ii. Project Narrative

INTRODUCTION

The purpose of this project is to provide direct financial assistance to the three-county Las Vegas Transitional Grant Area (LVTGA). The LVTGA is severely impacted by the HIV epidemic, with extensive studies referencing the correlation to poverty and social determinants of health. The following section will describe the impact of the HIV epidemic in the LVTGA, including how HIV infection rates are increasing, documentation of need and service gaps, and a demonstrated disproportionate impact on vulnerable populations.

Figure 1: Las Vegas TGA: Nye, Clark Counties Nevada and Mohave County, Arizona

NEEDS ASSESSMENT

The purpose of this section is to demonstrate the severity of the HIV epidemic in the EMA/TGA. Include quantifiable data on HIV epidemiology, the HIV care continuum, unmet need, co-occurring conditions, complexity of providing care, and the early identification of individuals with HIV/AIDS. Also, include the identification of subpopulations of focus.

The severity of the HIV epidemic in the LVTGA is evidenced by the persistently high number of new HIV infections and increasing prevalence rates, especially in communities of color. The LVTGA's subpopulations of focus are: 1) Hispanics; 2) MSM and 3) African Americans. These three populations account for the majority of the LVTGA's Unmet Need, In Care but not Virally Suppressed and late diagnosed HIV infections. Additionally, the populations have lower health outcomes along the LVTGA's HIV Care Continuum compared to other populations in the LVTGA's HIV epidemic. Further detail of the LVTGA's three subpopulation of focus is discussed throughout the application including EIIHA strategies focusing on the three subpopulations.

In preparation to respond to the 2022 Ryan White Part A Notice of Funding Opportunity, the LVTGA conducted a Comprehensive People with HIV (PWH) Needs Assessment during Spring and Summer of 2021. Data from the 2021 Comprehensive PWH Needs Assessment informed numerous sections throughout the LVTGA's 2022 Ryan White Part A grant application. The total number of PWH surveyed was 378, representing 3.39% of the LVTGA's total PWH population and 8.74% of the Ryan White Part A client population. PWH survey responses were filtered by the LVTGA's subpopulations of focus. Despite the ongoing COVID -19 pandemic, the LVTGA was successful in gathering community input. Finally, the LVTGA collaborated with Ryan White Parts B, C and D to successfully complete the 2021 Comprehensive PWH Needs Assessment.

A. Demonstrated Need: The LVTGA FY 2022 plan, budget and allocations table were developed in response to the demonstrated need represented by the LVTGA's Epidemiological Profile. Supplemental funding is urgently needed to address the increasing HIV/AIDS epidemic in the LVTGA.

1) Epidemiologic Overview

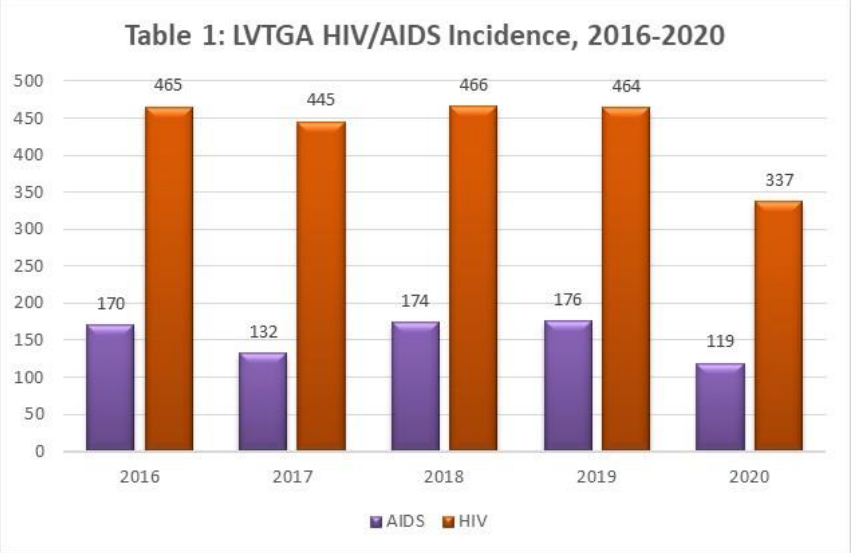
a) Provide a summary of the HIV epidemic in your TGA geographic area

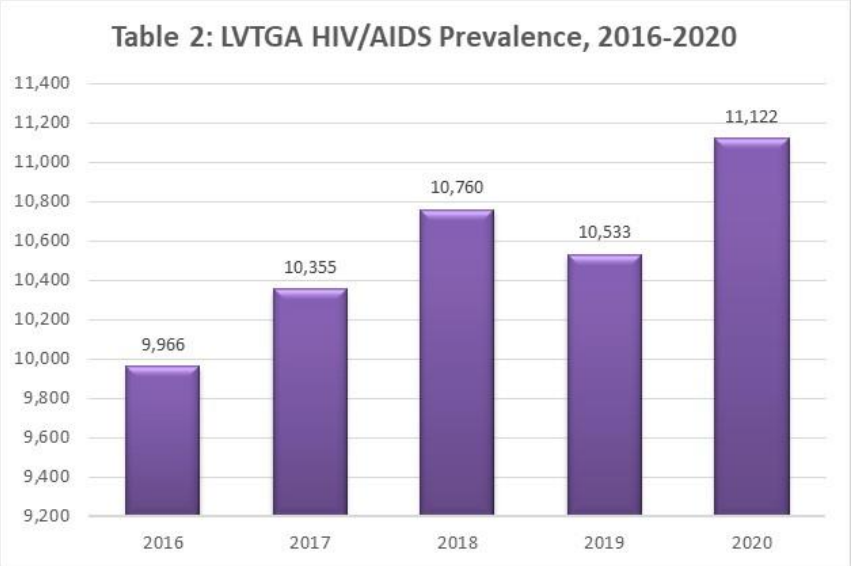
As of December 31, 2020, there were 11,122 People with HIV (PWH) residing in the LVTGA, which is a 5% (n=589) increase from 2019. In 2020, the LVTGA had 337 new HIV infections, of which 119 (36%) were late diagnoses (AIDS). ***According to data supplied by Southern Nevada Health District (SNHD), the LVTGA has seen 307 new HIV cases from 1/1/21 to 9/27/21***. Since 2016, the LVTGA has averaged 435 new HIV cases annually, of which 35% (n=154) were late diagnoses (AIDS). Since 2016, the LVTGA has seen a 10% increase (n=1,156) in PWH prevalence. Results from the LVTGA's 2021 PWH Needs Assessment, 25.47% (n=81) reported their HIV diagnosis was outside of the LVTGA. Clark County, home to Las Vegas, has been identified as one of the 48 counties in the *Ending the HIV Epidemic: A Plan for America's* Phase I plan. Ninety-six percent of the 2020 LVTGA's HIV Incidence (n=325) and Prevalence (n=10,694) are in Clark County. As of December 31st, 2020, **MSM** comprised 63% (n=213) of new HIV infections, of which 31% (n=67) were late diagnoses (AIDS). **MSM** account for 66% (n=7,288) of the LVTGA's total HIV prevalence. **African Americans** are disproportionately impacted by HIV in the LVTGA. While representing only 12% of the general population, **African Americans** account for 31% (n=106) of all 2020 new HIV infections, of which 33% (n=35) were late diagnoses (AIDS). **African Americans** account for 30% (n=3,319) of total HIV prevalence. **Hispanics** are also disproportionately impacted by HIV representing 30% of LVTGA's general population yet 32% (n=108) of all 2020 new HIV infections of which 33% (n=39) were late diagnoses (AIDS). **Youth** (ages 13-19) HIV infections have increased 43% (n=6) since 2016 including a 21% (n=3) increase from 2019 to 2020. **Youth** were the only age group to report an increase from 2019 to 2020. **Youth** HIV prevalence has increased 38% (n=11) from 2016 to 2020.

b) Describe the socio-demographic characteristics of: (1) persons newly diagnosed, (2) people with HIV, and (3) persons at higher risk for HIV infection in the service area. Include the following, as available in the geographical region of the jurisdiction:

i. Demographic data (e.g., race, age, sex, transmission category, current gender identity)

Tables 1 and 2 show the LVTGA HIV/AIDS incidence and prevalence for the past five calendar years (2016-2020). A narrative description of the five-year period from 2016 to 2020 is provided following the epidemiologic overview**. *(Please see Attachment #3 for the LVTGA's Epidemiological Profile).***





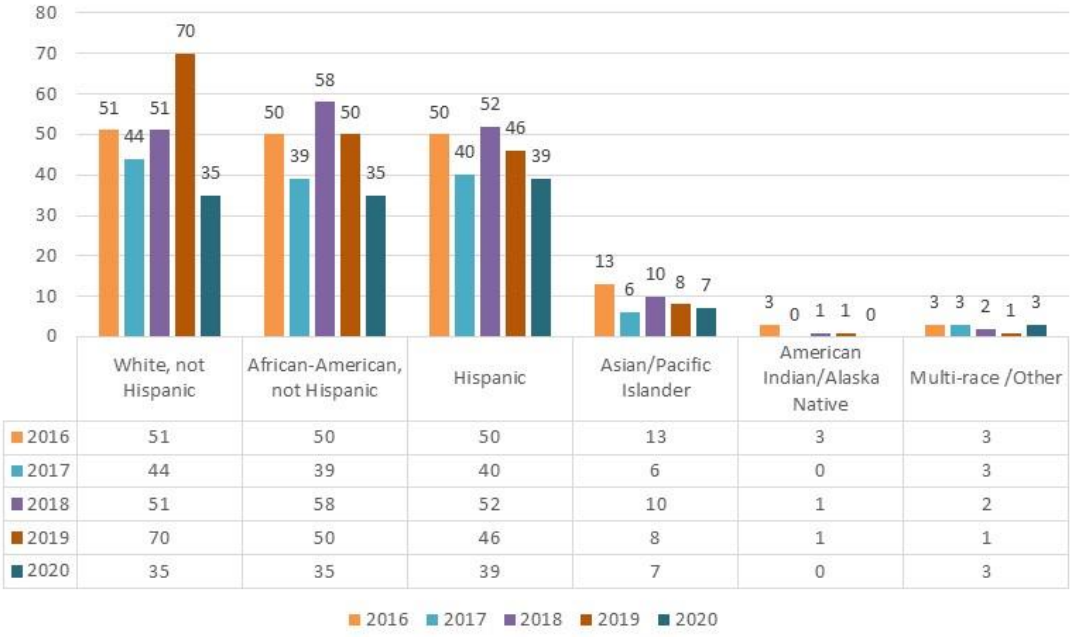
The LVTGA has averaged 154 new AIDS cases over the past five years. According to data supplied by SNHD, the LVTGA has seen 307 new HIV infections from 1/1/21 to 9/27/21.

Further data analysis of the LVTGA's 2020 AIDS incidence indicates:

- 33% Hispanic; 29% White; 29% African American and 6% Asian/Pacific Islander
- 56% are 20-44 years old and 44% 45 years old and older
- 83% Male and 17% Female
- 56% MSM; 8% Heterosexual; 8% MSM/IDU and 7% IDU

Further detail of the LVTGA 2016-2020 AIDS incidence is detailed in **Tables 3-6**.

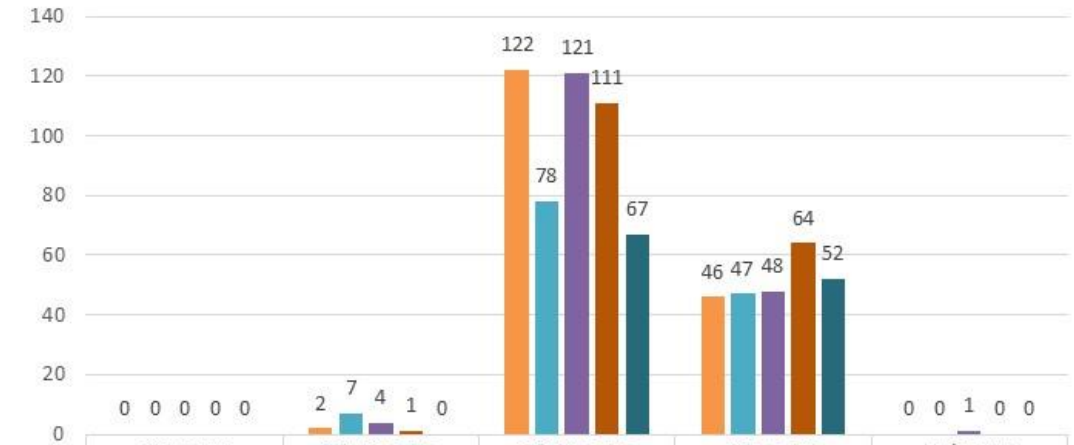
Table 3: LVTGA AIDS Incidence, Race/Ethnicity, 2016-2020



	White, not Hispanic	African-American, not Hispanic	Hispanic	Asian/Pacific Islander	American Indian/Alaska Native	Multi-race /Other
2016	51	50	50	13	3	3
2017	44	39	40	6	0	3
2018	51	58	52	10	1	2
2019	70	50	46	8	1	1
2020	35	35	39	7	0	3

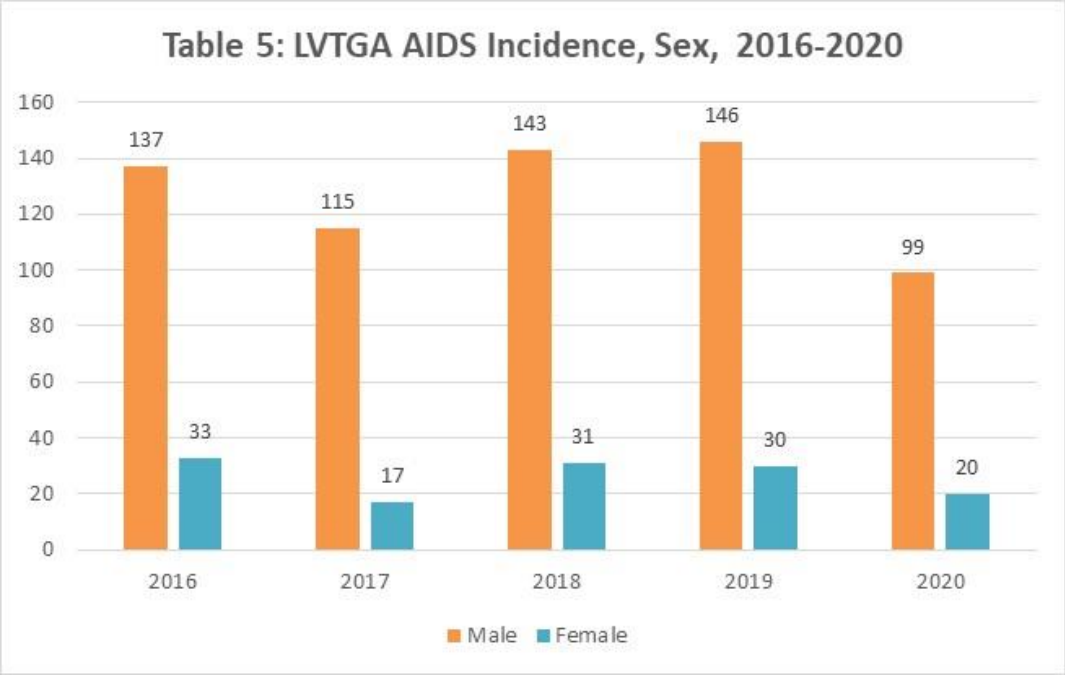
2016 2017 2018 2019 2020

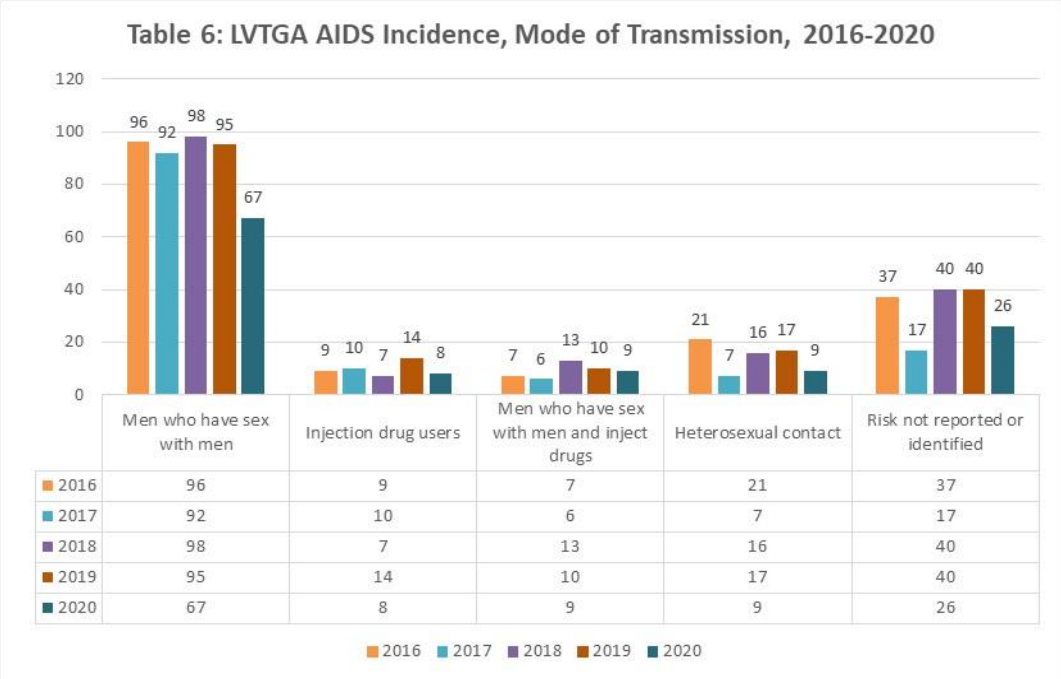
Table 4: LVTGA AIDS Incidence, Age at Diagnosis, 2016-2020



