MINUTES
Joint Meeting
Northern and Southern Nevada HIV Prevention Planning Groups
June 3, 2026, 2:00 pm – 4:00 pm

MEMBERS/VISITORS/PUBLIC ATTENDANCE

Please see attached sign-in sheet for further information on attendance. This is a joint meeting with Northern HIV Prevention Planning Group (NNHPPG) and Southern Nevada HIV Prevention Panning Group (SoN HPPG). This meeting has been scheduled to review, discuss, and vote on Nevada's Syndemic Plan.

I. CALL TO ORDER – NOTICE OF POSTING AGENDA

SoNo HPPG Chair, Cheryl Radleoff called the meeting to order at 2:04 pm and advised that this meeting is being recorded. Reviewed virtual meeting etiquette.

II. WELCOME AND INTRODUCTIONS OF MEMBERS AND GUESTS

Cheryl Radeloff welcomed all attendees and noted that this meeting is being recorded, any public health information (PHI) disclosure will be part of the recording and part of the public record.
Welcomed and introduced new voting member Lyell Collins, approved by voting members via email.

III. PUBLIC COMMENT: Public comment is a period devoted to comments by the general public about those items appearing on the agenda. Comments will be limited to five (5) minutes per speaker. SoN HPPG Chair, Cherly Radeloff asked if any member of the general public wished to make a public comment, either in person or via MS Teams, or request time from a NNHPPG/SoN HPPG co-chair. No public comments were presented.

IV. CONSENT AGENDA: Items to be considered by the Northern and/or Southern Nevada HIV Prevention Planning Group which may be enacted by one motion. Any item may be discussed separately per Voting Member request before action. Any exceptions to the Consent Agenda must be stated prior to approval. The agenda is accepted.

V. VOTING ITEMS (Albert Sedano)

A. See presentation titled "Overview of the 2027 – 2031 Nevada Syndemic Plan" presented by Taylor Lensch and Heather Kerwin.

- The Nevada Syndemic Plan serves as one of Nevada's roadmaps for HIV prevention, treatment, and ancillary care services through 2031. This iteration also includes sexually transmitted infections, viral hepatitis and substance use, all of which are reflected in the goals and the objectives.
- The plan will be submitted to CDC/HRSA at the end of this month to meet our State's HIV integrated planning purpose, however it is still considered a living document.
- Monitoring and evaluation will continue throughout the five-year planning period.
- The Key Stages of Plan Development were reviewed, see slide 4.
- The full 7 sections of the plan were reviewed. The major updates and changes were provided including:
    - Section 4 – Situational Analysis
        - Identified strengths, challenges and needs as it relates to Diagnose, Treat, Prevent, and Respond.
    - Section 5 – Diagnose and Detect
        - Goal 1 was expanded to include additional conditions such as syphilis, chlamydia, gonorrhea and viral hepatitis.
        - For goal 2 the benchmark was moved up on most of the Linkage to Care objectives.
        - By 2028 develop and implement an evaluation plan to assess the impact for the expansion of the mobile unit's medication assisted treatment (MAT) network for rural and frontier communities.
        - By 2029, develop a statewide network for telehealth pertaining to treatment and recovery services and promote a pipeline for telehealth.
    - Section 7 – Letter of Concurrence
        - HIV planning bodies will provide a letter of concurrence specifying how the planning body was involved in the plan development.
- Any updates will be shared with the HPPG group as the plan is revised and improved over time.
- A copy of the PowerPoint Presentation was shared with the members.

Q: Victoria Young- Under treatment for pillars, it is focused on HIV and MAT program but do notice the additional conditions have been added elsewhere. Is there a plan to add the other conditions to this treatment section as well?

A: Subgroups guided these treatment plans. This portion is reliant on providers to report the treatment or the epidemiology and disease surveillance. Will look at adding other conditions to this portion in the future.

Q: Chris Reynolds noted that some of the verbiage and phrases will need to be reviewed and updated based on changes related to DEI terminology.

A: Taylor Lensch noted that these updates were implemented in the plan, but they will do a final comb through to ensure the wording and phrases align appropriately.

Q: Albert Sedano inquired about their previous email that was sent regarding the possibility of adding family planning and/or birth control access in the future.

A: Heather noted that this topic will be brought up for discussion in the meeting this week with the Office of HIV. It would be a new avenue for this team, but it is possible to add these in the future.

B. <u>Action Item:</u> <u>Vote on the 2027-2031 Nevada Syndemic Plan</u>

- Call for a vote of concurrence; Lyell Collins motioned, Robert Harding seconded; Voting members for Northern and Southern Nevada HPPG voted in concurrence.
    - Northern Nevada voting members in concurrence- Gwen Taylor, Robert Harding, and Jen Howell as proxy for Doug Hodges and Scott Benton.
    - Southern Nevada voting members in concurrence- Xavier Foster, Lyell Collins, Preston Tang, Leana Ramirez, Cheryl Radeloff, Albert Sedano, Raychel Holbert, and Chris Reynolds
- Letter of Concurrence for voting will be submitted jointly by SoN HPPG and NNHPPG.
    - Taylor Lensch shared the CDC letter of concurrence template in the chat.
    - In the letter UNR and the State will be listed as organizations that helped to prepare this plan.
    - Southern Nevada to send to Northern Nevada for review and signature.

C. Location of past SoN HPPG agendas and minutes

- https://www.southernnevadahealthdistrict.org/meetings/southern-nevada-hiv-prevention-planning-group/

VI. PUBLIC COMMENT: Public comment is a period devoted to comments by the general public, if any, and discussion of those comments, about matters relevant to the planning group's jurisdiction will be held. All comments are limited to five (5) minutes per speaker.

There was discussion among members regarding the Sydemic Plan presentation. Members thanked everyone who worked on the planning and implementation of the Syndemic Plan. Members also praised the workgroup for their hard work, focus on details, and for preparing and creating an excellent plan.

No additional public comment.

VII. ADJOURNMENT

Motion to Adjourn made by Chris Reynolds, seconded by Raychel Holbert, all in favor. Meeting adjourned at 3:43 pm.

Overview of the 2027 – 2031 Nevada Syndemic Plan

Taylor Lensch
Larson Institute for Health Impact and Equity
School of Public Health
University of Nevada, Reno

Heather Kerwin
Office of State Epidemiology
Division of Public and Behavioral Health
Nevada Department of Human Services

Overview

- Purpose: Present highlights of the 2027 – 2031 Nevada Syndemic Plan.

- The plan serves as one of Nevada's roadmaps for HIV prevention, treatment, and ancillary care services through 2031, and includes STIs, viral hepatitis, and substance use into the priorities.

- Initial version of plan has been developed; however, this is a living document that will be evaluated and revised across the planning period.

Plan Overview

- The plan has seven sections: We will discuss these today.
- The goals and objectives (one of the key plan sections) will be monitored and evaluated across the plan period to measure our state's progress.
- Again, the plan is meant to be a living document.
  - Goals/objectives and other content can be updated, as needed.

Key Stages of Plan Development

1. Formed a Syndemic Planning Member group, based largely on participants from previous 2022-2026 HIV Integrated Plan.
2. Introductory meetings with many members, others were invited to participate through wide range of recruitment.
3. Three meetings during 2025
   - Introduced the concept of syndemic planning.
   - Presentation of data highlights for syndemic conditions.
   - Helped guide recruitment for needs assessment, provided contacts, solicited survey participation.
4. During 2026 subgroups (infectious disease and substance use) met every other week to discuss priorities, evaluate progress on previous plan, and develop objectives.
5. Conducted needs assessment – focus groups (N = 88 participants) and Community Survey (N = 250 respondents)
6. Produced final drafts for review; concurrence from planning groups.
7. Submit final draft to CDC and HRSA for feedback by June 30th.
8. Finalize plan with CDC and HRSA approval later this fall.

Section 1

- **Introduction.**

- Provides an overall description of an existing plan, including the approach and other documents being referenced.

Section 2

- **Community Engagement and Planning Process.**

- Describes how Nevada approached the planning process, engaged community members and stakeholders, and fulfilled legislative and programmatic requirements.

Section 2

- Planning led by Syndemic Planning Member Workgroup.
  - Two subgroups, Infectious Disease and Substance Use, met every other week to develop the plan through prioritizing and identifying objectives to pursue, reviewed progress, provide insight and expertise.
  - Representatives from key stakeholders across state invited to join.
    - Over 92 people, representing 33 organizations, with ~20-40 individuals regularly participating.

- Community engagement through:
  - Needs assessments (surveys/focus groups).
  - Planning Groups.
  - Feedback on drafts of individual plan sections.
  - Feedback on full drafts of plan.

Section 3

- **Contributing Datasets and Assessments.**

- Analyze the assessment qualitative and quantitative data to describe how HIV, STIs, viral hepatitis, and substance use impacts our state.

- Determine the services needed by clients to access and maintain HIV prevention, care, and treatment services.

- Identify barriers for clients accessing those services and assess gaps in the service delivery system.

- This section included three main components (see next slide).

Section 3

- **Epi snapshot:** HIV, STI, viral hepatitis, and substance use data from 2020 – 2024 to highlight trends and data for priority groups (people living with HIV, men who have sex with men, youth and young adults, people of color, people who use substances).

- **Resource inventory:** Collected information on Syndemic funding from agencies funded through CDC, HRSA, HUD/HOPWA, etc., to outline current state of funding in Nevada.

- **Needs assessment:** Presented key themes that emerged from needs assessment for priority populations.

Section 4

- **Situational Analysis.**

- Provide an overview of strengths, challenges, and identified needs with respect to several key aspects overlapping between focus group and survey findings, epi data, and stakeholder priorities.

- Analysis of structural and systemic issues, and how the goals and objectives address the needs based on the Community Engagement and Planning Process in Section 2 and the Contributing Data Sets and Assessments detailed in Section 3.

Section 4

- Strengths, challenges, and needs are outlined within the 4 pillars: Diagnose, Treat, Prevent, Respond, which mirror the Ending the HIV Epidemic (EHE) Pillars.

- Example provided on next few slides.

Example: Diagnose Pillar Strengths

- Communities who are adversely impacted by HIV were generally knowledgeable about testing locations and resources
- Community events and trusted spaces were identified as effective venues for testing outreach
- Availability of quality training and certification to provide rapid testing
- Increase in alternative methods to acquire testing (e.g., Collect 2 Protect program), home test kits in vending machines, etc.
- High levels of partner screening and partner services

Example: Diagnose Pillar Challenges

- Stigma is a consistent barrier — fear of being outed, shame around a positive result, and reluctance to discuss sexual health with providers
- Providers outside specialty clinics rarely conduct sexual health histories or offer routine HIV screening
- Lower awareness of available testing and limited local access to services in rural and frontier areas
- For a quarter of new diagnoses, no identified risk for transmission is ascertained because some individuals can be difficult to locate for interviews

Example: Diagnose Pillar Needs

- Normalize testing by integrating it into routine care and bringing it to trusted community spaces and events
- Availability of after-hours and weekend testing
- Peers and trusted community members as messengers for normalizing testing, particularly in communities where stigma is highest

Section 5

- **2027 – 2031 Goals and Objectives.**

- Detail goals and objectives for prevention, care, and treatment through 2031.

- Outlined within EHE framework: Diagnose, Treat, Prevent, Respond.

Diagnose Pillar Goal

- **Diagnose all individuals with HIV, syphilis, chlamydia, gonorrhea, and viral hepatitis as early as possible after infection**.

Diagnose Pillar Objectives

- From 2027 to 2031, reduce the number of new HIV stage 3 diagnoses by 10%.
- Annually, 20,000 federally funded HIV tests will be conducted within the state of Nevada.
- Annually, increase the number of rapid or point-of-care (POC) tests conducted for syphilis by 5%.
- Annually, increase the number of rapid or point-of-care tests conducted for HCV by 5%.
- From 2027 through 2031, increase the proportion of people with a positive HCV antibody test receiving a viral load, PCR, or genotype test from 50% to 60%.
- Annually, 95% of clients testing HIV-positive will be informed of their test result within 7 business days from report to health authority.
- Identify at least 3 substance use treatment organizations willing to implement opt-out screening for HIV and HCV by 2031
- Identify at least 3 organizations to partner with overdose prevention and street outreach programs to offer screening for HIV and HCV by 2031.

Diagnose Pillar Objectives Continued

- By 2028, engage with at least 5 hospital systems to facilitate the development of policy to test all pregnant persons for syphilis in accordance with Nevada Revised Statutes (NRS) 442.010, and other STI's in accordance with NRS 441A.315.

- Annually, identify at least 1 primary care facility in high-risk counties not following the CDC's syphilis screening recommendation (to test all sexually active persons aged 15-44 years in counties with morbidity rates > 4.6 per 100,000) to implement standing orders for screening in alignment with the recommended practices.

- Annually, promote awareness of the STD Clinical Consultation Service for healthcare professionals https://www.stdccn.org/render/Public as well as afterhours call lines for Nevada's respective LHA STD Programs, by providing information to at least 10,000 healthcare professionals in Nevada.

Treat Pillar Goals

- Treat people with HIV rapidly and effectively to reach sustained viral suppression.
- Develop medication assisted treatment (MAT) network for persons with opioid-use disorder.

Treat Pillar Objectives

Linkage to Care

- Annually, 85% of newly diagnosed HIV-positive individuals will be linked to care, as measured by a CD4 or a viral load test conducted within 30 days from earliest specimen collection date.

- Annually, 85% of newly diagnosed HIV-positive individuals will be referred to a healthcare provider within 30 days from initial CDC-funded test collection date.

- Annually, among individuals engaged in the Las Vegas TGA EHE Rapid stART program, 90% of newly diagnosed HIV-positive individuals, those new to care, and/or persons returning to care will be linked to HIV care within 7 days of time zero date.

Treat Pillar Objectives Continued

Antiretroviral Therapy (ART) and Viral Suppression

- Annually, among individuals engaged in the Las Vegas TGA EHE Rapid stART program, 90% of newly diagnosed HIV-positive individuals, persons new to care, and/or persons returning to care will have initiated ART within 7 days of first medical appointment.

- Annually, 75% of HIV-positive individuals will have achieved viral suppression (less than 200 copies/ml at last viral load) within 12 months of initial diagnosis among those who are newly diagnosed.

- Annually, among individuals engaged in the Las Vegas TGA Rapid stART program, 90% of newly diagnosed HIV-positive individuals, those new to care, and/or persons returning to care will have achieved viral suppression by 90 days after initiation of ART.

Treat Pillar Objectives Continued

- By 2028, develop and implement an evaluation plan to assess impacts of the expansion of mobile MAT for rural and frontier communities.

- By 2029, develop a statewide network map for telehealth for treatment and recovery services and promote (or support) a pipeline for telehealth.

Prevent Pillar Goals

- Prevent new HIV and STI transmissions by using proven interventions, including condom use, post-exposure prophylaxis (PEP), doxy-PEP, pre-exposure prophylaxis (PrEP), and proven prevention methods among those who use substances.

- Prevent the initiation of use and reduce regular use of substances.

- Prevention of unwanted harm among those who use substances.

Prevent Pillar Objectives

- By 2031, reduce by 10% the rate of new HIV diagnoses.
- Increase the number of providers receiving training or education about expedited partner therapy (EPT), DoxyPEP, PrEP, PEP, or 3-site STI testing annually, by 5% each year.
- Increase number of healthcare professionals educated about NRS 441A.315, regarding testing for sexually transmitted infections in emergency services settings and primary care clinics by 5% each year.
- Increase the number of people who have access to overdose prevention services, health recovery supplies, counseling, and education annually by 10%.
- Increase the number of new zip codes receiving mail-based overdose prevention and health recovery supplies annually by 10 zip codes.
- Annually update an accessible resource for general public regarding sexual health advocacy designed to take to providers.
- Maintain condom distribution in Nevada.
- Syndemic team to promote awareness of the NSIP-SOR partnerships to increase hepatitis A, hepatitis B, HPV, and other vaccinations including, but not limited to, among people who are living with HIV and HCV in high overdose and high VPD zip codes, by engaging with all three tiers of VFC, 317, and other NSIP providers serving these zip codes while funding is available.

