118	49%	111	50%	7	37%
Out of State	121	51%	109	50%	12	63%
Race/Ethnicity						
White, non-Hispanic	38	16%	30	14%	8	42%
Black, non-Hispanic	106	44%	101	46%	5	26%
Hispanic	63	26%	59	27%	4	21%
Asian/Hawaiian/Pacific Islander	10	4%	10	5%	0	0%
American Indian/Alaska Native	4	2%	4	2%	0	0%
Multi-race/Other	18	8%	16	7%	2	11%
Age at End of Calendar Year 2019						
<13	0	0%	0	0%	0	0%
13 to 24	13	5%	13	6%	0	0%
25 to 34	80	33%	77	35%	3	16%
35 to 44	76	32%	68	31%	8	42%
45 to 54	38	16%	33	15%	5	26%
55 to 64	30	13%	27	12%	3	16%
65+	2	1%	2	1%	0	0%
Transmission Category						
Sexual Contact	189	79%	181	82%	8	42%
IDU	4	2%	1	0%	3	16%
Sexual Contact + IDU	26	11%	26	12%	0	0%
Perinatal Exposure	0	0%	0	0%	0	0%
NIR/NRR	20	8%	12	5%	8	42%
Total	**239**		**220**		**19**	

Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

Race and Ethnicity

Figure 10 shows the annual rate of new HIV diagnoses by race and ethnicity. Black persons had a much higher rate of new HIV diagnoses compared all other races and ethnicities across all years. Rates among Hispanic persons were consistently the second highest rates across all five years but were only about one-third of the rates for Black persons.

Figure 10. Annual rate of new HIV diagnoses in Nevada by race and ethnicity, 2017 – 2021.

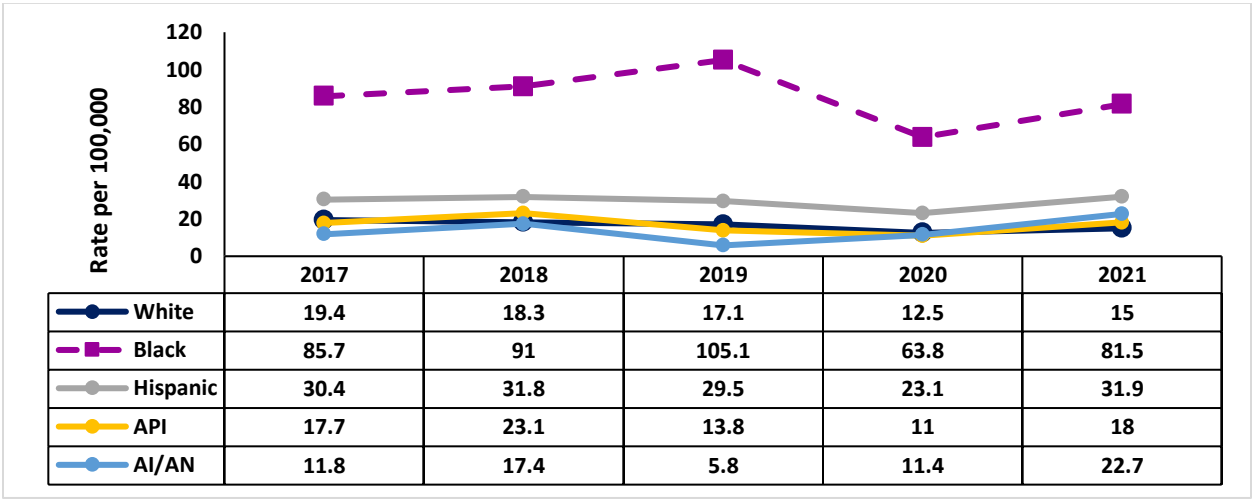


	2017	2018	2019	2020	2021
White	10.9	10.6	10.2	7.3	8.5
Black	54	59	63.6	39.5	51
Hispanic	16.7	16.7	16.1	12.4	17.6
API	9.6	11.8	8	6.6	8.9
AI/AN	11.6	8.5	5.7	5.6	11.1

Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

Figure 11 illustrates the annual rate of new HIV diagnoses among males by race and ethnicity between 2017 and 2021 in Nevada. Black males had the highest rates in comparison to other races and ethnicities between 2017 and 2021. Rates among Hispanic persons were consistently the second highest rates across all five years.

Figure 11. Annual rate of new HIV diagnoses among males in Nevada by race and ethnicity, 2017 – 2021.

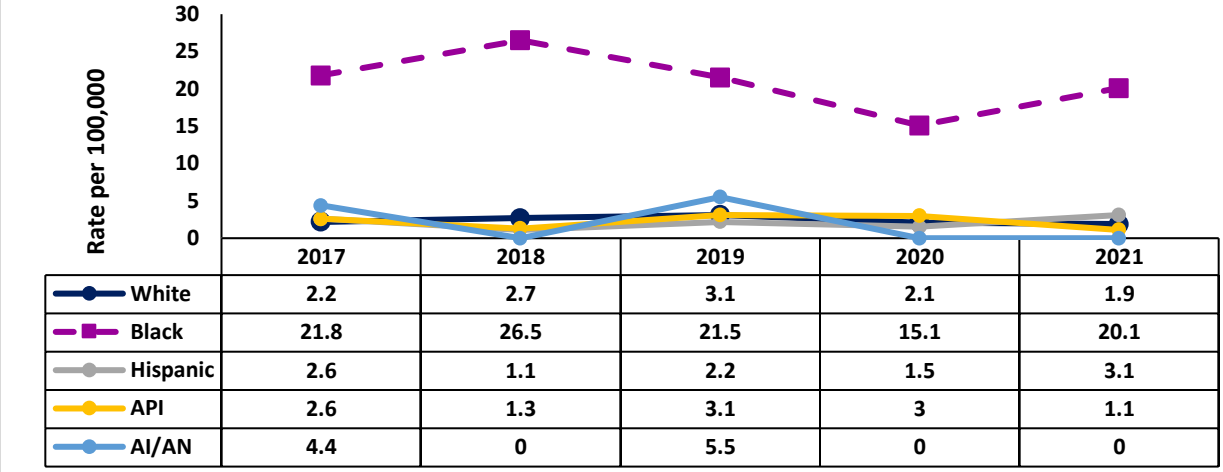


	2017	2018	2019	2020	2021
White	19.4	18.3	17.1	12.5	15
Black	85.7	91	105.1	63.8	81.5
Hispanic	30.4	31.8	29.5	23.1	31.9
API	17.7	23.1	13.8	11	18
AI/AN	11.8	17.4	5.8	11.4	22.7

Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

Figure 12 shows the annual rate of new HIV diagnoses among females by race and ethnicity between 2017 and 2021 in Nevada. Similar to the data presented in Figure 11 for males in Nevada, Black females had the highest rates in comparison to the other races and ethnicities between 2017 and 2021.

Figure 12. Annual rate of new HIV diagnoses among females in Nevada by race and ethnicity, 2017 – 2021.



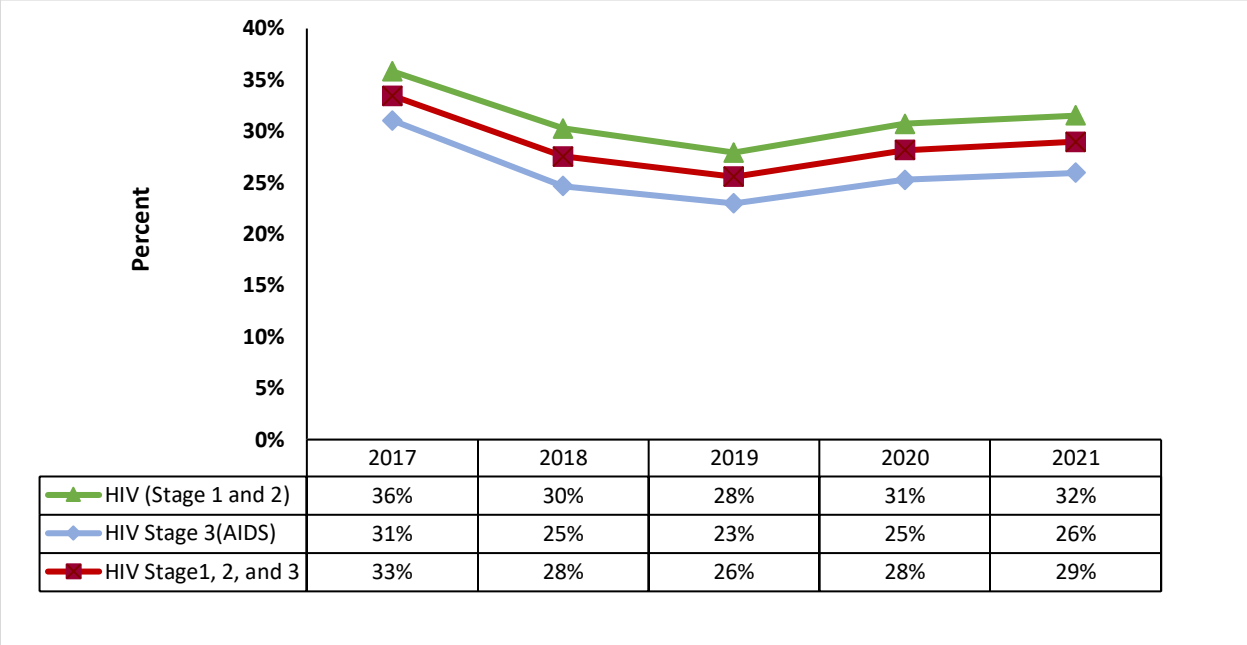
	2017	2018	2019	2020	2021
White	2.2	2.7	3.1	2.1	1.9
Black	21.8	26.5	21.5	15.1	20.1
Hispanic	2.6	1.1	2.2	1.5	3.1
API	2.6	1.3	3.1	3	1.1
AI/AN	4.4	0	5.5	0	0

Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

HIV Care Continuum

Figure 13 shows the percentage of PLWH in Nevada who were out of care between 2017 and 2021. Between 2017 and 2019, the percentage of PLWH who were out of care decreased each year before increasing in 2020 and again in 2021. The slight increases in PLWH who were out of care may be due to factors associated with the COVID-19 pandemic. In 2021, 32% of persons with HIV and 26% of persons with HIV Stage 3 were currently out of care.

Figure 13. Percentage of persons with HIV (Stage 1 and 2) and HIV Stage 3 (AIDS) who were out of care, 2017-2021.

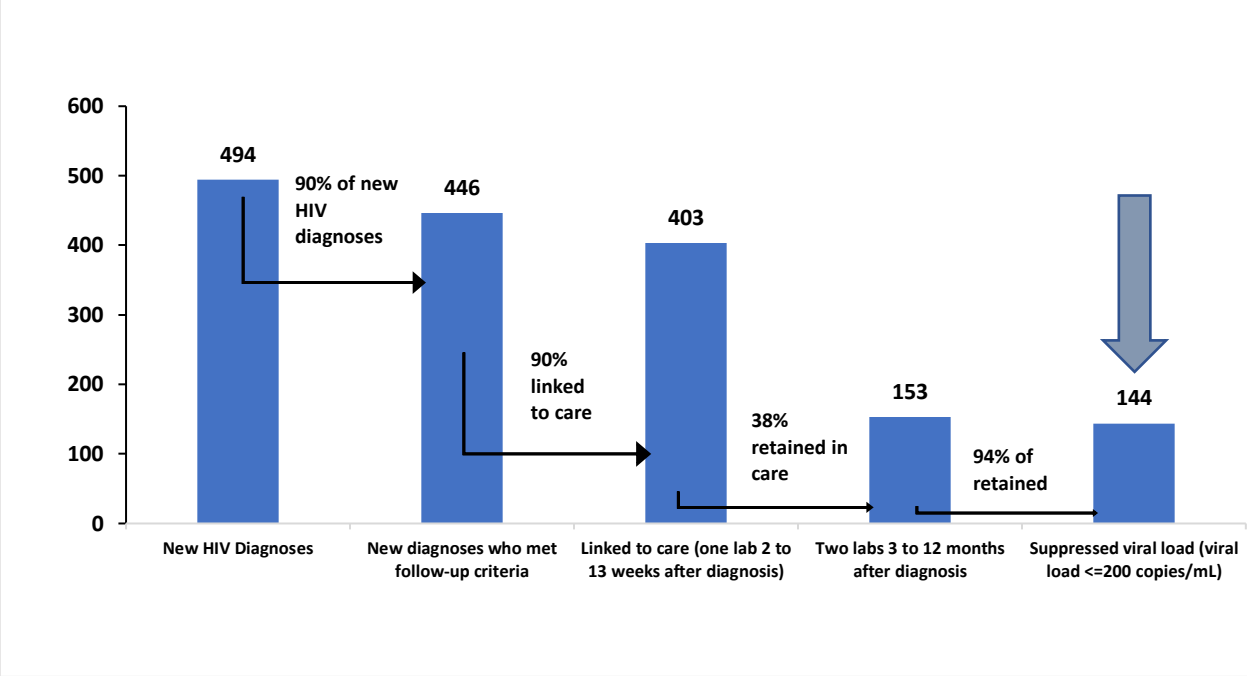


	2017	2018	2019	2020	2021
HIV (Stage 1 and 2)	36%	30%	28%	31%	32%
HIV Stage 3(AIDS)	31%	25%	23%	25%	26%
HIV Stage1, 2, and 3	33%	28%	26%	28%	29%

Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

Figure 14 shows the continuum of care for the 494 persons diagnosed with HIV in 2021. Of the 494 persons who were newly diagnosed with HIV in 2021, 446 (90.3%) met the follow-up criteria. Of those 446 cases who met follow-up criteria, 403 (90.4%) were linked to care, meaning they had one or more documented medical visit(s) and viral load or CD4 tests within 3 months after their diagnosis. Among the 403 cases linked to care, 153 (38.0%) were retained the care, meaning that the cases had a minimum two documented medical visits and lab test as defined above at least three to twelve months after diagnosis. Viral suppression was observed in 144 cases (94.1%) of the 153 cases who were retained in care, highlighting the importance of retaining PLWH in care. In total, of the 446 persons newly diagnoses with HIV in 2021 who met follow-up criteria, 34.3% (153) were retained in care and 32.3% (144) had a suppressed viral load.

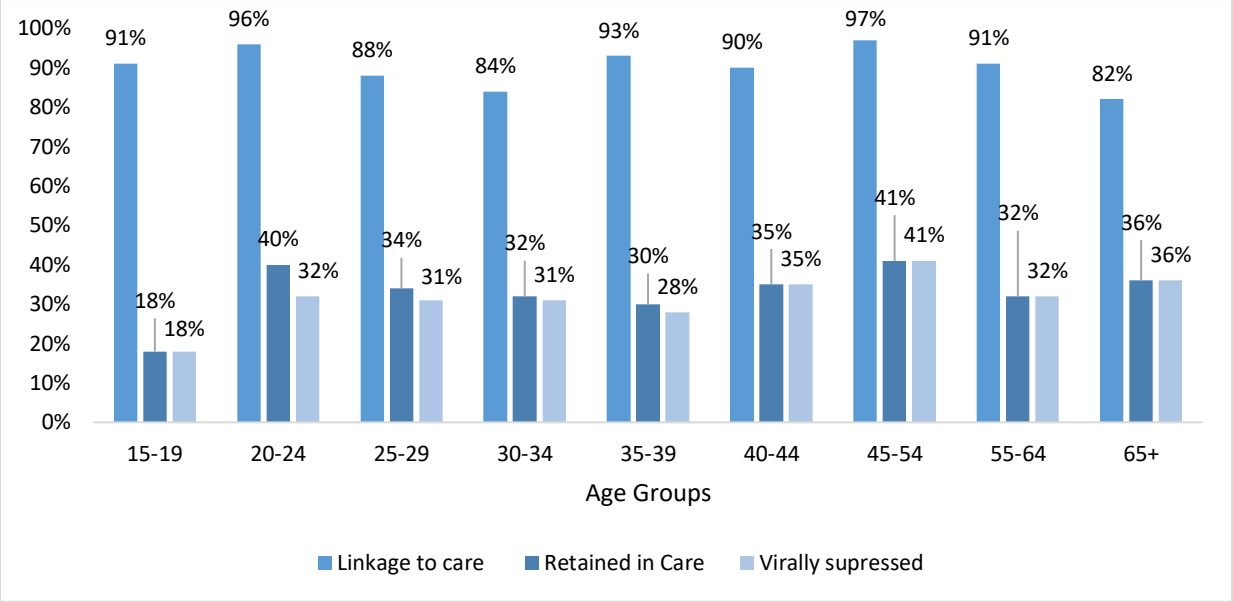
Figure 14. New HIV infections continuum of care for Nevada, 2021.



Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

There are noteworthy disparities regarding linkage to health care within 90 days, retention in care, and viral suppression when examining differences by sociodemographic characteristics. Figure 15 shows differences in these outcomes by age group, Figure 16 shows differences by sex at birth, and Figure 17 shows differences by race and ethnicity. Regarding age (Figure 15), the percentage of persons linked to care was lowest for those aged 65 and older (82%), those aged 30 – 34 (84%) and those aged 25 – 29 (88%). The percentage of persons retained in care and virally suppressed generally increased with age, with lowest the percentage among those aged 15 – 19 and the highest percentage among those 45 – 54.

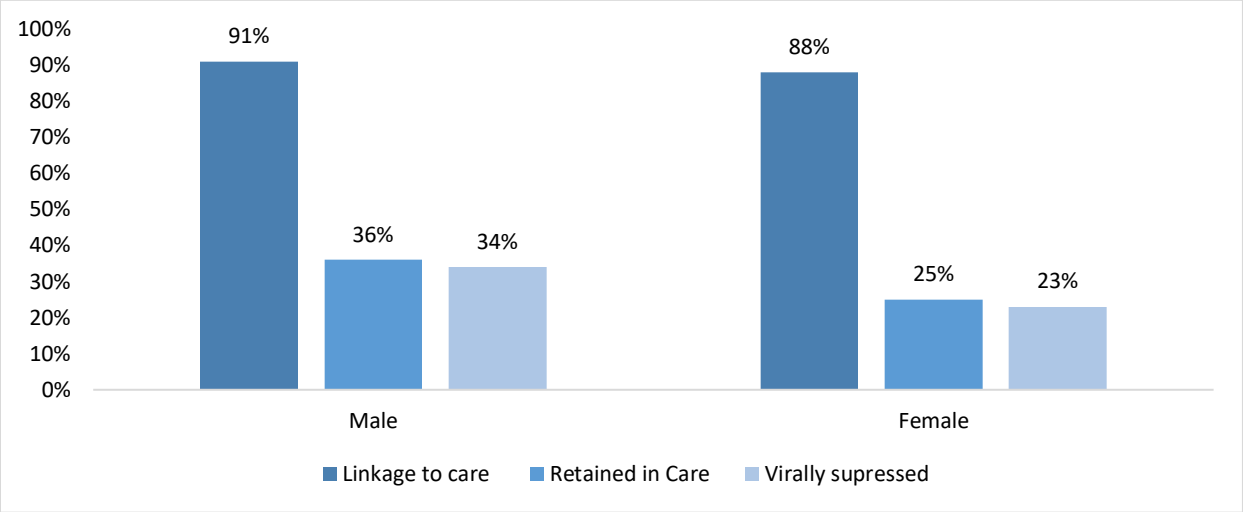
Figure 15. Linkage to care with 90 days of diagnosis, retention in care and viral suppression by age in Nevada, 2021.



Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

Regarding sex at birth, the percentage of males and females linked to care in 2021 was relatively similar (91% vs 88%), however, the percentages of females who were retained in care (25%) was much lower than the percentage for males (36%).

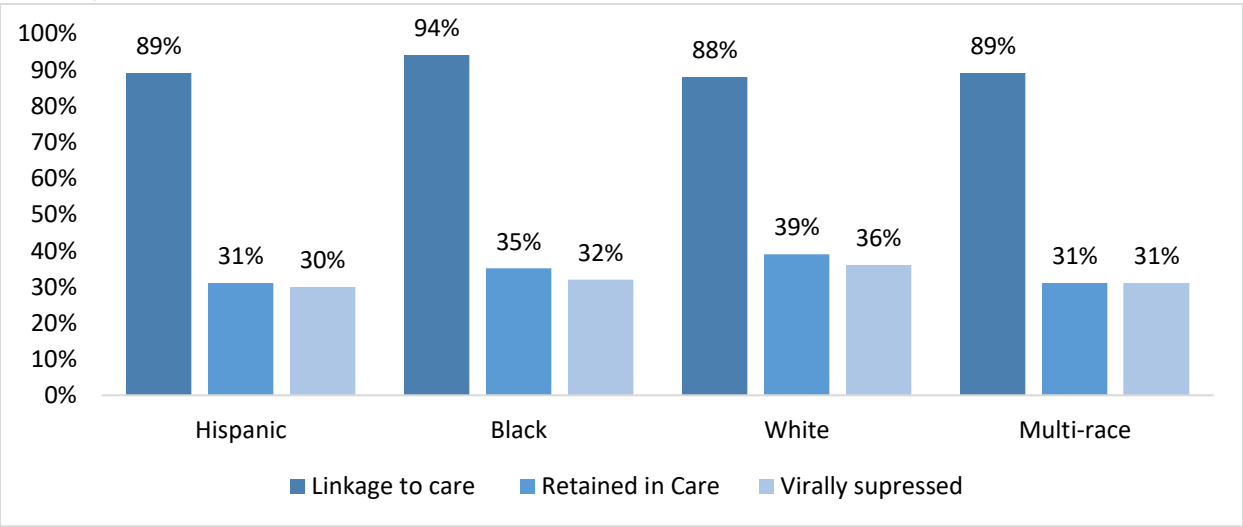
Figure 16. Linkage to care with 90 days of diagnosis, retention in care and viral suppression by sex in Nevada, 2021.



Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

Regarding race and ethnicity, linkage to care was highest among Black persons (94%). Retention in care was highest for White persons (39%), followed by Black persons (35%).

Figure 17. Linkage to care with 90 days of diagnosis, retention in care and viral suppression by age in Nevada, 2021.



Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), 2022.

HIV Mortality

Table 8 shows deaths among PLWH in Nevada in 2021. Statewide, there were a total of 123 deaths among PLWH. The rate of death among PLWH was higher in Clark County (4.8 per 100,000 population) compared to Washoe County (2.1 per 100,000 population). Rates of death were highest for Black PLWH (11.7 per 100,000 population) compared to all other races and ethnicities. In general, rates of death among PLWH were higher for those in older age groups compared to those in younger age groups.

Table 8. Deaths among persons living with HIV in Nevada, 2021.

	Total			Male			Female		
	N	**%**	**Rate***	**N**	**%**	**Rate***	**N**	**%**	**Rate***
County at Death									
Clark County	113	92%	4.8	98	91%	8.3	15	100%	1.3
Washoe County	10	8%	2.1	10	9%	4.1	0	0%	0.0
All Other Counties	0	0%	0.00	0	0%	0.0	0	0%	0.0
Race/Ethnicity									
White, non-Hispanic	48	39%	3.1	42	39%	5.3	6	40%	0.8
Black, non-Hispanic	34	28%	11.7	26	24%	17.8	8	53%	5.6
Hispanic	30	24%	3.0	30	28%	6.0	0	0%	0.0
Asian/Hawaiian/Pacific Islander	4	3%	1.0	4	4%	2.7	0	0%	0.0
American Indian/Alaska Native	0	0%	0.0	0	0%	0.0	0	0%	0.0
Multi-race/Other	7	6%	NA	6	6%	NA	1	7%	NA
Age at End of Calendar Year 2021									
<25	0	0%	0.0	0	0%	0.0	0	0%	0.0
25 to 29	4	3%	1.7	4	4%	3.4	0	0%	0.0
30 to 34	8	7%	3.5	8	7%	6.9	0	0%	0.0
35 to 39	11	9%	5.3	10	9%	9.5	1	7%	1.0
40 to 44	10	8%	4.6	10	9%	9.2	0	0%	0.0
45 to 54	25	20%	6.1	20	19%	9.6	5	33%	2.5
55 to 64	32	26%	8.3	26	24%	13.6	6	40%	3.1
65+	33	27%	6.8	30	28%	13.5	3	20%	1.1
Transmission Category									
MSM	69	56%	NA	69	64%	NA	0	0%	NA
IDU	11	9%	NA	8	7%	NA	3	20%	NA
MSM + IDU	12	10%	NA	12	11%	NA	0	0%	NA
Heterosexual Contact	9	7%	NA	4	4%	NA	5	33%	NA
Perinatal Exposure	1	1%	NA	1	1%	NA	0	0%	NA
NIR/NRR	20	16%	NA	13	12%	NA	7	47%	NA
Transfusion/Hemophilia	1	1%	NA	1	1%	NA	0	0%	NA
Total	**123**	**100%**	**3.8**	**108**	**100%**	**6.7**	**15**	**100%**	**0.9**

Source: Division of Public and Behavioral Health, enhanced HIV/AIDS Reporting System (eHARS), (March 2022).
**Rates per 100,000 population were calculated using 2021 population projections.*
***All other counties include Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine Counties.*

HIV and Substance Use

Table 9. Substance Abuse Prevention and Treatment Agency/ Persons Living with HIV/AIDS Linkage Analysis.

	Nevada Prevalence					
	SAPTA (2017-2021)		MATCHED (Deduplicated)		HIV/AIDS (2021 Prevalence)	
	n	%	n	%	n	%
Sex At Birth						
Male	36,545	50.4%	61	24.7%	10,909	84.8%
Female	35,958	49.6%	186	75.3%	1,957	15.2%
Unknown	65	0.1%	0	0.0%	0	0.0%
Total	72,568	100%	247	100.0%	12,866	100.0%
Race/Ethnicity						
White, non-Hispanic	33,629	46.3%	76	30.8%	5,014	39.0%
Black, non-Hispanic	8,356	11.5%	81	32.8%	3,690	28.7%
Hispanic	9,229	12.7%	27	10.9%	3,313	25.8%
Asian/Hawaiian/Pacific Islander	2,059	2.8%	5	2.0%	523	4.1%
American Indian/Alaska Native	973	1.3%	4	1.6%	78	0.6%
Multi-race/Other/Unknown	18,322	25.2%	54	21.9%	248	1.9%
Total	72,568	100.0%	247	100.0%	12,866	100.0%
Age						
Missing	138	0.2%	0	0.0%	0	0.0%
<13	2,062	2.8%	0	0.0%	5	0.0%
13-14	1,253	1.7%	0	0.0%	3	0.0%
15-19	3,775	5.2%	3	1.2%	33	0.3%
20-24	5,436	7.5%	16	6.5%	263	2.0%
25-29	7,660	10.6%	30	12.1%	902	7.0%
30-34	7,766	10.7%	38	15.4%	1,508	11.7%
35-39	7,292	10.0%	43	17.4%	1,548	12.0%
40-44	6,418	8.8%	15	6.1%	1,347	10.5%
45-54	12,988	17.9%	55	22.3%	2,880	22.4%
55-64	12,286	16.9%	45	18.2%	3,053	23.7%
>65	5,494	7.6%	2	0.8%	1,324	10.3%
Total	72,568	100.0%	247	100.0%	12,866	100.0%
Transmission Category						
Male						
MSM			104	54.5%	8,256	75.7%
IDU			21	11.0%	485	4.4%
MSM+IDU			39	20.4%	762	7.0%
Heterosexual Contact			7	3.7%	353	3.2%
Perinatal Exposure			2	1.0%	33	0.3%
Transfusion/Hemophilia			0	0.0%	3	0.0%
NIR/NRR			18	9.4%	1,017	9.3%
Subtotal			191	100.0%	10,909	100.0%
Female						
IDU			19	33.9%	274	14.0%
Heterosexual Contact			16	28.6%	1,033	52.8%
Perinatal Exposure			3	5.4%	54	2.8%
Transfusion/Hemophilia			0	0.0%	3	0.2%
NIR/NRR			18	32.1%	593	30.3%
Subtotal			56	100.0%	1,957	100.0%
Total	72,658	100%	247	100.0%	12,866	100.0%

Source: Division of Public and Behavioral Health, Enhanced HIV/AIDS Reporting System (eHARS) as of March 2022
SAPTA and PLWHA were matched using Match Pro. First name, last name, date of birth, and social security number were paired using probabilistic matching.
Matches were deduplicated.
SAPTA: Substance Abuse, Prevention & Treatment Agency. Counts represent admissions to Nevada State-funded substance abuse and treatment facilities and are not deduplicated.

As shown in Table 9, during 2021, there were 12,866 PLWH in Nevada and of those, 247 were also admitted to a program monitored by the Substance Abuse Prevention and Treatment Agency (SAPTA). Characteristics of these individuals are presented in Table 9.

Ryan White Clients

Table 10 shows characteristics of Ryan White Program clients in Nevada and in the Las Vegas TGA in 2020.[9] There were a total of 5,262 Ryan White Program clients in 2020 across the state and 4,182 in the Las Vegas TGA. In general, the sociodemographic characteristics of Ryan White clients in Nevada reflect the sociodemographic characteristics of PLWH in Nevada. Nearly 90% of clients in the Las Vegas TGA and statewide were between the ages of 25 and 64. Regarding race and ethnicity, 34.0% of clients statewide were White, 30.3% were Hispanic or Latino, and 27.9% were Black or African American. In the Las Vegas TGA, a similar proportion of clients were Hispanic/Latino (30.9%), but a larger proportion were Black or African American (34.5%) and a smaller proportion were White (27.6%). About 80% of clients statewide and in the Las Vegas TGA were male and the most common transmission category in both areas was MSM, followed by heterosexual contact, and IDU.

[9] *Ryan White HIV/AIDS Program Annual Client-Level Data Report Ryan White HIV/AIDS Program Services Report, 2020.*

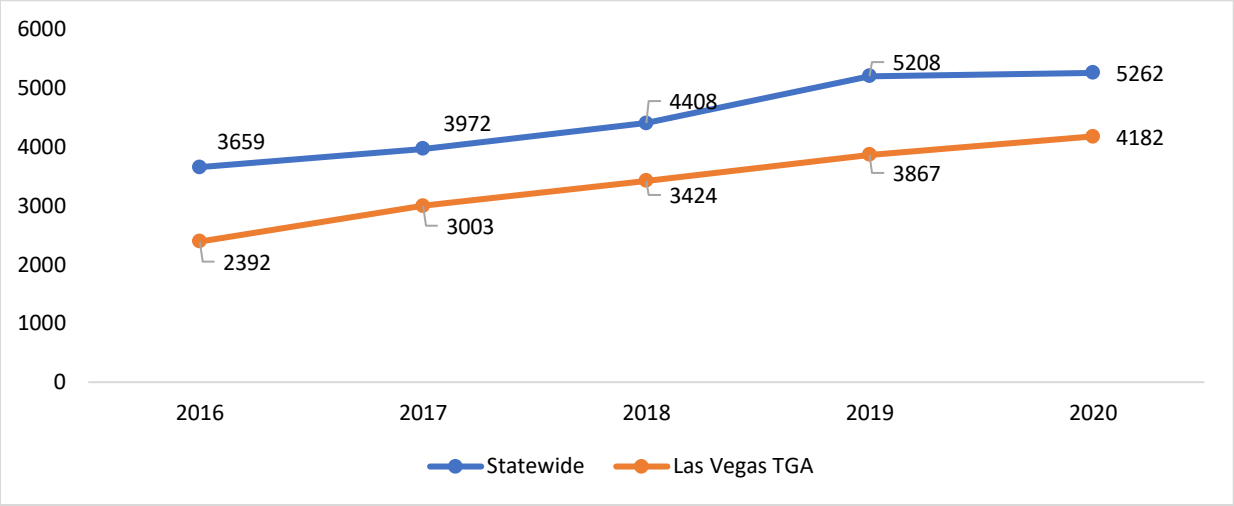
Table 10. Sociodemographic characteristics of Ryan White clients in Nevada and in the Las Vegas TGA, 2020.