	<13 years	13-19 years	20-44 years	45+ years	Unknown
2016	0	2	122	46	0
2017	0	7	78	47	0
2018	0	4	121	48	1
2019	0	1	111	64	0
2020	0	0	67	52	0

2016 2017 2018 2019 2020





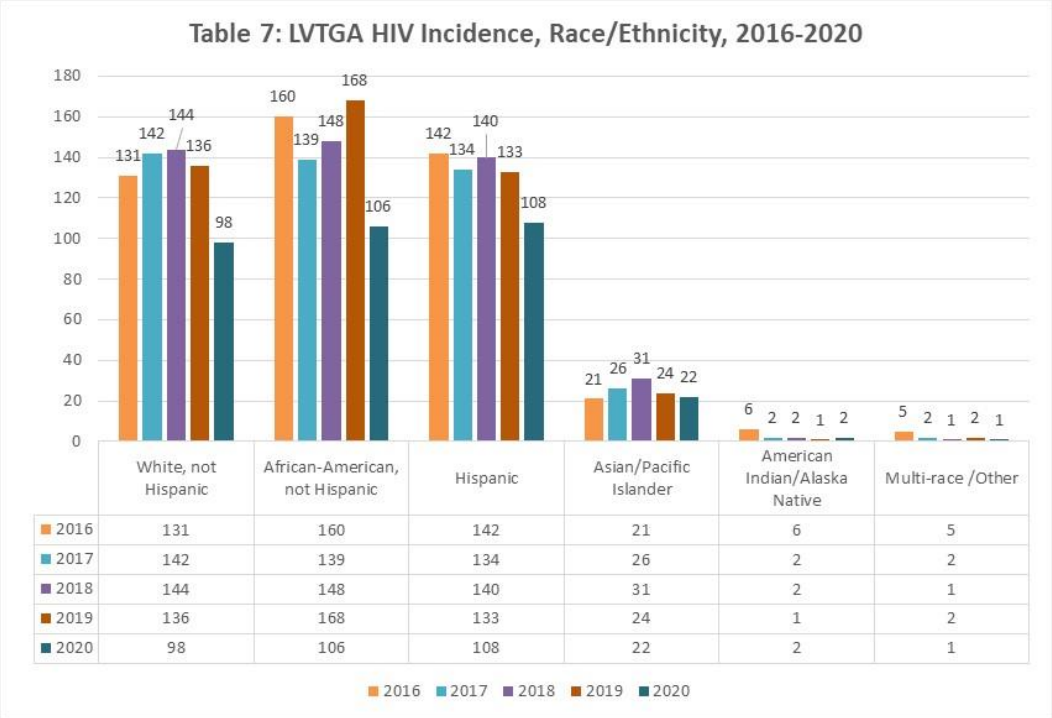
	Men who have sex with men	Injection drug users	Men who have sex with men and inject drugs	Heterosexual contact	Risk not reported or identified
2016	96	9	7	21	37
2017	92	10	6	7	17
2018	98	7	13	16	40
2019	95	14	10	17	40
2020	67	8	9	9	26

Gender Identity

Gender Identity is not reportable in Nevada and Arizona. However, in June 2021, Nevada passed state legislation requiring governmental agencies to request from certain persons information related to sexual orientation and gender identity or expression; providing, with certain exceptions, that such information is confidential; requiring a governmental agency to annually report certain information related to sexual orientation and gender identity or expression.

Gender identity will be reportable in Nevada going forward. Until state information is available, the data available on gender identity is among PWH in the Ryan White Part A program which is presented in

Table 16.



	White, not Hispanic	African-American, not Hispanic	Hispanic	Asian/Pacific Islander	American Indian/Alaska Native	Multi-race /Other
2016	131	160	142	21	6	5
2017	142	139	134	26	2	2
2018	144	148	140	31	2	1
2019	136	168	133	24	1	2
2020	98	106	108	22	2	1

Over the past five years (2016-2020), the LVTGA has averaged 435 new HIV infections per year. It is notable that in four of the past five years, the LVTGA has seen new HIV cases exceed 430 per year.

According to data supplied by SNHD, the LVTGA has seen 307 new HIV infections from 1/1/21 to 9/27/21. A total of 2,177 new HIV cases have been reported since 2016. Further detail of the LVTGA HIV Incidence is detailed in **Tables 7-10.**

Analysis of the LVTGA's 2020 HIV incidence shows:

- 32% Hispanic; 31% African American; 29% White and 7% Asian/Pacific Islander
- 71% 20-44 years old; 25% 45 years old and older and 4% 13-24 years old
- 87% Male; 13% Female
- 63% MSM; 4% Heterosexual; 5% MSM/IDU and 4% IDU

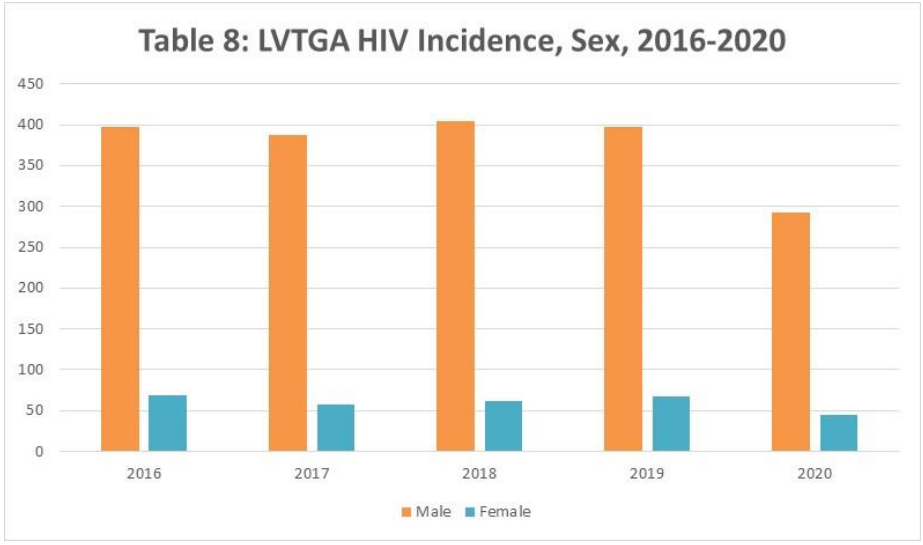
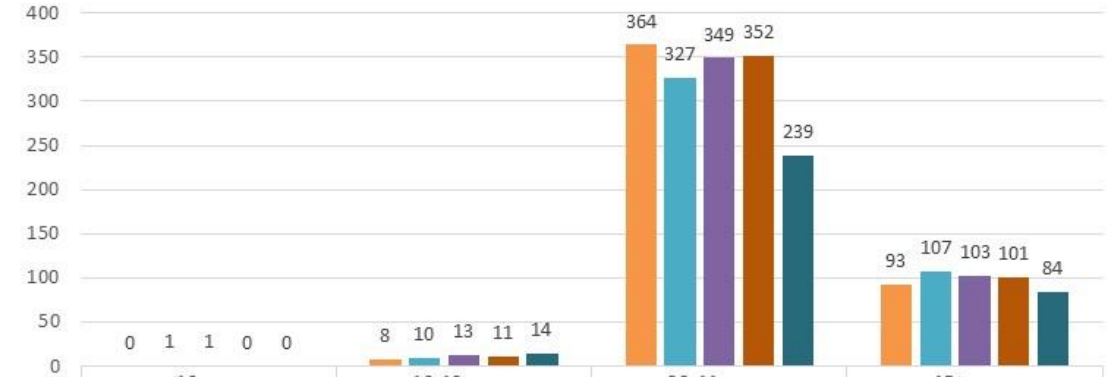
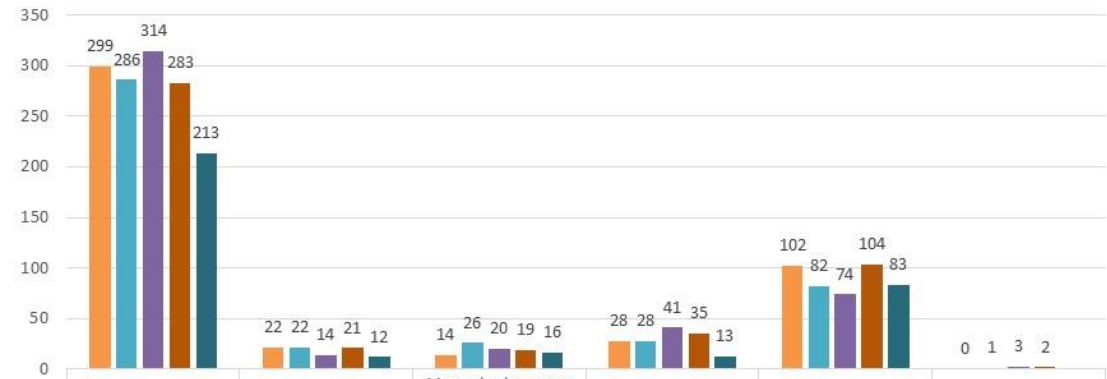


Table 9: LVTGA HIV Incidence, Age at Diagnosis, 2016-2020



	<13 years	13-19 years	20-44 years	45+ years
2016	0	8	364	93
2017	1	10	327	107
2018	1	13	349	103
2019	0	11	352	101
2020	0	14	239	84

Table 10: LVTGA HIV Incidence, Mode of Transmission, 2016-2020



	Men who have sex with men	Injection drug users	Men who have sex with men and inject drugs	Heterosexual contact	Risk not reported or identified	Perinatal exposure
2016	299	22	14	28	102	0
2017	286	22	26	28	82	1
2018	314	14	20	41	74	3
2019	283	21	19	35	104	2
2020	213	12	16	13	83	

Since 2016, the LVTGA has seen a 10% increase in PWH prevalence (n=1,156) with a 5% increase (n=589) from 2019 to 2020. Results from the LVTGA's 2021 PWH Needs Assessment, 25.47% (n=81) reported their HIV diagnosis was outside of the LVTGA.

Further detail of the LVTGA's HIV/AIDS prevalence is detailed in **Tables 12-15**.

Table 11: LVTGA HIV/AIDS Prevalence, 2016-2020

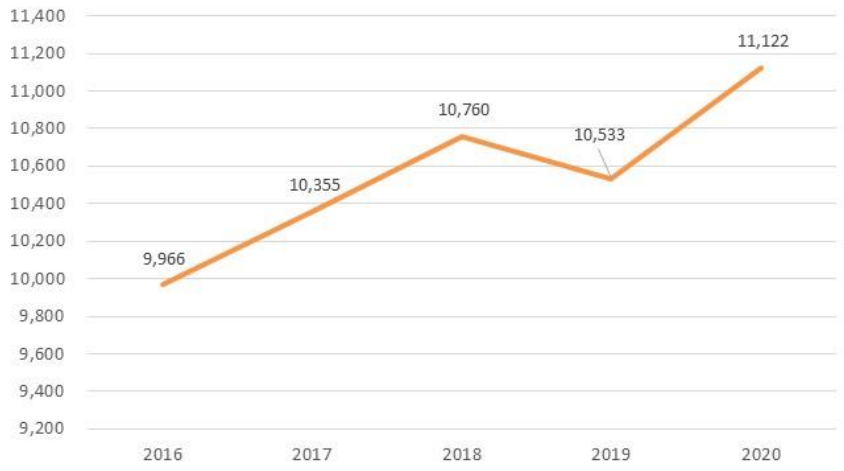
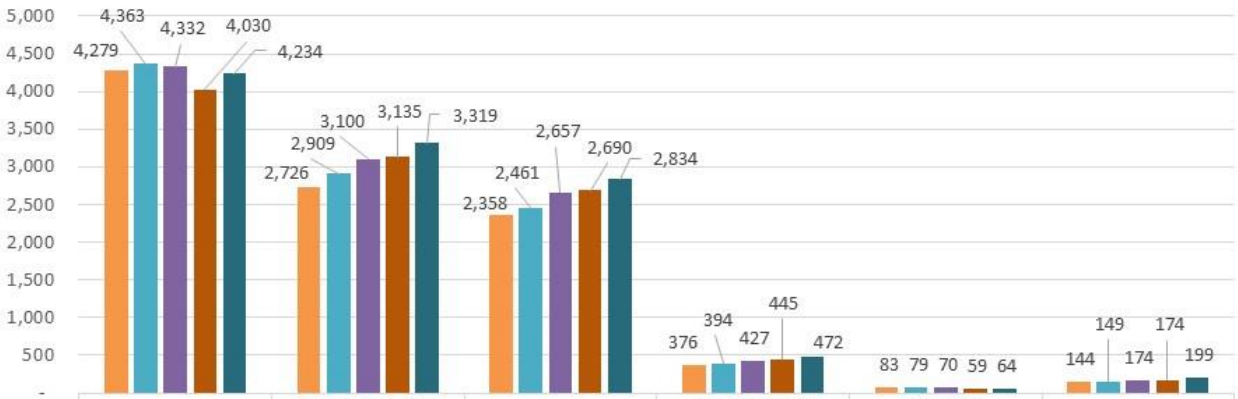
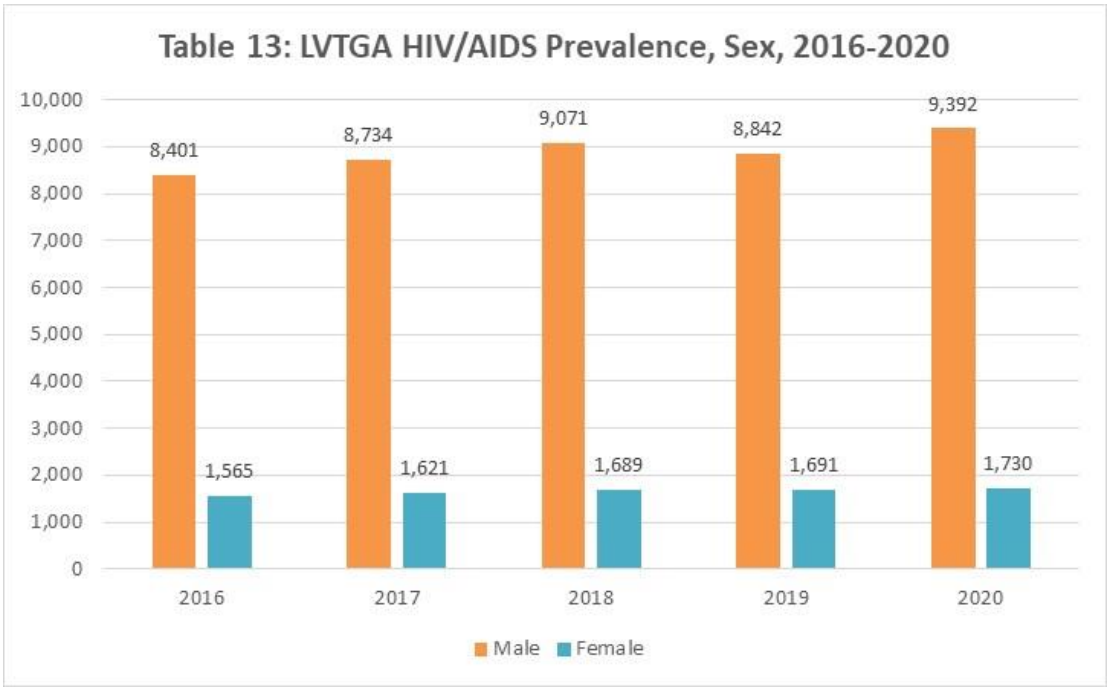
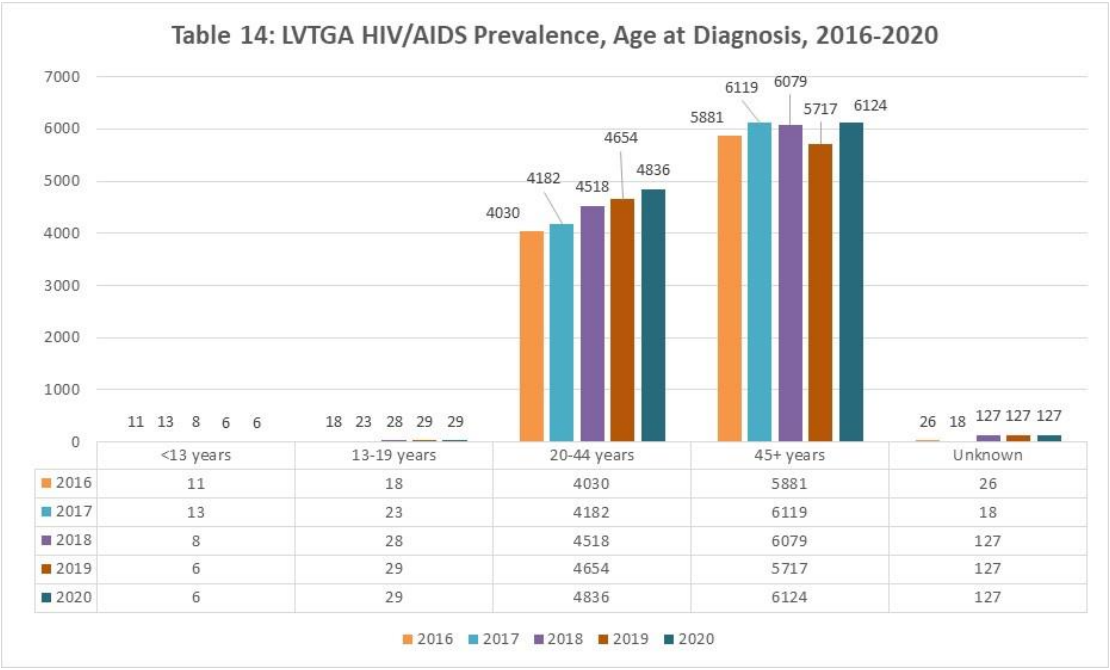