Prevent Pillar Objectives Continued

- By 2028, identify at least three partnerships with existing initiatives to provide parents information and education focused on healthy youth development, prevention strategies, and risk factors associated with substance use.
- By 2029, build an interactive webpage to illustrate which evidence-based substance use prevention programs are being delivered to youth across Nevada.
- By 2028, 30% of Syndemic Plan Partner organizations' leadership will receive a presentation to learn more about Foundation for Recovery (FFR) programs, to increase the number of Recovery Friendly Workplaces (RFW).
- By 2031, at least half of Syndemic Plan Partner organizations will make a connection between FFR and at least one non-behavioral health organizational or business contact to encourage becoming RFW certified.
- By 2029, establish at least 10 connections between naloxone distribution partnerships between substance use prevention coalitions sites, behavioral health sites, primary care offices and community-based support groups including local Narcotics Anonymous and faith-based programs.
- By 2028, increase awareness of naloxone distribution by encouraging naloxone/Narcan to be offered in a visually obvious location and/or display of obvious signage, as appropriate.

Respond Pillar Goal

- Respond quickly to potential HIV, STI, and HCV outbreaks and sudden increases in overdoses to get necessary prevention and treatment services to people who need them.

Respond Pillar Objectives

- Annually, local and state health authorities and community stakeholders will review and update the existing HIV/STI and Hepatitis Outbreak Response Plans, as necessary.
- Maintain capacity for infectious disease cluster detection at state and local health departments.
- By 2030, assess capacity for overdose increase “spike” detection response in each county.
- Perform timely analysis of case surveillance data to identify possible transmission clusters each month.

Section 6

- **2027-2031 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up.**

- Describe the infrastructure, procedures, systems, and/or tools that will be used to support the key phases of integrated planning, including:
    - Implementation.
    - Monitoring.
    - Evaluation.
    - Improvement.
    - Reporting and Dissemination.

Section 6

- This plan is meant to be a living document! Our work is just getting started.

- Plans for regular review/updates of plan based on new epi data, progress on achieving goals/objectives, and emergence of new funding priorities.
  - Internal Workgroup will meet 4x per year.
  - Syndemic Planning Members to meet 2x per year.
  - Present to Prevention Planning Groups and others at least once per year.
  - Includes opportunities for feedback from stakeholders and community members.

Section 7

- **Letters of Concurrence.**

- Provide letters of concurrence for HIV planning bodies. The letter should specify how the planning body was involved in the Plan development.
  - Members involved in sydnemic workgroups
  - Review of goals/objectives and full plan with opportunity for feedback
  - Regular updates on monitoring/evaluation once plan starts

Summary

- Syndemic Plan covers 2027 – 2031.
- Goals, objectives, and activities will be monitored and evaluated at least annually and updates will be shared with planning groups and community members.
- The plan is meant to be revised and improved over time.
  - Opportunities for feedback across entire plan period.

Questions or Comments?

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FULL DRAFT FOR REVIEW

2027-2031 Syndemic Plan Goals and Objectives

- Indicates an objective as a Las Vegas TGA EHE-specific objective and will be measured among TGA region only.

Diagnose and Detect

Goal 1: Diagnose all individuals with HIV, syphilis, chlamydia, gonorrhea, and viral hepatitis as early as possible after infection.

Obj 1.1 From 2027 to 2031, reduce the number of new HIV stage 3 diagnoses by 10%.

Source: eHARS annual reported data

Baseline: 226 new HIV stage 3 diagnoses in 2025

Activities

a. Increase awareness of Southern Nevada Health Districts (SNHD) at home HIV screening program, Collect-2-Protect.
   - Suggested metric(s): Number of website impressions; Number of social media posts about program. https://www.southernnevadahealthdistrict.org/programs/collect-2-protect/.

b. Increase testing among people of color
   - Suggested metric(s): Proportion of tests provided to key populations for late-stage diagnoses (LHAs report total number and race/ethnicity).

Obj 1.2 Annually, 20,000 federally funded HIV tests will be conducted within the state of Nevada.

Source: CDC-required performance metrics; RWPA performance metrics.

Baseline: TBD, pending 2025 reported number

Activities

a. Increase community awareness about location of testing sites and at-home testing.
   - Suggested metric(s): Number of website impressions on the End HIV Nevada website for testing locations and the SNHD Collect-2-Protect. Add the link on End HIV website to Consortium website for calendar of events in Clark County.

b. Implement targeted HIV testing strategies among MSM, people living with HIV, youth (ages 13 – 17), young adults (ages 18 – 24), and persons who use injection drugs
   - Suggested metric(s): Number of tests provided to the identified target populations.

c. SNHD provider education about rapid HIV testing
   - Suggested metric(s): Number of providers trained on rapid HIV testing per calendar year.

a. Increase HIV prevention events and testing opportunities.
   - Suggested metric(s): Number of impressions on websites (e.g., End HIV Nevada website and Rethink HIV Nevada website); Number of testing opportunities.

Obj 1.3 Annually, increase the number of rapid or point-of-care (POC) tests conducted for syphilis by 5%.

Source: LHAs, LifeCare Partners

Baseline: 1,222 (SNHD) + 100 (LifeCare Partners) + 164 (CCHHS) + 1,027 (NNPH) = 2,513 total

Activities

a. Identify funding sources to acquire additional rapid tests for partners to utilize.
    - Suggested metric(s): Number of test kits distributed to partner organizations
b. Annually update syphilis hotspots (by zip code) and distribute information to partners.

Obj 1.4 Annually, increase the number of rapid or point-of-care tests conducted for HCV by 5%.

Source: Local Health Authorities, LifeCare Partners

Baseline: 788 (SNHD) + 300 (Life Care Partners) + 711 (The Center) = 1,088+ total

Note - Some agencies are being funded through other organizations and are being rolled up into other organizations testing counts, so be careful this is not double counted.

Activities

a. Identify additional funding sources to acquire additional rapid tests for partners to utilize.
    - Suggested metric(s): Number of test kits distributed to partner organizations
b. Identify acute HCV hotspots for potential community outreach and testing.
    - Suggested metric(s): Annually update acute HCV hotspots (by zip code) and distribute information to partners.

Obj 1.5 From 2027 through 2031, increase the proportion of people with a positive HCV antibody test receiving a viral load, PCR, or genotype test from 50% to 60%.

Source: Office of Analytics HCV Clearence Continuum data, second column

Baseline: 9,880 new HCV diagnosis from 2021-2023, only 4,927 (49.8%) received a viral test

Activities

a. Conduct a laboratory assessment to identify barriers to running the reflex HCV RNA test if antibody positive.
b. Determine patterns associated with gaps in reflex testing and determine if a policy issue or workflow challenges exist.

Obj 1.6 Annually, 95% of clients testing HIV-positive will be informed of their test result within 7 business days from report to health authority.

Outcome: % of clients testing HIV-positive informed of test result within 7 business days from report to health authority.

Source: PS24-0047 performance metric.

Baseline: 2025 TBD

Activities

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

Obj 1.7 Identify at least 3 substance use treatment organizations willing to implement opt-out screening for HIV and HCV by 2031.

Outcome: Number of substance use treatment organizations implementing true opt-out screening for HIV and HCV.

Source: Syndemic Plan evaluation

Baseline: 0

Activities

a. Conduct theoretical modeling to identify estimate of number of people to be impacted by these screenings. Use modeling to identify the parameters for defining a pilot site (volume of testing goals suggested by model).
b. Identify pilot sites, at least one in an urban county and one in a rural/frontier county.
c. Work with sites to identify the barriers and potential successful actions to implement opt-out testing.

Obj 1.8 Identify at least 3 organizations to partner with overdose prevention and street outreach programs to offer screening for HIV and HCV by 2031.

Outcome: Number of new organizations able to provide testing for HIV and HCV through partnership with overdose prevention and street outreach programs.

Source: Syndemic Plan evaluation

Baseline: 0

Activities

a. Coordinate with Syndemic Planning partners who provide street outreach and rapid testing to identify new partnership organizations across urban and rural/frontier counties.
b. Identify barriers and solutions for facilitating testing for HIV and HCV in non-traditional locations and/or with organizations not already conducting testing in-house.

Obj 1.9 By 2028, engage with at least 5 hospital systems to facilitate the development of policy to test all pregnant persons for syphilis in accordance with Nevada Revised Statutes (NRS) 442.010, and other STI's in accordance with NRS 441A.315.

Source: Syndemic Plan evaluation

Baseline: 0

Activities

a. Identify 5 hospital systems with high volume testing for the region/county (at least 2 will be in rural or frontier counties) and assess whether policies exist for testing in accordance with 442.010 and 441A.315.
b. Meet with hospital leadership to identify major barriers to implementing best-practice testing and screening methods.
c. Determine if major barriers can be resolved and engage with other organizations that have successfully implemented these changes to help communicate the value.

Obj 1.10 Annually, identify at least 1 primary care facility in high-risk counties not following the CDC's syphilis screening recommendation (to test all sexually active persons aged 15-44 years in counties with morbidity rates > 4.6 per 100,000) to implement standing orders for screening in alignment with the recommended practices.

Source: Syndemic Plan evaluation

Baseline: 0

Activities

a. Conduct analyses utilizing all-payer and Medicaid databases to identify primary care providers with highest volume of female patients between 15 to 44 years, then among those the providers with the highest proportion of patients not being screened for syphilis.
b. Engage with providers identified through analysis and determine what best approach for implementing screening recommendations might be.
c. Provide resources or address concerns to increase screening rates.

Obj 1.11 Annually, promote awareness of the STD Clinical Consultation Service for healthcare professionals https://www.stdccn.org/render/Public as well as afterhours call lines for Nevada's respective LHA STD Programs, by providing information to at least 10,000 healthcare professionals in Nevada.

Source: Syndemic Plan evaluation

Baseline: 1,200 providers engaged with the QR code on a sexual health one-pager sent to providers during 2025.

Activities

a. Continue to promote a sexual health one-pager through medical licensure email listservs.
b. Partner with medical licensure boards, Nevada Hospital Association, Nevada Rural Hospital Partners, and Nevada Primary Care Association to increase reach and reinforcement of messaging.
c. Identify provider materials that can have a QR code sticker to scan to education and other resources.

Treat

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

Linkage to Care

Obj 2.1 Annually, 85% of newly diagnosed HIV-positive individuals will be linked to care, as measured by a CD4 or a viral load test conducted within 30 days from earliest specimen collection date.

Source: eHARS data measured in days from (time 0) earliest specimen collection date to a CD4 or viral load test.

Baseline: Among those newly diagnosed with HIV, 79% were linked to care within 30 days after diagnosis in 2024.

Activities

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

Obj 2.2 Annually, 85% of newly diagnosed HIV-positive individuals will be referred to a healthcare provider within 30 days from initial CDC-funded test collection date.

Source: EvalWeb, date from CDC-funded initial HIV test specimen collection date to referral to a healthcare provider.

Baseline: Measured among only CDC-funded tests, NV is at 90% within 30 days after first positive test (this is a much smaller number of persons as compared to 2.1, which is statewide).

Activities – Same as Objective 2.1

- **Obj 2.3 Annually, among individuals engaged in the Las Vegas TGA EHE Rapid stART program, 90% of newly diagnosed HIV-positive individuals, those new to care, and/or persons returning to care will be linked to HIV care within 7 days of time zero date.**

  Source: Rapid stART module CAREWare RWPA specific

  Baseline: 2025 TBD

Activities

a. Expand partnerships with CBOs, healthcare providers, testing sites and nontraditional partners to facilitate the identification, diagnosis, and rapid linkage of newly diagnosed and out-of-care PWH. This includes an emphasis on building partnerships that reflect the identities of populations of focus.
b. Disseminate Rapid stART protocols that expedite and streamline ART initiation for newly diagnosed and out-of-care PWH.
c. Provide orientation on Rapid stART protocols to new Rapid stART partners and refresher training to existing partners.
d. Implement first-year-in-care guidance (community developed in 2024) which includes tiered medical case management, improved client-centered treatment adherence counseling, expanded psychosocial support, mental health services, and strengthened collaboration between healthcare facilities & support services to ensure a comprehensive, coordinated approach to care.
e. Increase access to Rapid stART data portal (RWISE Viewer) to improve the monitoring and reporting of Rapid stART performance measures/metrics and re-engagement efforts.

Antiretroviral Therapy (ART)

- **Obj 2.4 Annually, among individuals engaged in the Las Vegas TGA EHE Rapid stART program, 90% of newly diagnosed HIV-positive individuals, persons new to care, and/or persons returning to care will have initiated ART within 7 days of first medical appointment.**

  Source: Rapid stART module CAREWare RWPA specific

  Baseline: 2025 TBD

Activities - Same as Objective 2.3

Viral Suppression

Obj 2.5 Annually, 75% of HIV-positive individuals will have achieved viral suppression (less than 200 copies/ml at last viral load) within 12 months of initial diagnosis among those who are newly diagnosed.

Source: eHARS, Continuum of Care

Baseline: Among those newly diagnosed in 2024, 63% of persons had achieved viral suppression (≤200 copies) within 12 months of diagnosis.

Activities – Same as Objective 2.1

- **Obj 2.6 Annually, among individuals engaged in the Rapid stART program, 90% of newly diagnosed HIV-positive individuals, those new to care, and/or persons returning to care will have achieved viral suppression by 90 days after initiation of ART.**

  Baseline: 78.19% in 2023; 79.90% in 2024

Activities - Same as Objective 2.3

Goal 3: Develop medication assisted treatment (MAT) network for persons with opioid-use disorder.

Obj 3.1 By 2028, develop and implement an evaluation plan to assess impacts of the expansion of mobile MAT for rural and frontier communities.

Source: Syndemic Plan evaluation

Baseline: N/A

Activities

a. Determine if any entity outside of required grant reporting is set up to evaluate the expansion of mobile MAT treatment.
b. If these are underway, can we evaluate the reach of these types of programs and how it is impacting the cascade of care for people living in rural and frontier communities.
c. Implementation evaluation to be used to identify barriers and facilitators.

Obj 3.2 By 2029, develop a statewide network map for telehealth for treatment and recovery services and promote (or support) a pipeline for telehealth.

Source: Syndemic Plan evaluation

Baseline: 0

Activities

a. Identify telehealth organizations to determine their existing networks.
b. Explore inclusion of a linkage to care network starting with drug courts and their referrals, then add MCO providers.
c. System map of what is available where and the access points, including physical location and provider contact information, then add telebup coverage.
d. Determine a strategy to maintain a dynamic system map, including internships, and organizational partnerships such as the Nevada Opioid Center of Excellence.

Prevent

Goal 4: Prevent new HIV and STI transmissions by using proven interventions, including condom use, post-exposure prophylaxis (PEP), doxy-PEP, pre-exposure prophylaxis (PrEP), and proven prevention methods among those who use substances.

Obj 4.1 By 2031, reduce by 10% the rate of new HIV diagnoses.

Source: eHARS annual data

Baseline: 502 new HIV diagnoses in 2025

Activities

a. Improve access to partner services for people newly diagnosed with HIV.
   - Suggested metric(s): % of newly diagnosed HIV-positive individuals interviewed for partner services within 30 days.

b. Reduce barriers to successful completion of partner service interviews and referrals.
   - Suggested metric(s): Summary of barriers and strategies for improvement.

c. Improve access to risk reduction services for people testing positive and negative for HIV.
   - Suggested metric(s): % of persons tested for HIV (HIV-positive and HIV-negative) screened for risk reduction intervention who are provided intervention.

Obj 4.2 Increase the number of providers receiving training or education about expedited partner therapy (EPT), DoxyPEP, PrEP, PEP, or 3-site STI testing annually, by 5% each year.

Sources: LHA trainings, AETC trainings, Rapid stART trainings

Baseline: ~1,200 providers trained per year through AETC and SNHD combined

Activities

a. Increase number of provider education sessions conducted by local health authorities and the AIDS Education and Training Center (AETC) within clinics, ERs, hospitals, and other healthcare organizations that are screening for HIV.
b. Updated one-pagers for providers regarding sexual health advocacy to include ordering labs for 3-site testing, taking a sexual history, laws, and recommendations.

Obj 4.3 Increase number of healthcare professionals educated about NRS 441A.315, regarding testing for sexually transmitted infections in emergency services settings and primary care clinics by 5% each year.

Sources: Rapid stART tracking on number of contacts made, MOUs signed with clinics, number of Rapid stART testing sites/medical care clinics. AETC provider education by number of sessions, number of staff trained. Potential to obtain data by provider type on tests ordered, to measure increase.

Baseline: TBD

Activities

a. Providers reached through passive outreach (i.e. sending out materials).
b. Rapid StART Response team partnerships.
c. SNHD SB211 “road show”, positive screening tests for congenital syphilis, syphilis, and HIV through nursing huddles/shift changes in ED and L & D.
d. LifeCare Partners is looking to expand to the north and could help to get the message to primary care providers.