	Statewide		Las Vegas TGA	
	N	%	N	%
Age				
< 13	41	0.8	38	0.9
13 – 24	189	3.6	172	4.1
25 – 34	1,196	22.7	1,030	24.6
35 – 44	1,139	21.8	975	23.3
45 – 54	1,136	21.6	888	21.2
55 – 64	1,145	21.8	830	19.8
≥ 65	416	7.9	249	6.0
Total	**5,262**	**100.0**	**4,182**	**100.0**
Race/ethnicity				
American Indian/Alaska Native	46	0.9	32	0.8
Asian	175	3.4	141	3.4
Black/African American	1,445	27.9	1,430	34.5
Hispanic/Latino	1,572	30.3	1,278	30.9
Native Hawaiian/Pacific Islander	57	1.1	26	0.6
White	1,760	34.0	1,144	27.6
Multiple Races	126	2.4	---	---
Total	**5,181**	**100.0**	**4,051**	**100.0**
Gender Identity				
Male	4,223	80.3	3,321	79.4
Female	907	17.2	749	17.1
Transgender female	122	2.3	103	2.5
Transgender male	8	0.2	7	0.2
Other gender identity	2	0.1	---	---
Total	**5,262**	**100.0**	**4,180**	**100.0**
Transmission Category				
Male-to-male sexual contact (MSM)	2,778	77.9	2,271	79.7
Injection drug use (IDU)	171	4.8	99	3.5
Male-to-male sexual contact and injection drug use (MSM + IDU)	89	2.5	78	2.7
Heterosexual contact	457	12.8	353	12.4
Perinatal	36	1.0	30	1.1
Other	35	1.0	17	0.6
Total	**3,556**	**100.0**	**2,848**	**100.0**

Data source: Ryan White HIV/AIDS Program Annual Client-Level Data Report Ryan White HIV/AIDS Program Services Report, 2020.

Since 2016, the number of clients in both areas has increased steadily (Figure 18).

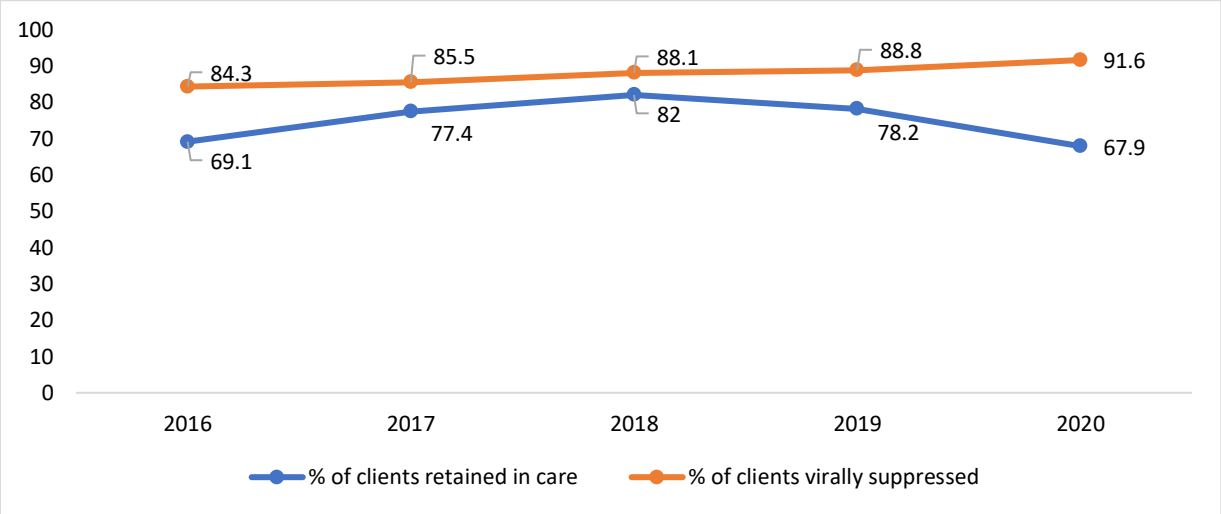
Figure 18. Number of Ryan White clients (non-AIDS Drug Assistance Program (ADAP)) in Nevada and in the Las Vegas TGA, 2016 – 2020.



Data source: Ryan White HIV/AIDS Program Annual Client-Level Data Report Ryan White HIV/AIDS Program Services Report, 2020.

Figure 19 demonstrates the proportion of Ryan White clients in Nevada who were virally suppressed steadily increased between 2016 (84.3% of clients) and 2020 (91.6% of clients). The proportion of clients retained in care steadily increased from 69.1% to 82.0% between 2016 and 2018 but decreased to 78.2% in 2019 and 67.9% in 2020 (Figure 19).

Figure 19. Percentage of Ryan White clients (non-ADAP) in Nevada and in the Las Vegas TGA who were retained in care and virally suppressed, 2016 – 2020.



Data source: Ryan White HIV/AIDS Program Annual Client-Level Data Report Ryan White HIV/AIDS Program Services Report, 2020.

Risky Sexual Behaviors and Sexually Transmitted Diseases (STDs)

Table 11 shows sexual behaviors among high school students in Nevada in 2017 and 2019.[10] The prevalence of high school students who ever had sexual intercourse (36.8% vs. 31.8%) and the prevalence of students who had sexual intercourse before age 13 (4.1% vs. 2.4%) significantly decreased between 2017 and 2019. In 2019, 8.1% of students had sexual intercourse with four or more persons during their life. Further, 17.9% of students drank alcohol or used drugs before last sexual intercourse and only 56.8% of students used a condom at last sexual intercourse. The prevalence of risky sexual behaviors among youth in Nevada was similar to the prevalence for youth across the United States.[11]

Table 11. Sexual behaviors among high school students in Nevada, Nevada Youth Risk Behavior Survey, 2017 and 2019.

Indicator	2017	2019	Change
Percentage of high school students who ever had sexual intercourse	36.8%	31.8%	**Significant decrease**
Percentage of high school students who had sexual intercourse for the first time before age 13 years	4.1%	2.4%	**Significant decrease**
Percentage of high school students who had sexual intercourse with four or more persons during their life	9.5%	8.1%	**No significant change**
Percentage of high school students who had sexual intercourse with at least one person during the 3 months before the survey	25.8%	22.4%	**No significant change**
Percentage of high school students who drank alcohol or used drugs before last sexual intercourse (among students who were sexually active in the past 3 months)	17.7%	17.9%	**No significant change**
Percentage of high school students who used a condom during last sexual intercourse (among students who were sexually active in the past 3 months)	55.7%	56.8%	**No significant change**

Source: State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. Nevada High School Youth Risk Behavior Survey (YRBS) Comparison Report, 2017- 2019.

Compared to heterosexual youth, lesbian, gay, bisexual, and questioning (LBGQ) students were significantly more likely to report having sexual intercourse for the first time before age 13 years, having sexual intercourse with four or more persons during their life, and were less likely to report using a condom at last sexual intercourse. Similar findings were observed when comparing cisgender students to transgender students.[12] Further, transgender students were more likely to report using alcohol or drugs before last sexual intercourse compared to cisgender students. Regarding race and ethnicity, Black or African American students were more likely to report having four or more sexual partners compared to

[10] Diedrick, M., Lensch, T., Zhang, F., Peek, J., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. *Nevada High School Youth Risk Behavior Survey (YRBS) Comparison Report, 2017- 2019.*

[11] Youth Online. High School YRBS. Centers for Disease Control and Prevention. Accessed at: https://nccd.cdc.gov/Youthonline/App/Default.aspx.

[12] Anderson, M., Diedrick, M., Lensch, T., Zhang, F., Peek, J., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. *2019 Nevada High School Youth Risk Behavior Survey (YRBS): Sexual and Gender Identity Special Report*.

other racial and ethnic groups. Further, Asian students, Black or African American students, and Hispanic students were less likely to report using a condom at last sexual intercourse compared to White students.

Table 12 shows the number and rate of incident chlamydia, gonorrhea, primary and secondary syphilis, and early latent syphilis cases in Nevada in 2020. Chlamydia was the most common STD in Nevada in 2020, with more than 14,700 reported cases in 2020 and a rate of 465.6 cases per 100,000 population. Gonorrhea was the second most common STD, followed by primary and secondary syphilis and early latent syphilis. Further, rates of these STDs were consistently higher among those living in Clark and Washoe counties, Black or African American persons, and younger persons.[13]

Table 12. Number and rate of incident chlamydia, gonorrhea, primary and secondary syphilis, and early latent syphilis cases in Nevada, 2020.

	N	Rate
Chlamydia	14,739	465.6 per 100,000 population
Gonorrhea	6,364	201.0 per 100,000 population
Primary and Secondary Syphilis	767	24.2 per 100,000 population
Early Latent Syphilis	496	15.7 per 100,000 population

Source: Office of Public Health Investigation and Epidemiology. Division of Public and Behavioral Health. State of Nevada 2020 STD Fast Facts. Reno, Nevada. e1.0. January 2021.

[13] Office of Public Health Investigation and Epidemiology. Division of Public and Behavioral Health. State of Nevada 2020 STD Fast Facts. Reno, Nevada. e1.0. January 2021.

HIV Prevention, Care, and Treatment Resource Inventory

The Nevada HIV prevention, care, and treatment resource inventory is presented below in Table 13 and Table 14. Both tables contain the same information regarding the funder, funding source, organization receiving the funding, the annual award amount, the subrecipients of funds, and services delivered. Table 13 includes information regarding the HIV care continuum steps impacted for each source of funding and Table 14 includes information regarding the EHE pillars addressed by each funding source. The tables were developed and produced using the *Resource Inventory Compiler Tool* provided to jurisdictions developing an Integrated Plan.[14]

The largest source of HIV funding in Nevada is through the HRSA RWHAP. Detailed information regarding RWHAP funding in Nevada is presented in Table 13 and Table 14 below. Clark County Social Services serves as the head of RWHAP Part A in Nevada, and these funds are used to provide core medical and support services for PLWH. Treatment and care services provided using these funds are delivered by agencies in Nevada that follow RWHAP standards.[15] The Las Vegas TGA Planning Council sets the basis for funding decisions, with the recipient's office handling awarding of contracts to service agencies. The Las Vegas TGA hosts monthly Action Planning Group (APG) meetings.[16] The APG is a collaborative of service providers representing a variety of disciplines in the Las Vegas TGA who meet monthly to discuss coordination of services and resources for clients.

The Nevada Office of HIV: Ryan White Part B Program receives funding for RWHAP Part B, which provides a comprehensive system of care including primary medical care, support services and access to medication through the ADAP to eligible PLWH in Nevada.[15] The Nevada Office of HIV also participates in the APG and conducts a similar meeting for northern Nevada subrecipients called SPEC, which is the Services, Planning and Evaluation Committee. Every quarter both the APG and SPEC come together to look at best practices, network and conduct agency presentations to help serve clients statewide.

RWHAP Part C funds are awarded to CBOs and service providers to support early intervention services and care. In Nevada, Northern Nevada HOPES in Reno, and University Medical Center (UMC) in Las Vegas, receive RWHAP Part C funds. RWHAP Part D funds are used to support family-centered, comprehensive care to women, infants, children, and youth living with HIV.[15] In Nevada, Northern Nevada HOPES in Reno and the Maternal and Child Wellness Program at University of Nevada, Las Vegas (UNLV) – College of Medicine receive RWHAP Part D funds. RWHAP Part F funds are awarded to education and training programs for health care providers treating PLWH.[15] The AIDS Education and Training Center (AETC) within the University of Nevada, Reno Office of Statewide Initiatives receives Part F funds.

The second largest source of funding for the HIV Prevention and Surveillance Programs are provided by the CDC. The Nevada Office of HIV: Prevention and Surveillance Program staff are responsible for coordination prevention and surveillance efforts with local health authorities, HPPGs, state and local HIV

[14] Target HIV. HIV Prevention, Treatment, and Care Resource Inventory Compiler. https://targethiv.org/library/hiv-prevention-care-and-treatment-resource-inventory-compiler.
[15] Nevada's Ryan White Program Resource Directory. Ending the HIV Epidemic. https://endhivnevada.org/directory/ryan-White-program-parts/
[16] Coordination of Resources. The Las Vegas Transitional Grant Area (TGA). https://lasvegastga.com/action-planning-2/

prevention providers, and other concerned and committed citizens.[17] The Nevada Office of HIV contracts with Nevada's three local health authorities to fund prevention and surveillance activities, which are Carson City Health and Human Services (CCHHS), Southern Nevada Health District (SNHD), and Washoe County Health District (WCHD).

CCHHS serves Carson City, Douglas County, Lyon County and Storey County, and uses CDC prevention funds to provide counseling, testing and referral services, partner notification, and HIV/STD education.[14] SNHD serves Clark County and uses HIV prevention funding, as well as RWHAP Part A and Part B funding, for HIV testing, HIV prevention efforts, early intervention services, and medical case management. Specific services provided by SNHD include HIV and STD testing, partner notification, HIV Client Centered Counseling, outreach programs, community referrals, and distribution of safer sex items. SNHD also receives additional CDC funding through PS20-2010 EHE initiatives. WCHD serves Washoe County and uses HIV prevention funds to provide screening, testing, and counseling for STDs, including HIV and STD prevention education, community outreach, partner notification, and referrals for PLWH.[18]

Finally, Nevada receives funding through HUD to support the Housing Opportunities for Persons with AIDS (HOPWA) program. These funds are used to provide housing support assistance for PLWH. The City of Las Vegas receives HUD/HOPWA funds to support PLWH in Southern Nevada while the Office of HIV receives HUD/HOPWA funds to support PLWH in Northern Nevada.

Strengths and Gaps

There are several strengths worth noting related to the HIV prevention, care, and treatment resource inventory. First, the Nevada Office of HIV, local health authorities, and RWHAP parts have built strong relationships with open lines of communication to ensure that quality prevention, treatment, and ancillary care services are available and accessible to Nevadans. Another strength is that state programs subcontract with a wide variety of CBOs and HIV programs who offer quality prevention, treatment, and ancillary care services to Nevadans across the state. These subrecipients have strong reputations in their communities and offer a variety of services to at-risk and marginalized Nevadans, as well as PLWH.

Several important gaps emerged during development of the resource inventory worth noting. As described in the next section, the Internal Workgroup collaborated with program staff of agencies and programs receiving HIV funding to complete the resource inventory assessment and made several attempts to collect resource information across several months. Another potential gap is that many programs in Nevada currently operate on very limited budgets despite the high burden of HIV in Southern Nevada. Some programs only have enough resources to carry out required activities and have little time and flexibility for conducting additional activities that could benefit PLWH and people at-risk for HIV in Nevada. Further, Nevada relies heavily on funding from HRSA, CDC, and HUD for HIV prevention, treatment, and ancillary care services. Throughout the process of compiling the resource inventory, it was evident that agencies and programs in Nevada are not seeking or receiving funding from other sources such as Indian Health Services (IHS) and National Institutes of Health (NIH).

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[17] Nevada HIV Prevention and Surveillance Program. Nevada Office of HIV, Nevada Department of Health and Human Services. https://dpbh.nv.gov/Programs/HIV/HIV_Prevention_-_Home/.

[18] Nevada Office of HIV. Nevada HIV Integrated Prevention and Care Plan 2017 – 2021. 2016. Accessed at: https://endhivnevada.org/wp-content/uploads/2020/01/Integrated-HIV-Prevention-and-Care-Plan-Final-9-29-16.pdf.

Approaches and Partnerships

The Internal Workgroup discussed several strategies for completing the resource inventory. Ultimately, the Internal Workgroup decided the most streamlined method for completing the resource inventory that would avoid possible duplication of reported funding was to have program leaders from agencies and organizations receiving HIV-related funding complete the *Resource Inventory Compiler Tool*. After individual program leaders completed the tool, the Larson Institute/UNR School of Public Health team combined all funding information and produced Table 13 and Table 14.

To supplement information included on major funding sources, the Internal Workgroup also offered subrecipients of major funding sources the opportunity to report any additional, independent funding that could be included in the resource inventory. Upon completion, the Internal Workgroup carefully reviewed the resource inventory to ensure that there was no duplication of data.

Table 13. Nevada HIV prevention, care, and treatment resource inventory, including HIV care continuum.

Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Subrecipients	Services Delivered	HIV Diagnosis	Linkage to Care	Engagement or Retention in Care	Prescription of ART	Viral Suppression
CDC	CDC PS18-1802: HIV Prevention	Nevada Office of HIV	$2,689,974.00	Southern Nevada Health District, Washoe County Health District, Carson City Health and Human Services, and Northern Nevada HOPES	Outreach services, capacity building/technical assistance, community engagement, community mobilization, condom distribution, HIV transmission cluster and outbreak identification and response, partner services, perinatal HIV prevention and surveillance, prep delivery, prevention for persons living with diagnosed HIV infection, social marketing campaigns, social media strategies, syringe services programs, testing, HIV prevention activities	•	•	•	•	•
CDC	CDC PS18-1802: HIV Surveillance	Nevada Office of HIV	$574,386.00	Southern Nevada Health District, Washoe County Health District, and Carson City Health and Human Services	Capacity building/technical assistance, Community engagement, Community mobilization, HIV transmission cluster and outbreak identification and response, perinatal HIV prevention and surveillance, prevention for persons living with diagnosed HIV infection, surveillance, HIV surveillance activities	•	•	•	•	•
CDC	Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases	Nevada Office of HIV	$1,687,948.09	ACCEPT, Aid for AIDS Network, Access to Healthcare Network, Carson City Health and Human Services, The Center Las Vegas, Northern Nevada HOPES, Planned Parenthood of the Rocky Mountains, Southern Nevada Health District	Early intervention services (EIS), medical nutrition therapy, mental health services, emergency financial assistance, health education/risk reduction, housing, legal services, medical transportation, non-medical case management services, psychosocial support services		•	•		•
CDC	Ending the HIV Epidemic PS20-2010	Southern Nevada Health District	$2,144,080.00	University Medical Center, Rescue Agency, Nevada AIDS Education Training Center	Other professional services, outreach services, PrEP delivery, social marketing campaigns, linkage to care	•	•	•	•	•
HRSA	AIDS Drug Assistance Program	Nevada Office of HIV	$7,000,162.00	Access to Healthcare Network, Community Medical Outreach	AIDS drug assistance program treatments, health insurance premium and cost sharing assistance for low-income individuals, outpatient/ambulatory health services,			•	•	•
HRSA	AIDS Education and Training Centers (RWHAP Part F)	Pacific AIDS Education and Training Center- Nevada, University of Nevada, Reno School of Medicine	$180,010.00	N/A	Capacity building/technical assistance, education, training	•	•	•	•	•
HRSA	Ending the HIV Epidemic: A Plan for America — Ryan White HIV/AIDS Program Parts A and B	Clark County Social Service	$1,577,515.00	Huntridge Family Clinic, Southern Nevada AIDS Research & Education Society, UMC Wellness Center, Southern Nevada Health District, Project HHHOME	Early intervention services (EIS), health insurance premium and cost sharing assistance for low-income individuals, medical case management, including treatment adherence services, outpatient/ambulatory health services, medical transportation, psychosocial support services, community engagement, social marketing campaigns, social media strategies	•	•	•	•	•
HRSA	RWHAP Part B	Nevada Office of HIV	$2,438,746.00	Access to Healthcare Network, Northern Nevada HOPES, Southern Nevada Health District	Medical case management, non-medical case management services	•	•	•	•	•

Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Subrecipients	Services Delivered	HIV Diagnosis	Linkage to Care	Engagement or Retention in Care	Prescription of ART	Viral Suppression
HRSA	RWHAP Part A	Clark County Social Service	$7,018,823.00	Access to Healthcare Network, AIDS Healthcare Foundation, Aid for AIDS of Nevada, Better Lunch, Community Counseling Center, Community Outreach Medical Center, Dignity Health, Golden Rainbow, Horizon Ridge Wellness Clinic, Huntridge Family Clinic, North Country Healthcare, Nye County Health and Human Services, Southern Nevada AIDS Research and Education Society, Southern Nevada Health District, UMC Wellness Center, UNLV School of Dental Medicine	Early intervention services (EIS) , health insurance premium and cost sharing assistance for low-income individuals , medical case management, including treatment adherence services, medical nutrition therapy, mental health services, oral health care, outpatient/ambulatory health services, substance abuse outpatient care, emergency financial assistance, food bank/home delivered meals, health education/risk reduction, linguistic services, medical transportation, psychosocial support services , oral health care, MAI medical case management, MAI outpatient/ambulatory health services, MAI health education/risk reduction, MAI psychosocial support services	•	•	•	•	•
HRSA	RWHAP Part C	Northern Nevada HOPES	$416,797.00	N/A	Early intervention services (EIS), medical case management, including treatment adherence services, medical nutrition therapy, mental health services, oral health care, outpatient/ambulatory health services, emergency financial assistance, housing, medical transportation, referral for health care and support services		•	•	•	•
HRSA	RWHAP Part C	University Medical Center	$765,754.00	N/A	Early intervention services (EIS), mental health services, oral health care, outpatient/ambulatory health services		•	•	•	•
HRSA	RWHAP Part C	University of Nevada, Las Vegas School of Medicine	$150,000.00	N/A	Capacity building		•	•	•	•
HRSA	RWHAP Part D	Northern Nevada HOPES	$268,097.00	N/A	Medical case management, including treatment adherence services, medical nutrition therapy, mental health services, outpatient/ambulatory health services, emergency financial assistance, medical transportation, non-medical case management services, referral for health care and support services		•	•	•	•
HRSA	RWHAP Part D	University of Nevada, Las Vegas School of Medicine	$190,317.00	N/A	Medical case management, including treatment adherence services, medical nutrition therapy, mental health services, outpatient/ambulatory health services, emergency financial assistance, medical transportation, non-medical case management services, referral for health care and support services		•	•	•	•
HUD	HUD/HOPWA	Las Vegas Community Services	$3,105,654.00	Access to Healthcare Network, Aid for AIDS Nevada, Economic Opportunity Board, Golden Rainbow, The Just One Project, Women's' Development Center	Medical case management, non-medical case management services, housing assistance			•		•
HUD	HUD/HOPWA	Office of HIV	$488,333.00	Northern Nevada HOPES	Tenant-based rental assistance, short-term rental, mortgage and utility assistance, permanent housing placement		•	•		•

Table 14. Nevada HIV prevention, care and treatment resource inventory, including Ending the HIV Epidemic (EHE) pillars.

Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Subrecipients	Services Delivered	Diagnose	Treat	Prevent	Respond
CDC	CDC PS18-1802: HIV Prevention	Nevada Office of HIV	$2,689,974.00	Southern Nevada Health District, Washoe County Health District, Carson City Health and Human Services, and Northern Nevada HOPES	Outreach services, capacity building/technical assistance, community engagement, community mobilization, condom distribution, HIV transmission cluster and outbreak identification and response, partner services, perinatal HIV prevention and surveillance, prep delivery, prevention for persons living with diagnosed HIV infection, social marketing campaigns, social media strategies, syringe services programs, testing, HIV prevention activities	●	●	●	●
CDC	CDC PS18-1802: HIV Surveillance	Nevada Office of HIV	$574,386.00	Southern Nevada Health District, Washoe County Health District, and Carson City Health and Human Services	Capacity building/technical assistance, Community engagement, Community mobilization, HIV transmission cluster and outbreak identification and response, perinatal HIV prevention and surveillance, prevention for persons living with diagnosed HIV infection, surveillance, HIV surveillance activities	●	●	●	●
CDC	Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases	Nevada Office of HIV	$1,687,948.09	ACCEPT, Aid for AIDS Network, Access to Healthcare Network, Carson City Health and Human Services, The Center Las Vegas, Northern Nevada HOPES, Planned Parenthood of the Rocky Mountains, Southern Nevada Health District	Early intervention services (EIS), medical nutrition therapy, mental health services, emergency financial assistance, health education/risk reduction, housing, legal services, medical transportation, non-medical case management services, psychosocial support services	●		●	
CDC	Ending the HIV Epidemic PS20-2010	Southern Nevada Health District	$2,144,080.00	University Medical Center, Rescue Agency, Nevada AIDS Education Training Center	Other professional services, outreach services, PrEP delivery, social marketing campaigns, linkage to care	●	●	●	●
HRSA	AIDS Drug Assistance Program	Nevada Office of HIV	$7,000,162.00	Access to Healthcare Network, Community Medical Outreach	AIDS drug assistance program treatments, health insurance premium and cost sharing assistance for low- income individuals, outpatient/ambulatory health services,	●	●		
HRSA	AIDS Education and Training Centers	Pacific AIDS Education and Training Center- Nevada, University of Nevada, Reno School of Medicine	$180,010.00	N/A	Capacity building/technical assistance, education, training	●	●	●	
HRSA	Ending the HIV Epidemic: A Plan for America — Ryan White HIV/AIDS Program Parts A and B	Clark County Social Service	$1,577,515.00	Huntridge Family Clinic, Southern Nevada AIDS Research & Education Society, UMC Wellness Center, Southern Nevada Health District, Project HHHOME	Early intervention services (EIS), health insurance premium and cost sharing assistance for low-income individuals, medical case management, including treatment adherence services, outpatient/ambulatory health services, medical transportation, psychosocial support services, community engagement, social marketing campaigns, social media strategies	●	●	●	●
HRSA	Ryan White Part B	Nevada Office of HIV	$2,438,746.00	Access to Healthcare Network, Northern Nevada HOPES, Southern Nevada Health District	Medical case management, non-medical case management services	●	●	●	●
HRSA	Ryan White Part A	Clark County Social Service	$7,018,823.00	Access to Healthcare Network, AIDS Healthcare Foundation, Aid for AIDS of Nevada, Better Lunch, Community Counseling Center, Community Outreach Medical Center, Dignity Health, Golden Rainbow, Horizon Ridge Wellness Clinic, Huntridge Family Clinic, North Country Healthcare, Nye County Health and Human Services, Southern Nevada AIDS Research and Education Society, Southern Nevada Health District, UMC Wellness Center, UNLV School of Dental Medicine	Early intervention services (EIS) , health insurance premium and cost sharing assistance for low-income individuals , medical case management, including treatment adherence services, medical nutrition therapy, mental health services, oral health care, outpatient/ambulatory health services, substance abuse outpatient care, emergency financial assistance, food bank/home delivered meals, health education/risk reduction, linguistic services, medical transportation, psychosocial support services , oral health care, MAI medical case management, MAI outpatient/ambulatory health services, MAI health education/risk reduction, MAI psychosocial support services	●	●		

Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Subrecipients	Services Delivered	Diagnose	Treat	Prevent	Respond
HRSA	RWHAP Part C	Northern Nevada HOPES	$416,797.00	N/A	Early intervention services (EIS), medical case management, including treatment adherence services, medical nutrition therapy, mental health services, oral health care, outpatient/ambulatory health services, emergency financial assistance, housing, medical transportation, referral for health care and support services		●		
HRSA	RWHAP Part C	University Medical Center	$765,754.00	N/A	Early intervention services (EIS), mental health services, oral health care, outpatient/ambulatory health services		●		
HRSA	RWHAP Part C	University of Nevada, Las Vegas School of Medicine	$150,000.00	N/A	Capacity building		●		
HRSA	RWHAP Part D	Northern Nevada HOPES	$268,097.00	N/A	Medical case management, including treatment adherence services, medical nutrition therapy, mental health services, outpatient/ambulatory health services, emergency financial assistance, medical transportation, non-medical case management services, referral for health care and support services		●		
HRSA	RWHAP Part D	University of Nevada, Las Vegas School of Medicine	$190,317.00	N/A	Medical case management, including treatment adherence services, medical nutrition therapy, mental health services, outpatient/ambulatory health services, emergency financial assistance, medical transportation, non-medical case management services, referral for health care and support services		●		
HUD	HUD/HOPWA	Las Vegas Community Services	$3,105,654.00	Access to Healthcare Network, Aid for AIDS Nevada, Economic Opportunity Board, Golden Rainbow, The Just One Project, Women's' Development Center	Medical case management, non-medical case management services, housing assistance		●		
HUD	HUD/HOPWA	Office of HIV	$488,333.00	Northern Nevada HOPES	Tenant-based rental assistance, short-term rental, mortgage and utility assistance, permanent housing placement		●		

Needs Assessments

Approach

HIV Prevention Needs Assessment

An HIV prevention needs assessment was conducted by the Larson Institute/UNR School of Public Health team in partnership with the Nevada Division of Public and Behavioral Health Office of HIV, between August and December 2021. The needs assessment consisted of a community survey and a series of focus groups across the state.

The 57-question community survey was completed by 1,498 eligible adults living in Nevada between September 23rd and December 6th of 2021. The survey instrument was drafted by the Larson Institute/UNR School of Public Health team and the Nevada Office of HIV and was shared with the Northern and Southern Nevada HPPGs and other key stakeholders to solicit feedback. Once the final survey instrument was approved, data collection began. Topics covered in the survey included HIV testing, sexual behaviors, pre-exposure prophylaxis (PrEP), injection drug use, healthcare, and HIV information and services. Data were primarily collected electronically, although a small number of paper surveys were completed. Data were cleaned using Microsoft Excel and were analyzed using SAS Vers`ion 9.4 (SAS Institute, Cary NC). Sociodemographic characteristics of community survey participants are presented in Table 15.

Overall, the demographic characteristics of community survey participants were similar to the demographics of Nevada, with a few caveats. Most community survey participants were between the ages of 18 and 34, and this was due to targeted recruitment efforts. Further, the proportion of Hispanic/Latinx persons (20.7%) was slightly lower than the state proportion (29.9%), although participants were asked to report their primary race/ethnicity in a single survey question which may have contributed to this difference.

Table 15. Sociodemographic characteristics of community survey participants, Nevada HIV Prevention Needs Assessment, 2021.

Characteristics		Percent
County of Residence	Clark County	14.0%
	Washoe County	67.7%
	Quad counties (Carson, Douglas, Storey, Lyon)	12.3%
	Other rural counties	6.0%
Age	18-24	63.9%
	25-34	19.2%
	35-44	5.6%
	45-54	6.0%
	55 and older	5.4%
Primary Race or Ethnicity	American Indian or Alaska Native	1.6%
	Asian	10.6%
	Black	6.4%
	Hispanic or Latinx	20.7%
	Native Hawaiian or Pacific Islander	1.2%
	White	58.0%
	Other and not responding	1.7%
Primary Gender Identity	Male	33.0%
	Female	63.8%
	Transgender or gender non-conforming	3.3%
Sexual orientation	Sexual minority	21.6%
	Heterosexual	78.4%
Educational Attainment	High School or Less/Technical School	20.0%
	Some College/Associate Degree	53.9%
	Bachelor's Degree	18.1%
	Master's Degree or Higher	8.1%
Annual Income	Less than $25K	52.5%
	$25 - $49	20.2%
	$50 - $74K	13.1%
	$75K - $99K	6.1%
	Greater than $100K	8.2%

Source: Lensch T, Etiler N, Dermid G, Nguyen Tang P, Collins L. 2021 Nevada HIV Prevention Needs Assessment. University of Nevada, Reno School of Public Health, Larson Institute for Health Impact and Equity. Nevada Office of HIV. 2022. Accessed June 2022.

In addition to the community survey, a series of 10 HIV prevention focus groups were completed between October 8th and December 10th of 2021 with a total of 65 participants. Nine of these focus groups were hosted in-person and one focus groups was hosted virtually through Zoom. The audio from all focus groups was recorded and transcribed by members of the Larson Institute/UNR School of Public Health team. The Larson Institute/UNR School of Public Health team analyzed the data using a condensed thematic inductive analysis. Table 16 shows the target population, location, and number of participants from each focus group.

Table 16. Characteristics of focus groups, Nevada HIV Prevention Needs Assessment, 2021.

Priority Population	Location	Number of Participants
Black or African American Adults	Southern NV	15
Young Adults	Southern NV	3
Latinx Adults	Southern NV	7
People Who Use Substances	Southern NV	4
People Who Use Substances	Southern NV	5
Sexual and Gender Minority Adults	Southern NV	8
Sexual and Gender Minority Adults	Southern NV	3
HIV+ Adults	Northern NV	12
Young Adults	Northern NV	4
Latinx Young Adults	Northern NV	4

Source: Lensch T, Etiler N, Dermid G, Nguyen Tang P, Collins L. 2021 Nevada HIV Prevention Needs Assessment. University of Nevada, Reno School of Public Health, Larson Institute for Health Impact and Equity. Nevada Office of HIV. 2022. Accessed June 2022.

Sociodemographic characteristics of focus group participants are present in Table 17 below. Overall, the sociodemographic characteristics represent the priority populations targeted for these groups, including people of color, young adults, and MSM, for example.

Table 17. Sociodemographic characteristics of focus group participants, Nevada HIV Prevention Needs Assessment, 2022.

Characteristics		Percent
Primary Race or Ethnicity	Black	32.8%
	Hispanic/Latinx	39.3%
	White	19.7%
	Other	8.2%
Primary Gender Identity	Male	59.0%
	Female	32.8%
	Transgender or gender non-conforming	8.2%
Sexual orientation	Sexual minority	41.0%
	Heterosexual	59.0%
Educational Attainment	High School or Less/Technical School	37.7%
	Some College/Associate Degree	37.7%
	Bachelor's Degree	19.7%
	Master's Degree or Higher	4.9%
Annual Income	Less than $25K	53.6%
	$25 - $49	17.9%
	$50 - $74K	14.3%
	$75K - $99K	3.6%
	Greater than $100K	3.6%

Source: Lensch T, Etiler N, Dermid G, Nguyen Tang P, Collins L. 2021 Nevada HIV Prevention Needs Assessment. University of Nevada, Reno School of Public Health, Larson Institute for Health Impact and Equity. Nevada Office of HIV. 2022. Accessed June 2022.