Table 12: LVTGA HIV/AIDS Prevalence, Race/Ethnicity, 2016-2020



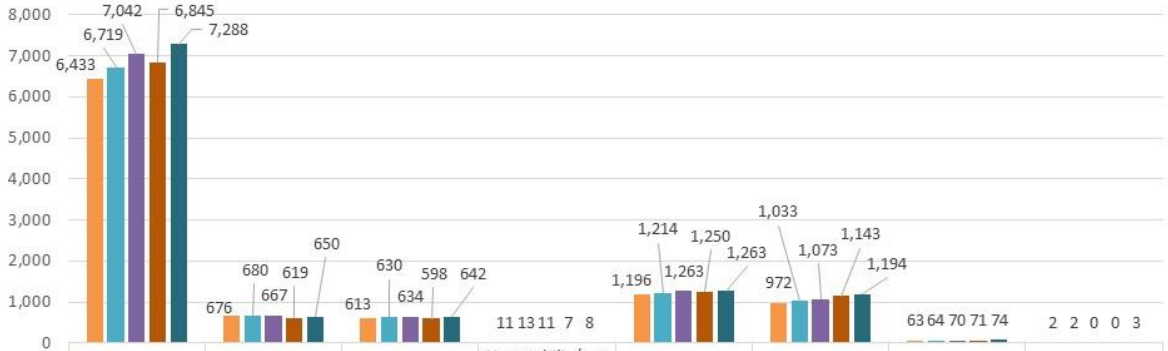
	White, not Hispanic	African-American, not Hispanic	Hispanic	Asian/Pacific Islander	American Indian/Alaska Native	Multi-race /Other
2016	4,279	2,726	2,358	376	83	144
2017	4,363	2,909	2,461	394	79	149
2018	4,332	3,100	2,657	427	70	174
2019	4,030	3,135	2,690	445	59	174
2020	4,234	3,319	2,834	472	64	199





	<13 years	13-19 years	20-44 years	45+ years	Unknown
2016	11	18	4030	5881	26
2017	13	23	4182	6119	18
2018	8	28	4518	6079	127
2019	6	29	4654	5717	127
2020	6	29	4836	6124	127

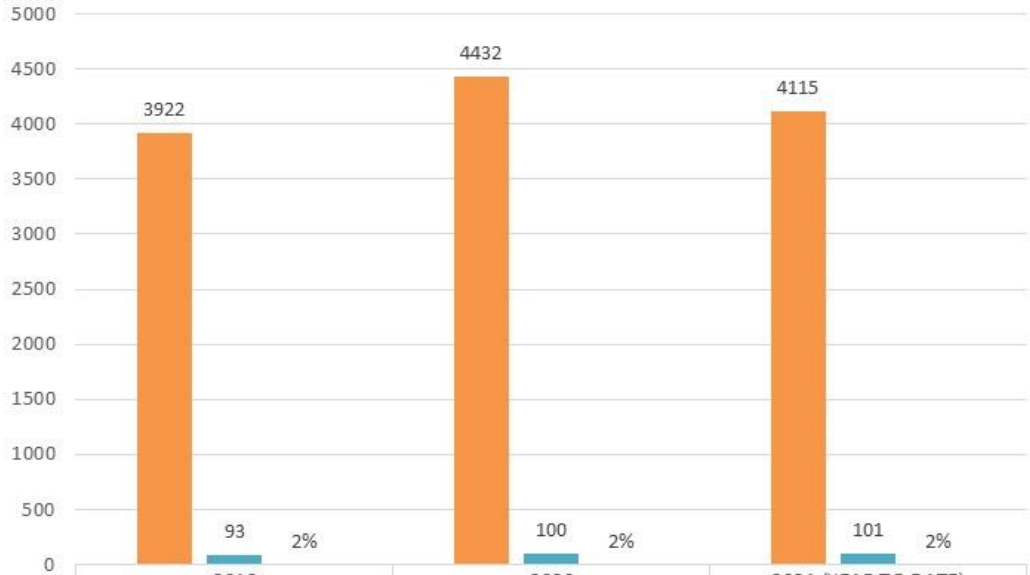
Table 15: LVTGA HIV/AIDS Prevalence, Mode of Transmission, 2016-2020



	Men who have sex with men	Injection drug users	Men who have sex with men and inject drugs	Hemophilia/coagulation Disorder/Transfusion	Heterosexual contact	Risk not reported or identified	Perinatal exposure	Mother with/at risk for HIV Infection
2016	6,433	676	613	11	1,196	972	63	2
2017	6,719	680	630	13	1,214	1,033	64	2
2018	7,042	667	634	11	1,263	1,073	70	0
2019	6,845	619	598	7	1,250	1,143	71	0
2020	7,288	650	642	8	1,263	1,194	74	3

2016 2017 2018 2019 2020

Table 16: RWHAP, Gender Identity, 2019-2021 (year to date to date)



	2019	2020	2021 (YEAR TO DATE)
Total RWPA PWH	3922	4432	4115
Transgender PWH	93	100	101
%	2%	2%	2%

Total RWPA PWH Transgender PWH %

ii. Socioeconomic data (e.g., percentage of federal poverty level, income, education, health insurance status, etc.)

The COVID pandemic had a dramatic impact on the LVTGA's unemployment rate, peaking at 33.3% in April 2020. The April 2020 record-breaking unemployment rate was due to COVID, and the state-wide shutdown order issued by the Governor. As of December 2020, the unemployment rate had dropped to 9.6%. As of July 2021, the unemployment rate was 9.4%. According to the Nevada Department of Employment, Training and Rehabilitation's (DETR) July 2020 economic report, Unemployment Insurance (UI) claims increased by 18,839 claims over the month and 56,826 over the year, or 39.4% and 575.6% respectively. Additionally, Nevada was the state with the highest 2020 Q2 Hispanic unemployment rate (30.1%), up from 4.6% in Q1. African American unemployment in the LVTGA was estimated to be 17,600, representing 95% of the ***state's total*** for the demographic group. The unemployment rate for African American in Clark County was 16.7%. *(3rd Quarter Nevada Unemployment Rate, Demographics Report, June 2020).*

Percentage of Federal Poverty Level (FPL) Income: Results from the LVTGA's 2021 PWH Needs Assessment showed 78% (n=249) at or below 200% FPL including 52% (n=166) at or below 138% FPL. Additionally, 8% (n=24) PWH reported no income. According to the 2019 US Census Quick Facts, the median household income for LVTGA residents was $48,593, while the per capita income (in 2018 dollars) was $26,392. Roughly 15% of persons residing in the LVTGA are living in poverty, compared to 11.8% nationally. The largest demographic living in poverty is females ages 25-44. The largest racial or ethnic group living below the poverty line is White, followed by Hispanic/Latino and African American. *(Clark County, Nevada Profile, 2017).*

Education: The LVTGA high school graduation rate is 86% compared to the U.S. rate of 87%. Only 24.5% of LVTGA residents have completed a college bachelor's degree compared to 31% nationally. *(US Census Quick Facts, 2019)*

Health Insurance Status: The LVTGA's uninsured rate is 13.7%, which is higher than the national average of 10% *(US Census Quick Facts, 2019)*. Despite significant improvements in the number of insured adults and children due to the state expanding Medicaid, Nevada ranked 48th in the nation for overall health care in a 2020 scorecard released by the Commonwealth Fund. Nevada also had the lowest rate of adults receiving the flu vaccine in the country. Nevada has low public health funding at $37 per person and high geographic disparity in public health funding within the state at 19.1%. Results from the LVTGA's 2021 PWH Needs Assessment showed 8.18% (n=26) reported having no health insurance. In 2020, the uninsured rate for PWH enrolled in Ryan White Part A services was 12.7% compared to 23% in 2019. Access to Healthcare Network (AHN), a Part A and B subrecipient, is charged with assisting clients in the eligibility and enrollment process for Medicare, Medicaid, and third-party marketplace insurance options. AHN is also subcontracted to administer the Health Insurance Continuation program and ADAP for Nevada's Ryan White Part B program. The coordination of services available to PWH decreases the concern of enrollment and minimizes transportation barriers. In Nevada, the marketplace options include: Anthem Health, Silver Summit Health Plan, and Health Plan of Nevada which has been part of the exchange since its inception. In 2020, ADAP added two new

off market health plans, Select Health and Friday Health. The two off market plans afford PWH, regardless of federal residency status, to obtain health insurance.

Language Barriers: Results from the LVTGA's 2021 PWH Needs Assessment which were used as one of the data sets the Planning Council considered in the 2022 Priority Setting and Resource Allocation process, language barriers were a theme for Hispanic/monolingual speakers. As a result, the Planning Council prioritized and funded Linguistic Services for the first time. The addition of Linguistic Services to the LVTGA's 2022 planned services will address the barriers Hispanic/monolingual speakers cited in the 2021 PWH Needs Assessment.

c) Describe the relative rates of increase in HIV diagnosed cases within new and emerging populations.

i. Include information on how you identified emerging populations, any unique challenges, and estimated costs to the RWHAP Part A, if applicable.

Based on the LVTGA's 2020 Epidemiological Profile, **Youth** (ages 13-19) have been identified as a new and emerging population. **Youth** HIV infections have increased 43% (n=6) since 2016 including a 21% (n=3) increase from 2019 to 2020. **Youth** were the only age group to report an increase in new HIV infections from 2019 to 2020. Since 2016, there have been 56 new **Youth** HIV cases of which 25% (n=14) were late diagnosed. **Youth** HIV prevalence has increased 38% (n=11) from 2016 to 2020. Unique challenges for the **Youth** population include: 1) Lower Viral Suppression rate (84%) than the In Care Virally Suppressed populations (93%); 2) Treatment adherence, both primary medical and medications; 3) HIV stigma; and 4) Communication strategies (social media). The estimated costs of the **Youth** population to RWHAP Part A are minimal. As most **Youth** have Medicaid, the LVTGA's Ryan White Part D program is an additional payor source.

ii. Describe the increasing need for HIV-related services based on the relative increase of HIV cases.

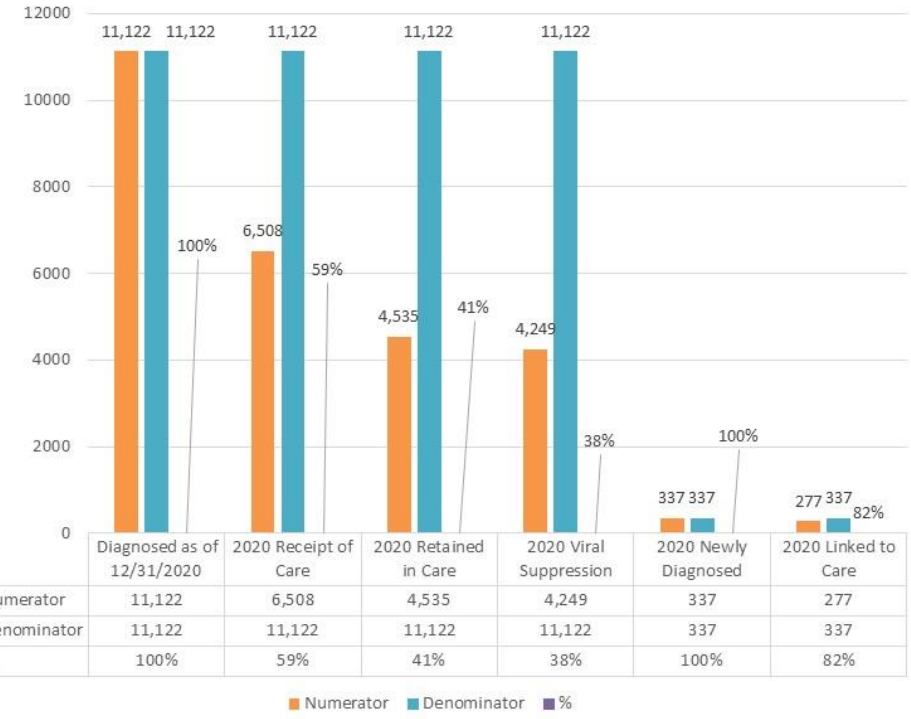
As of December 31, 2020, there were 11,122 People with HIV (PWH) residing in the LVTGA, which is a 5% (n=589) increase from 2019. In 2020, the LVTGA had 337 new HIV infections, of which 119 (36%) were late diagnoses (AIDS). ***According to data supplied by SNHD, the LVTGA has seen 307 new HIV infections from 1/1/21 to 9/27/21***. Since 2016, the LVTGA has averaged 435 new HIV cases annually, of which 35% (n=154) were late diagnoses (AIDS). Since 2016, the LVTGA has seen a 10% increase (n=1,156) in PWH prevalence. Results from the LVTGA's 2021 PWH Needs Assessment showed 25.47% (n=81) reporting their HIV diagnosis outside of the LVTGA.

2) HIV Care Continuum

a) Provide a graphic depiction of the HIV care continuum for the jurisdiction using the most current calendar year data. You must clearly state the definitions of the numerator and the denominator for each stage of the care continuum. Use readily available and validated data and indicate whether it represents data for RWHAP-eligible clients only or is population-based.

Table 17 shows the LVTGA's 2020 Diagnosed-Based HIV Care Continuum based on data supplied by Nevada Department of Health and Human Services, Office of Analytics and Arizona Department of Health Services, Epidemiological Unit.

Table 17: LVTGA Diagnosed-Based HIV Care Continuum, 2020



	Diagnosed as of 12/31/2020	2020 Receipt of Care	2020 Retained in Care	2020 Viral Suppression	2020 Newly Diagnosed	2020 Linked to Care
Numerator	11,122	6,508	4,535	4,249	337	277
Denominator	11,122	11,122	11,122	11,122	337	337
%	100%	59%	41%	38%	100%	82%

Definitions for the LVTGA's Diagnosed-Based Care Continuum are as follows:

- **Diagnosed:** Number of persons aged ≥13 years with HIV infection in the jurisdiction at the end of the calendar year.
- **Receipt of Care:** Percentage of persons with diagnosed HIV who had at least one CD4 or viral load test during the calendar year.
  - Numerator: Number of persons aged ≥13 years with diagnosed HIV infection who had a care visit during the calendar year (2020), as measured by documented test results for CD4 count or viral load.
  - Denominator: Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end (2020).
- **Retained in Care:** Percentage of persons with documentation of two or more CD4 or viral load tests performed at least three months apart during the calendar year.
  - Numerator: Number of persons aged ≥13 years with diagnosed HIV infection who had two care visits that were at least 90 days apart during the calendar year (2020), as measured by documented test results for CD4 count or viral load.
  - Denominator: Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end (2020).
- **Viral Suppression:** Percentage of persons aged ≥13 years with HIV infection who had a viral load test result of <200 copies/mL at the most recent viral load test during the calendar year.

• Numerator: Number of persons aged ≥13 years with diagnosed HIV infection whose most recent viral load test in the calendar year showed that HIV viral load was suppressed.
• Denominator: Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.

- **Linked to Care:** Percentage of persons with newly diagnosed HIV infection who were linked to care within one month after diagnosis as evidenced by a documented CD4 count or viral load.
  • Numerator: Number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year who were linked to care within one month of their diagnosis date as evidenced by a documented test result for a CD4 count or viral load.
  • Denominator: Number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year.

3) Unmet Need

Please see Attachment #4.

Based on the Unmet Need Framework estimates provided in Attachment 4, provide responses to the following:
a) Identify whether the enhanced method was utilized (in addition to the required method) to provide the Unmet Need Framework estimates. Describe any data system and/or other limitations that impacted your ability to provide these estimates.