Obj 4.4 Increase the number of people who have access to overdose prevention services, health recovery supplies, counseling, and education annually by 10%.

Source: Trac-B

Engaged with services baseline to include: Number of educational materials distributed, number of clients engaged via in person education or counseling encounters, number of mail orders, number of prevention supplies distributed, number of people accessing vending machines, number of clients visiting storefront.

Baseline: TBD

Partner organizations: Trac-B, SNHD, LHAs, LifeCare Partners, SOR, RISE

Activities - TBD

Obj 4.5 Increase the number of new zip codes receiving mail-based overdose prevention and health recovery supplies annually by 10 zip codes.

Source: Trac-B data by zip code to determine the expansion patterns geographically and will include number of new individuals as well.

Baseline: TBD

Activities

a. Engage with substance use prevention coalitions and social services to increase knowledge and awareness, specifically in rural and frontier communities.
b. Determine what is preferred from an outreach perspective within each community and actively engage with various priority populations to provide information on overdose prevention program options.

Obj 4.6 Annually update an accessible resource for general public regarding sexual health advocacy designed to take to providers.

Source: Syndemic Plan evaluation

Baseline: 0

Activities

a. Develop a webpage, linked resources, and an app.
b. Create a STI/HIV one-pager specific for patients.

Obj 4.7 Maintain condom distribution in Nevada.

Source: HIV Program performance metrics

Baseline: 370,000 condoms distributed in 2025

Activities

a. Maintain number of agencies distributing free condoms.

Obj 4.8 Syndemic team to promote awareness of the NSIP-SOR partnerships to increase hepatitis A, hepatitis B, HPV, and other vaccinations including, but not limited to, among people who are living with HIV and HCV in high overdose and high VPD zip codes, by engaging with all three tiers of VFC, 317, and other NSIP providers serving these zip codes while funding is available.

Sources

a. Analysis through NSIP IIS (WebIZ) data in 2027 (matched with eHARS and EpiTrax data for PLWH and PLW HCV) to look are reach specifically to populations of focus for the syndemic plan and key populations.
b. Number of NSIP vaccinating partners ordering SOR vaccines per calendar year.

Baseline: TBD

Activities

a. Partner with NSIP and SOR to identify hot-spot zip codes and determine which providers may be eligible, but have not yet become an NSIP provider.

Goal 5: Prevent the initiation of use and reduce regular use of substances.

Obj 5.1 By 2028, identify at least three partnerships with existing initiatives to provide parents information and education focused on healthy youth development, prevention strategies, and risk factors associated with substance use.

Source: Syndemic Plan evaluation

Baseline: 0

Activities

a. Possible partnerships include Substance Use Prevention Coalitions, EMS, law enforcement, PWLE delivering messages, PRSS, and EfC D2A Program.
b. Focus on delivery of fact-based information.
c. Tailored to the group(s) receiving the message (community-specific).
d. Opportunities to increase information in Back-to-School Nights for parents.

Obj 5.2 By 2029, build an interactive webpage to illustrate which evidence-based substance use prevention programs are being delivered to youth across Nevada.

Source: Substance Use Prevention Coalition data reported to WITS (DPBH)

Baseline: 0

Activities

a. Partner with SNOAC, DPBH, and possibly Office of Analytics to pipeline the data into a dynamic and interactive mapping tool.
b. Develop a webpage to host the information including program descriptions and testimonials, as appropriate. This site would include program descriptions, proportion of students in each county receiving evidence-based programs, and program evaluation data, to inform the statewide reach and promote possible peer-to-peer conversations among school administrators.

Obj 5.3 By 2028, 30% of Syndemic Plan Partner organizations' leadership will receive a presentation to learn more about Foundation for Recovery (FFR) programs, to increase the number of Recovery Friendly Workplaces (RFW).

Source: Syndemic Plan evaluation

Baseline: 0

Activities

a. Send email communications to Syndemic Partner members to encourage reaching out to FFR.
b. Provide descriptions about FFR and RFW to help leadership better understand the presentation intentions and purpose.

Obj 5.4 By 2031, at least half of Syndemic Plan Partner organizations will make a connection between FFR and at least one non-behavioral health organizational or business contact to encourage becoming RFW certified.

Source: Syndemic Plan evaluation

Baseline: 0

Activities

a. When a syndemic partner organization provides training or tabling of an event, share FFR resources with other entities.

Goal 6: Prevention of unwanted harm among those who use substances.

Obj 6.1 By 2029, establish at least 10 connections between naloxone distribution partnerships between substance use prevention coalitions sites, behavioral health sites, primary care offices and community-based support groups including local Narcotics Anonymous and faith-based programs.

Source: Syndemic Plan evaluation

Baseline: 0

Activities

a. Identify NA groups, faith-based programs and other community-based gatherings for people who use drugs.
b. Connect organizations distributing Narcan including substance use prevention coalitions sites, behavioral health sites, primary care offices with the contact people who host or organize the community-based gatherings for people who use drugs.

Obj 6.2 By 2028, increase awareness of naloxone distribution by encouraging naloxone/Narcan to be offered in a visually obvious location and/or display of obvious signage, as appropriate.

Source: Syndemic Plan evaluation

Baseline: 0

Activities

a. Include promotion of clear advertising/knowledge at places where it is available, if not free (e.g. pharmacies).
b. Low barrier, 24-7 naloxone access in more places.
c. Mapping locations for distribution sites.

Respond

Goal 7: Respond quickly to potential HIV, STI, and HCV outbreaks and sudden increases in overdoses to get necessary prevention and treatment services to people who need them.

Obj 7.1 Annually, local and state health authorities and community stakeholders will review and update the existing HIV/STI and Hepatitis Outbreak Response Plans, as necessary.

Source: Syndemic Plan evaluation

Baseline: 0

Activities

a. Engage in semi-annual reviews and update of Nevada's HIV Cluster and Outbreak Detection and Response Plan.
b. Engage in annual review and update of Nevada's Hepatitis Outbreak Detection Plan.
c. Share statewide Outbreak Response Plan which can be adopted by Local Health Authorities, as needed for responding to an increase in STIs.

Obj 7.2 Maintain capacity for infectious disease cluster detection at state and local health departments.

Outcomes: Number of trainings received annually; Number of educational opportunities share with LHAs and community partners.
Source: Logs of training, educational opportunities, and agenda topics.
Baseline: NA

Activities

a. Identify and document potential training and educational opportunities for state and local surveillance and investigation staff, including through AETC.
b. Engage with Nevada's HIV Prevention Planning Groups to determine how to partner with community organizations to identify and address prevention gaps.
c. Identify opportunities for implementing advanced scientific methods (i.e. molecular sequencing data, time-space analyses) to identify and connect people with prevention and treatment services.

Obj 7.3 By 2030, assess capacity for overdose increase "spike" detection response in each county.

Outcomes: Number of counties (out of 17) contacted; Number of counties with monitoring entity(ies) identified; Number of counties with response entity(ies) identified.
Source: NA
Baseline: 0

Activities

a. Determine which entities are responsible for monitoring county-level data for early detection of drug-related overdoses.
b. Determine which entities are involved in a response if/when increases "spikes" occur.
c. Assess if there are gaps that need to be addressed at the local level and whether state-level monitoring would be helpful via ESSENCE and OD Maps data.

Obj 7.4 Perform timely analysis of case surveillance data to identify possible transmission clusters each month.

Outcome: Monthly cluster analysis completed.
Source: NA
Baseline: Ongoing

Activities

a. Review alerts, analysis, and response as needed during Quarterly Surveillance Data Quality/Cluster Detection and Response meetings.
b. Consult with CDC regarding capacity to implement Secure HIV-TRACE in Nevada in Nevada by 2031.

Nevada Syndemic Community Needs Assessment: Key Findings from the Qualitative Assessment

Priorities

Eight major themes synthesized across all focus groups:

1. Stigma and Shame as a Pervasive Barrier
2. Gaps in Knowledge and Awareness — Uneven Across Populations
3. Intersection of Substance Use and Sexual Health
4. Fragmented, Inequitable Care
5. Structural Barriers and Social Determinants of Health
6. Rural-Specific Gaps
7. What Works — Facilitators and Bright Spots
8. What Participants Want — Recommendations

1. Stigma and Shame as a Pervasive Barrier Stigma emerged across every focus group as the most consistent barrier, cutting across HIV, STIs, and substance use.

- Fear of testing positive, shame around disclosing status or risky behaviors, and reluctance to discuss sexual health with providers were nearly universal
- Stigma is compounded for BIPOC, Latino, and LGBTQ+ communities, and is greater in rural and tribal settings where these topics are less openly discussed
- Internalized stigma around SUD — including shame when seeking basic care like detox or treatment for an abscess — deters help-seeking
- The emotional toll of living with HIV and not being able to talk openly about it was described as significant; building community was identified as essential
- Concern that naloxone and PrEP enable risky behavior reflects lingering stigma and misconceptions that complicate prevention messaging

2. Gaps in Knowledge and Awareness — Uneven Across Populations Awareness of prevention tools, transmission routes, and available services varied widely by population, geography, and age.

- Naloxone awareness was relatively strong; PrEP awareness was moderate but uneven; PEP and DoxyPEP were largely unknown across most groups
- Persistent misconceptions remain — that HIV is a "gay disease," that it is curable, and that modern medications eliminate the need for prevention behaviors
- Prevention advertising was seen as too narrowly targeted, reinforcing stereotypes and excluding heterosexual men, Black cis women, elderly populations, and rural communities
- Seniors, tribal communities, and youth were consistently identified as under-reached populations with distinct awareness gaps
- Outdated views on HIV transmission persist broadly, including misinformation about mother-to-child transmission and casual contact

3. Intersection of Substance Use and Sexual Health Participants consistently described substance use and sexual risk as deeply intertwined.

- Drug use and sexual behavior frequently co-occur, with substances influencing decision-making, medication adherence, and engagement in higher-risk behaviors
- Sex work intersects with both substance use and HIV/STI risk across multiple communities
- Substance use was described as a coping mechanism for trauma, pain, isolation, and stress — with addiction often intergenerational
- Withdrawal symptoms were identified as a direct barrier to safer use practices

4. Fragmented, Inequitable Care Participants described a healthcare system that is inconsistent, fragmented, and frequently failing those who need it most.

- Care is siloed — patients navigate multiple providers and locations for HIV, SUD, mental health, and primary care, creating gaps and burden
- Provider quality varies widely; some providers listen and screen comprehensively while others turn patients away, don't read charts, or perpetuate stereotypes
- Providers outside specialty settings are less educated on transmission, at-risk populations, and how to communicate a positive diagnosis
- High provider turnover disrupts continuity of care, particularly damaging for PLWH managing long-term treatment
- Insurance barriers — excessive documentation requirements, forced provider changes, and Ryan White bureaucracy — were described as exhausting and a driver of disengagement
- The cumulative burden of simultaneously attending multiple required programs while maintaining employment was identified as unsustainable (e.g., IOP, NA, etc.)
- Fear of funding cuts and losing access to life-saving medication was prominent among PLWH

5. Structural Barriers and Social Determinants of Health Structural conditions consistently compound health risks and limit access to care.

- Homelessness creates cascading barriers — no address for results, no phone for callbacks, medication loss or theft, and unsafe living conditions
- Transportation is a major barrier across settings — long bus routes, inability to reach services, and difficulty getting to pharmacies
- Cost of medications, insurance, food, and rent creates compounding financial strain that deprioritizes health
- Immigration status prevents some individuals from seeking care due to fear of legal repercussions
- Lack of cultural and familial connection was named as a driver of substance use, suggesting social belonging is a protective factor current services don't adequately address

6. Rural and Frontier-Specific Gaps Rural, frontier, and tribal communities represent a distinct and acute level of need.

- HIV, STIs, and substance use are not openly discussed in rural and tribal communities, and awareness of available resources is extremely low
- Specialty HIV care, SUD treatment, mental health providers, and stocked pharmacies are largely absent outside urban centers
- Frontier areas were described as having essentially no resources
- LGBTQ+ individuals in rural settings face compounded stigma with fewer support structures
- Telehealth and medication mail delivery were identified as needed solutions but are not yet widely accessible

7. What Works — Facilitators and Bright Spots Despite significant barriers, participants identified conditions and approaches that support engagement.

- Staff and outreach workers with lived experience were the most consistently cited facilitator — building trust and rapport quickly
- Established provider relationships were identified as a key driver of retention in care
- Walk-in, low-barrier service models and one-stop-shop care settings were praised where available
- Peer support groups and a sense of community were identified as protective factors, particularly for PLWH
- Incentives such as gift cards and bus passes for attending appointments or getting tested were identified as effective engagement tools
- Non-fear-based, normalizing social media messaging and community event outreach were seen as the most effective communication approaches

8. What Participants Want — Recommendations Participants offered concrete, actionable recommendations across all pillars.

- A one-stop-shop care model integrating HIV, SUD, mental health, and primary care was the most frequently cited recommendation
- Care navigators or CHWs embedded in clinical appointments, particularly for people with infectious disease
- Mental health support and peer community spaces specifically for PLWH to address the emotional burden of living with HIV
- Expanded funding for Certified Peer Recovery Support Specialists, particularly in rural and frontier areas
- Mobile medical services, telehealth, and medication mail delivery for rural populations
- 24/7 SSP access and community-based distribution of naloxone, condoms, and fentanyl test strips
- Diversified, inclusive prevention messaging across all media channels representing the full range of affected populations
- Transportation support and appointment incentives as standard components of care engagement

Situational Analysis

Pillar One: Diagnose

In focus groups, stigma and uneven awareness of testing resources were the most prominent barriers to diagnosis, alongside provider-level gaps in routine screening.

Strengths

- Sexual and gender minority participants were generally knowledgeable about testing locations and resources
- Community events and trusted spaces such as LGBTQ+ centers and SSPs were identified as effective venues for testing outreach

Challenges

- Stigma was a consistent barrier — participants described fear of being outed, shame around a positive result, and reluctance to discuss sexual health with providers
- Providers outside specialty clinics rarely conduct sexual health histories or offer routine HIV screening
- Rural, frontier, and tribal participants had little awareness of available testing and limited local access to services
- Fear of legal repercussions due to immigration status prevents some individuals from seeking testing
- Jail represents a missed opportunity — some screening occurs but with no linkage to care upon release

Needs

- Normalize testing by integrating it into routine care and bringing it to trusted community spaces and events
- Peers and trusted community members as messengers for normalizing testing, particularly in communities where stigma is highest
- Diversify prevention messaging to reach heterosexual men, Black cis women, elderly populations, and rural communities
- Provider training on sexual health screening and communicating a positive diagnosis, ideally delivered by people with lived experience

Pillar Two: Treat

Focus groups highlighted fragmented care, provider inconsistency, and the emotional burden of living with HIV as central treatment challenges, with strong consensus around integrated, navigated care models.

Strengths

- Participants who found a trusted HIV specialist and primary care provider described significantly better care experiences
- Staff and outreach workers with lived experience were identified as key to building trust and supporting retention in care

- Peer support groups and community spaces for PLWH were identified as meaningful facilitators of treatment engagement and emotional wellbeing

Challenges

- Care is fragmented — PLWH navigate multiple providers and locations for HIV, SUD, mental health, and primary care
- Provider quality varies widely; high turnover disrupts continuity of care
- Insurance barriers — excessive documentation, forced provider changes, and Ryan White bureaucracy — were described as exhausting and a driver of disengagement
- Rural and frontier participants face acute shortages of HIV specialty care, SUD treatment, and mental health providers
- Fear of funding cuts and losing access to life-saving medication was prominent among PLWH

Needs

- Integrated one-stop-shop care model covering HIV, SUD, mental health, and primary care
- Care navigators or CHWs embedded in clinical appointments for people with infectious disease
- Telehealth and medication mail delivery for rural and frontier populations
- Culturally and linguistically appropriate treatment options, including Spanish-speaking SUD programs
- The emotional toll of living with HIV was described as significant and underaddressed — dedicated mental health support and support groups specifically for PLWH are needed

Pillar Three: Prevent

Focus groups identified uneven awareness of prevention tools, persistent misconceptions about who prevention medications are for, and strong support for community-based outreach and social media engagement.