HIV Treatment and Care Needs Assessment

An HIV treatment and care needs assessment was conducted by Collaborative Research in partnership with the State of Nevada RWHAP Part B, the Las Vegas TGA, and the Clark County EHE teams. The needs assessment consisted of a community survey among PLWH in Nevada.[19]

The 2022 Nevada Statewide HIV Care and Treatment Needs Assessment aimed to assess the current care and service needs of PLWH in Nevada and in the Las Vegas TGA. The survey assessed HIV-related care and service needs, experiences using services, and perceived barriers to those services. The survey was distributed through palm cards, flyers, the Las Vegas TGA planning website, and email distribution.[15] Further, the online survey was sent via email to clients who indicated consent to receive emails from RWHAP Part A and RWHAP Part B recipients and individual service providers of these programs.

[19] Daniel J, Rodriguez-Schucker T, Jackson D. *2022 Nevada HIV Statewide Needs Assessment.* Collaborative Research. 2022. Accessed July 2022.

A total of 386 PLWH completed the needs assessment, representing an estimated 3% of the population of PLWH in Nevada. Sociodemographic characteristics of participants are presented in Table 18. About three-quarters of participants (73.8%) were diagnosed in Nevada and the remainder were diagnosed out of state. A little over half of participants (58.5%) were diagnosed with HIV within the last 3 years and 31.9% of participants were diagnosed 10 or more years ago. Nearly half of participants (45.1%) were Hispanic/Latinx.

Table 18. Sociodemographic characteristics of participants, Nevada HIV Treatment and Care Needs Assessment, 2022.

Characteristics		Percent
Place of Diagnosis	Nevada	73.8%
	Somewhere else	26.2%
Time Since Diagnosis	Less than 1 year	7.9%
	1 – 3 years	21.9%
	4 – 6 years	28.7%
	7 – 9 years	9.0%
	10 or more years	31.4%
	Don't Know	1.1%
Race	American Indian or Alaska Native	16.9%
	Asian	6.3%
	Black or African American	22.7%
	Native Hawaiian or Pacific Islander	7.7%
	White	37.4%
	Other	9.0%
Ethnicity	Hispanic/Latinx	45.1%
	Non-Hispanic/Latinx	54.9%
Age	21 to 30 years old	18.6%
	31 to 40 years old	31.7%
	41 to 50 years old	16.4%
	51 to 60 years old	22.1%
	61 to 70 years old	9.6%
	71 years or older	1.6%
Gender Identity	Female – born/identify	27.6%
	Male – born/identify	65.0%
	Gender fluid	3.6%
	Gender neutral	0.6%
	Trans female/woman	1.6%
	Trans male/man	1.6%

Source: Daniel J, Rodriguez-Schucker T, Jackson D. 2022 Nevada HIV Statewide Needs Assessment. Collaborative Research. 2022. Accessed July 2022.

Potential Limitations of Needs Assessments

Since the HIV prevention community survey was primarily completed electronically and targeted outreach was done through email listservs and social media, the sample consisted of younger adults. Similarly, the HIV treatment and care survey was also completed online. For both surveys, since potential participants were not randomly sampled, the results of the survey are not generalizable to the entire adult population in Nevada or to PLWH in Nevada. All study data were self-reported by participants, thus, there is potential for social desirability bias – particularly for the questions that addressed sensitive topics such as sexual behaviors, exposure to violence and discrimination, and experience with providers and case managers.

However, participants completed the survey online without a researcher present and no personal identifying information was collected. Regarding the focus groups, due to the COVID-19 pandemic, the Larson Institute/UNR School of Public Health experienced significant difficulties in scheduling, hosting, and recruiting participants for the HIV prevention focus groups. Only one virtual focus group was conducted due to concerns about bias in excluding participants who only had access to internet or cellular service and due to lack of interest from potential participants. Despite the potential limitations of the HIV prevention needs assessment and the HIV treatment and care needs assessment, the results from these initiatives provided important information that was used to guide the development of the Integrated Plan goals and objectives.

Priorities

This section provides an overview of key findings from the needs assessment process along with a summary of priorities that emerged through this process. Additional related priorities are also discussed in *Section 4: Situational Analysis* in greater detail.

Services people need to access HIV testing

About 38% of HIV prevention community survey participants reported they had an HIV test in their lifetime. Of those who received a test, 47% reported their test occurred in the last 12 months. The prevalence of having an HIV test was higher for transgender and gender non-conforming persons, MSM, Black or African American persons. The prevalence of having an HIV test was lower for persons with lower income levels, lower education levels, and for 18 – 24-year-olds. Over half of HIV tests were administered at a private doctor's office (32.3%) or a public health clinic or health center (26.2%). Other common testing locations included family planning/obstetrics clinics (13.3%) and HIV testing and outreach clinics (11.8%). Similar findings regarding testing locations were observed for all priority populations. Among the subset of participants who had never had an HIV test, main reasons for not having ever received an HIV test included low perceived risk of contracting HIV (63.4%), never having thought about it (49.6%), and not knowing where to get a test (10.5%). Similar findings were observed across priority populations.

In focus groups, perceived access to testing varied greatly among different priority populations. Sexual and gender minority populations were knowledgeable of testing but other communities less aware of free and mobile testing. Additionally, stigma was identified as a barrier to testing in focus groups. For example, some participants expressed fear that getting a test would "out" their risky behaviors to friends and family and felt testing can be stigmatizing. Participants expressed a need to normalize HIV testing by incorporating it into routine care and providing access to testing at community events and in places that are trusted in the community, such as LGBTQ+ organizations, community centers, SSPs, etc. Further,

cultural and family norms, values, and beliefs impacted knowledge and behaviors related to testing among focus groups participants.

Several priorities emerged from the needs assessment process related to HIV testing. Overall, a reasonable percentage of prevention community survey participants in Nevada had ever had an HIV test (nearly 40%) and testing was higher among several priority populations, including Black or African American persons, MSM, and transgender and gender non-conforming persons. The biggest barriers to testing included not feeling at risk for contracting HIV, not having thought about getting a test, and to a lesser extent, not knowing how to access a test or not being able to afford a test. The findings highlight a need to normalize HIV testing by promoting culturally competent education and awareness about HIV testing and improving access to HIV testing resources. Several focus groups also noted the importance of targeted efforts to address stigma associated with HIV testing.

Services people need to stay HIV negative: Pre-exposure prophylaxis (PrEP), Condom Use, and Syringe Service Programs, and Culturally Competent Information and Education

About 43% of prevention community survey participants had heard of pre-exposure prophylaxis (PrEP) prior to completing the survey. The prevalence was lower for young adults (35.4%) and Asian persons (37.7%), while the prevalence was higher for MSM (77.1%) and Black or African American (53.5%) persons. Further, 15.4% of participants had spoken to a doctor or provider about PrEP and 9.3% of participants were using PrEP or had used PrEP at some point in the past. Of those who had used PrEP, most received it via a prescription from a healthcare provider (65.5%) or directly from a health care provider (18.2%). Among those who did not use PrEP, 25% were willing to use PrEP in the future, while 36.8% of participants were unsure. Reasons for not wanting to use PrEP included not knowing how to get it (40.0%), not wanting to take it every day (28.0%), and that it is too expensive (22.0%). Hispanic/Latinx persons, young adults, and people who inject substances were less willing to use PrEP compared to those who were Black, Asian, and MSM. In focus groups, knowledge, access to PrEP, and insurance coverage of PrEP emerged as key themes. Most participants had heard of PrEP but felt people in their community were not fully aware of it or who it was for. The biggest perceived barrier to PrEP was access and insurance coverage. Many participants expressed a lack of knowledge about PrEP programs and insurance coverage in their communities.

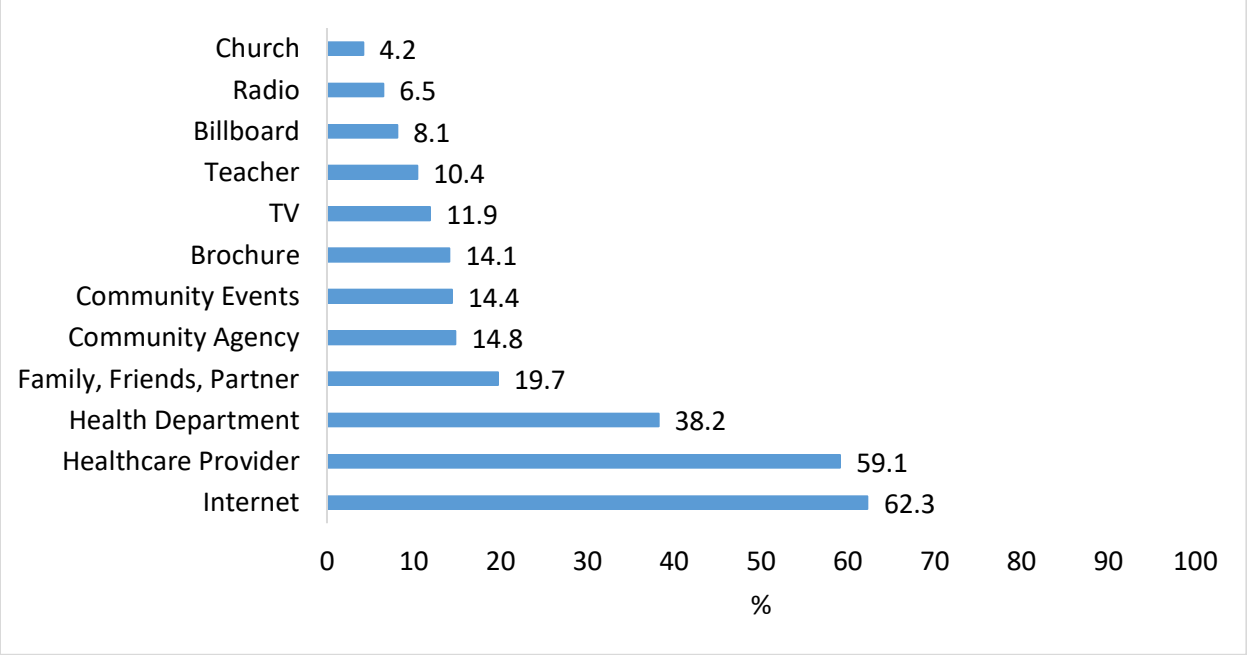
In the prevention community survey, over half (56%) of sexually active participants never or rarely used condoms. The main reasons for not using condoms included only having one partner (48.6%), that condoms are an inconvenience (12.1%), and other reasons such as use of other birth control methods. The prevalence of having sex with multiple partners without using condoms was highest among young adults (18–24-year-old age group), those with lower education levels, and MSM. About one-third (31.0%) of participants had obtained free condoms in the past year. Most obtained them from a doctor's office (56.8%) or health department (25.3%). In focus groups, participants reported engagement in unprotected sex, anal sex, having many sexual partners, and sex with alcohol and drugs. Dorms, parties, bars, clubs, and dating apps were commonly identified as locations where risky behaviors occur or originate from. Participants expressed a willingness to access free condoms when they are available at convenient locations.

Regarding injection substance use, about 9% of prevention community survey participants had injected a substance in the past year. Among those who injected a substance, only 73.6% always used a clean syringe. One in five participants who injected a substance (20.0%) reported sharing a syringe at some

point in the previous year. Nearly half of participants (45.3%) were willing to access syringes from a syringe service program, while 22.2% were not sure. Most participants (74.4%) felt it would be easy or very easy to access syringes from a syringe service program. In focus groups, participants expressed a need for more education and outreach about safe needle use and the risk of HIV transmission from shared needles. Participants were generally aware of needle exchange services and used them at times.

Figure 21 shows the percentage of participants who would like to receive HIV information from a variety of sources. Most participants were interested in information on the internet, from a healthcare provider, or from a health department or agency.

Figure 21. Desired sources of HIV-related information among community survey participants, Nevada HIV Prevention Needs Assessment, 2021.



Source: Lensch T, Etiler N, Dermid G, Nguyen Tang P, Collins L. 2021 Nevada HIV Prevention Needs Assessment. University of Nevada, Reno School of Public Health, Larson Institute for Health Impact and Equity. Nevada Office of HIV. 2022. Accessed June 2022.

Among target populations, many members expressed unawareness of Nevada's available resources and support systems dedicated to reducing HIV transmission among at-risk persons. For example, a common thread within focus groups emphasized the lack of knowledge with communities surrounding PrEP. Participants expressed concern surrounding community members not knowing how to access PrEP or being uninterested in PrEP because of an inability to afford the medication.

Services people need to rapidly link to HIV medical care and treatment after receiving an HIV positive diagnosis

Early intervention services are a critical component of providing newly diagnosed PLWH an opportunity to rapidly achieve viral suppression. Among PLWH who completed the treatment and care needs assessment, a little over one-third of participants (37.6%) reported that they needed early intervention services and were able to access them, while 21.5% of participants needed early intervention services and

were not able to access them. Further, over two-thirds of participants felt early intervention services were very or extremely important for achieving and maintaining viral suppression and for ending the HIV epidemic.

Table 19 shows experiences with HIV medical visits among people with HIV in Nevada. Over half of participants left their medical visit with questions (55.1%) and 36.8% of participants whose HIV care provider did not speak their language felt their provider did not always use an interpreter. However, 82.0% of participants felt their provider spent enough time with them during visits.

Table 19. Experiences with HIV medical visits among people with HIV, Nevada HIV Treatment and Care Needs Assessment, 2022.

Description of Experiences	Always	Sometimes	Never	N/A
Do you ever leave your HIV medical visit with unanswered questions, or questions you didn't ask?	**17.2%**	**37.9%**	**42.9%**	**2.0%**
My HIV care provider spends enough time with me during visits.	**55.8%**	**27.2%**	**15.3%**	**1.7%**
My HIV care provider listens to me during my visits.	**61.7%**	**29.8%**	**6.8%**	**1.7%**
If my HIV care provider doesn't speak my language, they use an interpreter to talk with me.	**25.4%**	**21.4%**	**15.4%**	**37.9%**
My HIV care provider is easy to reach when needed.	**46.3%**	**39.0%**	**8.5%**	**6.2%**
It is easy to schedule an appointment with my HIV care provider.	**54.4%**	**30.4%**	**11.2%**	**4.0%**

Source: Daniel J, Rodriguez-Schucker T, Jackson D. 2022 Nevada HIV Statewide Needs Assessment. Collaborative Research. 2022. Accessed July 2022.

Table 20 shows experiences with HIV case managers among PLWH in Nevada who completed the treatment and care survey. Over half of participants left their HIV case manager visits with questions (53.4%). Regarding potential language barriers, 34.3% of participants identified their HIV case managers not always using an interpreter. However, most participants felt their provider sometimes or always spent enough time with them (81.4%).

Table 20. Experiences with HIV case managers among people with HIV, Nevada HIV Treatment and Care Needs Assessment, 2022.

Description of Experiences	Always	Sometimes	Never	N/A
Do you ever leave your HIV case manager with unanswered questions or questions you didn't ask?	**18.2%**	**35.2%**	**38.4%**	**8.2%**
My HIV case manager spends enough time with me during visits.	**56.6%**	**24.8%**	**10.9%**	**7.7%**
My HIV case manager listens to me during my visits.	**56.8%**	**26.8%**	**8.8%**	**7.7%**
If my HIV case manager doesn't speak my language, they use an interpreter to talk with me.	**26.5%**	**20.6%**	**13.8%**	**39.1%**
My HIV case manager is easy to reach when needed.	**49.7%**	**32.7%**	**8.8%**	**8.8%**

Source: Daniel J, Rodriguez-Schucker T, Jackson D. 2022 Nevada HIV Statewide Needs Assessment. Collaborative Research. 2022. Accessed July 2022.

The treatment and care needs assessment findings provide support for continuing to enhance and promote early intervention services for people who test positive for HIV. In Southern Nevada, the Rapid stART program enables medical care to new and confirmed HIV positive diagnosis.[20] Once individuals are diagnosed, Rapid stART allows clients to receive same day medication, supplemental lab testing, RWHAP and case management services. The program will soon be expanding to other areas of the state.