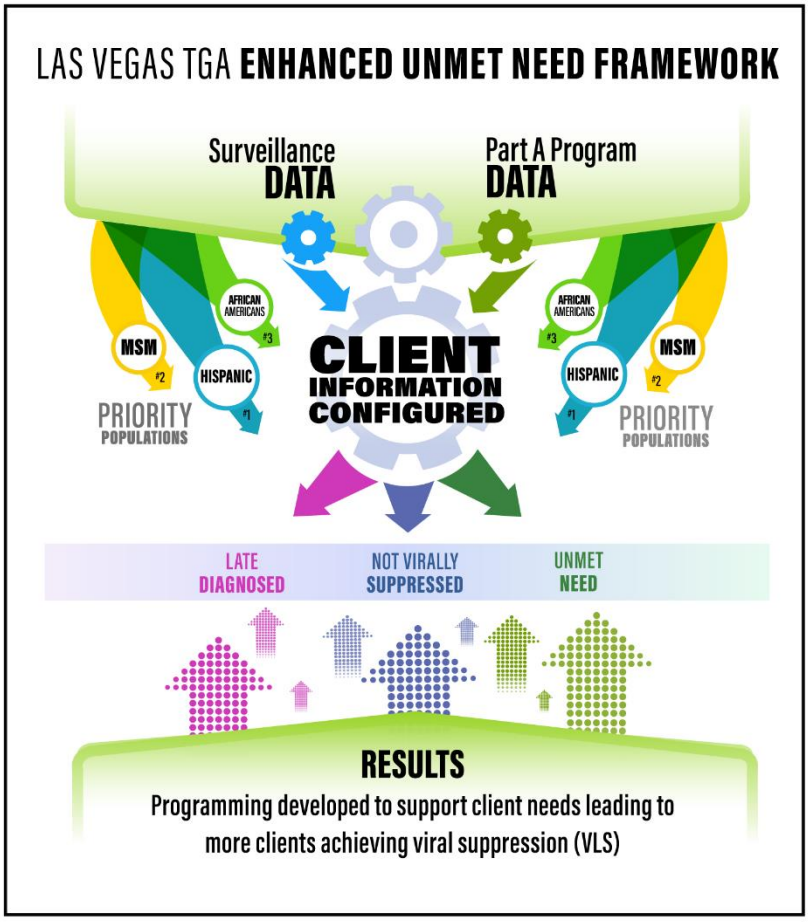


Figure 1 provides a graphic description of the *LVTGA's Enhanced Unmet Need Framework.*

The unmet need framework presented is the required method only. The enhanced method will be used in future reports. Currently, the Recipient is working with the Nevada state surveillance department and Part B program to automate a lab import process which will provide a robust reporting of client's health status and

allow for accurate reporting of the enhanced method of unmet need. Currently the lab import process is person dependent. Over the last two years the Part A and B programs have experienced staff turnover in these key positions.

b) Based on the estimates included in Attachment 4, describe the need(s) of the estimated number of people in your jurisdiction that are 1) late diagnosed, 2) have unmet need, and 3) are in care but not virally suppressed.

Using the *Ending the HIV Epidemic: A Plan for America Phase I* methodology ("48 counties, plus Washington, DC, and San Juan, PR, where >50% of HIV diagnoses occurred in 2016 and 2017"), the LVTGA has focused on three sub populations that combined, account for 64% of new HIV infections, 62% of late diagnosed, 41% of Unmet Need and 7% of in care but not virally suppressed. Additionally, the LVTGA has identified three zip codes in Clark County with the highest HIV incidence and prevalence (89101, 89119 and 89108) and will target EIIHA activities to these locations.

1) Late Diagnosed

As of December 31st, 2020, the LVTGA recorded 337 new HIV cases of which, 35% (n=119) were late diagnosed. Since 2016, the LVTGA has averaged 35% (n=771) late diagnosed cases of the total 2,177 new HIV cases. In 2020, **MSM** accounted for 56% (n=67) of late diagnosed cases, **Hispanics 33% (n=39) and African Americans 29% (n=35). Hispanics and Africa Americans** represent 30% and 12% of the general population, respectively. These three demographic groups comprise the subpopulations of focus in LVTGA's Early Identification of Individuals with HIV work plan.

Table 20 shows the LVTGA's 2020 HIV/AIDS Incidence Diagnosis Location and Percentage of Total as reported by the Nevada Department of Health and Human Services, Division of Public and Behavioral Health and Arizona's Department of Health Services, Epidemiological Unit. As evidenced in **Table 20**, 77% (n=92) of late diagnosed PWH were diagnosed in an Outpatient Facility, Private Physician's Office, or Inpatient Facility (Hospital).

Table 20: LVTGA HIV/AIDS Incidence Diagnosis Location, 2020

Nevada Department of Health and Human Services DIVISION OF PUBLIC AND BEHAVIORAL HEALTH	2020 LVTGA HIV Incidence Diagnosis Location		2020 LVTGA AIDS Incidence Diagnosis Location	
Facility of Diagnosis	**N**	**%**	**N**	**%**
HIV Counseling and Testing Site	29	9%	2	2%
Private Physician's Office	110	33%	34	29%
Inpatient Facility (Hospital)	19	6%	15	13%
Outpatient Facility	86	26%	43	36%
Adult HIV Clinic	5	1%	4	3%
Correctional Facility	19	6%	1	1%
STD Clinic	41	12%	8	7%
Blood Bank or Plasma Center	13	4%	0	0%
Emergency Room	2	1%	2	2%
TB Clinic	2	1%	0	0%
Other/Unknown	11	3%	10	8%
Total	**337**	100%	**119**	100%

Data from the LVTGA's 2021 Comprehensive PWH Needs Assessment informed the Unmet Need Subpopulations of Focus sections. The total number of PWH surveyed was 378,

representing 3.39% of the LVTGA's total PWH population and 8.65% of the Ryan White Part A client population. PWH survey responses were filtered by subpopulation and based on the unmet need care stages.

Subpopulation of Focus #1: Hispanic late diagnosed needs: □ Access to condoms. Schools should have some available. □ Sex education in schools desperately needs to be improved. □ Accessible, bilingual, and culturally appropriate preventive materials □ Admitting that it is still a relevant issue that needs to be addressed and that it affects all groups □ Better access to testing, free testing □ Events in the streets where information is provided for free □ Las Vegas would greatly benefit from more public service announcements related to HIV/AIDS and services □ Less of a stigma when it comes to sex and sexual acts □ Need more of an open dialogue □ More availability of HIV information for women □ More awareness & people willing to talk about it in a public forum/meeting □ More doctors to talk with people □ More Latino outreach to reduce HIV/AIDS stigma □ More needle exchanges □ More publication of HIV testing □ Awareness of symptoms of HIV □ More testing sites □ More websites. □ Not enough agencies promote their services to mainstream community due to stigma □ Rising poverty and drug use needs to be addressed □ Start education young, in middle school, on STI and HIV/AIDS which will help younger population not spread it around

Subpopulation of Focus #2: African American late diagnosed needs: □ Access to free or low cost tests □ Access to reduced price condoms and protection methods □ Advertisements on where to get tested □ Awareness and outreach to keep the community educated and aware that HIV/AIDS are real and can be dangerous □ Clean needle drives or supplies to the public to promote clean needle injections □ Educate on how behaviors affect the risk of getting HIV □ Free testing □ Funding for dental, vision and gerontology □ Safe, affordable housing □ Generalized public awareness because of stigma and lack of awareness □ More required information in middle/high school □ Leaders both young and old pushing the movement □ More clinics that address HIV/AIDS and talk about it □ More community information and statistics for certain populations □ More information geared toward youth □ More mobile presence □ More walk-in clinics

Subpopulation of Focus #3: MSM late diagnosed needs: □ Access and affordability to PrEP services □ Housing Support Services □ Oral Health Care □ Increased/more convenient access to HIV testing □ General awareness of HIV in communities of color □ Less stigma when it comes to sex □ Substance Abuse services □ Peer educators who represent communities impacted by HIV □ More publication of HIV testing. □ More information that is available online □ Not enough agencies promote their services to mainstream community due to stigma □ Health Education/Risk Reduction □ Psychosocial Support groups

2) Have Unmet Need

Subpopulation of Focus #1: Hispanic unmet needs: □ Monolingual reengagement specialists □ Peer outreach workers □ Culturally appropriate educational information about HIV including affordability of HIV medical care □ General awareness of HIV in communities of color □ Newly Diagnosed University/The Empowerment Academy □ Substance Abuse services □ Peer educators who represent communities impacted by HIV □ More publication of HIV testing □

Undetectable=Untransmittable Campaign □ Health Education/Risk Reduction □ Psychosocial Support groups

Subpopulation of Focus #2: African American unmet needs: : □ Peer outreach workers □ Culturally appropriate educational information about HIV including affordability of HIV medical care □ General awareness of HIV in communities of color □ Newly Diagnosed University/The Empowerment Academy □ Substance Abuse services □ Peer educators who represent communities impacted by HIV □ More publication of HIV testing □ Undetectable=Untransmittable Campaign □ Health Education/Risk Reduction □ Psychosocial Support groups □ Engagement of community faith leaders □ Newly Diagnosed University/The Empowerment Academy

Subpopulation of Focus #3: MSM unmet needs: □ Housing Support Services □ Oral Health Care □ General awareness of HIV in communities of color □ Less of a stigma when it comes to □ More HIV information that is available online □ Not enough agencies promote their services to mainstream community due to stigma □ Health Education/ Risk Reduction □ Psychosocial Support groups □ Newly Diagnosed University/The Empowerment Academy □ Undetectable=Untransmittable Campaign

3) In care but not virally suppressed

Results from the LVTGA's 2021 PWH Needs Assessment indicated:

- 14% (n=54) of in care PWH were not virally suppressed
- 60% (n=32) of in care PWH not virally suppressed were diagnosed outside of the LVTGA
- 36% (n=19) of in care PWH not virally suppressed identified as **African American**
- 26% (n=14) of in care PWH not virally suppressed identified as **Hispanic**
- 69% (n=37) of in care PWH not virally suppressed identified their exposure mode as **MSM**
- 10% (n=5) of in care PWH not virally suppressed were uninsured
- 33% (n=24) of in care PWH not virally suppressed reported a sexually transmitted disease (Gonorrhea, Syphilis, Chlamydia, Hepatitis B and C) in the past 12 months
- 13% (n=7) of in care PWH not virally suppressed were diagnosed with COVID-19 in the past 12 months
- 60% (n=32) of in care PWH not virally suppressed have or plan to have a COVID-19 vaccination
- 22% (n=12) of in care PWH not virally suppressed are unsure if they will receive a COVID-19 vaccination
- 22% (n=11) of in care PWH not virally suppressed were unstably housed

Subpopulation of Focus #1: Hispanic in care but not virally suppressed needs: □ Patient Navigators □ Outpatient/Ambulatory Health Services □ Health Insurance Premium/Cost Sharing Assistance □ Emergency Financial Assistance □ Substance Abuse services □ Peer educators who represent communities impacted by HIV □ Oral Health Care □ Medical Transportation □ Undetectable=Untransmittable Campaign □ Health Education/Risk Reduction

□ Psychosocial Support groups □ Mental Health Services □ Food Bank/Home Delivered Meals □ Medical Case Management services

Subpopulation of Focus #2: African American in care but not virally suppressed needs: □ Patient Navigators □ Outpatient/Ambulatory Health Services □ Health Insurance Premium/Cost Sharing Assistance □ Emergency Financial Assistance □ Substance Abuse services □ Peer educators who represent communities impacted by HIV □ Oral Health Care □ Medical Transportation □ Undetectable=Untransmittable Campaign □ Health Education/Risk Reduction □ Psychosocial Support groups □ Mental Health Services □ Food Bank/Home Delivered Meals □ Housing Services □ Medical Case Management services

Subpopulation of Focus #3: MSM in care but not virally suppressed needs: □ Housing Services □ Undetectable=Untransmittable Campaign □ Outpatient/Ambulatory Health Services □ Health Insurance Premium/Cost Sharing Assistance □ Emergency Financial Assistance □ Substance Abuse services □ Peer educators who represent communities impacted by HIV □ Oral Health Care □ Medical Transportation □ Health Education/Risk Reduction □ Psychosocial Support groups □ Mental Health Services □ Food Bank/Home Delivered Meals □ Medical Case Management services

4) Co-occurring Conditions

Please see Attachment #5

5) Complexities of Providing Care

a) If the EMA/TGA experienced a reduction in RWHAP Part A formula funding last year (FY 2021) provide a narrative that addresses both the impact and response to the funding reduction.

Not applicable. The LVTGA received an increase in RWPHAP Part A formula funding in FY 2021.

b) Provide an overall description of health care coverage options available to all people with HIV in the jurisdiction.

Health care coverage options available to PWH in the Las Vegas TGA include third party insurance options available through the marketplace and expanded Medicaid. Nevada and Arizona chose to expand Medicaid and work with the federally facilitated insurance marketplace through healthcare.gov. The Silver State Health Insurance Exchange is the state agency that oversees and operates the online health insurance marketplace in the state of Nevada, known as Nevada Health Link. The Exchange facilitates and connects eligible Nevadans who are not insured by their employer, Medicaid, or Medicare to health insurance options. Individuals can purchase ACA certified Qualified Health Plans through the Exchange and if eligible, can receive subsidy assistance to help offset monthly premiums and out-of-pocket costs. Through Nevada Health Link individuals can find affordable health insurance plans, by shopping for, comparing, and purchasing qualified health insurance plans with tax credits or subsidies that are based on income. Nevada Health Link is the only health insurance resource that can provide applicants with federal tax credits and subsidies to help cover the cost of health insurance.

Access to Healthcare Network (AHN), a Part A and B subrecipient, is charged with assisting clients in the eligibility and enrollment process for Medicare, Medicaid, and third-party marketplace insurance options. AHN is also subcontracted to administer the Health Insurance Continuation program and ADAP for Nevada's Ryan White Part B program. The coordination of services available to PWH decreases the concern of enrollment and minimizes transportation barriers. In Nevada, the marketplace options include: Anthem Health, Silver Summit Health Plan, and Health Plan of Nevada which has been part of the exchange since its inception. In 2020, ADAP added two new off market health plans, Select Health and Friday Health. The two off market plans afford PWH, regardless of federal residency status, the ability to obtain health insurance.

Arizona also expanded Medicaid coverage in the state, including Mohave County. In Mohave County there are five federally facilitated marketplace plans available, all through Blue Cross Blue Shield, one of which is supported by ADAP.

Through Nevada ADAP, standalone dental insurance through the Liberty Dental Plan is available to PWH and provides comprehensive oral health care services such as periodic and routine dental services needed for restoration of teeth, prevention of oral disease and maintenance of dental health.

i. Explain how coverage options in the jurisdiction negatively or positively influence access to direct health care services and health outcomes.

The LVTGA's uninsured rate is 13.7%, which is higher than the national average of 10% *(US Census Quick Facts, 2019)*. Despite significant improvements in the number of insured adults and children due to the state expanding Medicaid, Nevada ranked 48th in the nation for overall health care in a 2020 scorecard released by the *Commonwealth Fund*. Nevada also had the lowest rate of adults receiving the flu vaccine in the country. Nevada has low public health funding at $37 per person and high geographic disparity in public health funding within the state at 19.1%. Results from the LVTGA's 2021 PWH Needs Assessment showed 8.18% (n=26) reported having no health insurance. In 2020, the uninsured rate for PWH enrolled in Ryan White Part A services was 12.7% compared to 23% in 2019.

This improvement was accomplished through intensive collaboration with Nevada ADAP, which was able to make new insurance products available to clients during the 2020 open enrollment period. During this collaboration, recipient staff communicated weekly with Ryan White Part A and B Medical Case Management subrecipients with a list of uninsured clients, asking them to reach out and provide support in scheduling appointments for open enrollment. This was an effective strategy that resulted in more than 300 Ryan White clients across the state being enrolled in a health insurance plan, some for the very first time; most of these clients reside in the LVTGA. The LVTGA is launching a pilot program through the service category Health Education/Risk Reduction in 2021 called "Health Benefits Take Charge" to support clients in understanding, navigating, and maximizing their health benefits.

Despite improvements in this area, PWH are still confronted with access barriers. Health insurance plans offered through the Exchange may not cover or have limited coverage for services critical to PWH positive health outcomes. For example, Medical Case Management,

Medical Nutritional Services, Emergency Financial Assistance, Housing Services and Psychosocial Support services are not covered by traditional health insurance plans. Additionally, Substance Abuse Services (Outpatient/Residential) and Mental Health Services are minimally covered in health insurance plans offered through the Exchange.

c) Describe any relevant factors that limit access to health care including geographic variation, adequacy of health insurance coverage, language barriers, or other major social determinants of health, as applicable.

Language Barriers/Foreign Citizenry

Almost 35% of people in Clark County speak a non-English language and 12% are not U.S. citizens. The most common birthplace for foreign born is Mexico followed by Philippines and El Salvador. The most common foreign languages are Spanish, Tagalog, and Chinese. *(Clark County NV Profile, 2017).*

Geographic Variation

The State's *Integrated HIV Prevention and Care Plan 2017-2021* noted that a structural barrier to care is the distance between HIV service providers in the Las Vegas area. For example, a Nye County PWH accessing HIV medical care in Las Vegas, faces a round trip of 120 miles. According to the *2019 Cities with the Best and Worst Transportation*, Las Vegas ranked 51st out of 100 cities. Another barrier is high transiency in Nevada, with people frequently moving in and out of state, as well as to other locations within cities and within the state, which can make it difficult to get HIV test results to people, to link individuals who test positive to care, and to retain PWH in care.