Strengths

- Naloxone awareness was relatively strong, attributed to distribution through SSPs and community-based settings
- Community events and social media identified as trusted, effective channels for prevention outreach and supply distribution
- Healthy peer networks and a sense of community connection were identified as protective factors against substance use initiation and risky sexual behavior

Challenges

- Persistent misconception that PrEP, PEP, and DoxyPEP are exclusively for LGBTQ+ populations; PEP and DoxyPEP awareness was low across nearly all groups
- Prevention advertising seen as too narrowly targeted, reinforcing stereotypes and excluding heterosexual men, Black cis women, and elderly populations
- PrEP has created a false sense of security among some groups, reducing condom use and perceived risk

- Retail cost of naloxone is a barrier for those without another source; 24/7 SSP access is unavailable in many areas
- Withdrawal symptoms and SSP access gaps lead to needle reuse

Needs

- Diversified, inclusive prevention messaging representing the full range of affected populations across all media channels
- Community event distribution of naloxone, condoms, and fentanyl test strips
- Expanded SSP hours and access points, particularly in rural and frontier areas
- Non-fear-based, normalizing social media campaigns as a primary outreach channel

Pillar Four: Respond

Focus groups identified structural barriers, systemic distrust, and rural service gaps as the most significant obstacles to an effective community response, with peer-based and integrated service models identified as key solutions.

Strengths

- Staff and outreach workers with lived experience were consistently identified as the most trusted model for community engagement
- Walk-in, low-barrier service models and one-stop-shop settings were praised where available
- Appointment incentives such as gift cards and bus passes were identified as effective tools for supporting engagement

Challenges

- Structural barriers — transportation, housing instability, lack of phone or address — prevent engagement even when services exist
- Distrust of systems among BIPOC, rural, and unhoused populations, driven by programs being started and then cut
- Frontier areas were described as having essentially no resources
- Low Medicaid reimbursement, funding cuts, and eliminated positions threaten continuity and quality of services
- Criminalization of homelessness and immigration-related fears create additional barriers to engagement

Needs

- CHWs and Certified Peer Recovery Support Specialists embedded in clinical settings and deployed for community outreach, with expanded funding particularly in underserved areas Sustained, consistent investment in programs to rebuild community trust
- Transportation support as a standard component of care, including ride services to appointments
- Mobile medical services and medication mail delivery for rural and frontier populations
- Support groups and community spaces — particularly for PLWH and PWUD — to address mental health, reduce isolation, and build connection were among the most frequently cited recommendations

Demographic Characteristics of Participants

Table 1. Sociodemographic characteristics of focus group participants, Nevada Syndemic Plan Community Assessment.

Demographic Characteristics (N = 88)	**N**	**%**
County of Residence		
Clark County	46	52.3
Washoe County	14	15.9
Quad Counties (Carson, Douglas, Storey, Lyon)	22	25.0
Other Rural Counties	6	6.8
Total	88	100.0
Age		
18-24	6	6.8
25-34	13	14.8
35-44	15	17.0
45-54	14	15.9
55-64	18	20.5
65 and older	21	23.9
Missing	1	1.1
Total	88	100.0
Primary Race or Ethnicity		
American Indian or Alaska Native	3	3.4
Asian/ Native Hawaiian or Pacific Islander	2	2.3
Black or African American	18	20.5
Hispanic/ Latinx/o/a	15	17.0
White, non-Hispanic	41	46.6
Multi-race/ethnicity	6	6.8
Other and missing	3	3.4
Total	88	100.0
Primary Gender Identity (Note: This will be revised in the integrated plan submission to comply with CDC and HRSA mandates on gender language).		
Male	49	55.7
Female	38	43.2
Transgender or gender non-conforming	1	1.1
Total	88	100.0
Educational Attainment		

Some high school (no diploma)	12	13.6
High school graduate (or equivalent, such as GED)	23	26.1
Some college, no degree	27	30.7
Technical school degree (such as cosmetology or computer technician)/ Associate degree (AA, AS, etc.)	12	13.7
Bachelor's degree (BA, BS, etc.)	13	14.8
Master's degree (MA, MS, MSW, etc.)/ Doctorate or professional degree (PhD, MD, JD, etc.)	1	1.1
Total	88	100.0
Identification Groups		
Sexually active individuals	52	59.1
People living with HIV	34	38.6
Individuals with a history of incarceration	26	29.5
Men who have sex with men	25	28.4
Former use of opioids or stimulants*	24	27.3
Currently using opioids or stimulants*	9	10.2
Current diagnosis or history of hepatitis C	5	5.7
Currently or previously engaged in sex work	4	4.5
Individuals who did not identify with any listed groups	8	9.1

* Non-medical use or used in a manner not prescribed

Source: 2027-2031 Syndemic Plan community focus groups demographic survey

Focus group participants were asked to select one or more populations they identify with from a list of groups disproportionately impacted by syndemic conditions (Table 1). Among the 88 focus group respondents, 50.0% identified as non-White, 6.8% were between the ages of 18–24 years, and 1.1% identified as transgender or gender non-conforming. The most frequently selected identification group was sexually active individuals (59.1%), followed by people living with HIV (38.6%), individuals with a history of incarceration (29.5%), men who have sex with men (28.4%), and individuals in recovery from non-medical opioid or stimulant use (27.3%). Smaller proportions of respondents identified as currently using opioids or stimulants in a manner not prescribed (10.2%), having a current diagnosis or history of hepatitis C (5.7%), or currently or previously engaging in sex work (4.5%). Additionally, 9.1% of respondents did not identify with any listed priority population.

2027 - 2031 NEVADA SYNDEMIC PLAN

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Table of Contents

SECTION 1: INTRODUCTION OF INTEGRATED SYNDEMIC PLAN AND STATEWIDE COORDINATED STATEMENT OF NEED (SCSN)

1.1: Introduction

Community Engagement and Planning Process

The 2027-2031 Nevada Syndemic Plan was developed over an 18-month period from 2025 through mid-2026 and utilized the HIV Integrated Prevention and Care Plan, including the Statewide Coordinated State of Need (SCSN), and process as a framework to expand the existing HIV-related priorities. Nevada's Syndemic Plan includes HIV, other sexually transmitted infections (STIs) including chlamydia, gonorrhea, syphilis and congenital syphilis, viral hepatitis, as well as substance use, to develop a whole-person approach to improving health outcomes for Nevadans. Nevada utilized a collaborative and community-engaged process to develop this plan. Many programs, agencies, community-based organizations (CBOs), and service providers engaged in HIV/STD and substance use prevention, treatment, and ancillary care services, as well as people living with HIV (PLWH), STDs, and substances, at-risk populations, people affected by HIV/STDs and substance use, community members, and other stakeholders participated in the development of this plan through various mechanisms, including participation in needs assessments, sharing personal experiences, and providing feedback on the plan.

The Office of State Epidemiology (OSE), the Department of Human Services (DHS) Office of HIV, and the Larson Institute for Health Impact and Equity within the School of Public Health at the University of Nevada, Reno (UNR), referred to as Larson Institute, collaborated together on an Internal Workgroup to create the timeline and ensure milestones were met through the planning process. Since this is the first Syndemic Plan in Nevada, and it is being submitted as the Nevada HIV Integrated Plan for 2027-2031, careful consideration was given to confirm processes in place would meet the requirements for the HIV Integrated Planning needs, in collaboration with the Nevada Office of HIV. The final plan was produced in June 2026. A full summary of community engagement is provided in Section 2: Community Engagement and Planning Process.

Data: Epidemiologic Snapshot, Resource Inventory, and Needs Assessments

In 2024, there were 619 Nevadans newly diagnosed with HIV and nearly 13,000 Nevadans were currently living with HIV. Rates of new HIV diagnoses were highest for the following populations: young adults (ages 20 – 44), Black or African American persons, Hispanic persons, and persons living in Clark County (home to Las Vegas). Of the 619 Nevadans diagnosed with HIV in 2024 who met follow-up criteria, 91% were linked to care and 38% were retained in care. Among those retained in care, 80% were virally suppressed, highlighting the importance of retaining PLWH in care. Further, there were more than 2,500 new chronic Hepatitis C Virus (HCV) cases and 23,237 total STI diagnoses in 2025 among Nevadans.

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

Data from two needs assessment were used to inform the development of plan priorities, goals, and objectives: Nevada Syndemic Community Needs Assessment (conducted in 2025/2026) and the Nevada HIV Treatment and Care Needs Assessment (conducted in 2022). The Syndemic Community Needs Assessment identified strong foundations supporting HIV prevention, testing, and care, including trusted community outreach, rapid testing programs, syringe service programs, home testing options, Ryan White-funded services, peer networks, and the Rapid stART program. At the same time, participants described ongoing barriers including stigma, fear of disclosure, low perceived HIV risk, immigration-related concerns, distrust of healthcare systems, limited awareness of PEP and Doxy PEP, transportation challenges, provider shortages, and fragmented systems of care, particularly in rural and frontier communities. Community survey findings showed that only 37% of participants had ever received an HIV test and 26% had been tested in the last year, with low perceived risk being the primary reason for never testing. Although awareness of PrEP was relatively high, few participants had discussed or used it. Survey findings also highlighted ongoing sexual and injection-related risk behaviors, including high rates of condomless sex and inconsistent use of clean syringes among people who inject substances. The Nevada HIV Treatment and Care Needs Assessment stakeholders emphasized the need for integrated care models, expanded peer-led outreach, telehealth and mobile services, transportation support, inclusive prevention messaging, and stronger mental health services to improve access to prevention, treatment, and long-term engagement in care. A full summary of the needs assessment findings is provided in Section 3: Contributing Data Sets and Assessments.

Situational Analysis

A situational analysis was compiled to identify strengths, challenges, and needs related to HIV, STI, and substance use prevention, treatment, and ancillary care services within each of the four EHE pillars: Diagnose, Treat, Prevent, Respond, by synthesizing information presented in Section 2: Community Engagement and Planning Process and Section 3: Contributing Data Sets and Assessments with experiences from those working in prevention, treatment, and ancillary care

services. Nevada's situational analysis identified both strong existing supports and significant ongoing barriers across diagnosis, treatment, prevention, and response efforts. Strengths included trusted community outreach, rapid testing programs, Ryan White services, peer support, naloxone distribution, and growing access to alternative testing and prevention resources, while major challenges included stigma, fragmented care systems, rural service shortages, low HIV testing uptake, limited awareness of prevention tools, and structural barriers such as transportation, housing instability, and funding concerns. A full summary of strengths, challenges, and needs is provided in Section 4: Situational Analysis.

Goals and Objectives

The goals, objectives, and activities presented in Section 5: 2027 – 2031 Goals and Objectives were developed by the Syndemic Workgroups over a four-month period and were finalized based on feedback from key stakeholders, including the Northern and Southern Nevada HIV Prevention Planning Groups (HPPGs), local health authorities (LHA), community-based organizations (CBOs), and service providers. The goals and objectives were framed within the four EHE pillars and are presented below. Specific activities for each objective are presented in in Section 5: 2027 – 2031 Goals and Objectives.

Diagnose and Detect

Goal 1: Diagnose all individuals with HIV, syphilis, chlamydia, gonorrhea, and viral hepatitis as early as possible after infection.

- Obj 1.1 From 2027 to 2031, reduce the number of new HIV stage 3 diagnoses by 10%.
- Obj 1.2 Annually, 20,000 federally funded HIV tests will be conducted within the state of Nevada.
- Obj 1.3 Annually, increase the number of rapid or point-of-care (POC) tests conducted for syphilis by 5%.
- Obj 1.4 Annually, increase the number of rapid or point-of-care tests conducted for HCV by 5%.
- Obj 1.5 From 2027 through 2031, increase the proportion of people with a positive HCV antibody test receiving a viral load, PCR, or genotype test from 50% to 60%.
- Obj 1.6 Annually, 95% of clients testing HIV-positive will be informed of their test result within 7 business days from report to health authority.
- Obj 1.7 Identify at least 3 substance use treatment organizations willing to implement opt-out screening for HIV and HCV by 2031.
- Obj 1.8 Identify at least 3 organizations to partner with overdose prevention and street outreach programs to offer screening for HIV and HCV by 2031.

- Obj 1.9 By 2028, engage with at least 5 hospital systems to facilitate the development of policy to test all pregnant persons for syphilis in accordance with Nevada Revised Statutes (NRS) 442.010, and other STI's in accordance with NRS 441A.315.
- Obj 1.10 Annually, identify at least 1 primary care practice in high-risk counties not following the CDC's syphilis screening recommendation (to test all sexually active persons aged 15-44 years in counties with morbidity rates > 4.6 per 100,000) to implement protocol changes to screening in alignment with the recommended practices.
- Obj 1.11 Annually, promote awareness of the STD Clinical Consultation Service for healthcare professionals https://www.stdccn.org/render/Public as well as afterhours call lines for Nevada's respective LHA STD Programs, by providing information to at least 10,000 healthcare professionals in Nevada.

Treat

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

- Obj 2.1 Annually, 85% of newly diagnosed HIV-positive individuals will be linked to care, as measured by a CD4 or a viral load test conducted within 30 days from earliest specimen collection date.
- Obj 2.2 Annually, 85% of newly diagnosed HIV-positive individuals will be referred to a healthcare provider within 30 days from initial CDC-funded test collection date.
- Obj 2.3 Annually, among individuals engaged in the Las Vegas TGA EHE Rapid stART program, 90% of newly diagnosed HIV-positive individuals, those new to care, and/or persons returning to care will be linked to HIV care within 7 days of time zero date.
- Obj 2.4 Annually, among individuals engaged in the Las Vegas TGA EHE Rapid stART program, 90% of newly diagnosed HIV-positive individuals, persons new to care, and/or persons returning to care will have initiated ART within 7 days of first medical appointment.
- Obj 2.5 Annually, 75% of HIV-positive individuals will have achieved viral suppression (less than 200 copies/ml at last viral load) within 12 months of initial diagnosis among those who are newly diagnosed.
- Obj 2.6 Annually, among individuals engaged in the Las Vegas TGA EHE Rapid stART program, 90% of newly diagnosed HIV-positive individuals, those new to care, and/or persons returning to care will have achieved viral suppression by 90 days after initiation of ART.

Goal 3: Develop medication assisted treatment (MAT) network for persons with opioid-use disorder.

- Obj 3.1 By 2028, develop and implement an evaluation plan to assess impacts of the expansion of mobile MAT for rural and frontier communities.
- Obj 3.2 By 2029, develop a statewide network map for telehealth for treatment and recovery services and promote (or support) a pipeline for telehealth.

Prevent

Goal 4: Prevent new HIV and STI transmissions by using proven interventions, including condom use, post-exposure prophylaxis (PEP), Doxy PEP, pre-exposure prophylaxis (PrEP), and proven prevention methods among those who use substances.

- Obj 4.1 By 2031, reduce by 10% the rate of new HIV diagnoses.
- Obj 4.2 Increase the number of providers receiving training or education about expedited partner therapy (EPT), Doxy PEP, PrEP, PEP, or 3-site STI testing annually, by 5% each year.
- Obj 4.3 Increase number of healthcare professionals educated about NRS 441A.315, regarding testing for sexually transmitted infections in emergency services settings and primary care clinics by 5% each year.
- Obj 4.4 Increase the number of people who have access to overdose prevention services, health recovery supplies, counseling, and education annually by 10%.
- Obj 4.5 Increase the number of new zip codes receiving mail-based overdose prevention and health recovery supplies annually by 10 zip codes.
- Obj 4.6 Annually update an accessible resource for general public regarding sexual health advocacy designed to take to providers.
- Obj 4.7 Maintain condom distribution in Nevada.
- Obj 4.8: Syndemic team to promote awareness of the NSIP-SOR partnerships to increase hepatitis A, hepatitis B, HPV, and other vaccinations including, but not limited to, among people who are living with HIV and HCV in high overdose and high VPD zip codes, by engaging with all three tiers of VFC, 317, and other NSIP providers serving these zip codes while funding is available.

Goal 5: Prevent the initiation of use and reduce regular use of substances.

- Obj 5.1 By 2028, identify at least three partnerships with existing initiatives to provide parents information and education focused on healthy youth development, prevention strategies, and risk factors associated with substance use.

- Obj 5.2 By 2029, build an interactive webpage to illustrate which evidence-based substance use prevention programs are being delivered to youth across Nevada.
- Obj 5.3 By 2028, 30% of Syndemic Plan Partner organizations' leadership will receive a presentation to learn more about Foundation for Recovery (FFR) programs, to increase the number of Recovery Friendly Workplaces (RFW).
- Obj 5.4 By 2031, at least half of Syndemic Plan Partner organizations will make a connection between FFR and at least one non-behavioral health organizational or business contact to encourage becoming RFW certified.