Services that people with HIV need to stay in HIV care and treatment and achieve viral suppression

Table 21 below depicts the HIV treatment and care needs assessment participant ranking of services that are important to achieve and maintain viral suppression. Outpatient ambulatory health services, early intervention services, and medical case management were the top three ranked service needs, although more than 44% of participants expressed that all service categories are extremely important.

Table 21. Ranking of services related to one's ability to achieve and maintain HIV viral load suppression (=<200 mL), Nevada HIV Treatment and Care Needs Assessment, 2022.

Service Category	Not at all important	Slightly important	Moderately important	Very important	Extremely important
Outpatient Ambulatory Health Services	3.6%	3.6%	10.7%	25.0%	57.1%
Early Intervention Services	6.0%	7.2%	10.8%	21.7%	54.2%
Medical Case Management	4.8%	6.6%	9.6%	25.2%	53.9%
Housing Services	5.4%	2.4%	13.7%	25.0%	53.6%
Health Insurance Premium and Cost Sharing Assistance	4.2%	4.2%	8.3%	30.4%	53.0%
Mental Health Services	3.6%	3.6%	11.9%	28.0%	53.0%
Psychosocial Support Services	4.2%	6.6%	12.1%	25.3%	51.8%
Health Education/Risk Reduction	5.4%	3.6%	12.0%	27.5%	51.5%
Emergency Financial Assistance	6.0%	4.2%	16.2%	23.4%	50.3%
Medical Transportation	6.0%	6.0%	13.9%	24.1%	50.0%
Oral Health Care	3.6%	9.5%	10.1%	28.0%	48.8%
Food Bank/Home Delivered Meals	5.4%	10.1%	11.9%	24.4%	48.2%
Substance Abuse Services	9.0%	7.8%	10.2%	27.0%	46.1%
Medical Nutrition Therapy	3.6%	7.1%	16.1%	28.6%	44.6%

Source: Daniel J, Rodriguez-Schucker T, Jackson D. 2022 Nevada HIV Statewide Needs Assessment. Collaborative Research. 2022. Accessed July 2022.

Further, more than 88% of PLWH who completed the needs assessment reported that their case management experience was good, very good, or excellent. On average, participants rated their experience as 4.1 out of 5 stars.

[20] Southern Nevada Health District. HIV Care Services – Ryan White Program. Accessed September 2022. https://www.southernnevadahealthdistrict.org/community-health-center/sexual-health-clinic/hiv-care-services/

To help PLWH stay in HIV care and treatment and achieve viral suppression, there is a need for strong case management, robust collaboration from health-related sectors, direct community engagement efforts, and new outreach and support programs. As shown in the needs assessment findings, on average, experiences with case managers and providers were positive. Areas for improvement include providing adequate time for patients to ask questions and ensuring that appropriate translation services are made available to provide non-English speakers with the same service and care quality through health equity and health literacy initiatives.

Actions taken

After completion of the HIV prevention needs assessment, the findings were shared with the Northern and Southern HPPGs followed by informal discussion of the findings and priorities. The findings from both needs assessments were also reviewed with the Nevada Office of HIV and later with the Integrated Plan Internal Workgroup where deeper discussions of priorities, needs, barriers, and gaps were reviewed. The summary of findings and emergent priorities were used to inform the development of *Section 4: Situational Analysis* and *Section 5: 2022 – 2026 Goals and Objectives*.

Section 4: Situational Analysis

This section presents a summary of the strengths, challenges, and identified needs with respect HIV prevention, treatment, and ancillary care services activities within the four EHE Pillars: *Diagnose, Treat, Prevent, Respond.* The situational analysis is based on themes that emerged from the community engagement and planning process, epidemiologic snapshot, resource inventory, and needs assessments.

Pillar One: Diagnose

Since the inception of the 2017 – 2021 Nevada HIV Integrated Prevention and Care Plan[21], Nevada has seen an increase in testing with an increased promotion of testing sites and opportunities. However, there are still many barriers to testing among Nevadans, as identified in the needs assessment process. Findings from the HIV prevention needs assessment[22] show that less than 40% of participants reported having been tested for HIV during their life. Of the participants who had never received an HIV test, over 60% reported a reason they had not been tested was due to low-risk perception for contracting HIV and another 50% said they had never thought about getting and HIV test. Further, about 10% of participants cited their reason for not getting tested was not knowing where to get tested or not wanting to pay for a test. While certain high-risk populations, such as sexual and gender minorities, were knowledgeable about testing and resources, many other priority groups had little to no knowledge of free and mobile testing or other testing-related resources. Participants also reported stigma associated with testing. For example, in several focus groups, participants highlighted a need for both providers and public health professionals to work with communities to normalize HIV testing and to make it part of routine health screenings. Many participants brought up examples of how COVID-19 vaccinations were integrated into community events and felt similar initiatives could help increase HIV testing. Discussions among the Internal Workgroup also revealed a need for resources for providers, including more training and education about sexual health screening and HIV testing. A summary of strengths, challenges, and needs related to HIV diagnosis are outlined below.

Strengths

Testing:

- Increase in testing over past several years.
- Increased promotion of testing and locations/opportunities.
- Greater access to testing through CBOs and community and events.
- Availability of quality training and certification to provide rapid testing.
- Increase in alternative methods to acquire testing (e.g., Collect 2 Protect program), home test kits in vending machines, etc.
- State policy and national initiatives to support testing in the community (e.g., EHE funding, and recent passage of Nevada 2021 legislative session senate bill 211 and senate bill 275 (SB211 and SB275).

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[21] Nevada Office of HIV. *Nevada HIV Integrated Prevention and Care Plan 2017 – 2021*. 2016. Accessed June 2022. https://endhivnevada.org/wp-content/uploads/2020/01/Integrated-HIV-Prevention-and-Care-Plan-Final-9-29-16.pdf.

[22] Lensch T, Etiler N, Dermid G, Nguyen Tang P, Collins L. *2021 Nevada HIV Prevention Needs Assessment.* University of Nevada, Reno School of Public Health, Larson Institute for Health Impact and Equity. Nevada Office of HIV. 2022. Accessed June 2022.

Screening/Notification:

- Nearly all persons testing positive for HIV are notified within 7 days.
- High levels of partner screening and partners services.

Challenges

Stigma/knowledge related to HIV among individuals

- People fear HIV testing and finding out they have HIV.
- Many people, including priority populations, think they are not at risk for HIV.
- People may be unaware of free testing opportunities.
- People at greatest risk may not seek care/testing due to lack of health insurance or knowledge about testing.

Provider/system challenges

- Providers may not routinely screen patients for testing.
- Some providers may feel HIV testing is out of their scope of practice.
- Providers may not test persons if they do not perceive them as being at-risk.
- Sexual histories not routinely conducted.
- Missed opportunities – universal testing may not be done at all primary care settings, urgent cares, emergency rooms (ERs) and hospitals.
- Some facilities feel that funding HIV testing is not a significant return on investment.
- Stigma among providers (MDs to MAs and front desk staff) to test (or conduct sexual histories).
- Many providers feel inadequate on how to communicate a positive test result.
- Challenges with hiring and adequate workforce development for staff.

Late diagnosis

- Large percentage of HIV diagnoses occur at late stage (42% of new diagnoses in 2021).

COVID-19 pandemic

- Increased burden on health care system.
- Increases in risky behaviors, especially among high-risk populations (e.g., substance use).
- Fear/hesitancy for going to health care facilities.

Data collection

- For a significant proportion of new diagnoses, no identified risk for transmission is ascertained because some individuals can be difficult to locate for interviews.
- No accurate way to capture amount of testing done in general, negatives included.

Needs

Individual knowledge/education/resources

- Education about risk for contracting HIV and free testing.
- Culturally competent, non-stigmatizing materials about HIV prevention and testing in multiple languages, particularly for priority populations.
- Increase access to community-based testing for high-risk and priority populations (emphasize convenience and normalize testing).

Provider and systems knowledge/education/resources

- Education/training for providers regarding newer testing resources, laws, etc.
- Expand community testing locations and hours.
- Improve accessibility to services (e.g., services near bus routes or rapid testing).
- Leverage community champions to provide education and resources.
- Holistic approach to testing for high-risk populations (including testing for STDs, substance use screening, etc.).
- Trauma-informed HIV screening for those impacted by sexual assault.

Pillar Two: Treat

Rapid linkage to care for all people newly diagnosed with HIV is an essential step to reducing the burden of HIV in Nevada. In 2021, about 80% of all Nevadans who were newly diagnosed with HIV were linked to care within 90 days, representing an important area of improvement in the coming years. Unfortunately, only 38% of those newly diagnosed with HIV are retained in care in Nevada, representing another important area requiring significant improvement. For PLWH who were retained in care, nearly all (94%) were virally suppressed. Given that nearly two-thirds of all persons newly diagnosed with HIV were not retained in care in Nevada in 2021, this is clearly an area that requires major improvement for Nevada in the coming years. Needs assessment findings identified early intervention services, medical case management, and outpatient ambulatory services as important factors for staying engaged in care and achieving viral suppression among PLWH in Nevada. PLWH in Nevada generally reported positive experiences with providers and case managers, representing an important strength for the state; however, improved continuity of services and stronger patient navigation services are needed to help retain PLWH in care.

The Rapid stART program is a critical component of improving HIV treatment and care for Nevadans in the future and to date, the program has been very successful. The program is currently operating for PLWH in Southern Nevada and will soon be expanding to Northern Nevada and other areas of the state. The Rapid stART program enables medical care for those newly diagnosed with HIV. The Rapid stART program allows PLWH to receive same day medication, additional lab testing, and Ryan White Eligibility and Case Management services.[23] A summary of strengths, challenges, and needs related to HIV treatment and care are outlined below.

[23] Southern Nevada Health District. HIV Care Services – Ryan White Program. Accessed September 2022. https://www.southernnevadahealthdistrict.org/community-health-center/sexual-health-clinic/hiv-care-services/

Strengths

Linkage to care/viral suppression

- Generally, percentage of persons newly diagnosed with HIV in Nevada who are linked to care is high.
- Majority of PLWH who are retained in care are virally suppressed.

Quality of treatment/care programs

- Many PLWH have positive experiences with CBOs, providers, and case managers.
- RWHAP Part A is a strength for getting PLWH into care and keeping them in care.
- Rapid stART program.

Challenges

Individual barriers

- Stigma related to HIV treatment and fear of people knowing they have HIV.
- Additional challenges/barriers to care for people who use substances and for people who experience mental health challenges.
- Lack of adequate housing/transportation/childcare for PLWH.

Provider and system barriers

- Some services may not be easily accessible (i.e., not centrally located or not near public transportation).
- Lack of providers in rural and underserved areas.
- Lack of culturally and linguistically appropriate services in certain areas of the state.
- General providers still need to be educated on basics of HIV care and that they can provide these services.

Needs

Improved assistance/resources/education for patients

- Financial assistance and resources for people who are uninsured or underinsured.
- Housing services.
- Linkage to other health care (dental, vision, psychiatry, substance use, mental health, etc.).
- Job rehabilitation and related resources.
- Peer advocates and navigators.
- Social support.
- Access for those in rural/underserved areas.
- Case management.
- Community health workers.

Providers/systems

- Increase the number of racial/ethnic and gender/sexual minority health care providers
- Improve access/linkage to care in rural areas
- Expand telehealth and rural services
- Expand clinic hours (i.e., nights and weekends)
- Services available in other languages
- Better follow-up from doctors and providers
- Care and medication coverage through insurance, Medicaid, Medicare, Ryan White, NMAP, etc.
- Offer training and education opportunities for providers and providers-in-training about how to treat PLWH
- Workforce development opportunities for new providers

Pillar Three: Prevent

Prevention of new HIV transmissions through proven interventions, including pre-exposure prophylaxis (PrEP), condoms, and syringe services programs (SSPs) is an essential component of Nevada's efforts to reduce the burden of HIV in the state. Nevada's state and local health authorities, CBOs, and other stakeholders are engaged in providing these interventions to constituents. However, findings from the needs assessments indicate that many Nevadans are unaware of available prevention resources. For example, many needs assessment participants were unaware of PrEP. Among those who were aware of PrEP, many were not aware of financial assistance programs and other PrEP-related resources. There were also interesting differences that emerged relative to priority populations for prevention. For example, Hispanic/Latinx persons, young adults, and people who inject substances reported they were less willing to use PrEP compared to those who were Black, Asian, and MSM. In focus groups, knowledge, access to PrEP, and insurance coverage of PrEP emerged as key themes. Discussions with key stakeholders also revealed that there is a need for PrEP/PEP education and resources for providers to better serve Nevadans who may benefit from PrEP/PEP.

In recent years, Nevada has developed and implemented resources for those in the state including a condom distribution plan and a publicly available condom locator. About one-third (31.0%) of prevention needs assessment participants reported that they had obtained free condoms in the past year, most commonly from a doctor's office or health department(s). However, many Nevadans are not using condoms. For example, over half (56%) of sexually active participants who completed the prevention needs assessment never or rarely used condoms. Additionally, findings revealed high-risk sexual behaviors, such as having sex with multiple partners without using condoms, were more common among certain subpopulations including young adults (aged 18 – 24), those with lower education levels, and MSM. These findings highlight the need for better sexual education to the public. Further, discussions among key stakeholders revealed that there is a need for training and education for providers to better assess risk among patients.

Regarding SSPs, nearly half of prevention needs assessment participants who injected substances (45.3%) were willing to access syringes from a syringe service program, while 22.2% were not sure. Most participants (74.4%) felt it would be easy or very easy to access syringes from an SSP. In focus groups, participants expressed a need for more education about safe needle use and the risk of HIV transmission from shared needles. These findings highlight the need for more culturally competent and non-stigmatizing education for those who use substances. It is also important for Nevada to provide education

and training to pharmacists and providers and to develop resources to help providers working with those who use substances.

A summary of strengths, challenges, and needs pertaining to HIV prevention are presented below.

Strengths

PrEP/PEP

- Increased availability of PrEP/PEP and higher rates of use each year.
- High levels of knowledge/awareness about PrEP/PEP in certain high-risk groups (e.g., MSM and transgender/gender non-conforming individuals).

Condom use

- Many community agencies and providers offer free condoms.
- Condom locator and condom distribution plan.

Syringe Service Programs (SSPs)

- Increase in available SSPs.
- SSPs have strong reputation in local communities and serve many constituents.

Challenges

PrEP/PEP

- Lack of knowledge about how to get PrEP/PEP and about resources to help pay for PrEP/PEP.
- Perceived difficulty for obtaining prescription.
- Adherence to PrEP.
- Not all insurance companies follow obligations regarding PrEP (i.e., offer PrEP with no cost sharing, etc.).
- Not all providers review resources/education about PrEP and PrEP assistance programs.
- Conscience clause for pharmacists may prevent some from prescribing PrEP.

Condom use

- Many in high-risk populations never/rarely use condoms.
- Lack of understanding of importance of using condoms.

Syringe Service Programs (SSPs)

- Despite increased availability in recent years, there is still only a small number of SSPs relative to population size.
- Resistance towards SSPs in community, particularly in rural areas.
- Conscience clause for pharmacists may prevent some from offering syringes.

Funding/staffing

- Limited funding for prevention and surveillance statewide.
- State policies are obstacles for creating new positions.
- Staff workforce development.
- Minimal staffing levels and resources.

Individual knowledge/stigma

- Stigma related to HIV and substance use.
- Fear of people knowing they have HIV.
- Lack of risk perception.
- Fear of deportation among undocumented persons.

Needs

Individual needs

- Consistent comprehensive HIV prevention education in schools statewide.
- Knowledge and awareness of PrEP, PEP, and condom availability in the community.
- Education about long-term PrEP injectables.
- Improve access to culturally competent, non-stigmatizing HIV prevention materials, programs, and campaigns for a variety of cultures and languages.
- Increase awareness of SSPs.
- Targeted education to high-risk individuals through dating apps/social media.

Provider and system needs

- Increase provider and community awareness of PrEP financial assistance programs and resources.
- Normalize HIV testing (e.g., make part of routine health screening).
- Harm reduction education/training for providers.
- Increase prevention services.
- Increase access to community-based testing for high-risk populations.
- Improve access and reduce barriers to PrEP and PEP.
- Additional services for those marginalized populations (e.g., those without homes, those using substances, those with mental health challenges).
- Additional funding for prevention initiatives.
- Syringe locator for community.