Navigating Health Insurance Plan Options Offered Through the Silver State Health Insurance Exchange

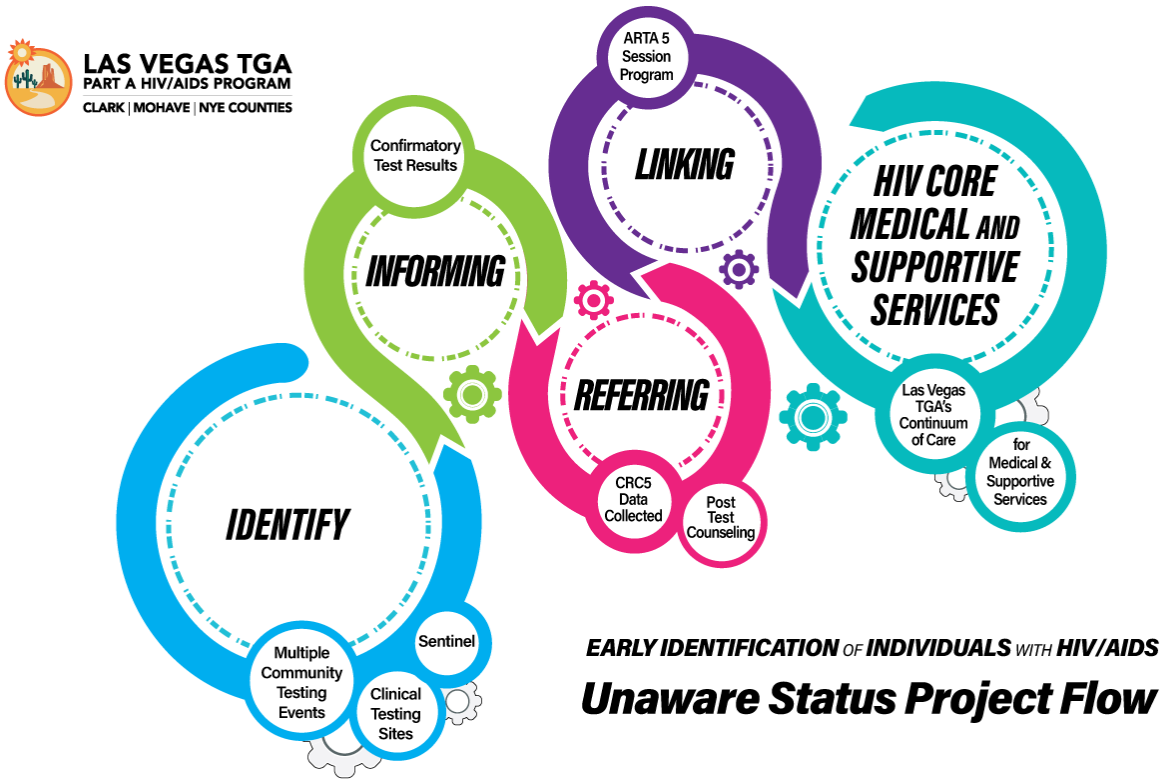
PWH must navigate the numerous plans offered through the Exchange to ensure their HIV providers accept the selected health insurance plan. Compounding this is the level of education PWH need to understand co-pays, deductibles, out-of-pocket costs, and coinsurance.

Health Insurance Portability

As previously stated, since 2016, the LVTGA has seen a 10% increase (n=1,156) in PWH prevalence. Results from the LVTGA's 2021 PWH Needs Assessment, 25.47% (n=81) reported their HIV diagnosis was outside of the LVTGA and health insurance portability is a barrier for PWH who move to the LVTGA.

B. Early Identification of Individuals with HIV/AIDS (EIIHA)

Figure 2 below provides a graphic description of the LVTGA's EIIHA process flow.



1) Describe the planned EMA/TGA EIIHA activities for the three-year period of performance. Include the following information:

Table 21 below shows the LVTGA's EIIHA activities for the three-year period of performance. Additionally, EIIHA activities are described in greater detail in the narrative following **Table 21.**

Table 21 Early Identification of Individuals with HIV/AIDS Three-Year Primary Activities

Primary Activities	Year 1: 2022-2023	Year 2: 2023-2024	Year 3: 2024-2025	Impact
1. Identifying individuals with HIV who do not know their HIV status	a. Increase knowledge and capacity of HIV testing, services, community engagement, peer networks and system navigation for PWH that are newly diagnosed, returning to care and/or are transitional aged youth with an emphasis on the importance of medical	b. Transition HIV Medical Providers to Rapid stART Protocol – By June 30, 2023, implement community wide Rapid stART Program in Clark County.	c. By February 28, 2025, at least 75% of people newly diagnosed with HIV after March 1, 2020, will be linked to care, and virally suppressed within 60 days of diagnosis.	1. 90% of clients are linked to HIV Medical Care within 7 days 2. 90% of clients initiate ART within 7 days from date of HIV diagnosis 3. 90% of clients will be virally suppressed by 60

Primary Activities	Year 1: 2022-2023	Year 2: 2023-2024	Year 3: 2024-2025	Impact
	care and supportive services.			days after initiation of ART 4. 90% of clients will be retained in care
2. Making individuals aware of their status and enabling them to access HIV medical and support services	a. Client Engagement Software –design and implement client engagement software.	b. Client Engagement Software will track applicable Rapid stART data elements, interface with CAREWare and report on 5 Rapid stART performance measures: 1. Linkage to HIV Medical Care within 7 days, 2. Initiation of ART within 7 days, 3. Median Days to Initiation of ART, 4. Viral Load Suppression, 5. Retention in Care	c. Client Engagement Software will track applicable Rapid stART data elements, interface with CAREWare and report on 5 Rapid stART performance measures: 1. Linkage to HIV Medical Care within 7 days, 2. Initiation of ART within 7 days, 3. Median Days to Initiation of ART, 4. Viral Load Suppression, 5. Retention in Care	1. 90% of clients are linked to HIV Medical Care within 7 days 2. 90% of clients initiate ART within 7 days from date of HIV diagnosis 3. 90% of clients will be virally suppressed by 60 days after initiation of ART 4. 90% of clients will be retained in care
3. Reducing barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities	a. Provider – based Viral Suppression/ U=U/HIV Client Education Campaign – design and implement by Feb. 28, 2023	b. Education Campaign will provide health education related to viral suppression, undetectable = untransmittable meaning and practice, understanding lab values and how to read labs, importance of staying in care, treatment adherence with medications and advocating for own	c. Education Campaign will provide health education related to viral suppression, undetectable = untransmittable meaning and practice, understanding lab values and how to read labs, importance of staying in care, treatment adherence with medications and advocating for own	1. 90% of clients are engaged in HIV medical care 2. 90% of clients linked to care are on ART 3. 90% of clients in HIV medical care are virally suppressed

Primary Activities	Year 1: 2022-2023	Year 2: 2023-2024	Year 3: 2024-2025	Impact
		healthcare and needs.	healthcare and needs.	
3. Reducing barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities	d. Rapid stART System Level Linkage Team/Newly Diagnosed SWAT/Out of Care Team – design and conduct RFP by Nov. 30, 2021	e. Rapid stART Linkage Team will oversee the Rapid stART community process to ensure newly diagnosed individuals are effectively and efficiently linked to medical care. This team will also provide technical assistance to any medical provider or hospital interested in joining the Las Vegas Rapid stART Community Protocol.	f. Rapid stART Linkage Team will oversee the Rapid stART community process to ensure newly diagnosed individuals are effectively and efficiently linked to medical care. This team will also provide technical assistance to any medical provider or hospital interested in joining the Las Vegas Rapid stART Community Protocol.	1. 90% of newly diagnosed clients are linked to care within 7 days of their diagnosis. 2. 90% of previously diagnosed clients are linked to care within 30 days of presenting for reengagement in care. 3. Each year increase the number of hospitals, medical clinics, community health centers participating in Rapid stART service continuum by at least two.
3. Reducing barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities	g. Develop Newly Diagnosed University (NDU) – branded as "The Empowerment Academy" design and implement by Feb. 28, 2023	h. Newly Diagnosed University (NDU) will educate newly diagnosed individuals on the importance of medical care, advocating for healthcare needs, understanding labs and healthcare services. An emphasis will be placed on retention in care, medication	i. Newly Diagnosed University (NDU) will educate newly diagnosed individuals on the importance of medical care, advocating for healthcare needs, understanding labs and healthcare services. An emphasis will be placed on retention in care, medication	1. Number of post-event participant surveys that rate the event 8 out of 10, or higher. 2. Comparison of pre- and post-event knowledge assessments demonstrate increased HIV knowledge and awareness.

Primary Activities	Year 1: 2022-2023	Year 2: 2023-2024	Year 3: 2024-2025	Impact
		adherence and viral suppression. NDU framework will resemble higher education structure with knowledge assessments, projects and pre and post-tests. Upon completion, graduates will receive a diploma.	adherence and viral suppression. NDU framework will resemble higher education structure with knowledge assessments, projects and pre and post-tests. Upon completion, graduates will receive a diploma.	

a) The primary activities that will be undertaken, including system-level interventions that will positively impact HIV outcomes (e.g., routine testing in clinical settings, expanding partner services).

The primary activities that will positively impact HIV outcomes and meet the goals of: 1) identifying individuals with HIV who do not know their HIV status; 2) making individuals aware of their status and enabling them to access HIV medical and support services; and 3) reducing barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities in the LVTGA are:

Goal: Increase knowledge and capacity of HIV testing, services, community engagement, peer networks and system navigation for PWH that are newly diagnosed, returning to care and/or are transitional aged youth with an emphasis on the importance of medical care and supportive services.

Objective 1: By February 28, 2025, at least 75% of people newly diagnosed with HIV after March 1, 2020, will be linked to care, and virally suppressed within 60 days of diagnosis.

Strategy 1: Transition HIV Medical Providers to Rapid stART Protocol – By June 30, 2023, implement community wide Rapid stART Program in Clark County.

Primary Activities:

Implement Rapid stART Protocol including community agreed upon policies and procedures supporting agencies through the Rapid stART service continuum.

Action Steps:

- Procure technical assistance from other jurisdiction(s), and/or UCSF thru SPNS grant.
- Recruit providers, contractors, stakeholders and PLWH to participate in learning collaborative
- Develop program framework
- Complete assessment of Rapid stART (RS) providers
- Engage participation from RS and LTC service providers
- Conduct stakeholder education on the Rapid stART process
- Develop programmatic protocols, policies and procedures, data sharing, etc.

- Finalize memoranda of understanding and other relevant documentation
- Develop plan, performance metrics
- Develop and produce client and provider/contractor education pieces
- Conduct program/provider training
- Implement the project
- Project evaluation, revisions as needed

Metrics:
90% of clients are linked to HIV Medical Care within 7 days
90% of clients initiate ART within 7 days from date of HIV diagnosis
90% of clients will be virally suppressed by 60 days after initiation of ART
90% of clients will be retained in care

Strategy 2: Client Engagement Software –design and implement client engagement software.
Primary Activities:
Client Engagement Software will track applicable Rapid stART data elements, interface with CAREWare and report on 5 Rapid stART performance measures 1. Linkage to HIV Medical Care within 7 days, 2. Initiation of ART within 7 days, 3. Median Days to Initiation of ART, 4. Viral Load Suppression, 5. Retention in Care
Action Steps:

- Develop a program framework
- Recruit contractors and PLWH to participate in the development of the project
- Identify potential partner agencies
- Procure final software platform selection
- Develop plan, performance metrics
- Transition contractors to software
- Implement the project
- Project evaluation, revisions as needed

Metrics:
90% of clients are linked to HIV Medical Care within 7 days
90% of clients initiate ART within 7 days from date of HIV diagnosis
90% of clients will be virally suppressed by 60 days after initiation of ART
90% of clients will be retained in care

Strategy 3: Provider – based Viral Suppression/U=U/HIV Client Education Campaign – design and implement by Feb. 28, 2023
Primary Activities:
Education Campaign will provide health education related to viral suppression, undetectable = Untransmittable meaning and practice, understanding lab values and how to read labs, importance of staying in care, treatment adherence with medications and advocating for own healthcare and needs.
Action Steps:

- Develop a program framework
- Recruit contractors, providers, stakeholders and PLWH to participate

- Research existing/previous campaigns created by peer jurisdictions, CDC, and others
- Define project components and partners
- Develop plan, performance metrics
- Procure contractor for design, production, and implementation
- Present concepts to stakeholders/clients
- Final design produced and executed
- Implement the project
- Project evaluation, revisions as needed

Metrics:
90% of clients are engaged in HIV medical care
90% of clients linked to care are on ART
90% of clients in HIV medical care are virally suppressed

Strategy 4: Rapid stART System Level Linkage Team/Newly Diagnosed SWAT/Out of Care Team – design and conduct RFP by Nov. 30, 2021
Primary Activities:
Rapid stART Linkage Team will oversee the Rapid stART community process to ensure newly diagnosed individuals are effectively and efficiently linked to medical care. This team will also provide technical assistance to any medical provider or hospital interested in joining the Las Vegas Rapid stART Community Protocol. This protocol is currently under development through a SPNS grant in collaboration with UCSF. The team will be comprised of a medical professional versed in HIV testing and medical provider/hospital protocols; social worker; peer support; medical assistant and any additional positions agreed upon through the Learning Collaborative. The Rapid stART Linkage Coordination Team will be contracted to a sub-recipient through the Clark County Request for Provider process.
Action Steps:

- Develop a program framework
- Recruit PLWH and contractors to participate in the development of the project
- Procure TA thru SPNS grant and Learning Collaborative
- Complete PLWH assessment
- Complete contractor assessment
- Develop service delivery model, policies, and procedures
- Develop plan, performance metrics
- Develop applicable job descriptions including peer support/navigator
- Conduct RFP
- Implement the project, provide training and support
- Project evaluation, revisions as needed

Metrics:
90% of newly diagnosed clients are linked to care within 7 days of their diagnosis.
90% of previously diagnosed clients are linked to care within 30 days of presenting for reengagement in care.

Each year increase the number of hospitals, medical clinics, community health centers participating in Rapid stART service continuum by at least two.

Strategy 5: Develop Newly Diagnosed University (NDU) branded as "The Empowerment Academy"– design and implement by Feb. 28, 2023

Primary Activities:

Newly Diagnosed University (NDU) will educate newly diagnosed individuals on the importance of medical care, advocating for healthcare needs, understanding labs and healthcare services. An emphasis will be placed on retention in care, medication adherence and viral suppression. NDU framework will resemble higher education structure with knowledge assessments, projects and pre and post-tests. Upon completion, graduates will receive a diploma.

Action Steps:

- Develop a program framework
- Recruit contractors, stakeholders and PLWH to participate in the project
- Complete newly diagnosed PLWH assessment
- Complete PLWH peer support assessment
- Develop service delivery model
- Develop plan, performance metrics
- Promote project and recruit participants
- Implement the project
- Project evaluation, revisions as needed
- Convene a local community advisory board (CAB), with representation of key populations, to provide feedback and guidance for program

Metrics:

Number of post-event participant surveys that rate the event 8 out of 10, or higher. Comparison of pre- and post-event knowledge assessments demonstrate increased HIV knowledge and awareness.

b) Major collaborations with other programs and agencies, including HIV prevention and surveillance programs and the Ending the HIV Epidemic in the U.S. effort in your jurisdiction (if applicable).

The recipient's office continually collaborates with multiple stakeholders including HIV prevention recipient and sub-recipients, Southern Nevada Health District surveillance programs, and the County owned hospital and outpatient HIV medical clinic, University Medical Center. These collaborations include developing and refining the HIV care continuum, engaging consumers, and developing the workplan for the Ending the HIV Epidemic efforts. The primary activities listed above are also included in our Ending the HIV Epidemic workplan.

Additionally, the recipient has engaged with many community partners through a Learning Collaborative focused on developing and implementing a community wide Rapid stART protocol. The participants include: subrecipients: Access to Healthcare Network, Dignity Health, TracB/NARES; government partners: Pacific AIDS Education & Training Center/University of Nevada Reno, School of Medicine, State of Nevada Part B program, University Medical Center Part C program, Southern Nevada Health District – Community Health Clinic and Sexual Health

Clinic, University of California San Francisco. The Learning Collaborative has been meeting regularly since October 2019 and holds quarterly learning sessions with all participants and provides technical assistance during the action periods that occur between learning sessions.

c) The anticipated outcomes of the jurisdiction's overall EIIHA strategy. Specifically provide anticipated outcomes for each of the four required EIIHA components: 1.) identification of individuals unaware of their HIV status; 2.) informing individuals that tested positive of their HIV diagnosis; 3.) referral to care of newly diagnosed individuals; and 4.) linkage to care of newly diagnosed individuals.