Goal 6: Prevention of unwanted harm among those who use substances.

- Obj 6.1 By 2029, establish at least 10 connections between naloxone distribution partnerships between substance use prevention coalitions sites, behavioral health sites, primary care offices and community-based support groups including local Narcotics Anonymous and faith-based programs.
- Obj 6.2 By 2028, increase awareness of naloxone distribution by encouraging naloxone/Narcan to be offered in a visually obvious location and/or display of obvious signage, as appropriate.

Respond

Goal 7: Respond quickly to potential HIV, STI, and HCV outbreaks and sudden increases in overdoses to get necessary prevention and treatment services to people who need them.

- Obj 7.1 Annually, local and state health authorities and community stakeholders will review and update the existing HIV/STI and Hepatitis Outbreak Response Plans, as necessary.
- Obj 7.2 Maintain capacity for infectious disease cluster detection at state and local health departments.
- Obj 7.3 By 2030, assess capacity for overdose increase "spike" detection response in each county.
- Obj 7.4 Perform timely analysis of case surveillance data to identify possible transmission clusters each month.

A full summary of all goals, objectives, activities, and specific outcomes measures is provided in Section 5: 2027 – 2031 Goals and Objectives.

Plan Implementation, Monitoring, and Jurisdictional Follow-Up

The Syndemic Plan is meant to be a living document that will be continuously revised and improved. Across the plan period (2027 – 2031), the Internal Workgroup and Syndemic Planning Members will be engaged through regular meetings where progress on goals, objectives, and activities will be reviewed in relation to

epidemiological data. All modifications to the plan will be implemented through input during meetings with the opportunity to weigh in via email. Any changes to the plan will be made public on the website, with explanations as to why objectives were modified or are no longer being pursued. A full description of all related implementation, monitoring, and follow-up activities is presented in Section 6: 2027-2031 Integrated Planning Implementation, Monitoring and Jurisdictional Follow-Up.

1.1.a: Approach

The process included both an update to the 2022-2026 HIV Integrated Plan objectives as well as creation of new goals and objectives to incorporate the addition of syndemic-related conditions under the pillars of Diagnose, Treat, Prevent, and Respond, with an inclusion of policy, where appropriate.

The Office of State Epidemiology, the Department of Human Services Office of HIV, and the Larson Institute collaborated together on an Internal Workgroup to create the timeline and ensure milestones were met through the planning process. Since this is the first syndemic plan in Nevada, and it is being submitted as the Nevada HIV Integrated Plan for 2027-2031, careful consideration was given to confirm processes in place would meet the requirements for the HIV Integrated Planning needs, in collaboration with the Nevada Office of HIV.

1.1.b: Documents submitted to meet requirements

The completed HIV Integrated Plan Checklist delineates whether each section of required material was new or existing material, the title/file name for materials, and the page numbers within the section.

SECTION 2: COMMUNITY ENGAGEMENT AND PLANNING PROCESS

2.1: Jurisdiction Planning Process

The planning process began in 2025 and engaged state and local stakeholders, community-based organizations (CBOs), local health authorities, service providers and other treatment and care facilitators involved in prevention, treatment, and ancillary care services, as well as persons living with HIV (PLWH) and other STIs, people at-risk for contracting HIV and other STIs, and addition to persons with lived experience (PWLE) with current or previous use of substances. Detailed descriptions of key planning activities, including the core planning team meetings, needs assessments, and development of goals and objectives, are outlined below.

Table 1: Identified people and communities who have been disproportionately impacted by HIV and other syndemic conditions.

People and Communities Disproportionately Impacted*	Which Planning Group Identified
People with HIV	HPPG & Syndemic
Men who have Sex with Men (MSM)	HPPG & Syndemic
People who are sexually active	HPPG & Syndemic
People who use substances	HPPG & Syndemic
Youth and young adults	HPPG & Syndemic
Care providers - informal (family/friends)	Syndemic
White populations between 25-44 years who use substances	Syndemic
Incarcerated populations/-persons with a history of incarceration	Syndemic
Persons who engage in sex work/trade legally & non-legally	Syndemic
Adult film entertainers	Syndemic
Persons who are gender non-conforming	Syndemic
Females who have sex with MSM &/or HIV positive men	Syndemic
Polyamorous individuals	Syndemic
Young adults 18-24 years	Syndemic
Care providers – formal (HIV/STI specific & Opioid/MOUD specific)	Syndemic
Providers who are not testing for HIV/STI or screening for substance use disorder	Syndemic
Persons who inject drugs	Syndemic
Pregnant persons	Syndemic

*Note: Communities of color for all populations

Secondary surveillance data were presented during the second Syndemic Planning meeting to help identify people and communities disproportionately impacted by HIV and other syndemic conditions. The Syndemic Planning members discussed and identified the populations provided in Table 1, which will be referred to throughout the document. Additionally, the HIV Prevention Planning Groups (HPPG) in Nevada formally voted to focus on the first five populations listed in Table 1, with attention to communities of color within each group.

2.1.a: Entities involved in the process

Syndemic Plan Workgroups

The formal planning process and plan development for the Sydemic Plan began in early 2025. The Nevada OSE and the Larson Institute team collaborated with the Nevada Office of HIV, and Ryan White partners to develop an Internal Workgroup to facilitate planning and development of the Syndemic Plan. More than 90 individuals representing over 30 programs, agencies, and CBOs working in HIV, STI, and substance use prevention, treatment, and care across the state were invited to join the Sydemic Workgroup meetings (see below). The Syndemic Workgroup held a kick-off meeting in 2025 and was later divided into two subgroups: Infectious Disease and Substance Use. These Sydemic Workgroups met biweekly from January – May 2026 to guide plan development, review progress, review assessment findings, outline priorities, and guide the development of goals and objectives.

Table 2: Syndemic partner organizations.

Syndemic Partner Organization	Number of Members
AIDS Education Training Center	3
AIDS Health Care Foundation	3
CAN Community Health	3
Carson City Health and Human Services*	4
Central Nevada Health District*	1
City of Henderson	1
Clark County Social Services	3
Community Counseling Center of Southern Nevada	1
Community Outreach Medical Center	2
Department of Human Services (DHS) - Immunization Program	3
DHS - Maternal Child Health	2
DHS - Office of HIV	9
DHS - Veterans Services	3
DHS - Office of Analytics	1
DHS - Office of State Epidemiology	6
DHS - Substance Use Prevention, Treatment and Recovery	4
DHS - Tribal Liaison	1
DHS - Division of Health Care Financing and Policy	2

Syndemic Partner Organization	Number of Members
Dignity Health	1
EMPOWERED	1
Gilead	2
Larson Institute	4
Las Vegas Metropolitan Police Department	1
LifeCare Partners	3
Northern Nevada HOPES	3
Northern Nevada Public Health*	5
RISE	2
Southern Nevada Health District*	10
Southern NV Health Consortium	1
Substance Use Prevention Coalitions	2
The Center	2
Trac-B	2
Unity Health Services	1
Total	**92**

*Local Health Authority

2.1.b: Role of the RWHAP Part A Planning Council/Planning Body

The Las Vegas Transitional Grant Area (TGA) Part A Planning Council has several members involved in the Syndemic Workgroups who directly participated in the plan creation. The OSE/Larson Institute team also presented the plan contents to the Planning Council and obtained a signed letter of concurrence.

2.1.c: Role of Planning Bodies and Other Entities

The Northern and Southern Nevada HIV Prevention Planning Groups (HPPGs) were also involved in the development of the Syndemic Plan. The existing planning groups include representatives from a diverse range of health departments, CBOs, and service providers involved in HIV prevention, treatment, and ancillary care services. The prevention planning groups also engage members of key populations who are impacted by HIV and their meetings are open to the public. These groups were heavily involved in the development and dissemination of the prevention, care, and treatment needs assessments and provided feedback on the final plan, with an emphasis on the goals and objectives. The OSE/Larson Institute team attended HPPG meetings on several occasions to provide a summary of needs assessment findings and provide updates on plan development. The OSE/Larson Institute team also presented the plan contents to the HPPGs and obtained a signed letter of concurrence.

2.1.d: Collaboration with RWHAP Parts – SCSN requirement

Similar to the HPPGs, members of the RWHAP Parts were invited to participate in the Syndemic Plan Workgroups. These members were directly involved in

reviewing the plan, with an emphasis on developing goals and objectives that align with their strategic priorities.

2.1.e: Engagement of people with HIV – SCSN requirement

PLWH contributed to plan development through participation in the prevention and treatment and care needs assessments, including both surveys and focus groups, through participation in planning group meetings, and through opportunities to provide feedback provided on drafts of the Syndemic Plan. Across all surveys and focus groups conducted as part of the needs assessment process, there was participation from 58 PLWH in Nevada. See Section 3: Contributing Data Sets and Assessments for specific details regarding participation from PLWH in the needs assessments. Further, PLWH were engaged in the Syndemic Workgroups and actively participated in the development of the plan and will be involved in the implementation, monitoring, evaluation, and improvement process. In addition to PLWH, the Northern and Southern Nevada HPPGs identified the following groups as priority populations for HIV prevention efforts in Nevada: MSM, people who are sexually active, people who use substances, youth and young adults, and communities of color. These priority populations were specifically recruited during the Syndemic needs assessment process to ensure the needs and priorities for HIV prevention, treatment, and ancillary care services were representative of these target populations.

2.1.f: Priorities

Throughout the community engagement and planning process, stakeholders prioritized development of measurable goals and objectives that push to lessen the burden of HIV, STIs, and substance use in Nevada. In doing so, the various planning bodies prioritized initiatives that focus on the populations disproportionately impacted by these conditions, as described in Table 1 above. A summary of overall priorities is included in Section 4: Situational Analysis.

Currently the Nevada HIV Prevention and Surveillance Program (HPSP) works closely with the LHAs and HPPGs to discuss ideas on how to address outbreaks and clusters in their respective communities. However, this was identified as a priority to continue to enhance and build upon by encouraging increased public feedback and recommendations for cluster detection and response.

2.1.g: Updates to Other Strategic Plans Used to Meet Requirements

No portions of other strategic plans were used to satisfy requirements of the Syndemic Plan and SCSN.

SECTION 3: CONTRIBUTING DATA SETS AND ASSESSMENTS

3.1: Data Sharing and Use

Data included in Section 3: Contributing Data Sets and Assessments come from a variety of sources and include primary and secondary data, individual agency and program data. The epidemiologic snapshot contains data from several sources including the enhanced HIV/AIDS reporting system (eHARS), the Youth Risk Behavior Surveillance System (YRBSS), the Ryan White HIV/AIDS Program (RWHAP) Annual Client-Level Data Report, and the National Electronic Disease Surveillance System (NEDSS) utilized in Nevada as of 2021, EpiTrax.

For all tables and figures, the most recent available data were utilized. Data for the prevention, care, and treatment resource inventory were reported by staff from agencies receiving HIV and syndemic funding. Further, two needs assessments, one for Syndemic purposes and one for HIV care and treatment, were conducted to understand gaps and barriers to HIV-related services in Nevada. The Syndemic needs assessment was conducted in late 2025-early 2026. The Syndemic needs assessment consisted of a community survey and a series of focus groups with priority populations across the state. The most recent HIV care and treatment needs assessment was conducted by Collaborative Research in partnership with the State of Nevada, the Las Vegas TGA, RWHAP parts, and Clark County Ending the HIV Epidemic (EHE) in 2022. The needs assessment consisted of a survey among PLWH in Nevada.

3.2: Epidemiologic Snapshot

Surveillance Data

Table 3 presents patterns in new HIV, chronic Hepatitis C Virus (HCV), and STI diagnoses in Nevada during 2025.[1] Across all three conditions, most diagnoses occurred in Clark County, which accounted for 90.4% of new HIV diagnoses, 81.6% of chronic HCV diagnoses, and 81.9% of combined STI diagnoses. Males represented most new HIV diagnoses (82.1%) and chronic HCV diagnoses (58.1%), while combined STI diagnoses were nearly evenly distributed between males and females. Racial and ethnic disparities were also evident, with Black non-Hispanic individuals experiencing the highest HIV diagnosis rate (39.0 per 100,000) and the highest combined STI diagnosis rate (1,629.6 per 100,000). Hispanic individuals accounted for the largest proportion of new HIV diagnoses (39.0%), while White non-Hispanic individuals accounted for the largest proportion of chronic HCV diagnoses (43.1%) and Hispanic individuals represented the largest proportion of combined STI diagnoses (27.0%). New HIV diagnoses were highest among adults aged 25 to 34 years, while combined STI diagnoses were highest among younger populations, particularly those aged 20 to 24 years, who had the highest diagnosis rate (2,459.5 per 100,000).

Table 3. New HIV, chronic HCV, and combined STI diagnoses in Nevada, 2025.

	HIV			Chronic HCV			Combined STI		
	N	Column %	Rate*	N	Column %	Rate*	N	Column %	Rate*
County of Diagnosis									
Clark	454	90.4%	18.7	2,161	81.6%	89.0	19,030	81.9%	784.0
Washoe	37	7.4%	7.1	141	5.3%	27.2	3,167	13.6%	609.8
All Other Counties**	11	2.2%	4.2	347	13.1%	91.5	1,040	4.5%	280.0
Sex									
Male	412	82.1%	24.9	1,543	58.1%	92.4	11,625	50.0%	701.6
Female	90	17.9%	5.4	1,106	41.7%	66.8	11,612	50.0%	695.3
Race/Ethnicity									
White, non-Hispanic	147	29.3%	9.3	1,143	43.1%	72.0	4,511	19.4%	284.3
Black, non-Hispanic	121	24.1%	39.0	248	9.3%	79.9	5,057	21.8%	1629.6
Hispanic	196	39.0%	18.7	261	9.8%	16.7	6,284	27.0%	598.1
Asian/Hawaiian/ Pacific Islander	26	5.2%	7.6	91	3.4%	26.5	942	4.1%	274.1
American Indian/Alaska Native	2	0.4%	5.6	11	0.4%	30.9	140	0.6%	392.9
Multi-race/Other /Unknown	10	2.0%	-	900	33.9%	-	6,325	27.2%	-
Age Group at Diagnosis									
< 14	1	0.2%	0.2	-	-	-	98	0.4%	17.3
15 to 19	7	1.4%	3.1	-	-	-	3,699	15.9%	1615.5
20 to 24	58	11.6%	24.5	-	-	-	5,833	25.1%	2459.5
25 to 29	83	16.5%	35.6	-	-	-	4,191	18.0%	1799.7
30 to 34	82	16.3%	34.2	-	-	-	3,333	14.3%	1388.9
35 to 39	60	12.0%	25.9	-	-	-	2,276	9.8%	983.4
40 to 44	63	12.5%	29.9	-	-	-	1,446	6.2%	686.3
45 to 54	79	15.7%	18.4	-	-	-	1,379	5.9%	320.8
55 to 64	60	12.0%	14.8	-	-	-	728	3.1%	179.6
65 +	9	1.8%	1.6	-	-	-	272	1.2%	49.9
Total	**502**	**100.0%**	**15.1**	**2,649**	**100.0**	**79.6**	**23,237**	**100.0%**	**698.5**

Source: Nevada Office of Analytics (March 2026). * Rates per 100,000 population were calculated using 2025 population projections from the Nevada State Demographer. **All other counties include Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine Counties. Due to rounding, percents may not add up to exactly 100.0%.

Table 4. Persons living with HIV in Nevada, 2024.