State of Nevada needs

- Increase funding for prevention and surveillance statewide.
- Develop State policies that make it easier to create new positions.
- Increase staffing levels and resources.

Pillar Four: Respond

To reduce the burden of HIV in Nevada, it is important for the state to be able to rapidly identify and respond to outbreaks and transmission clusters. The Nevada Office of HIV has been collaborating with federal, state, and local partners to develop an HIV Outbreak Response Plan, which will be finalized in December 2022. This plan will provide a formal and coordinated structure to respond to outbreaks and transmission clusters. It will be critical to monitor and evaluate this plan regularly and to adjust, as needed. It is also important for Nevada to improve its capacity to investigate outbreaks and transmission clusters using modern tools in the future, such as molecular surveillance, and to communicate noteworthy trends to public health and medical professionals, CBOs, and the public.

A summary of strengths, challenges, and needs related to the state's ability to respond to HIV outbreaks and transmission clusters are outlined below.

Strengths

Outbreak response/surveillance

- HIV Outbreak Response Plan will be finalized in December 2022.
- Meets quarterly to discuss data quality, review data to identify possible outbreak/cluster.
- Local health authorities and State DIS will provide ongoing monitoring to address possible outbreaks.
- Monthly analysis of case surveillance data to identify transmission clusters conducted.

Challenges

Staffing Capacity

- Limited staffing capacity for these initiatives.

Funding

- Limited funding for surveillance and outreach.
- Lack of funding for additional surveillance efforts.

Data

- Sexual orientation and gender identity expression (SOGIE) data quality. Limited data variable on older cases.

Needs

Capacity

- Increase capacity to identify and investigate active HIV transmission clusters.
- Increase capacity for molecular surveillance.

Funding/Resources

- Increase funding for surveillance and outreach efforts.
- Training for epidemiology staff to work on Secure HIV-TRACE and other relevant epidemiology programs.

Data

- Stronger communication with community about the molecular surveillance trends and data among certain populations. This will assist with building community trust for molecular surveillance activities.

Priority Populations

In 2021, the Northern and Southern Nevada HPPGs identified the following groups as priority populations in Nevada: PLWH, MSM, people who are sexually active, people who use substances, youth and young adults, and communities of color. Whenever possible, the community engagement and planning process, the epidemiologic snapshot, and the needs assessments focused on these priority populations to ensure that information presented in Section 4: Situational Analysis and Sections 5: 2022 – 2026 Goals and Objectives were based on the needs of these populations.

Section 5: 2022 – 2026 Goals and Objectives

The goals, objectives, and activities presented below were developed based on the needs and priorities identified through the community engagement and planning process (see *Section 2: Community Engagement and Planning Process*), development and review of the epidemiologic snapshot, resource inventory, and needs assessment (see *Section 3: Contributing Datasets and Assessments*), and development and review of the situational analysis (see *Section 4: Situational Analysis*). All goals, objectives and activities were developed within the four EHE Pillars to align with other national, state, and local initiatives and will be evaluated, updated, and improved across the planning period, as needed.

Diagnose

Goal 1: Diagnose all individuals with HIV as early as possible after infection.

Key Objectives and Activities:

1.1 By 2026, 20,000 federally funded HIV tests will be conducted annually within the state of Nevada.

Outcome: # of tests conducted.

Source: PS18-1802 performance metrics; PS20-2010 performance metrics; PS-21-2102 performance metrics; RWPA performance metrics.

Baseline: 15,000 tests conducted.

a. Implement targeted HIV testing strategies among priority populations while utilizing testing and educational material in languages that are appropriate for those populations and ensuring materials meet culturally and linguistically appropriate standards (CLAS).
    i. Suggested metric(s): # of tests provided to the identified target populations.
b. Increase number of provider education sessions conducted by local health authorities and the AIDS Education and Training Center (AETC) within clinics, ERs, hospitals, and other healthcare organizations that are screening for HIV.
    i. Suggested metric(s): # of providers trained to perform tests; # of testing locations (End HIV Nevada website).
c. Increase HIV prevention events and testing opportunities.
    i. Suggested metric(s): # of impressions on websites (e.g., End HIV Nevada website and Rethink HIV Nevada website); # of testing opportunities.

1.2 By 2026, 90% of all persons testing negative for HIV will be informed of their test results within 90 days from report to health authority.

Outcome: % of persons testing negative for HIV informed of results within 90 days from report to health authority.
Data source: PS18-1802 performance metrics; PS20-2010 performance metrics; and PS-21-2102 performance metrics.
Baseline: 75% for 2021.

a. Document challenges associated with notifying persons of results.
    i. Suggested metric(s): HIV Testing documentation and eHARS.
b. Based on documented challenges, develop strategies to improve percentage of persons informed of results.
    i. Suggested metric(s): Strategies for improvement developed.

1.3 By 2026, reduce the number of new HIV stage 3 diagnoses by 10%.

Outcome: # of new HIV stage 3 diagnoses.
Data source: Annual Nevada HIV Fast Facts (surveillance report).
Baseline: 208 new diagnoses in 2021 (out of 494 total diagnoses).

a. Implement targeted HIV testing strategies among priority populations, while utilizing testing and educational material in languages that are appropriate for those populations and ensuring materials meet CLAS standards.
    i. Suggested metric(s): # of tests provided to the identified target populations.
b. Increase community awareness about location of testing sites and at-home testing.
    i. Suggested metric(s): # of website impressions (e.g., End HIV Nevada website and Rethink HIV Nevada website).
c. Increase awareness of Southern Nevada Health Districts (SNHD) Collect-2-Protect program (a statewide at home HIV screening program).
    i. Suggested metric(s): # of website impressions; # of social media posts about program.

1.4 By 2026, 95% of clients testing HIV-positive will be informed of their test result within 7 business days from report to health authority.

Outcome: % of clients testing HIV-positive informed of test result within 7 business days from report to health authority.
Data source: PS18-1802 performance metric.
Baseline: 75%.

a. Document challenges associated with notifying persons of results.
    i. Suggested metric(s): Challenges documented.
b. Based on documented challenges, develop strategies to improve notification.
    i. Suggested metric(s): Strategies for improvement developed.

Key partners: NV DPBH, CCHHS, WCHD, SNHD, Nevada AETC, RWHAP Part A, UMC, The LGBTQ Center of Southern Nevada, and other CBOs.

Potential funding resources: TBD.

Estimated funding allocation: CDC Prevention (PS18-1802): $2,689,974.00; CDC Surveillance (PS18-1802): $574,386.00. CDC Ending the HIV Epidemic (PS20-2010): $2,144.080.00. HRSA AIDS Education Training Center: $180,000.00

Outcomes: Specific outcomes and metrics listed under each objective/strategy.

Monitoring data sources: Data sources listed under each objective.

Treat

Goal 2: Treat people with HIV rapidly and effectively to reach sustained viral suppression.

Key Objectives and Activities:

Medical Visits

2.1 By 2026, 85% of newly diagnosed HIV-positive individuals will be linked to care and attend their first medical appointment with a provider within 30 days from HIV confirmatory test result(s).
Outcome: % of newly diagnosed HIV-positive individuals attending appointment within 30 days.
Data Source: Enhanced HIV/AIDS reporting system (eHARS).
Baseline: 50%.

a. Review regional flow chart (resource map) of services/activities for persons newly diagnosed with HIV and for providers and update it regularly.
    i. Suggested metric(s): Documentation that flow chart was reviewed annually.
b. Utilize referral systems to coordinate new patient intakes between organizations.
    i. Suggested metric(s): # of referrals being scheduled; # of referrals lost to follow up.

2.2 For individuals engaged in the Rapid stART program, by 2026, 85% of newly diagnosed HIV-positive individuals, those new to care, and/or those out of care will be linked to HIV care within 7 days.*
Outcome: % of individuals in Rapid stART program linked to care within 7 days.
Data Source: RWHAP CAREWare dataset, Rapid stART Module dataset.
Baseline: 70%.

a. Review regional flow chart (resource map) of services/activities for persons newly diagnosed with HIV and for providers and update it regularly.
    i. Suggested metric(s): Documentation that flow chart was reviewed annually.
b. Utilize referral systems to coordinate new patient intakes between organizations.
    i. Suggested metric(s): # of referrals being scheduled; # of referrals lost to follow up.

*Note: Within 7 days after “time zero”, as defined by Rapid stART program guidance.

Antiretroviral Therapy (ART)

2.3 For individuals engaged in the Rapid stART program, by 2026, 85% of newly diagnosed HIV-positive individuals, persons new to care, and/or persons out of care will have initiated ART within 7 days. *

Outcome: % of individuals in Rapid stART who initiated ART within 7 days.
Data Source: RWHAP CAREWare dataset, Rapid stART Module dataset.
Baseline: 56%.

a. Identify barriers to adherence.
    i. Suggested metric(s): Documentation of barriers.
b. Develop strategies to improve adherence.
    i. Suggested metric(s): Strategies identified.
c. Educate individuals about the importance of obtaining and maintaining an undetectable viral load and the importance of individual viral load regarding community viral load.
    i. Suggested metric(s): # of individuals educated; # of educational materials produced.

*Note: Within 7 days after "time zero", as defined by Rapid stART program guidance.

Viral Suppression

2.4 By 2026, 85% of HIV-positive individuals enrolled in core medical and/or support services will have achieved viral suppression (less than 200 copies/ml at last viral load).

Outcome: % of HIV-positive individuals engaged/enrolled in core medical and/or support services that have received at least one (1) service during the regular grant period, who are virally suppressed.
Data source: eHARS dataset.
Baseline: TBD.

a. Increase the percentage of HIV-positive individuals who are referred to RWHAP services through RWHAP Part B and/or AIDS Drug Assistance Program (ADAP).
    i. Suggested metric(s): % of diagnosed HIV-positive individuals referred to case management assistance.
b. Increase the percentage of HIV-positive individuals requiring health insurance who are referred to ADAP services to continue to access core medical services.
    i. Suggested metric(s): % of HIV-positive individuals requiring health insurance who are referred to ADAP services.

2.5 For individuals engaged in the Rapid stART program, by 2026, 85% of newly diagnosed HIV-positive individuals, those new to care, and/or those out of care will have achieved viral suppression by 60 days after initiation of ART.*

Outcome: % of individuals in Rapid stART program achieving viral suppression within 60 days.
Data Source: RWHAP CAREWare dataset, Rapid stART Module dataset.
Baseline: 58%.

a. Increase patient education around the importance of obtaining and maintaining an undetectable viral load, and the importance of the individual viral load in relation to the community viral load.
    i. Suggested metric(s): Documentation of educational materials/services provided (e.g., Rapid stART marketing campaign materials).

*Note: Within 7 days after "time zero", as defined by Rapid stART program guidance.

Retention and Reengagement into Case Management and Care

2.6 By 2026, 85% of HIV-positive individuals living in Nevada who are lost to care within the past 3 years will be reengaged into case management and/or medical care.

Outcome: % of HIV-positive individuals living in Nevada who are lost to care within the past 3 years who are reengaged.
Data source: RWHAP CAREWare dataset; eHARS datasets; local health authority databases and reporting systems.
Baseline: TBD.

a. Evaluate clients who have fallen out of care on an annual basis.
    i. Suggested metric(s): # of clients lost to care and characteristics of these clients.

2.7 For individuals engaged in the Rapid stART program, by 2026, 85% of newly diagnosed HIV-positive individuals, persons new to care, and/or persons out of care who initiated ART will have at least 1 medical visit in each six-month period at least 90 days apart, annually.*

Outcome: % of individuals in Rapid stART who initiated ART who have at least 1 medical visit in each 6-month period.
Data Source: RWHAP CAREWare dataset, Rapid stART Module dataset.
Baseline: TBD.

a. Identify barriers to adherence.
    i. Suggested metric(s): Documentation of barriers.
b. Develop strategies to improve adherence.
    i. Suggested metric(s): Strategies identified.
c. Increase patient education around the importance of obtaining and maintaining an undetectable viral load, and the importance of the individual viral load in relation to the community viral load.
    i. Suggested metric(s): Documentation of educational materials/services provided (e.g., Rapid stART marketing campaign materials).

*Note: Within 7 days after "time zero", as defined by Rapid stART program guidance.

2.8 A quality improvement evaluation and assessment process will be initiated on HIV case management with recommendations for implementation by 2026.

Outcome: Revised case management system, that could possibly be acuity based within a tiered system of access to care.

Data source: NA.

Baseline: NA.

a. Document areas for improvement with current case management system.
    i. Suggested metric(s): Documented challenges; review of current case management system; research best practices related to case management; look at case management workforce (i.e., education levels).
b. Collaborate with health authorities, providers, and other key stakeholders to develop new system.
    i. Suggested metric(s): Published overview/outline of new system; conduct focus groups with clients; establishment of ad hoc work groups.

Key partners: NV DPBH, CCHHS, WCHD, SNHD, AETC, RWHAP Part A, RWHAP Part B, UMC, Northern Nevada HOPES, the Center Las Vegas, and other CBOs.

Potential funding resources: TBD.

Estimated funding allocation: CDC Prevention (PS18-1802): $2,689,974.00; CDC Surveillance (PS18-1802): $574,386.00. CDC Ending the HIV Epidemic (PS20-2010): $2,144.080.00. HRSA Ryan White Part A: $7,018,823.00. HRSA Ryan White Part B: $2,438,746.00.

Outcomes: Specific outcomes and metrics listed under each objective/strategy.

Monitoring data sources: Data sources listed under each objective.

Prevent

Goal 3: Prevent new HIV transmissions by using proven interventions, including condom use, post-exposure prophylaxis (PEP), pre-exposure prophylaxis (PrEP), and syringe services programs (SSPs).

Key Objectives and Activities:

3.1 By 2026, reduce by 10% the rate of new HIV diagnoses.

Outcome: % reduction in new HIV diagnoses.
Data source: Annual Nevada HIV Fast Facts (surveillance report).
Baseline: 494 new HIV diagnoses in 2021.

a. Improve access to partner services for people newly diagnosed with HIV.
    i. Suggested metric(s): % of newly diagnosed HIV-positive individuals will be interviewed for partner services within 30 days.
b. Reduce barriers to successful completion of partner service interviews and referrals.
    i. Suggested metric(s): Summary of barriers and strategies for improvement.
c. Improve access to risk reduction services for people testing positive and negative for HIV.
    i. Suggested metric(s): % of persons tested for HIV (HIV-positive and HIV-negative) screened for risk reduction intervention who are provided intervention.

3.2 By 2026, increase the number of providers receiving PrEP and PEP training or education, annually.

Outcome: # of providers who offer PrEP/PEP; # of providers offered training, education, or academic detailing on PrEP/PEP.
Data source: Local health districts (PrEP and PEP education); PrEP/PEP provider list on End HIV Nevada website.
Baseline: TBD.

a. Improve PEP knowledge among providers training, education, academic detailing, and reference guides and increase the number of providers who offer PEP.
    i. Suggested metric(s): # of providers who offer PEP; # of providers offered training, education, or academic detailing on PEP.
b. Improve PrEP knowledge among providers through training, education, academic detailing, and reference guides and increase the number of providers who offer PrEP.
    i. Suggested metric(s): # of providers who offer PrEP; # of providers offered training, education, or academic detailing about PrEP.
c. Increase PrEP coverage among at-risk persons.
    i. Suggested metric(s): % of HIV-negative persons screened and identified as eligible for PrEP are referred to PrEP.
d. Explore the feasibility of improving measurement of PrEP use through various data sources in the future (e.g., pharmacy claims data).
    i. Suggested metric(s): Document existing limitations of PrEP data in Nevada and identify potential solutions.

3.3 By 2026, increase the number of syringes distributed through syringe service programs (SSPs) by 10%.*

Outcome: # of syringes distributed.

Data source: Reported by Trac-B exchange; possible data available from HOPES.

Baseline: 549,501 syringes distributed in 2021.

a. Increase access to SSPs through non-traditional methods of service delivery including mobile outreach, vending machines, secondary exchange, and others.
    i. Suggested metric(s): # of SSPs; # of vending machines and locations.

*Dependent on private funding.

3.4 By 2026, increase the number of syringes collected through syringe service programs (SSPs) by 10%.*

Outcome: # of syringes collected.

Data source: Reported by Trac-B exchange; possible data available from HOPES.

Baseline: 526,373 syringes collected in 2021.

a. Increase access to SSPs through non-traditional methods of service delivery including mobile outreach, vending machines, secondary exchange, and others.
    i. Suggested metric(s): # of SSPs; # of vending machines and locations.