The anticipated outcomes of the EIIHA strategies are listed below. The strategies encompass the four required EIIHA components: 1) identification of individuals unaware of their HIV status; 2) informing individuals that tested positive of their HIV diagnosis; 3) referral to care of newly diagnosed individuals; and 4) linkage to care of newly diagnosed individuals.

Strategy 1: Transition Providers to Rapid stART Protocol – By June 30, 2023, implement community wide Rapid stART Program in Clark County.
Metrics:
90% of clients are linked to HIV Medical Care within 7 days
90% of clients initiate ART within 7 days
90% of clients will be virally suppressed by 60 days after initiation of ART
90% of clients will be retained in care

Strategy 2: Client Engagement Software – By August 31, 2021, design and implement client engagement software.
Metrics:
90% of clients are linked to HIV Medical Care within 7 days
90% of clients initiate ART within 7 days
90% of clients will be virally suppressed by 60 days after initiation of ART
90% of clients will be retained in care

Strategy 3: Provider – based Viral Suppression/U=U/HIV Client Education Campaign – design and implement by Feb. 28, 2023
Metrics:
90% of clients are engaged in medical care
90% of clients linked to care are on ART
90% of clients in medical care are virally suppressed

Strategy 4: Rapid stART System Level Linkage Team/Newly Diagnosed SWAT/Out of Care Team – design and conduct RFP by Nov. 30, 2021
Metrics:
90% of newly diagnosed clients are linked to care within 7 days of their diagnosis.
90% of previously diagnosed clients are linked to care within 30 days of presenting for reengagement in care.
Each year increase the number of hospitals, medical clinics, community health centers participating in Rapid stART service continuum by at least two.

Strategy 5: Develop Newly Diagnosed University (NDU) branded as "The Empowerment Academy"– design and implement by Feb. 28, 2023

Metrics:

Number of post-event participant surveys that rate the event 8 out of 10, or higher. Comparison of pre- and post-event knowledge assessments demonstrate increased HIV knowledge and awareness.

2) As applicable, describe any planned efforts to remove legal barriers, including state laws and regulations that increase HIV stigma and discrimination and can pose complex barriers for people with or at risk for HIV, preventing them from seeking prevention tools, learning their HIV status, and accessing medical care, treatment, and supportive service. Also, include program/policy efforts to expand implementation of routine HIV testing.

The Nevada legislature has recently passed legislation allowing pharmacies to prescribe PEP/PrEP and provide HIV testing. To support these efforts the Part A Recipient's office has included language in an upcoming RFP for the Rapid stART System Level Linkage Team (Strategy 4) specific support to pharmacies for testing and notifying individuals of a positive HIV test result to ensure individuals that test positive are linked to care rapidly and pharmacy personnel have the most up-to-date information available.

C) Subpopulations of Focus

1) Identify three (3) subpopulations with disparities in health outcomes in your jurisdiction (e.g., subpopulations with disparities in viral suppression, receipt of care, retention in care, late diagnosis, HIV incidence, etc.), and describe the specific needs for each subpopulation.

Data from the LVTGA's 2021 Comprehensive PWH Needs Assessment informed the specific needs for each subpopulation of focus sections. The total number of PWH surveyed was 378, representing 3.39% of the LVTGA's total PWH population and 8.65% of the Ryan White Part A client population. PWH survey responses were filtered by subpopulation and based on the unmet need care stages.

Subpopulation of Focus #1: Hispanics

Subpopulation of Focus #1: Hispanic late diagnosed needs: □ Access to condoms. Schools should have some available. Sex education in schools desperately needs to be improved. □ Accessible, bilingual, and culturally appropriate preventive materials □ Admitting that it is still a relevant issue that needs to be addressed and that it affects all groups □ Better access to testing, free testing □ Events in the streets where information is provided for free □ Las Vegas would greatly benefit from more public service announcements related to HIV/AIDS and services □ Less stigma when it comes to sex and sexual acts □ Need more of an open dialogue □ More availability of HIV information for women □ More awareness & people willing to talk about it in a public forum/meeting □ More doctors to talk with people □ More Latino outreach to reduce HIV/AIDS stigma □ More needle exchanges □ More publication of HIV testing □ Awareness of symptoms of HIV □ More testing sites □ More websites □ Not enough agencies promote their services to mainstream community due to stigma □ Rising poverty and drug use needs to be addressed □ Start education young, in middle school, on STI and HIV/AIDS which will help younger population not spread it around

Subpopulation of Focus #1: Hispanic unmet needs: □ Monolingual reengagement specialists □ Peer outreach workers □ Culturally appropriate educational information about HIV including affordability of HIV medical care □ General awareness of HIV in communities of color □ Newly Diagnosed University/The Empowerment Academy □ Substance Abuse services □ Peer educators who represent communities impacted by HIV □ More publication of HIV testing □ Undetectable=Untransmittable Campaign □ Health Education/Risk Reduction □ Psychosocial Support groups

Subpopulation of Focus #1: Hispanic in care but not virally suppressed needs: □ Patient Navigators □ Outpatient/Ambulatory Health Services □ Health Insurance Premium/Cost Sharing Assistance □ Emergency Financial Assistance □ Substance Abuse services □ Peer educators who represent communities impacted by HIV □ Oral Health Care □ Medical Transportation □ Undetectable=Untransmittable Campaign □ Health Education/Risk Reduction □ Psychosocial Support groups □ Mental Health Services □ Food Bank/Home Delivered Meals □ Medical Case Management services

2. How the data in LVTGA's Unmet Need Framework informed the process for identifying the subpopulations: **Hispanics** are disproportionately impacted by HIV representing 30% of LVTGA's general population yet 32% (n=108) of all 2020 new HIV infections of which 33% (n=39) were late diagnoses (AIDS). As of December 31st, 2020, the total **Hispanic** HIV prevalence was 2,834 of which 31% (n=877) had an unmet need while 3% (n=47) were in care but not virally suppressed.

3) As applicable, identify activities for each required EIIHA component (identification of individuals unaware of HIV status; informing newly diagnosed individuals of HIV status; referral to care of newly diagnosed individuals; and linkage to care of newly diagnosed individuals) and describe how the activities align with the needs of the identified subpopulations of focus for the jurisdiction.
Hispanics will be enrolled in the RAPID stART program and receive medical care and medications within 72 hours of diagnosis. Linkage coordinators, nurse navigators or peer advocates will provide education, strengths-based case management and a support system to the newly diagnosed individual. All appointments are built on a strength based and goal making model that is led by the client, each client interaction will be tailored to meet that client's needs and provide the best support and encouragement for maintaining medical care and their medication regimen.

Subpopulation of Focus #2: African American

Subpopulation of Focus #2: African American late diagnosed needs: □ Access to free or low cost tests □ Access to reduced price condoms and protection methods □ Advertisements on where to get tested □ Awareness and outreach to keep the community educated and aware that HIV/AIDS are real and can be dangerous □ Clean needle drives or supplies to the public to promote clean needle injections □ Educate on how behaviors affect the risk of getting HIV □ Free testing □ Funding for dental, vision and gerontology □ Safe, affordable housing □ Generalized public awareness because of stigma and lack of awareness □ More required

information on it in middle/high school Leaders both young and old pushing the movement More clinics that address HIV/AIDS and talk about it More community information and statistics for certain populations More information geared toward youth More mobile presence More walk-in clinics

Subpopulation of Focus #2: African American unmet needs: : Peer outreach workers Culturally appropriate educational information about HIV including affordability of HIV medical care General awareness of HIV in communities of color Newly Diagnosed University/The Empowerment Academy Substance Abuse services Peer educators who represent communities impacted by HIV More publication of HIV testing Undetectable=Untransmittable Campaign Health Education/Risk Reduction Psychosocial Support groups Engagement of community faith leaders Newly Diagnosed University/The Empowerment Academy

Subpopulation of Focus #2: African American in care but not virally suppressed needs: Patient Navigators Outpatient/Ambulatory Health Services Health Insurance Premium/Cost Sharing Assistance Emergency Financial Assistance Substance Abuse services Peer educators who represent communities impacted by HIV Oral Health Care Medical Transportation Undetectable=Untransmittable Campaign Health Education/Risk Reduction Psychosocial Support groups Mental Health Services Food Bank/Home Delivered Meals Housing Services Medical Case Management services

2. How the data in LVTGA's Unmet Need Framework informed the process for identifying the subpopulations: **African Americans** are disproportionately impacted by HIV in the LVTGA. While representing only 12% of LVTGA's general population, **African Americans** account for 31% (n=106) of all 2020 new HIV infections, of which 33% (n=35) were late diagnoses (AIDS). **African Americans** comprise 30% (n=3,319) of total HIV prevalence. As of December 31st, 2020, the total **African American** HIV prevalence was 3,319 of which 32% (n=1,061) had an unmet need while 5% (n=104) were in care but not virally suppressed. **African Americans** account for 5% (n=104) of the LVTGA's ***total in care not virally suppressed***.

3) As applicable, identify activities for each required EIIHA component (identification of individuals unaware of HIV status; informing newly diagnosed individuals of HIV status; referral to care of newly diagnosed individuals; and linkage to care of newly diagnosed individuals) and describe how the activities align with the needs of the identified subpopulations of focus for the jurisdiction.
African Americans will be enrolled in the RAPID stART program and receive medical care and medications within 72 hours of diagnosis. Linkage coordinators, nurse navigators or peer advocates will provide education, strengths-based case management and a support system to the newly diagnosed individual. All appointments are built on a strength based and goal making model that is led by the client, each client interaction will be tailored to meet that client's needs and provide the best support and encouragement for maintaining medical care and their medication regimen.

Subpopulation #3: MSM

Subpopulation of Focus #3: MSM late diagnosed needs: □ Access and affordability to PrEP services □ Housing Support Services □ Oral Health Care □ Increased/more convenient access to HIV testing □ General awareness of HIV in communities of color □ Less stigma when it comes to sex □ Substance Abuse services □ Peer educators who represent communities impacted by HIV □ More publication of HIV testing □ More information that is available online □ Not enough agencies promote their services to mainstream community due to stigma □ Health Education/Risk Reduction □ Psychosocial Support groups

Subpopulation of Focus #3: MSM unmet needs: □ Housing Support Services □ Oral Health Care □ General awareness of HIV in communities of color □ Less stigma when it comes to sex □ More HIV information that is available online □ Not enough agencies promote their services to mainstream community due to stigma □ Health Education/Risk Reduction □ Psychosocial Support groups □ Newly Diagnosed University/The Empowerment Academy □ Undetectable=Untransmittable Campaign

Subpopulation of Focus #3: MSM in care but not virally suppressed needs: □ Housing Services □ Undetectable=Untransmittable Campaign □ Outpatient/Ambulatory Health Services □ Health Insurance Premium/Cost Sharing Assistance □ Emergency Financial Assistance □ Substance Abuse services □ Peer educators who represent communities impacted by HIV □ Oral Health Care □ Medical Transportation □ Health Education/Risk Reduction □ Psychosocial Support groups □ Mental Health Services □ Food Bank/Home Delivered Meals □ Housing Services □ Medical Case Management services

2. How the data in LVTGA's Unmet Need Framework informed the process for identifying the subpopulations: **MSM** comprised 63% (n=213) of 2020 new HIV infections, of which 31% (n=67) were late diagnoses (AIDS). **MSM** account for 66% (n=7,288) of 2020 total HIV prevalence. As of December 31st, 2020, the total **MSM** HIV prevalence was 7,288 of which 28% (n=2043) had an unmet need while 2% (n=108) were in care but not virally suppressed. **MSM** account for 43% (n=2043) of the LVTGA's ***total unmet need*** and 5% (n=108) of the LVTGA's ***total in care not virally suppressed***.

3) As applicable, identify activities for each required EIIHA component (identification of individuals unaware of HIV status; informing newly diagnosed individuals of HIV status; referral to care of newly diagnosed individuals; and linkage to care of newly diagnosed individuals) and describe how the activities align with the needs of the identified subpopulations of focus for the jurisdiction.
This population will be enrolled in the RAPID stART program and receive medical care and medications within 72 hours of diagnosis. Linkage coordinators, nurse navigators or peer advocates will provide education, strengths-based case management and a support system to the newly diagnosed individual. All appointments are built on a strength based and goal making model that is led by the client, each client interaction will be tailored to meet that client's needs and provide the best support and encouragement for maintaining medical care and their medication regimen.

A. Planning Responsibilities

1) Please see Attachment #6.

2) Resource Inventory

a) Coordination of Services and Funding Streams.

Please see Attachment #7.

WORK PLAN

A. HIV Care Continuum Services Table and Narrative

1) FY 2022 HIV Care Continuum Services Table

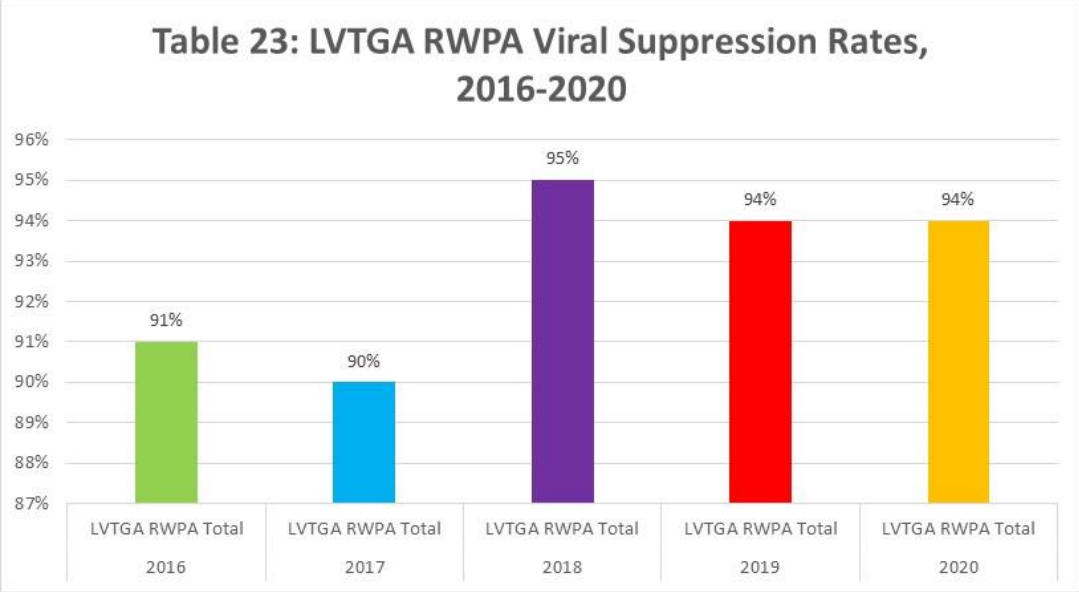
Please see Attachment #8.

2. HIV Care Continuum Narrative

Please provide a narrative on your HIV care continuum addressing the following:

a) Any changes in your HIV care continuum from CY 2017 to CY 2019, or the most current (3) years for which data are available, the impact those changes had on your program, and how you respond or addressed those identified changes.