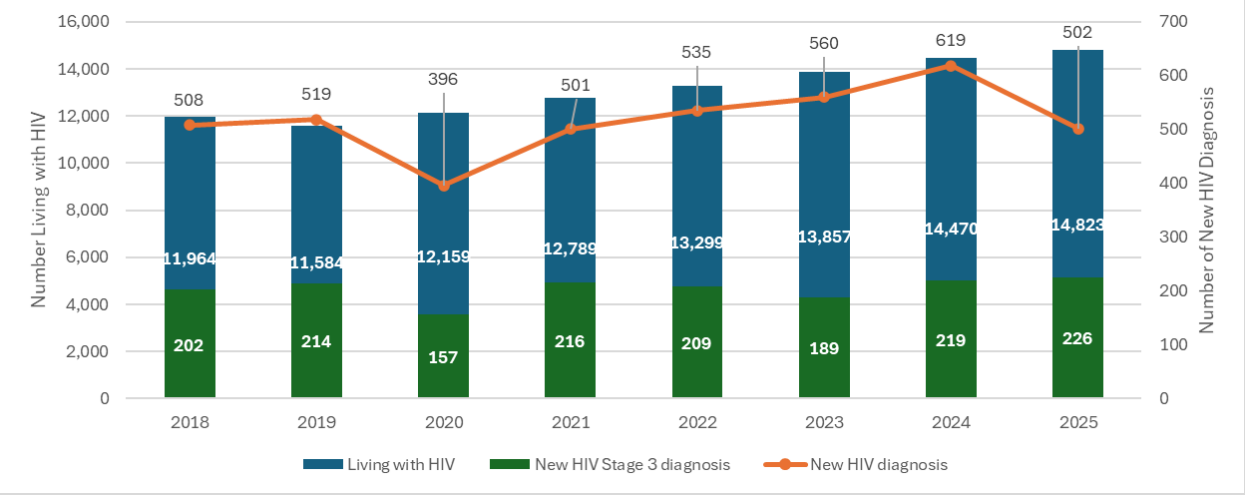
	Total			Males			Females		
	N	Column %	Rate*	N	Column %	Rate*	N	Column %	Rate*
County of Diagnosis									
Clark	11,132	86.5%	467.9	9,431	86.5%	794.4	1,701	86.9%	142.7
Washoe	1,169	9.1%	242.5	1.023	9.4%	422.7	146	7.5%	60.8
All Other Counties**	565	4.4%	160.0	455	4.2%	256.4	110	5.6%	62.6
Race/Ethnicity									
White, non-Hispanic	5,014	39.0%	318.2	4,424	40.60%	556.6	590	30.1%	75.5
Black, non-Hispanic	3,690	28.7%	1,271.9	2,763	25.30%	1,892.1	927	47.4%	643.3
Hispanic	3,313	25.8%	335.8	3,001	27.50%	602.2	312	15.9%	63.9
Asian/Hawaiian/ Pacific Islander	523	4.1%	160.6	444	4.10%	296.1	79	4.0%	45.0
American Indian/Alaska Native	78	0.6%	216.0	61	0.60%	364.2	17	0.9%	91.9
Multi-race/other	246	1.9%	-	215	2.00%	-	31	1.6%	-
Unknown	2	0.0%	-	1	0.0%	-	1	0.1%	-
Age Group at Diagnosis									
< 13	5	0.0%	1.0	1	0.0%	0.4	4	0.2%	1.6
13 to 14	3	0.0%	3.3	1	0.0%	2.2	2	0.1%	4.5
15 to 19	33	0.3%	15.0	21	0.2%	18.6	12	0.6%	11.2
20 to 24	263	2.0%	122.0	224	2.1%	201.1	39	2.0%	37.4
25 to 29	902	7.0%	389.2	813	7.5%	688.7	89	4.5%	78.3
30 to 34	1,508	11.7%	663.7	1,362	12.5%	1,172.5	146	7.5%	131.5
35 to 39	1,548	12.0%	740.0	1,350	12.4%	1,282.6	198	10.1%	190.5
40 to 44	1,347	10.5%	619.7	1,128	10.3%	1,033.0	219	11.2%	202.5
45 to 54	2,880	22.4%	701.3	2,343	21.5%	1,125.7	537	27.4%	265.1
55 to 64	3,053	23.7%	793.9	2,571	23.6%	1,346.0	482	24.6%	249
65 +	1,324	10.3%	272.1	1,095	10.0%	493.7	229	11.7%	86.5
Total	**12,866**	**100.0%**	**400.3**	**10,909**	**100.0%**	**678.9**	**1,957**	**100.0%**	**121.7**

Source: Nevada Office of Analytics (March 2025). * Rates per 100,000 population were calculated using 2024 population projections from the Nevada State Demographer. **All other counties include Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine Counties. Persons Living with HIV indicate any person diagnosed with HIV regardless of HIV staging, including HIV stage 3 (AIDS). Due to rounding, percents may not add up to exactly 100.0%.

Table 4 summarizes PLWH in Nevada in 2024 and highlights substantial geographic and demographic disparities.[1] Most PLWH resided in Clark County (86.5%), followed by Washoe County (9.1%). Males accounted for the majority of PLWH (84.8%), with a rate of 678.9 per 100,000 population compared to 121.7 among females. Black non-Hispanic individuals experienced the highest prevalence rate of HIV (1,271.9 per 100,000), substantially higher than any other racial or ethnic group. White non-Hispanic individuals represented the largest proportion of PLWH overall (39.0%), followed by Black non-Hispanic individuals (28.7%) and Hispanic individuals (25.8%). HIV prevalence was concentrated among middle-aged adults, with the largest proportions occurring among persons aged 45 to 54 years (22.4%) and 55 to 64 years (23.7%). Rates were highest among adults aged 55 to 64 years (793.9 per 100,000).

Figure 1 provides an overview of the trend of total persons living with HIV, new HIV infections, and new Stage 3 HIV infections by year from 2018 through 2025 in Nevada.[1] The total number of PLWH in Nevada has increased annually from 2018 to 2025 and was estimated at 14,823 at end of 2025 (Figure 1). The number of new HIV infections reached a peak of 619 in 2024, decreasing to 502 in 2025, however the proportion of new diagnosis that were already in HIV Stage 3 were highest in 2025 at 45%.

Figure 1: Persons living with HIV, new HIV diagnosis, and new HIV Stage 3 diagnosis, Nevada, 2018-2025



Source: Nevada Office of Analytics, HIV Surveillance Dashboard.

Ryan White Clients

Table 5 shows characteristics of Ryan White Program clients in Nevada and in the Las Vegas TGA in 2024.[2] There were a total of 5,695 clients in 2024 across the state and 4,467 in the Las Vegas TGA. In general, the sociodemographic characteristics of Ryan White clients in Nevada reflect those of PLWH in Nevada. Nearly 90% of clients in the Las Vegas TGA and statewide were between the ages of 25 and 64. Regarding race and ethnicity, 26.2% of clients statewide were White, 33.4% were Hispanic or Latino, and 34.2% were Black or African American. In the Las Vegas TGA, a larger proportion of clients were Hispanic/Latino (39.0%).

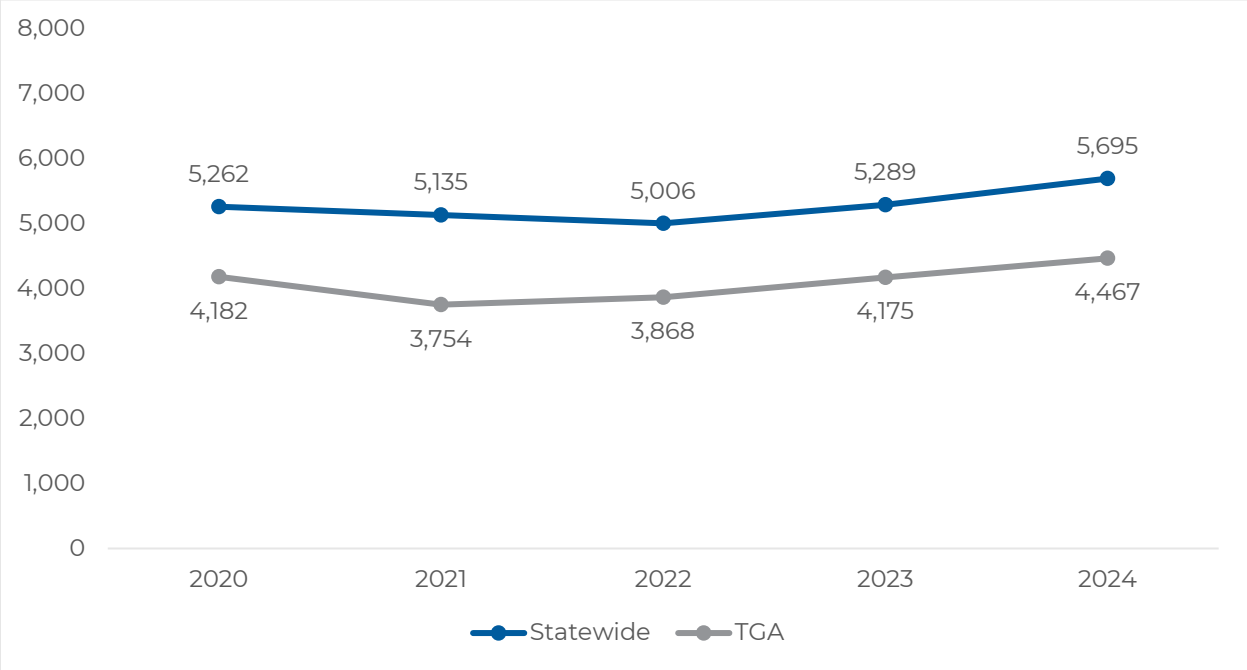
Table 5. Sociodemographic characteristics of Ryan White clients in Nevada and in the Las Vegas TGA, 2024.

	Statewide		Las Vegas TGA	
	N	**%**	**N**	**%**
Age				
< 13	57	1.0	47	1.1
13 – 24	178	3.1	154	3.4
25 – 34	1,149	20.2	1,012	22.7
35 – 44	1,443	25.3	1,253	28.1
45 – 54	1,028	18.1	824	18.4
55 – 64	1,188	20.9	801	17.9
65+	652	11.4	376	8.4
Total	**5,695**	**100.0**	**4,467**	**100.0**
Race/ethnicity				
American Indian/Alaska Native	30	0.5	22	0.5
Asian	171	3.0	147	3.3
Black/African American	1,941	34.2	1,401	31.5
Hispanic/Latino	1,895	33.4	1,735	39.0
Native Hawaiian/Pacific Islander	38	0.7	31	0.7
White	1,487	26.2	1,010	22.7
Multiple Races	119	2.1	---	---
Total	**5,681**	**100.0**	**4,454**	**100.0**
Gender Identity				
Male	4,697	82.5	3,720	83.4
Female	998	17.5	742	16.6
Total	**5,695**	**100.0**	**4,462**	**100.0**

Source: Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Data Report 2024. https://ryanwhite.hrsa.gov/data/reports. Published December 2025.

From 2020 - 2022, the number of clients in Nevada and the Las Vegas TGA decreased, before steadily increasing in 2023 and 2024 (Figure 2).[2]

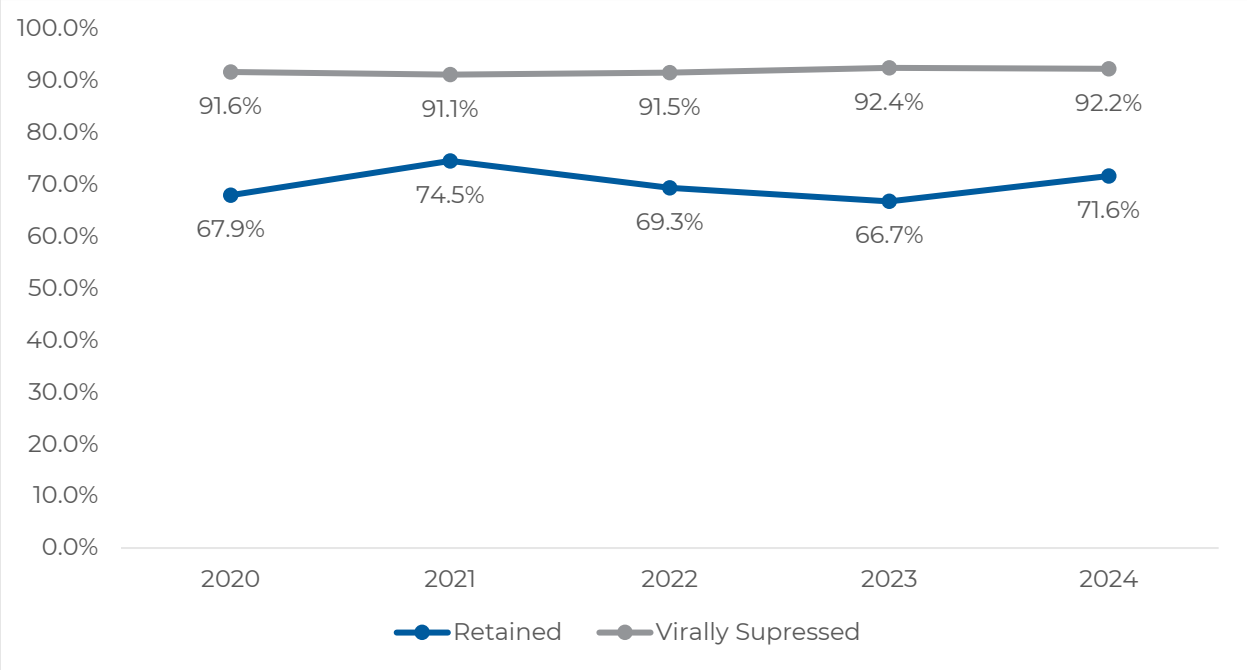
Figure 2. Number of Ryan White clients (non-AIDS Drug Assistance Program (ADAP)) in Nevada and in the Las Vegas TGA, 2020 – 2024.



Source: Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Data Report 2024. https://ryanwhite.hrsa.gov/data/reports. Published December 2025.

Figure 3 demonstrates the proportion of Ryan White clients in Nevada who were virally suppressed remained high and stable between 2020 (91.6% of clients) and 2024 (92.2% of clients).2 The proportion of clients retained in care fluctuated between 2020 and 2024, but did increase between 2020 (67.9%) and 2024 (71.6%) .

Figure 3. Percentage of Ryan White clients (non-ADAP) in Nevada and in the Las Vegas TGA who were retained in care and virally suppressed, 2020 – 2024.



Source: Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Data Report 2024. https://ryanwhite.hrsa.gov/data/reports. Published December 2025.

2024 HIV Continuum of Care

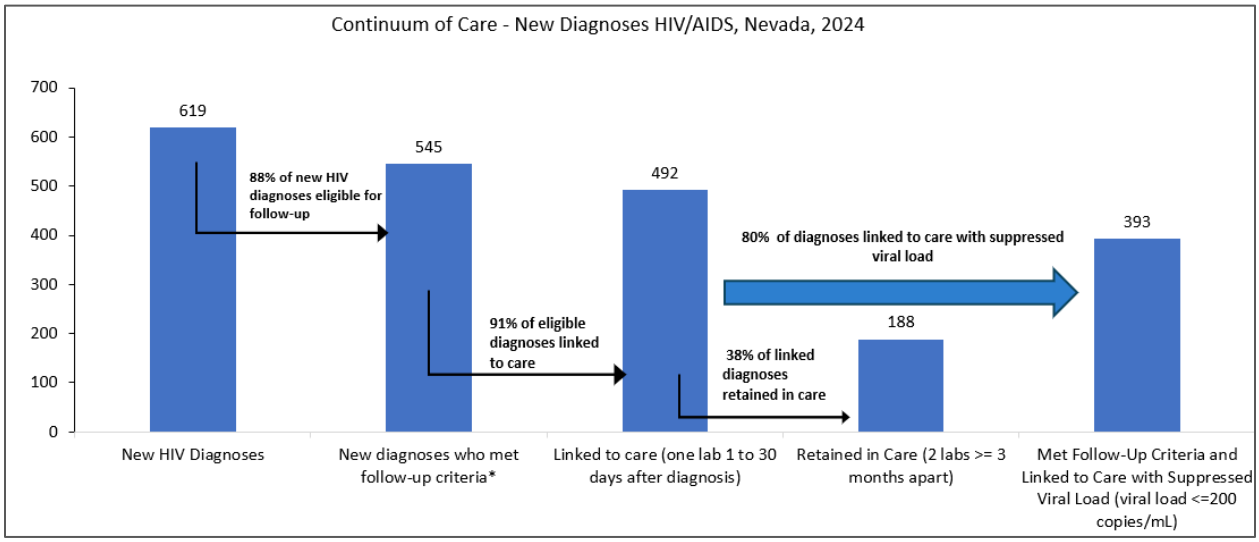
Figure 4 provides the most recent 2024 HIV Continuum of Care (CoC) data for Nevada.[1] Among the 619 persons newly diagnosed with HIV or Stage 3 HIV in Nevada in 2024, 88% were still alive and living in Nevada 15 months post-diagnosis. Of those still living in Nevada, 91% were linked to care within 1 month of diagnosis, and 80% of those persons had a suppressed viral load.