*Dependent on private funding.

3.5 By 2026, increase the number of condoms distributed in Nevada by 10%.

Outcome: # of condoms distributed.

Data source: PS18-1802 performance metrics; PS20-2010 performance metrics; PS-21-2102 performance metrics.

Baseline: 100,000 condoms distributed.

a. Increase the number of agencies distributing free condoms.
    i. Suggested metric(s): # of agencies distributing condoms (Ending HIV Epidemic Condom Finder and local health district reporting).

Key partners: NV DPBH, CCHHS, WCHD, SNHD, AETC, UMC, Northern Nevada HOPES, The LGBTQ Center of Southern Nevada, Trac-B Exchange.

Potential funding resources: TBD.

Estimated funding allocation: CDC Prevention (PS18-1802): $2,689,974.00; CDC Surveillance (PS18-1802): $574,386.00. CDC Ending the HIV Epidemic (PS20-2010): $2,144.080.00. HRSA AIDS Educations Training Center: $180,000.00.

Outcomes: Specific outcomes and metrics listed under each objective/strategy.

Monitoring data sources: Data sources listed under each objective.

Respond

Goal 4: Respond quickly to potential HIV outbreaks to get necessary prevention and treatment services to people who need them.

Key Objectives and Activities:

4.1 By January 31, 2023, local and state health authorities and community stakeholders will develop and implement an HIV Outbreak Response Plan and by 2026, Outbreak Response Plans will be reviewed and updated quarterly, as necessary.

Outcome: Completed response plan; quarterly meeting minutes.
Data source: NA.
Baseline: NA.

a. Increase response to HIV transmission clusters and outbreaks.
    i. Suggested metric(s): Published Nevada HIV Outbreak Response Plan.
b. Engage in quarterly review and update of Nevada's HIV Cluster and Outbreak Detection and Response Plan.
    i. Suggested metric(s): Meeting agenda/minutes from quarterly review meetings.
c. Investigate programs and initiatives of other jurisdictions for ideas and lessons learned in outbreak and molecular surveillance.
    i. Suggested metric(s): Produce summary of ideas and lessons learned.
d. Consult with CDC regarding capacity to implement Secure HIV-TRACE in Nevada.
    i. Suggested metric(s): Document progress on implementation of Secure HIV-Trace in Nevada.
e. Continue collaboration with the San Diego Center for AIDS Research, SNHD, and DPBH to explore potential use molecular surveillance data to identify the appropriate interventions for specific target populations.
    i. Suggested metric(s): NA.

4.2 By 2026, increase capacity for cluster detection at state and local health departments.

Outcome: # of trainings received; # of educational opportunities pursued.
Data source: NA.
Baseline: NA.

a. Identify and document potential training and educational opportunities.
    i. Suggested metric(s): Log of training and educational opportunities.
b. Explore the possibility of joining the cluster detection learning collaborative.
    i. Suggested metric(s): NA.

4.3 By 2026, perform monthly analysis of case surveillance data to identify transmission clusters.

Outcome: Monthly cluster analysis completed.
Data source: NA.
Baseline: NA.

a. Review analyses at quarterly cluster detection meetings.
    i. Suggested metric(s): Meeting notes.

Key partners: NV DPBH, CCHHS, WCHD, SNHD.

Potential funding resources: TBD.

Estimated funding allocation: CDC Prevention (PS18-1802): $2,689,974.00.

Outcomes: Specific outcomes and metrics listed under each objective/strategy.

Monitoring data sources: Data sources listed under each objective.

Section 6: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up

2022-2026 Integrated Planning Implementation Approach

The Larson Institute/UNR School of Public Health team will lead implementation, monitoring, evaluation, improvement, reporting, and dissemination of the plan. Details regarding these efforts, including a flexible timeline, are outlined below.

Implementation

It is essential to ensure that implementation of the integrated plan is successful by coordination of efforts from a variety of partners, including new partners, PLWH, people affected by HIV, people at-risk for contracting HIV, and service providers and administrators from different funding streams. The Internal Workgroup will meet every six months to carefully review progress on the goals, objectives, and activities outlined in the plan and to ensure proper coordination of tracking and reporting efforts. The Larson Institute/UNR School of Public Health team will develop an online tracking instrument that will be shared with all partners and stakeholders that outlines all goals, objectives, and activities, as well as roles, responsibilities, and expectations for reporting.

Monitoring and Evaluation

The Larson Institute/UNR School of Public Health team will be in contact with key stakeholders quarterly to monitor progress on plan goals, objectives, and activities and to ensure that all documented performance metrics are being measured. All performance measures that will be reported on by key stakeholders are outlined in *Section 5: 2022 – 2026 Goals and Objectives*. In developing goals, objectives, and activities, the Internal Workgroup utilized existing performance metrics from various programs within the state as indicators that will be used to track progress on goals and objectives whenever possible. The purpose of this was to ensure that all goals, objectives, and activities are measurable and to reduce the burden placed on programs and organizations that are operating on limited resources. Data for performance measures will be collected from stakeholders and partners responsible for reporting every six months. Shortly after the evaluation data are collected, the Larson Institute/UNR School of Public Health team will provide updates to the Internal Workgroup and other key stakeholders through brief reports and/or presentations.

Improvement

It is expected that the Integrated Plan will be improved, as needed, at regular intervals across the project period based on new epidemiological data, progress on goals, objectives, activities, and feedback from community members/stakeholders. At each biannual Internal Workgroup meeting, progress on goals, objectives, and activities will be reviewed in relation to epidemiological data. The Internal Workgroup will thoroughly discuss the plan goals and objectives and relevant data. The Larson Institute/School of Public Health team will develop recommendations for plan improvement, as needed. The Larson Institute/UNR School of Public Health team will share updates with community planning groups and at other relevant community events to solicit additional feedback and suggestions for improvement.

Reporting and Dissemination

Brief monitoring and evaluation reports and/or presentations will be produced by the Larson Institute/UNR School of Public Health team every six months and will be made publicly available on the End HIV Nevada website. The team will also seek opportunities to present updates to planning groups, community members, and other stakeholders, as applicable. Further, all updates and improvements made to the plan during the project period will be carefully documented and shared with the CDC and HRSA.

Annual Flexible Timeline of Key Milestones

Table 22 shows a proposed, flexible timeline for plan implementation, monitoring, evaluation, and improvement activities. This timeline will be adapted as needed across the Integrated Plan period.

Table 22. Timeline of key evaluation and monitoring milestones.

Dates	Activities
Jan 1 – Feb 15	Collect data for all evaluation metrics from reporting parties
Feb 16 – Mar 31	Develop and publish annual report
Apr 1 – Apr 30	Review evaluation data from prior grant year with internal committee and document successes/challenges, and solicit feedback for improvement
May 1 – Aug 15	Disseminate annual findings with community groups and solicit feedback for improvement
Aug 15 – Sept 30	Collect data for evaluation metrics
Oct 1 – Oct 31	Review mid-year evaluation data with internal committee and document successes/challenges, and solicit feedback for improvement
Nov 1 – Dec 31	Disseminate mid-year findings with community groups and solicit feedback for improvement

Note: The evaluation grant year is from April 1 – March 31.

Section 7: Letters of Concurrence

Northern Nevada HIV Prevention Planning Group
&
Southern Nevada HIV Prevention Planning Group

October 26, 2022

To Whom It May Concern:

The Northern Nevada HIV Prevention Planning Group (NNHPPG) and the Southern Nevada HIV Prevention Planning Group (SoN HPPG) jointly concurs with the Nevada Integrated HIV Prevention and Care Plan, submitted by the Office of HIV, State of Nevada Division of Public and Behavioral Health and the Las Vegas TGA Ryan White Part A HIV Program. This plan was developed in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention and HRSA's HIV/AIDS Bureau.

The HIV Prevention Planning Groups (HPPGs) have reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The HPPGs concur that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's PS18-1802 Funding Opportunity Announcement and the Ryan White HIV Program guidance.

Both HPPGs participated in the planning process through attendance at HIV stakeholder group meetings, participation in needs assessment surveys, focus groups, and other activities, reviewing and providing feedback on plan goals, objectives and strategies, and reviewing and providing feedback on the overall integrated plan document. The Integrated Planning process in Nevada was a collaborative effort between the Nevada Office of HIV Prevention and Surveillance and Ryan White Part B programs; Las Vegas TGA Ryan White Part A program; the HPPGs; and the Las Vegas TGA Part A Planning Council, facilitated by the University of Nevada, Reno, School of Public Health's Center for Community Engaged Research in Practice.

Jennifer Howell
NNHPPG Public Health Co-Chair

Cheryl Radeloff
SoN HPPG Public Health Co-Chair

Robert Harding
NNHPPG Community Co-Chair

Robert Thurmond
SoN HPPG Community Co-Chair

Leana Ramirez
SoN HPPG Community Co-Chair Elect

LAS VEGAS
TGA RYAN WHITE PART A
PLANNING COUNCIL

Monday, November 7, 2022

Nevada Department of Health and Human Services
Nevada Division of Public and Behavioral Health
HIV Integrated Prevention and Care Team

The Las Vegas Transitional Grant Area Ryan White Part A Planning Council concurs with the following submission by the Nevada Department of Health and Human Services, Nevada Division of Public and Behavioral Health (DPBH) in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The Las Vegas Transitional Grant Area Ryan White Part A Planning Council has reviewed the Nevada Department of Health and Human Services, Nevada Division of Public and Behavioral Health 2022-2026 Integrated HIV Prevention and Care Plan submission to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The Las Vegas Transitional Grant Area Ryan White Part A Planning Council concurs that the Nevada Department of Health and Human Services, Nevada Division of Public and Behavioral Health 2022-2026 Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

Nevada DPBH in conjunction with Las Vegas Transitional Grant Area Ryan White Part A Planning Council and community members conducted an extensive planning process throughout 2021-2022 to develop the Integrated Plan. Activities included needs assessments statewide surveys for HIV Care and HIV Prevention Services, Hepatitis C Care and Prevention Services and STI/Sexual Health; iterative community engagement sessions and focus groups of diverse communities; subject matter expert workgroups and a systems-level oversight committee; and sharing and listening sessions held during planning bodies meetings. These activities included

persons with HIV and hepatitis C, community advocates, community-based organizations providing care and prevention services, medical providers, and other community groups affected by HIV who had not previously been engaged in planning processes.

The signatures below confirm the concurrence of the Las Vegas Transitional Grant Area Ryan White Part A Planning Council with the Nevada Department of Health and Human Services, Nevada Division of Public and Behavioral Health 2022-2026 Integrated HIV Prevention and Care Plan submission.

Respectfully,

Lourdes Yapjoco (Nov 3, 2022 17:58 PDT)

Lourdes Yapjoco
Planning Council Co-Chair

Gary Costa (Nov 3, 2022 18:14 PDT)

Gary Costa
Planning Council Co-Chair

Appendices

Appendix 1: Completed Integrated Plan Checklist

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Section I: Executive Summary of Integrated Plan and SCSN				
1. Executive Summary of Integrated Plan and SCSN	New Material	NA	5-9	
a. Approach	New Material	NA	5-9	
b. Documents Submitted to Meet Requirements	New Material	NA	NA	
Section II: Community Engagement and Planning Process				
1. Jurisdiction Planning Process	New Material	NA	10-13	
a. Entities Involved in Process	New Material	NA	10-13	
b. Role of the RWHAP Part A Planning Council/Planning Body (not required for state only plans)	New Material	NA	NA	
c. Role of Planning Bodies and Other Entities	New Material	NA	12	

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
d. Collaboration with RWHAP Parts – SCSN Requirement	New Material	NA	12	
e. Engagement of People with HIV – SCSN Requirement	New Material	NA	13	
f. Priorities	New Material	NA	13	
g. Updates to Other Strategic Plans Used to Meet Requirements	New Material	NA	NA	
Section III: Contributing Data Sets and Assessments				
1. Data Sharing and Use	New Material	NA	14	
2. Epidemiologic Snapshot	New Material	NA	15-39	
3. HIV Prevention Care and Treatment Resource Inventory	New Material	NA	41-47	
a. Strengths and Gaps	New Material	NA	42	
b. Approaches and Partnerships	New Material	NA	43	
4. Needs Assessment	New Material	NA	48-58	
a. Priorities	New Material	NA	53	
b. Actions Taken	New Material	NA	58	

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
c. Approach	New Material	NA	48	
Section IV: Situational Analysis				
1. Situational Analysis	New Material	NA	59-66	
a. Priority Populations	New Material	NA	59-66	
Section V: 2022-2026 Goals and Objectives				
Goals and Objectives Description	New Material	NA	68-78	
a. Updates to Other Strategic Plans used to Meet Requirements	NA	NA	NA	
Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up				

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
1. 2022-2026 Integrated Planning Implementation Approach	New Material	NA	79-80	
a. Implementation	New Material	NA	79	
b. Monitoring	New Material	NA	79	
c. Evaluation	New Material	NA	79	
d. Improvement	New Material	NA	80	
e. Reporting and Dissemination	New Material	NA	80	
f. Updates to Other Strategic Plans Used to Meet Requirements	NA	NA	NA	
Section VII: Letters of Concurrence				
1. CDC Prevention Program Planning Body Chair(s) or Representative(s)	New Material	NA	82-83	
2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)	New Material	NA	84-85	

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
3. RWHAP Part B Planning Body Chair or Representative	NA	NA	NA	
4. Integrated Planning Body	NA	NA	NA	
5. EHE Planning Body	NA	NA	NA	

Appendix 2: Nevada HIV Needs Assessment Reports

Prevention

The 2021 Nevada HIV Prevention Needs Assessment aimed to understand the scope of HIV-related knowledge and behaviors among priority populations in Nevada. The needs assessment was conducted by the Larson Institute/UNR School of Public Health team in partnership with the Nevada Division of Public and Behavioral Health Office of HIV, between August and December 2021.

The full report can be accessed at the following link:
https://endhivnevada.org/wp-content/uploads/2022/06/NV-HIV-Prevention-Needs-Assessment-1.pdf.

The community survey questions can be accessed at the following link:
https://files.cdn.thinkific.com/file_uploads/266305/attachments/f3f/349/caa/HIV_Community_Survey.pdf.

The focus group guide can be accessed at the following link:
https://files.cdn.thinkific.com/file_uploads/266305/attachments/798/db2/977/HIV_Focus_Group_Guide.pdf.

Treatment and Care

The 2022 Nevada Statewide HIV Care and Treatment Needs Assessment aimed to assess the current care and service needs of PLWH in Nevada and in the Las Vegas TGA. The needs assessment was conducted by Collaborative Research in partnership with the State of Nevada RWHAP Part B, the Las Vegas TGA, and the Clark County EHE teams.

The full report, including the survey questions, can be accessed at the following link:
https://endhivnevada.org/wp-content/uploads/2022/11/2022-Nevada-HIV-Care-Statewide-Needs-Assessment.pdf.

Appendix 3: Acronyms

ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AIDS	Acquired Immunodeficiency Syndrome, also referred to as HIV stage 3 (AIDS).
AI/AN	American Indian/Alaskan Native
API	Asian/Hawaiian/Pacific Islander
ART	Antiretroviral therapy
CBO	Community Based Organization
CCHHS	Carson City Health and Human Services
CDC	Centers for Disease Control and Prevention
CPG	Community Planning Group
DPBH	Division of Public and Behavioral Health
eHARS	Enhanced HIV/AIDS Reporting System
EHE	Ending the HIV Epidemic
EPI	Epidemiology
FTM	Female to male
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
HOPWA	Housing Opportunities for Persons with AIDS
HPPGs	Nevada HIV Prevention Planning Groups
IDU	Injection drug use
MSM	Male-to-male sexual contact or men who have sex with men
MTF	Male to female
NHAS	National HIV/AIDS Strategy
NIR	No identified risk
PEP	Post-exposure prophylaxis
PLWH	Persons living with HIV
PrEP	Pre-exposure prophylaxis
RWHAP	Ryan White HIV/AIDS Program
RWPA	Ryan White HIV/AIDS Part A Program
RWPB	Ryan White HIV/AIDS Part B Program
SAPTA	Substance Abuse Prevention and Treatment Agency
SB	Senate Bill
SPH	School of Public Health
SNHD	Southern Nevada Health District
STD/I	Sexually transmitted disease/infection
TGA	Transitional Grant Area
UNLV	University of Nevada, Las Vegas
UNR	University of Nevada, Reno
WCHD	Washoe County Health District