Tables 23-26 show changes from 2016 to 2020 in the LVTGA's HIV Care Continuum's Viral Suppression Rates among: **1) All Ryan White Part A clients; 2) Subpopulation of focus #1: Hispanics; 2) Subpopulation of focus #2: African Americans; and 3) Subpopulation of focus #3: MSM**



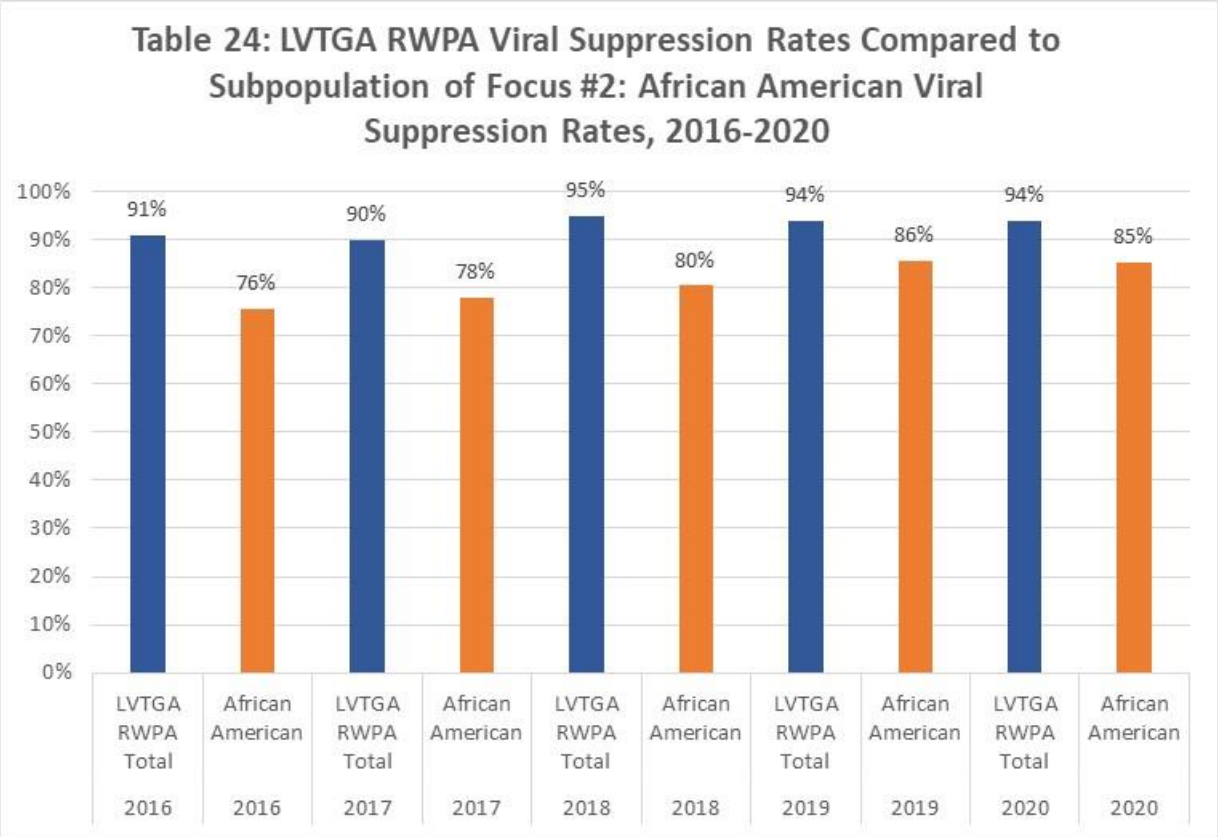


Table 24: LVTGA RWPA Viral Suppression Rates Compared to Subpopulation of Focus #2: African American Viral Suppression Rates, 2016-2020
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
91%
76%
90%
78%
95%
80%
94%
86%
94%
85%
LVTGA RWPA Total 2016
African American 2016
LVTGA RWPA Total 2017
African American 2017
LVTGA RWPA Total 2018
African American 2018
LVTGA RWPA Total 2019
African American 2019
LVTGA RWPA Total 2020
African American 2020

Table 25: LVTGA RWPA Viral Suppression Rates Compared to Subpopulation of Focus #1: Hispanic Viral Suppression Rates, 2016-2020

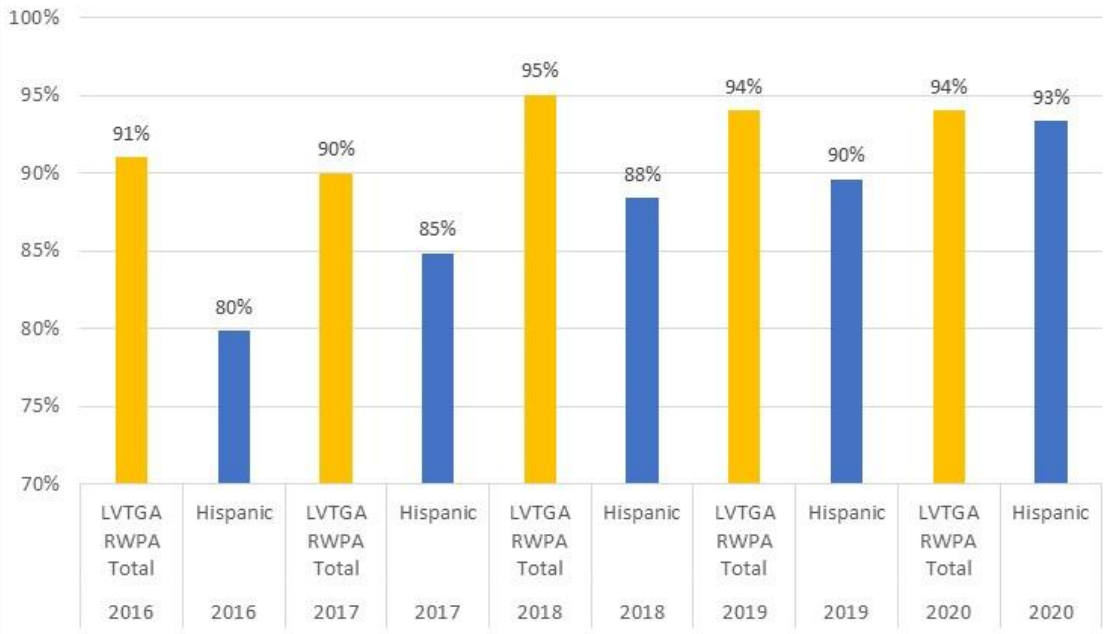
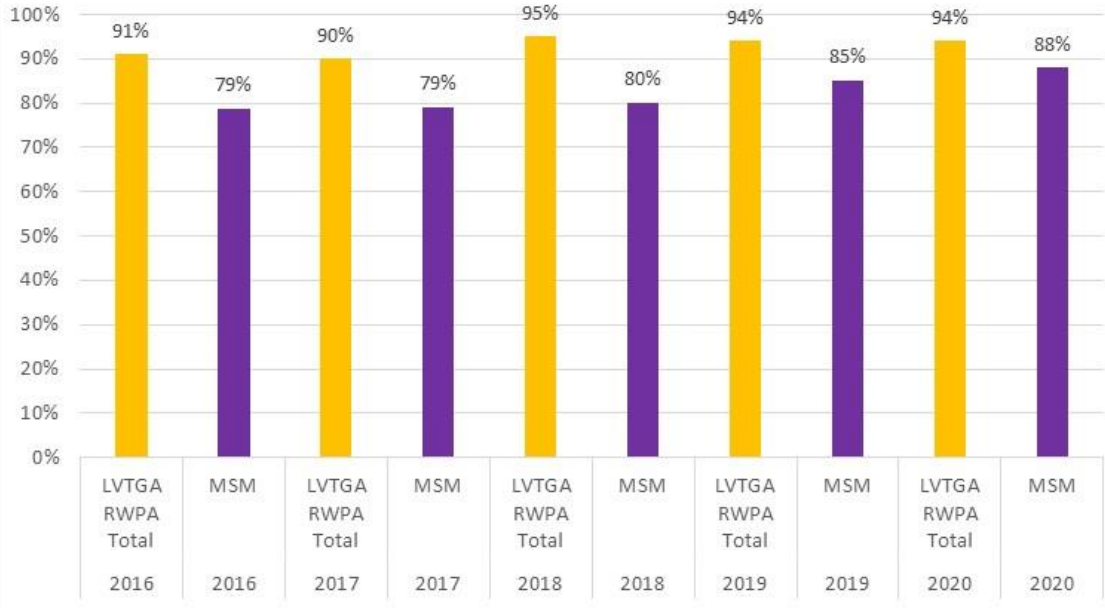


Table 26: LVTGA RWPA Viral Suppression Rates Compared to Subpopulation of Focus #3: MSM Viral Suppression Rates, 2016-2020



The LVTGA uses a diagnosed-based HIV Care Continuum to closely examine the percentage of PWH impacted by each point along the continuum. This approach gives the LVTGA more detailed information within subpopulations of focus to plan and prioritize needs. Furthermore, the HIV Care Continuum is also used by LVTGA to derive actionable insights and identify gaps in care that exist in connecting PWH to sustained quality care. Identifying significant discrepancies is critical to determining how, where, and when to intervene to break the cycle of HIV transmission, reduce unmet need and increase viral suppression rates. Deploying resources for the identified segments increases the proportion of PWH who are prescribed antiretroviral therapy and can adhere to their treatment to achieve the desired viral load suppression. By gaining access to antiretroviral therapy and adhering to treatment PWH can stay healthy, have improved quality of life, and live longer. PWH who maintain viral suppression have effectively no risk of passing HIV to others which has a positive consequential impact to our jurisdiction.

The LVTGA currently uses a diagnosed-based HIV Care Continuum in the following ways: 1) during the Planning Council's annual Priority Setting and Resource Allocation (PSRA) process; 2) it is analyzed and evaluated by the Planning Council's Strategic Planning and Assessment committee for possible trends, gaps, and opportunities for improvement; 3) the HIV Care Continuum promotes discussion on steps to improve HIV care outcomes 4) aids in the development and refinement of Clark County's *Ending the HIV Epidemic* workplan; 5) in planning quality improvement projects, 6) to assist in determining populations for targeted needs assessments; 7) in the development and evaluation of the Integrated HIV Prevention and Care Plan; 8) to better understand any disparities in subpopulations and how to modify engagement efforts to specific communities; 9) as part of the annual TGA-wide "out of care" project that brings people who have fallen out of care back in to care; 10) in the quarterly sub-recipient reports that require a narrative on successes and barriers engaging PWH, removing health disparities or concerns throughout each stage and ultimately achieving viral suppression, and 11) to assist in the development of Clinical Quality Management plans and training at the sub-recipient level to help agencies frame their programs in relation to the care continuum. The Recipient's Clinical Quality Management Analyst works with each subrecipient to identify interventions targeted at specific steps of the continuum to improve engagement and outcomes. Developed worksheets and custom reports provide each agency the ability to create specific care continuums on a quarterly basis, which quickly illustrate successes and opportunities for improvement at an agency specific level and service category level.

Overall, the HIV Care Continuum is used to monitor progress toward achieving the goals of the *Ending the HIV Epidemic: A Plan for America the* and the *HIV National Strategic Plan* to ensure that people are linked to HIV medical care and retained in care. LVTGA uses the HIV Care Continuum to closely examine the proportion of PWH engaged in each of the stages of the continuum to pinpoint where gaps may exist in connecting PWH to sustained quality care and to implement system improvements and service enhancements that better support individuals as they move from one stage in the continuum to the next. Knowing where the drop-offs are most pronounced, and for what populations is vital to knowing how, where, and when to intervene to break the cycle of HIV transmission in the TGA. With the change in Nevada law that requires reporting of all CD4 measures and HIV viral load now in effect, Nevada now has enhanced data to pinpoint gaps and implement improvements, thereby increasing the proportion of PWH who prescribed ART can adhere to their treatment regimen so that they can achieve viral load

suppression. This will allow individuals to live healthier, longer lives and reduce the chances that they will transmit HIV to others.

B. Funding for Core and Support Services
1) Service Category Plan
a) Service Category Plan Table
Please see Attachment #9.

b) MAI Service Category Plan Narrative
Two agencies currently receive MAI funding for Outpatient Ambulatory Health Services and Medical Case Management: Community Outreach Medical Center (COMC) and AIDS Healthcare Foundation (AHF). COMC is an outpatient community health clinic that provides a full range of medical services from standard outpatient care to OB/GYN and other specialty medical care. COMC prides itself in providing comprehensive medical care to any individual who walks through the front door. COMC welcomes all members of a family from the youngest infant to an individual in their later years. COMC's team of Physicians, Nurse Practitioners and Nurses operate in a culturally inclusive manner, spending extra time with patients who have questions, helping to explain the pros and cons of prescribed medication, food, and lifestyle changes, especially those that are culturally accepted but not necessarily beneficial to a person living with HIV. An intensive and tailored intake session is done with each patient to review medications, labs, and any other health related concerns specific to the individual.

COMC also has a comprehensive Medical Case Management program where all case managers are not only bi-lingual, but clearly understand the cultural norms of their clientele. COMC's Medical Case Managers understand that many of their clients are dealing with unique issues and/or barriers and spend as much time as required helping clients, especially African American and Latino/a individuals understand paperwork, eligibility processes for Ryan White and other programs and assist in obtaining important identification documents. COMC works with approximately 50 clients per year who have significant barriers related to obtaining identification or are undocumented and have very little long-term resources to assist with their care as health issues arise due to age and being HIV positive. Issues range from a green card expiring to an individual being without a stable home, no support system, is undocumented and does not qualify for disability income. Case managers carry cell phones, which are the primary source of communication for clients to contact their case manager. Case managers will respond to client questions or concerns 24 hours/day by phone or text, whichever communication style the client feels most comfortable.

AIDS Healthcare Foundation (AHF) operates two clinics in Las Vegas. One clinic is in a predominantly Latino/a area and the other clinic is in a predominantly African/American area, both conveniently located next to a hospital. AHF is contracted to provide Outpatient/ Ambulatory Health Services and Medical Case Management MAI services. The additional medical provider and locations create more choice as to where to access services. As with COMC, the benefit of having medical care and medical case management under one roof is also available at AHF. This provides more opportunity for client's needs to be addressed within one appointment, reducing transportation burden, and increasing continuity of care. AHF also

receives Part A funding for Early Intervention Services, targeting, finding, and returning to care newly diagnosed individuals and individuals that have fallen out of care.

The Grant Administrator and recipient staff are planning to enhance the MAI program by implementing new MAI-specific services including: 1) a Psychosocial Support program which will include training and supporting HIV-positive African American and Latinx peers, and implementing a peer-matching component to better ensure compatibility in those relationships to support retention in care and viral suppression; and 2) a Health Education/Risk Reduction program to ensure culturally appropriate and responsive approach to the provision of education to PWH about HIV transmission and how to reduce the risk of HIV transmission.

i. Describe how MAI services will be implemented to address the needs of (each population identified in) the Subpopulations of Focus section.

The Recipient is conducting a competitive bid for Ryan White services beginning in the 22/23 project year. Proposers will be required to submit a separate proposal for each Planning Council-approved MAI service category including Outpatient/Ambulatory Health Services, Medical Case Management, Health Education/Risk Reduction and Psychosocial Support Services. Successful proposers will detail their history with providing services to the subpopulation(s) of focus and clearly outline their plan to use the service category to meet the unique needs of these populations to reduce the HIV-related health disparities and improve the health outcomes. Recipient staff will oversee service delivery to ensure awarded subrecipients; adhere to the proposed MAI service delivery plan; incorporate information from the comprehensive needs assessment in program design; adjust as needed to ensure continual effectiveness; and remain in compliance with HRSA and other applicable federal regulations.

Using Ending the HIV Epidemic funds, the Recipient is also working with the Nevada Public Health Training Center at the University of Nevada, Reno to develop "Building Blocks to Peer Success," an MAI-specific Psychosocial Support program for the Clark County area. The program will include 1) a campaign to combat stigma surrounding HIV and care by engaging HIV-Positive peers to become peer-to-peer support leaders in the community; 2) a 16-hour module-based peer training certificate program for 50 peer leaders to engage PWH in care, prevention efforts, and outreach; 3) peer matching component to connect peers by common interest, philosophies, and/or demographic attributes; 4) a virtual safe space for peers to connect; and 5) evaluation of the efficiency and effectiveness of the program

ii. Describe how MAI services to be implemented may prevent new HIV infections, improve health outcomes, and decrease health disparities and inequities among the identified subpopulations of focus.

Core Medical Services (Outpatient/Ambulatory Health Services, Medical Case Management) provided with a lens on the unique needs of the subpopulations of focus will support the development of culturally and linguistically responsive relationships with medical providers and medical case managers. These relationships act as a mechanism to retain clients in care and support them in achieving and maintaining viral suppression; this serves to prevent new HIV infections, improve health outcomes and decrease health disparities. The addition of Support Services (Health Education/Risk Reduction, Psychosocial Support Services) will further address these goals by ensuring the subpopulations of focus have access to culturally and linguistically

appropriate peer support, as well as the information and empowerment needed to remain engaged in care, develop health literacy, understand how to navigate health insurance and service delivery systems and engage in risk reduction strategies.

c) Unmet Need

i. Identify specific interventions that are focused on improving the outcomes for individuals with unmet need that 1) are late diagnosed, 2) have unmet need, and 3) are in care but not virally suppressed, as outlined in Attachment 4. This information can be provided as a table.

Table 27 Identifies specific interventions that are focused on improving the outcomes for individuals with unmet need in the LVTGA.

Table 27: Specific Interventions to Improve Outcomes for Individuals with Unmet Need

Intervention	Late Diagnosed PWH	PWH with Unmet Need	PWH In Care but Not Virally Suppressed
Strategy 1: Transition Providers to Rapid stART Protocol – By June 30, 2023, implement community wide Rapid stART Program in Clark County.	✓	✓	✓
Strategy 2: Client Engagement Software – By August 31, 2021, design and implement client engagement software.	✓	✓	✓
Strategy 3: Provider – based Viral Suppression/U=U/HIV Client Education Campaign – design and implement by Feb. 28, 2023		✓	✓
Strategy 4: Rapid stART System Level Linkage Team/Newly Diagnosed SWAT/Out of Care Team – design and conduct RFP by Nov. 30, 2021	✓	✓	✓

Strategy 5: Develop Newly Diagnosed University (NDU) branded as "The Empowerment Academy"– design and implement by Feb. 28, 2023	✓	✓	

ii. If applicable, describe how activities related to re-engaging individuals with unmet need into care (along with how activities addressing the needs for the late-diagnosed and not virally suppressed populations) intersect with plans or strategies in your jurisdiction, such as Ending the HIV Epidemic in the U.S., Getting to Zero, and/or 90/90/90 efforts.

The LVTGA is implementing a communitywide Rapid stART protocol as part of Clark County's Ending the HIV Epidemic workplan. As part of this protocol, Rapid REstART will also be launched. This is focusing on the unique and high acuity needs of those that are re-engaging in care. Patient navigators, peer navigators and linkage coordinators experienced in working with individuals that are re-engaging in care will be utilized. The REstART portion of the protocol will be piloted after the Rapid stART protocol goes live.