Corresponding figures are not provided in this document to illustrate the disparities in linkage to care and viral suppression that exist within subgroups of PLWH in Nevada described below:[1]

- Proportionally fewer females were linked to care within a month following diagnosis compared to males, 86% and 91% respectively, although proportionally fewer males achieved viral suppression once linked to care, compared to females, at 79% and 82% respectively.

- Those aged 15 to 19 years (73%) and 55 to 64 years (83%) had the lowest proportion linked to care, and the 15-to-19-year-old group (64%) and the 40-to-44-year-old group (71%) were the lowest proportion to achieve viral suppression, by age.
- Of those who are White, non-Hispanic, 85% were linked to care within a month following diagnosis, which was the lowest among all race/ethnicities, with the exception of multi-race at 71%, however the multi-race number is small (n < 10) and should be interpreted with caution.
- White, non-Hispanic were lowest in terms of viral suppression as well at 77%, with the exception of American Indian at 67%, however the American Indian number is small (n < 5) and should be interpreted with caution as well.
- Those with no reported risk factor (81%), those who identified as MSM and IDU (82%), and those who identified as IDU only (83%) were the lowest proportion to be linked to care among the risk groups.
- Those who identified as IDU (70%) and those with no reported risk factor (74%) were the lowest proportions to achieve viral load suppression among the risk groups.

Figure 4: Continuum of Care among New HIV Diagnoses, Nevada, 2024



Note: *Met follow-up criteria is alive 15 months post-diagnosis and still living in Nevada.

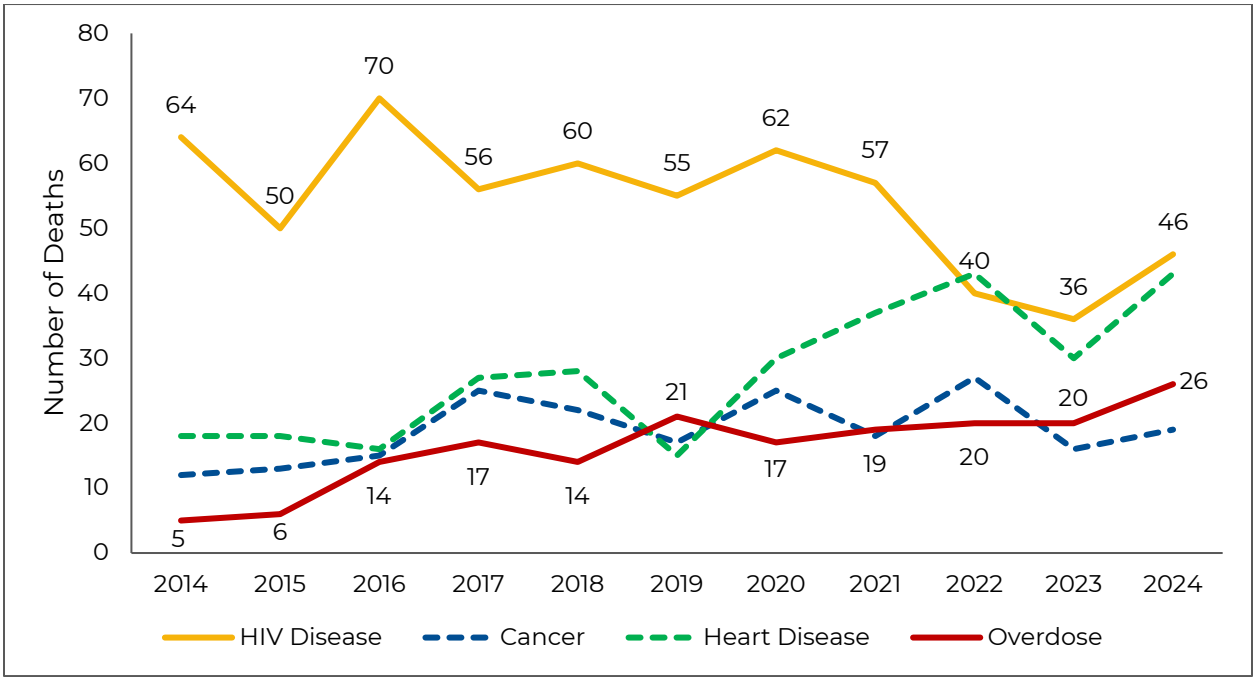
Source: Nevada Office of Analytics, data provided upon request.

Leading Causes of Death among People with HIV

The Nevada Office of Analytics was provided code from Washington Department of Health to produce a cause of death analysis with special attention to causes of death due to overdose. Results are presented in Figure 5.[1] From 2014 to 2024 the number of persons with HIV who died due to overdose increased from 5 to 26 (Figure 5). As of 2024, overdoses due to drugs accounted for 12.8% of deaths among

those with HIV in Nevada. Note the cause of deaths provided in Figure 5 are only shown for HIV-related, cancer, heart disease, and overdose, there were other causes of death contributing to the 202 deaths occurring in 2024 among those with HIV.

Figure 5. Leading Causes of Death Among People Living with HIV in Nevada, 2021-2024.



Note: Overdose included ICD Code of X41-X44, X61-X64, or Y12-Y11 anywhere on the death certificate. HIV included ICD code of B20-24, B59, or R75 AND evidence of uncontrolled HIV (final VL>5000 and final CD4<200 OR no viral load within 2 years of death).

Source: Nevada Office of Analytics, data provided upon request.

Sexual Health and Substance Use Indicators for High School Students

Data from the Nevada High School Youth Risk Behavior Survey (YRBS) Comparison Report, 2023-2025 related to sexual health and substance use are summarized below:[3]

- There were no significant changes in sexual behaviors among high school students from 2023 to 2025.
- There was a significant increase in the percentage of high school students who had ever taken prescription pain medicine without a prescription or differently than a doctor told them to use it and who had done so in the 30 days before the survey.

- There were no significant changes in use of other illegal drugs including cocaine, heroin, or methamphetamines among high school students from 2023 to 2025.
- In 2025:
    - 29.6% of high school students reported ever having sexual intercourse
    - 50.1% of sexually active high school students used a condom the last time they had sexual intercourse
    - 19.8% of high school students who were sexually active in the last 3 months used no form of pregnancy prevention during last sexual intercourse with opposite-sex partner
    - 3.3% of all high school students had ever injected any illegal drug
    - 16.3% of all high school students had ever misused a prescription drug
    - 25.5% of high school students though it would be easy to get prescription pain medicine if they wanted some

3.3: HIV Prevention, Care and Treatment Resource Inventory

The Nevada Syndemic Resource Inventory reflects programs and organizational funding for syndemic activities and was adapted from the HIV Inventory Resource Compiler Tool. Table 6 contains information regarding the funder, funding source, organization receiving the funding, the subrecipients of funds, and services delivered. Both the HIV care continuum steps and EHE pillars addressed by each funding source are indicated in the left-hand columns. Additional funding sources which address conditions other than HIV were encouraged to be reported, therefore not all funding sources have a corresponding HIV or EHE pillar indicated. The tables were developed and produced using the Resource Inventory Compiler Tool provided by the Integrated HIV/AIDS Planning Technical Assistance Center.

The funding summary described below includes HIV-specific funding sources only. Note the descriptions are based on data reported, which may not reflect the full amount of funding received to support people living with HIV.

The largest source of reported HIV funding in Nevada is through the HRSA AIDS Drug Assistance Program, followed by RWHAP. Clark County Social Services (Clark County) serves as the head of RWHAP Part A in Nevada, and these funds are used to provide core medical and support services for PLWH. Treatment and care services provided using these funds are delivered by agencies in Nevada that follow RWHAP standards.[4] The Las Vegas TGA Planning Council is a collaborative of service providers representing a variety of disciplines in the Las Vegas TGA and sets the basis for funding decisions, with the recipient's office handling awarding of contracts to service agencies. The Las Vegas TGA hosts monthly Action Planning Group (APG) meetings to discuss coordination of services and resources for clients.[5]

The second largest source of funding reported by HIV Prevention and Surveillance Programs is from the CDC. The Nevada Office of HIV, Prevention and Surveillance Program staff are responsible for coordination prevention and surveillance efforts with local health authorities, HPPGs, state and local HIV prevention providers, and other concerned and committed citizens. The Nevada Office of HIV contracts with three of Nevada's local health authorities (LHA) to fund prevention and surveillance activities, including Carson City Health and Human Services (CCHHS), Southern Nevada Health District (SNHD), and Northern Nevada Public Health (NNPH).

CCHHS serves Carson City, Douglas County, Lyon County, and Storey County, while NNPH serves Washoe County, all of which are counties in the northern part of Nevada. The Northern LHAs use CDC prevention funds to provide counseling, testing and referral services, community outreach, partner notification, and HIV/STD education, as well as disease surveillance. SNHD serves Clark County, the southern part of Nevada, where the majority of burden of disease occurs. SNHD uses HIV prevention funding, as well as RWHAP Part A and Part B funding, for HIV testing, HIV prevention efforts, early intervention services, and medical case management. Specific services provided by SNHD include HIV and STD testing, partner notification, HIV Client Centered Counseling, outreach programs, community referrals, and distribution of safer sex items. SNHD also receives additional CDC funding through EHE initiatives.

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

Although not all are reflected in Table 6, the RWHAP Part C funds are awarded to CBOs and service providers to support early intervention services and care. In Nevada, Northern Nevada HOPES in Reno, and University Medical Center (UMC) in Las Vegas, receive RWHAP Part C funds. RWHAP Part D funds are used to support family-centered, comprehensive care to women, infants, children, and youth living with HIV. In Nevada, Northern Nevada HOPES in Reno and the Maternal and Child Wellness Program at University of Nevada, Las Vegas (UNLV) – College of Medicine receive RWHAP Part D funds. RWHAP Part F funds are awarded to education and training programs for health care providers treating PLWH. The AIDS Education and Training Center (AETC) within the University of Nevada, Reno Office of Statewide Initiatives receives Part F funds.

Finally, Nevada receives funding through HUD to support the Housing Opportunities for Persons with AIDS (HOPWA) program. These funds are used to

provide housing support assistance for PLWH. The City of Las Vegas receives HUD/HOPWA funds to support PLWH in Southern Nevada while Northern Nevada HOPES (NN HOPES) receives HUD/HOPWA funds to support PLWH in Northern Nevada.

3.3.a: Assessment of Strengths and Gaps across the HIV Prevention and Care Continuum

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

Several important gaps emerged during development of the resource inventory worth noting. As described in the Approaches and Partnerships subsection, the Internal Workgroup collaborated with program staff of agencies and programs receiving HIV funding to complete the resource inventory assessment and made several attempts to collect resource information across several months. Another potential gap is that many programs in northern Nevada currently operate on very limited budgets due to the high burden of HIV in southern Nevada. This leaves programs with resources to carry out only required activities and have little time and flexibility for conducting additional activities that could benefit PLWH and people at-risk for HIV in Nevada. Additionally, Nevada relies heavily on federal funding from HRSA, CDC, and HUD for HIV prevention, treatment, and ancillary care services.

3.3.b: Approaches and partnerships

The Internal Workgroup discussed several strategies for completing the resource inventory. Ultimately, the Internal Workgroup decided the most streamlined method for completing the resource inventory that would avoid possible duplication of reported funding was to have program leaders from agencies and organizations receiving Syndemic-related funding complete the Resource Inventory Compiler Tool. Given the uncertain federal landscape related to health funding, the Internal Workgroup offered a survey so Syndemic Partners could report which services would be prioritized or dropped, if their organizations were to be required operate with a substantial loss in budget or a federal shift in priorities. Among responding agencies, most indicated they would prioritize direct patient services and would drop case management, administrative, or other supportive services. After individual program leaders completed the tool, the Office of State

Epidemiology combined all funding information to produce Table 6 and reviewed the Resource Inventory to ensure that there was no duplication of data.

Table 6: Resource inventory.

					HIV Care Continuum Steps Impacted					EHE Strategies			
Funder	Funding Source	Organization Receiving the Funding	Subrecipients	Services Delivered	HIV Diagnosis	Linkage to Care	Engagement or Retention in Care	Prescription of ART	Viral Suppression	Diagnose	Treat	Prevent	Respond
HRSA	-	NN HOPES	-	Early Intervention Services (EIS), Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Mental Health Services, Outpatient/Ambulatory Health Services, Food Bank/Home Delivered Meals, Medical Transportation/Rideshare Linkages to Treatment/Recovery, Non-Medical Case Management Services, Psychosocial Support Services, Referral for Health Care and Support Services									
HRSA	-	NN HOPES	-	Early Intervention Services (EIS), Medical Nutrition Therapy, Substance Abuse Outpatient Care, Health Education/Risk Reduction, Outreach Services, Referral for Health Care and									

				Support Services, Perinatal HIV prevention and surveillance, PrEP delivery, Prevention for persons living with diagnosed HIV infection, Medication for Opioid Use Disorder (MOUD) or Medication Assisted Treatment (MAT), Prevention for substance use/misuse, Peer Recovery Support Specialist Services (PRSS)/Community Health Workers					
HOPWA	-	NN HOPES	-	Housing/Recovery Housing/Housing Assistance, Referral for Health Care and Support Services					
CDC	OD2A	DPBH	UNR Larson Institute, Foundation for Recovery, NAMI Western NV, Washoe County Regional Medical Examiners, Board of Pharmacy, SNHD	Health Education/Risk Reduction, Medical Transportation/Rideshare Linkages to Treatment/Recovery, Non-Medical Case Management Services, Outreach Services, Referral for Health Care and Support Services, Community engagement, Social marketing campaigns, Surveillance/Data Systems Strengthening, Overdose Prevention Supply Distribution	✓	✓		✓	✓	✓

				(Naloxone/Narcan, Fentanyl and Xylazine Test Strips), Prevention for substance use/misuse, Peer Recovery Support Specialist Services (PRSS)/Community Health Workers						
SAMHSA	SUPTR	DPBH	CARE Coalition, PACT Coalition, PACE, Join Together Northern NV, Nye Community Coalition, UNR PEAT, Churchill Community, Frontier Community Coalition, Nevada Public Health Foundation Inc, North & South, Family Support Center, Washoe County, Clark County, Ridge	Substance Abuse Outpatient Care, Legal Services/System Navigation and Reentry Services, Medical Transportation/Rideshare Linkages to Treatment/Recovery, Outreach Services, Referral for Health Care and Support Services, Capacity building/Technical Assistance/Workforce Training, Community engagement, Social marketing campaigns, Surveillance/Data Systems Strengthening, Overdose Prevention Supply Distribution (Naloxone/Narcan, Fentanyl and Xylazine Test Strips), Prevention for substance use/misuse,	✓	✓		✓	✓	✓

	House, Carson City Community Counseling Center, RNC, New Frontier, Living Free Health & Fitness, Step 1, 8th Judicial LIMA, 8th Judicial Jail De-Pop, WestCare, Living Free and Fitness, UNR Prenatal Health Education, WestCare - Transitional Housing, Foundation for Recovery, Tru Vista, Ridge House, RISE, NDVS, Oxford House, Foundation for Recovery - Mobilize Recovery, Foundation for Recovery - RFW, Healthy	Overdose Ambassador/Peer Outreach/Prevention/Crisis Response Teams, Peer Recovery Support Specialist Services (PRSS)/Community Health Workers	

			Communities Coalition, Partnership Douglas County, New Frontier, Nevada Public Health Foundation Inc, North & South, Family Support Center, Washoe County, Clark County, UNR CASAT										
HRSA	DPBH	ACCEPT	-	Health Education/Risk Reduction, Medical Transportation/Rideshare Linkages to Treatment/Recovery, Non-Medical Case Management Services, Outreach Services, Referral for Health Care and Support Services	✓	✓		✓					✓
CDC	PS21-2102 Comprehensive High Impact Prevention (NCHHSTP)	The LGTBQ Center	-	Outreach Services, Community engagement, Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, PrEP delivery, Prevention for persons living with diagnosed HIV infection,	✓	✓	✓	✓	✓	✓	✓	✓	✓

				Social media strategies, Screening and Testing, Mobile Health Services										
SAMHSA	Substance Abuse and Mental Health Services - Projects of Regional and National Significance	The LGBTQ Center	-	Mental Health Services, Substance Abuse Outpatient Care, Housing/Recovery Housing/Housing Assistance, Medical Transportation/Rideshare Linkages to Treatment/Recovery, Outreach Services, Referral for Health Care and Support Services, Community engagement, Condom distribution, PrEP delivery, Prevention for persons living with diagnosed HIV infection, Social marketing campaigns, Screening and Testing, Overdose Prevention Supply Distribution (Naloxone/Narcan, Fentanyl and Xylazine Test Strips), Medication for Opioid Use Disorder (MOUD) or Medication Assisted Treatment (MAT), Prevention for substance use/misuse, Overdose Ambassador/Peer Outreach/Prevention/Crisis	✓	✓	✓	✓	✓	✓	✓	✓	✓