Additionally, the LVTGA has multiple strategies focused on empowerment, education and skill building. These strategies will be utilized to provide education on the importance of viral suppression, treatment adherence and personal responsibility while taking into consideration cultural differences, education differences and any other differences between populations. These strategies will build confidence, leadership skills and create a path for peer navigation services. The intent of these strategies is to stop people from falling out of care and create a strong workforce of peer navigators that will help to re-engage individuals that do fall out of care.

d) Core Medical Services Waiver

Not applicable for the LVTGA. For the FY 2022 period of performance, the LVTGA's core medical services/supportive services split is 85%/15%.

A. Resolution of Challenges Table

1) Challenges and barriers anticipated in the larger context of implementing RWHAP Part A activities (e.g., changes in the health care landscape, community engagement, barriers for populations experiencing inequities in health outcomes).

2) Challenges and barriers that may be encountered with integrating the HIV care continuum into planning and implementing the RWHAP Part A program (e.g., linkage to care and retention in care strategies).

3) Anticipated challenges with implementing activities for the Subpopulations of Focus.

Table 28: Resolution of Challenges			
Challenges/Barriers	**Proposed Resolution**	**Intended Outcome**	**Current Status**
Managing the changing needs of consumers and subrecipients during the COVID-19 pandemic.	Continue to assess needs based on consumer and subrecipient input. Continue to provide technical assistance to subrecipients to navigate safe service delivery during the pandemic.	Effective identification of consumer needs and adequate funding to applicable service categories.	Consumers surveyed about needs in 2020 and 2021; additional funds allocated Food Bank-Home Delivered Meals during the 21-22 GY to support increased food insecurity throughout the TGA. Continuing to meet monthly with HOPWA recipient and subrecipients to assess and manage needs related to EFA and housing.
African American and Latinx populations are experiencing disproportionate rates of new HIV and AIDS infections and/or lower rates of viral suppression.	Development of MAI-specific Psychosocial Support program, including a peer-matching component to better ensure cohesive peer relationships.	Improved retention in care and viral suppression among African American and Latinx populations.	Recipient's office is working with the NV Public Health Training Center through University of NV, Reno to develop this program.
Delays in procurement and contracting processes required by the County due to impact of COVID-19 and long-term vacancies across county departments due to the Voluntary Separation Program.	Recipient's office is working proactively with the Purchasing Department to expedite projects related to HIV services. We are also advocating with the County for a Purchasing Analyst to be dedicated to Social Service projects, including Ryan White Part A.	Timely start/continuation of new and existing Ryan White Part A services.	The Recipient is working closely with Purchasing on a competitive bid for Ryan White services beginning 3/1/22; we have strategized a backup plan to continue services should this process take longer than anticipated. County management is considering a dedicated Purchasing Analyst for Social Service.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

A. Clinical Quality Management (CQM) Program

1) What changes have been made to your current clinical quality management program based on previous years' experience, outcomes, etc.

The Clinical Quality Management (CQM) Analyst completed technical assistance with HRSA on behalf of the LVTGA. This training provided the resources and support to assist with meeting HRSA/HAB's compliance requirements and to establish the expectations for a productive Clinical Quality Management (CQM) program. The 11-month training consisted of reviewing the components of the CQM program's infrastructure, explaining, and understanding the utility and purpose of Policy Clarification Notice 15-02, the use of the performance measures and Plan, Do, Study, Act cycle methodologies.

Based on the previous years' experience, the CQM program and plan were developed by collecting both qualitative and quantitative methods of data to apply logic and provide a better context of how the LVTGA can improve work and appropriately evaluate the effectiveness of CQI activities and objectives. To assess the LVTGA's overall CQM program, the CQM Analyst and subrecipients collectively participated in a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis to examine the program from a fact-based analytical perspective. The SWOT analysis imparted concerns, various viewpoints, and new ideas. In addition, the SWOT analysis assisted with decision making to focus on quality management resources that included building capacity, providing support to subrecipients, and creating educational and informational materials to enhance the CQM program.

Currently, the outcome of the CQM program continues to consist of reviewing the LVTGA's HIV Care Continuum data as well as subpopulation HIV Care Continuum data. Additionally, the CQM program is expanding subrecipient capacity by providing technical assistance and online/in person support during the reporting and evaluation phase of the quarterly PDSA cycles. The PDSA evaluation consists of formally documenting concerns, improvements, successes, and results on a quarterly basis in a Specific, Measurable, Achievable, Relevant and Time-Bound (SMART) and synchronized manner. The outcomes will continue to guide the development of structured activities that will improve health outcomes for PWH receiving care from all LVTGA funded subrecipients.

2) How CQM data have been used to improve patient care, health outcomes, or patient satisfaction and/or change service delivery in the jurisdiction, including strategic long-range service delivery planning.

The CQM program utilizes a coordinated, comprehensive, and continuous process to monitor subrecipients and implement quality improvement projects to improve health outcomes for PWH. LVTGA subrecipients continue to access their own metrics for each funded service through CAREWare 6. Subrecipients use the performance measurement tool in CAREWare 6 that provides an extensive module that continues to grow in utility and function because of continuous quarterly viral load, CD4 and other care lab imports. The usability of this embedded tool includes access to viral suppression, in-care and undetectable, performance measures. The CAREWare *Create a Client List* tool enables subrecipients to drill down to the individual clients that make up the number of clients that are out of care. The *Create a Client List* tool helps subrecipients use appropriate intervention strategies to remove barriers to care and support clients in achieving and maintaining viral load suppression. These CAREWare tools support subrecipients in gaining insight on how to improve Patient Care, Health Outcomes, and Patient Satisfaction (PCHOPS) which enhances the TGA's service delivery continuum.

The LVTGA's website (www.lasvegastga.com) has a provider portal with a Quality Management tab that provides easily understandable and accessible updates, educational resources, and a Quality Improvement Newsletter for subrecipients and potential subrecipients.

ORGANIZATIONAL INFORMATION

A. Grant Administration

1) Program Organization

a) Describe how RWHAP Part A funds are administered within the EMA/TGA with reference to the staff positions, including program and fiscal staff, described in the budget narrative and the program organizational chart included as Attachment 11.

Please see Attachment 11.

The Clark County Department of Social Service is the officially designated recipient for all Part A funds in the Las Vegas TGA. The Part A Recipient is housed within the Department of Social Service and is organized as an independent sub-unit within the Department's Community Programs section. As an independent sub-unit, the Part A Recipient program consists of seven individuals totaling 5.8 FTEs, which include: 1) a Grant Administrator (.8 FTE), 2) one Management Analyst I/II - Program (1 FTE), 3) one Management Analyst I/II - Clinical Quality Management (1 FTE), 4) one Management Analyst I/II - Compliance Monitoring (1 FTE), 5) one Administrative Specialist (.75 FTE), 6) one Administrative Specialist (.25 FTE) and 7) one Financial Office Specialist (1 FTE). Planning Council support is provided through a contractual agreement. There are currently no vacancies within the Part A Recipient team. Together, this team of dedicated staff addresses all the requirements of the Ryan White Part A and MAI program in a team-oriented manner that fosters cooperation, innovation and effective problem identification and resolution. Please see **Attachment 1** for staffing plan.

b) If you administer the RWHAP Part A funds by a contractor or fiscal agent, describe the staffing, fiscal agent scope of work or services to be provided, and how you will evaluate the performance of the work or services being provided.
Not applicable for the LVTGA.

2) Grant Recipient Accountability
a) Monitoring - Provide a narrative that describes the following:
i. Describe how subrecipient monitoring was performed during the FY2021 period of performance to ensure fiscal and program compliance. Describe on-site or other monitoring practices if on-site visits did not occur (i.e., virtual).
Subrecipient monitoring for the 2021/2022 project period has been waived by HRSA. Per the letter from HRSA dated February 10, 2021, this activity was waived during the public health emergency.

The Recipient staff has incorporated desk-audit processes for 2021/2022 to ensure comprehensive monitoring occurs to maximum extent possible Subrecipients are required to submit agency General Administrative/Operational Policies and Procedures (including records management and personnel documentation) and individual Programmatic Policies and Procedures (for Ryan White funded categories). The desk-audit will also include review of a limited number of client files, review of current Ryan White Part A contracts and scopes of work, and subrecipient policies regarding Program Income and Payer of Last Resort. A virtual meeting has been incorporated into the monitoring process to facilitate an accurate overview of the subrecipient process and ensure that clients' needs are being met. Currently the Recipient is reviewing and updating existing Compliance Policies and Procedures and developing a Compliance Manual to be incorporated as a part of a Ryan White Part A Compliance Training which will be provided to subrecipients on a bi-annual basis.

Additionally, monthly programmatic and fiscal monitoring occurs monthly through desk review of Requests for Reimbursement (RFR) and CAREWare entries. The monthly review of RFRs is to ensure that funding is being used for authorized purposes, in compliance with federal statutes, regulations, and the terms and conditions of the subaward, including achievement of subaward performance goals.

ii. The process for ensuring subrecipient compliance with the single audit requirement in Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirement for HHS Awards (45 CFR part 75); and

Notice is given in the Request for Proposal regarding the audit requirement as described in the Uniform Administrative Requirements (45 CFR part 75) and is included as a contractual requirement for all subrecipients. Once a contract has been executed a certified letter is sent detailing deliverable requirements, including the single audit submission requirement. The Recipient's Financial Office Specialist keeps a detailed spreadsheet with Single Audits due for each subrecipient. A reminder email is sent prior to the audit due date. If the audit is not received in a timely manner, the Grant Administrator will follow up with the subrecipient.

iii. If there were findings in any subrecipient single audit or program-specific audit reports, describe what you have done to ensure that subrecipients have taken appropriate corrective action. Corrective actions may include, but are not limited to, HRSA-sponsored TA and training requests from the grant recipient of record.

There have been no findings in any subrecipients' single audit or program specific audit report. If there were to be findings, the Recipient would use the following process: 1) A Certified Letter to the subrecipient of the finding and a request for a Corrective Action Plan within 30 days; 2) Grant Administrator's review of the Corrective Action Plan for thoroughness and reasonability; 3) Initiating technical assistance as required to assist in Corrective Action Plan; 4) Follow up with subrecipient to monitor progress of the Corrective Action Plan.

b) Third Party Reimbursement

i. The process used to ensure that subrecipients are pursuing third party reimbursement and utilizes contract language or another mechanism to ensure that this takes place.

In Nevada, most third-party reimbursement is through the State Medicaid Program. There are many services offered through Nevada State Medicaid that directly benefit Part A clients. Services offered include ambulatory and specialty medical lab and x-ray services, adult emergency dental, mental health services, home health care, transportation to medical appointments, and over-the-counter medications. At this time, case management for support services is not covered under Nevada State Medicaid; therefore, case management agencies are not required to have a Medicaid billing number. Each client receiving services through our Sub-recipient medical providers, will have the pay source for their appointment verified prior to their office visit; thus, reducing the risk of improper billing. Contract language specifying that the Ryan White Part A program is payer of last resort and that all other pay sources must be exhausted prior to using Ryan White funds is included in all contracts.

ii. Indicate the federal poverty level (FPL) to determine client eligibility within the jurisdiction and methods used to conduct screening and eligibility to ensure the RWHAP is the payor of last resort.

The LVTGA uses 400% FPL to determine client eligibility. The Ryan White Part A Eligibility Policies and Procedures Manual has been designed to ensure Part A funds are used as payor of last resort. All Persons with HIV (PWH) must complete an initial eligibility assessment to qualify for Part A services. The manual includes policies for registration, client eligibility, early intervention services, re-certification of eligibility, waitlist criteria, determining what third party insurance the client has applied for and criteria for the discontinuation of services. For the 2021-2022 grant year, the Recipient contracted with twelve subrecipients for eligibility services to be provided to PWH. Subrecipients are contractually required to assess the client's proof of HIV status, financial status, and residency. To reduce the amount of paperwork and to streamline the eligibility process for PWH, the Ryan White Part A, B, C and D programs have aligned eligibility requirements, allowing for universal eligibility across all Parts. Clients who do not have insurance are assessed for eligibility for all available health insurance plans and are assisted with completing such applications prior to using Part A funds for medical services.

iii. How you monitor and track the source and use of any program income earned at the recipient and subrecipient levels.

Program income is monitored monthly through the Request for Reimbursement (RFR) forms required for payment, which includes detail on amounts earned. This process is being updated to include a proposed budget at the request for funding stage and will be tracked separately monthly with the requirements to include 1) Amounts Earned, 2) Where the funds originated, and 3) How/where funds were distributed (utilized). Additionally, the Recipient's Office is developing a Program Income Manual, which will be incorporated into a training to be conducted with subrecipients on an annual basis. These processes are being designed to support subrecipients in developing a more robust understanding of program income requirements. During 2021-2022 subrecipient monitoring, additional documentation is being required to demonstrate where program income originated and how it has been distributed to ensure compliance with HRSA rules and regulations.

c) Fiscal Oversight - Provide a narrative that describes the following:

i. The process used by program and fiscal staff to coordinate activities, ensuring adequate reporting, reconciliation, and tracking of program expenditures (e.g., meeting schedule, information sharing regarding subrecipient expenditures, UOB, and program income).

Fiscal tracking, reporting, and reconciliation are conducted by the two Administrative Specialists and Financial Office Specialist. One Administrative Specialist is a full charge bookkeeper who directs the work of the other two fiscal team members. The Program Management Analyst crosschecks the programmatic data with the submitted fiscal data to ensure services are accurately documented, all charges are being charged to the correct service category and that funds are being utilized for approved activities. The Grant Administrator supervises the tracking and reporting processes for all programmatic and fiscal reporting requirements, both internal and external and performs the task of reviewing and approving all fiscal work. The coordination of activities and information across the fiscal and programmatic sides of the program occurs in many informal and formal methods including monthly staff meetings involving all seven staff

members during which reporting deadlines are discussed, fiscal tracking information is reported on for all the staff to understand and programmatic issues are discussed. Coordination and communication are all made highly effective in that all Ryan White staff members are within the same program. No Ryan White administrative services are provided by non-Ryan White staff.

ii. The process used to separately track formula, supplemental, MAI, and carryover funds, including information on the data systems utilized.

The process by which the grant recipient tracks the Formula, Supplemental, MAI and Carryover funds begins with the Priority Setting and Resource Allocation (PSRA) process. During the PSRA process, potential funding is examined by individual funding stream in relation to service categories (i.e., formula, supplemental, etc.) and then in the aggregate after priorities are determined and allocations are finalized. This process ensures that each funding stream is conceptualized and viewed as a distinct funding stream. The process of individual tracking of the funding streams continues in the development of contracts for services. Initial contracts are drafted, negotiated, finalized, and executed beginning with specific budget allocations for formula and supplemental funding amounts. This process is followed for all additional funds that may be allocated to subrecipients throughout the year (i.e., carryover funding). Each contract for service contains detailed processes for expenditure reporting and request for reimbursement processes that are tailored to each funding stream. The fiscal forms contained in the contract for use by subrecipients are nearly identical aside from being designated for each individual funding stream an agency may be receiving. The grant recipient utilizes SAP accounting software and Microsoft Excel to track expenses for each funding stream.

iii. The process for reimbursing subrecipients, from the time a voucher/invoice is received to payment.

Once contracts are fully executed, all subrecipients follow the same procedure to receive reimbursement for the cost of providing services. All reimbursements are paid through a cost-based reimbursement system. By the 15th day of the month subrecipients submit a Request for Reimbursement with all required supporting documentation for the previous month's services/activities. These Requests for Reimbursement detail out all the costs for the previous month by service category, including personnel costs, benefits information, and direct service costs (i.e. food voucher, housing assistance vouchers). All costs identified in the Request for Reimbursement must be supported with hard copy supporting documentation (i.e. copies of payroll reports, time sheets, photocopies of all vouchers). Once received from the subrecipient, the Request for Reimbursement packets are checked by recipient fiscal staff who review the packet to ensure all the mathematical calculations are correct, that all charges are being charged to the appropriate budget line item (i.e., administrative costs are being changed to administrative line item, all direct service charges are being charged to the direct services line item), and that all required back up documentation supports each charge identified in the packet. The Program Management Analyst crosschecks the programmatic data with the submitted fiscal data to ensure services are accurately documented, all charges are being charged to the correct service category and that funds are being utilized for approved activities. Any identified discrepancies are brought to the attention of the subrecipient, corrections are made, and the packet is resubmitted. Once the packet is completely correct and ready to be processed, fiscal staff input the expenditure documentation into the Ryan White fiscal tracking system. The Grant Administrator supervises the tracking and reporting processes for all programmatic and fiscal reporting

requirements, both internal and external and performs the task of reviewing and approving all fiscal work. Once the Grant Administrator is satisfied with the accuracy of the packet, the information is entered into Clark County's accounting system SAP. Once entered, the Ryan White-specific and the SAP systems it is placed into a review and approval cue that consists of the following, in this order: 1) the Clark County Social Services (non-Ryan White) Fiscal Administration office, 2) Grant Administrator for Ryan White, 3) Clark County Social Services Manager, 4) Clark County proper Fiscal Analyst for final review and approval. Once all approvals have been given, the reimbursement is provided to the subrecipient. The approximate time for reimbursement, from initial submission by sub-recipient to receipt of payment, is two weeks.

B. Maintenance of Effort (MOE)

Please see Attachment #12.