				Response Teams, Peer Recovery Support Specialist Services (PRSS)/Community Health Workers							
SOR	SOR	The LGBTQ Center	-	Medical Transportation/Rideshare Linkages to Treatment/Recovery, Outreach Services, Community engagement, Community mobilization, Condom distribution, Perinatal HIV prevention and surveillance, Prevention for persons living with diagnosed HIV infection, Social marketing campaigns, Screening and Testing, Overdose Prevention Supply Distribution (Naloxone/Narcan, Fentanyl and Xylazine Test Strips), Medication for Opioid Use Disorder (MOUD) or Medication Assisted Treatment (MAT), Prevention for substance use/misuse, Mobile Health Services, Overdose Ambassador/Peer Outreach/Prevention/Crisis Response Teams, Peer Recovery Support	✓	✓	✓		✓	✓	✓	✓

				Specialist Services (PRSS)/Community Health Workers							
CDC	-	Northern Nevada Public Health	-	Outreach Services, Community engagement, HIV transmission cluster and outbreak identification and response, Partner services, Perinatal HIV prevention and surveillance, PrEP delivery, Prevention for persons living with diagnosed HIV infection, Social marketing campaigns, Social media strategies, Surveillance/Data Systems Strengthening, Screening and Testing	✓	✓	✓	✓	✓		
CDC	HIV Prevention/HIV Surveillance	Carson City Health and Human Services	-	Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Perinatal HIV prevention and surveillance, Prevention for persons living with diagnosed HIV infection, Screening and Testing	✓	✓				✓	✓
CDC	HIV Prevention and Surveillance Program	Carson City Health and Human Services	-	Referral for Health Care and Support Services, Partner services, Prevention for persons living with diagnosed HIV infection, Surveillance/Data	✓					✓	✓

				Systems Strengthening, Screening and Testing					
CDC	PS 19-1901	LifeCare Partners	-	AIDS Drug Assistance Program Treatments, Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Outpatient/Ambulatory Health Services, Health Education/Risk Reduction, Medical Transportation/Rideshare Linkages to Treatment/Recovery, Other Professional Services, Outreach Services, Referral for Health Care and Support Services, Community engagement, Condom distribution, Partner services, Perinatal HIV prevention and surveillance, PrEP delivery, Prevention for persons living with diagnosed HIV infection, Social media strategies, Surveillance/Data Systems Strengthening, Screening and Testing	✓	✓	✓	✓	✓
CDC	Viral Hepatitis	SNHD	-	Outreach Services, Partner services, Prevention for substance use/misuse,					

				Health Services for Incarcerated Persons							
CDC	HIV Prevention	SNHD	-	Health Education/Risk Reduction, Non-Medical Case Management Services, Referral for Health Care and Support Services, Capacity building/Technical Assistance/Workforce Training, Community engagement, HIV transmission cluster and outbreak identification and response, Partner services, Perinatal HIV prevention and surveillance, Syringe services programs, Screening and Testing	✓	✓	✓		✓	✓	✓	✓
CDC	HIV Surveillance	SNHD	-	HIV transmission cluster and outbreak identification and response, Partner services, Perinatal HIV prevention and surveillance, Surveillance/Data Systems Strengthening	✓		✓					
CDC	Overdose Data to Action	SNHD	-	Outreach Services, Referral for Health Care and Support Services, Capacity building/Technical Assistance/Workforce Training, Community engagement, Community mobilization, Prevention								

				for substance use/misuse, Health Services for Incarcerated Persons, Peer Recovery Support Specialist Services (PRSS)/Community Health Workers
CDC	STD Prevention	SNHD	-	Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services, Community engagement, Partner services, Surveillance/Data Systems Strengthening, Screening and Testing, Health Services for Incarcerated Persons
CDC	Office of Behavioral Health Wellness and Prevention	SNHD	Foundation for Recovery, PACT Coalition, Rescue	Health Education/Risk Reduction, Referral for Health Care and Support Services, Capacity building/Technical Assistance/Workforce Training, Community engagement, Social marketing campaigns, Prevention for substance use/misuse
CDC	TB Surveillance	SNHD	-	Health Education/Risk Reduction, Outreach Services, Community engagement

CDC	Nevada EHE	SNHD	The Center, AIDS Healthcare Foundation, Impact Exchange, AETC, Rescue	Outreach Services, Referral for Health Care and Support Services, Capacity building/Technical Assistance/Workforce Training, Community engagement, HIV transmission cluster and outbreak identification and response, Partner services, Social marketing campaigns, Social media strategies, Screening and Testing, Health Services for Incarcerated Persons	✓	✓	✓		✓	✓	✓	✓
CDC	Strengthening STD Prevention and Control	Central Nevada Health District	-	Health Education/Risk Reduction, Capacity building/Technical Assistance/Workforce Training, Condom distribution, Partner services, Social marketing campaigns, Social media strategies, Surveillance/Data Systems Strengthening, Screening and Testing	✓	✓						
COSSUP	American Rescue Plan Act of 2021, U.S. Treasury, Coronavirus State Fiscal Recovery Funds (CSFRF)	Central Nevada Health District	-	Health Education/Risk Reduction, Linguistic Services, Outreach Services, Referral for Health Care and Support Services, Capacity building/Technical Assistance/Workforce	✓	✓						

				Training, Community engagement, Condom distribution, Partner services, Social marketing campaigns, Social media strategies, Screening and Testing, Overdose Prevention Supply Distribution (Naloxone/Narcan, Fentanyl and Xylazine Test Strips)					
HRSA	Ryan White Part A	Clark County	AIDS Healthcare Foundation, CAN Community Health, The Center, Community Counseling Center, Community Outreach Medical Center, CPLC Nevada, Inc., Dignity Health, North Country Health Care, Nye County HHS, Southern Nevada Health District, University	Early Intervention Services (EIS), Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Case Management, including Treatment Adherence Services, Mental Health Services, Oral Health Care, Outpatient/Ambulatory Health Services, Substance Abuse Outpatient Care, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Linguistic Services, Medical Transportation/Rideshare Linkages to Treatment/Recovery, Referral for Health Care and Support Services	✓	✓	✓	✓	✓

			Medical Center Wellness Center										
HRSA	Minority AIDS Initiative	Clark County	Asian Community Resource Center, Access to Healthcare Network, CAN Community Health, Dignity Health, REACH, Vegas Stronger	Outreach Services	✓	✓							
HRSA	Ending the HIV Epidemic	Clark County	AIDS Healthcare Foundation, CAN Community Health, Clark County Social Services, Community Counseling Center, Community Outreach Medical Center, Dignity Health, Southern Nevada Health District, The Center, University	Medical Case Management, including Treatment Adherence Services, Mental Health Services, Linguistic Services, Medical Transportation/Rideshare Linkages to Treatment/Recovery, Psychosocial Support Services, Capacity building/Technical Assistance/Workforce Training, Community engagement, HIV transmission cluster and outbreak identification and response, Social marketing campaigns, Peer Recovery Support Specialist Services	✓	✓	✓	✓	✓	✓	✓		✓

			Medical Center Wellness Center	(PRSS)/Community Health Workers			
HRSA	Status Neutral Approaches for Racial & Ethnic Minorities	Clark County	Southern Nevada Health District	Non-Medical Case Management Services, Outreach Services, Community engagement	✓		
HOPWA	HOPWA	Aid for AIDS of Nevada	-	Emergency Financial Assistance, Permanency Planning			
HRSA	Ryan White Part B	Aid for AIDS of Nevada	-	Non-Medical Case Management Services			
HRSA	HRSA	Access To HealthCare Network	-	AIDS Drug Assistance Program Treatments, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Nutrition Therapy, Health Education/Risk Reduction, Medical Transportation/Rideshare Linkages to Treatment/Recovery, Non-Medical Case Management Services, Other Professional Services, Referral for Health Care and Support Services		✓	✓

3.4: Needs Assessments

Prior to the formation of the Syndemic Workgroups, a needs assessment was conducted in late 2025 and early 2026 to understand needs and priorities for HIV prevention, treatment, and ancillary care services in the state. The Nevada Division of Public and Behavioral Health Office of State Epidemiology team led the Syndemic Needs Assessment in collaboration with the Larson Institute/UNR School of Public Health and the Office of HIV within the Nevada Division of Public and Behavioral Health. The assessment included a community survey completed by 250 community members and a series of focus groups involving more than 80 individuals from priority populations across the state, including people living with HIV (PLWH), people of color, people who use substances, and young adults, across the state.

The most recent needs assessment specific to treatment and care for PLWH was conducted in early 2022 by Collaborative Research in partnership with the State of Nevada, RWHAP parts, the Las Vegas Transitional Grant Area (TGA), and Clark County Ending the HIV Epidemic.[6] These RWHAP parts, along with representatives from over 20 state and local health departments, CBOs, and service providers, offered guidance on survey development and dissemination and assisted with participant recruitment. Nearly 400 PLWH completed the assessment and provided valuable information about experiences with treatment and care in the state. These assessments were used to complete the situational analysis and to develop goals and objectives.

Limitations of Syndemic Needs Assessments

Since the Nevada Syndemic Community Survey was primarily completed online and distributed through targeted outreach methods such as email listservs and community networks, participants were not randomly sampled. As a result, findings from the survey are not generalizable to the adult population in Nevada. However, the sample included participants across a wide range of age groups and demographic backgrounds. All study data were self-reported, which may have introduced social desirability bias, particularly for questions related to sensitive topics such as sexual behaviors, substance use, exposure to violence and discrimination, and experiences with healthcare and support services.

To help reduce this potential bias, participants completed the survey anonymously online without a researcher present, and no personal identifying information was collected. Focus groups and interviews were conducted both in person and virtually to increase accessibility and participation across communities throughout Nevada.

Despite these limitations, the Nevada Syndemic needs assessment provided valuable insight into community experiences, service gaps, and emerging priorities that helped guide the development of the Nevada Syndemic Plan goals and objectives.

Syndemic Needs Assessment – Community Survey

The 57-question community survey was completed by 281 respondents between October 7th of 2025 and May 1st of 2026. Of these, 31 responses were excluded due to ineligibility or insufficient survey completion, including those under 18 years of age (n=2), persons who did not reside in Nevada (n=3), respondents who provided only county of residence information (n=11), completed only demographic questions (n=6), or indicated they were over 18 but left the eligibility question incomplete (n=9). The survey instrument was drafted by the OSE team and the Nevada Office of HIV and was shared with the Syndemic Planning Group. The survey was piloted with persons who identified with the populations identified in Table 1 to solicit feedback. Topics covered in the survey included HIV, STI, and HCV testing, sexual health behaviors, Doxy PEP, PrEP, injection drug use, substance use behaviors, exposure to violence and discrimination, and information and services. Data were collected electronically, cleaned using Microsoft Excel, and analyzed using SAS Version 9.4 (SAS Institute, Cary, NC). Sociodemographic characteristics of community survey participants are presented in Table 7.

Table 7. Sociodemographic characteristics of community survey participants, Nevada Syndemic Plan Community Assessment.

Demographic Characteristics (n=250)	N	Percent
County of Residence		
Clark County	181	72.4
Washoe County	50	20.0
Quad counties (Carson, Douglas, Storey, Lyon)	14	5.6
Other rural counties	5	2.0
Total	250	100.0
Age		
18-24	13	5.2
25-34	54	21.6
35-44	66	26.4
45-54	45	18.0
55-64	29	11.6
65 and older	21	8.4
Missing or prefer not to disclose	22	8.8
Total	250	100.0
Primary Race or Ethnicity		
American Indian or Alaska Native	6	2.4
Asian/ Native Hawaiian or Pacific Islander	31	12.4
Black or African American	39	15.6
Hispanic/ Latinx/o/a	37	14.8
White	97	38.8
Multi-race/ ethnicity	33	13.2
Other and missing	7	2.8

Demographic Characteristics (n=250)	N	Percent
Total	250	100.0
Gender		
Male	64	26.8
Female	175	73.2
Total	239	100.0
Sexual Orientation		
Straight/ Heterosexual/ Heteroromantic	165	66.0
Gay	38	15.2
Lesbian	6	2.4
Bisexual	17	6.8
Queer	11	4.4
Asexual	2	0.8
Pansexual/ Panromantic	8	3.2
Questioning	2	0.8
Blank	1	0.4
Total	250	100.0
Educational Attainment		
Some high school (no diploma)	4	1.6
High school graduate (or equivalent, such as GED)	27	10.8
Technical school degree (such as cosmetology or computer technician)/ Associate degree (AA, AS, etc.)	44	17.6
Bachelor's degree (BA, BS, etc.)	74	29.6
Master's degree (MA, MS, MSW, etc.)/ Doctorate or professional degree (PhD, MD, JD, etc.)	100	40.0
Don’t know	1	0.4
Total	250	100.0

Source: 2027-2031 Syndemic Plan Community Survey.

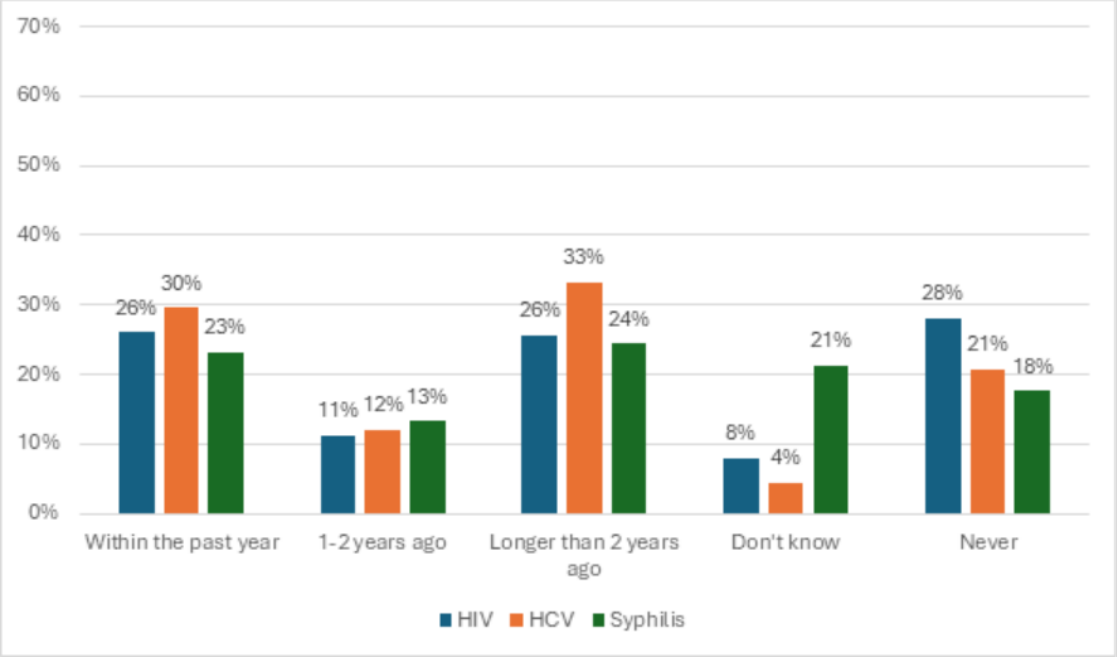
Overall, the demographic characteristics of community survey participants reflected a diverse sample across Nevada. Participants represented multiple regions of the state, with most respondents residing in Clark County (72.4%), followed by Washoe County (20.0%). The largest age group represented was adults ages 35–44 (26.4%), followed by adults ages 25–34 (21.6%), and 45–54 (18.0%). Participants also represented a range of racial and ethnic backgrounds, with White participants accounting for 38.8% of the sample, followed by Hispanic/Latinx/o/a participants (14.8%), Black or African American participants (15.6%), and Asian, Native Hawaiian, or Pacific Islander participants (12.4%). Smaller proportions of participants identified as multi-race/ethnicity (13.2%) or American Indian or Alaska Native (2.4%).

Key Findings

About 37% of syndemic survey participants reported they had an HIV test in their lifetime. Of all respondents, 26% reported their HIV test occurred in the last 12

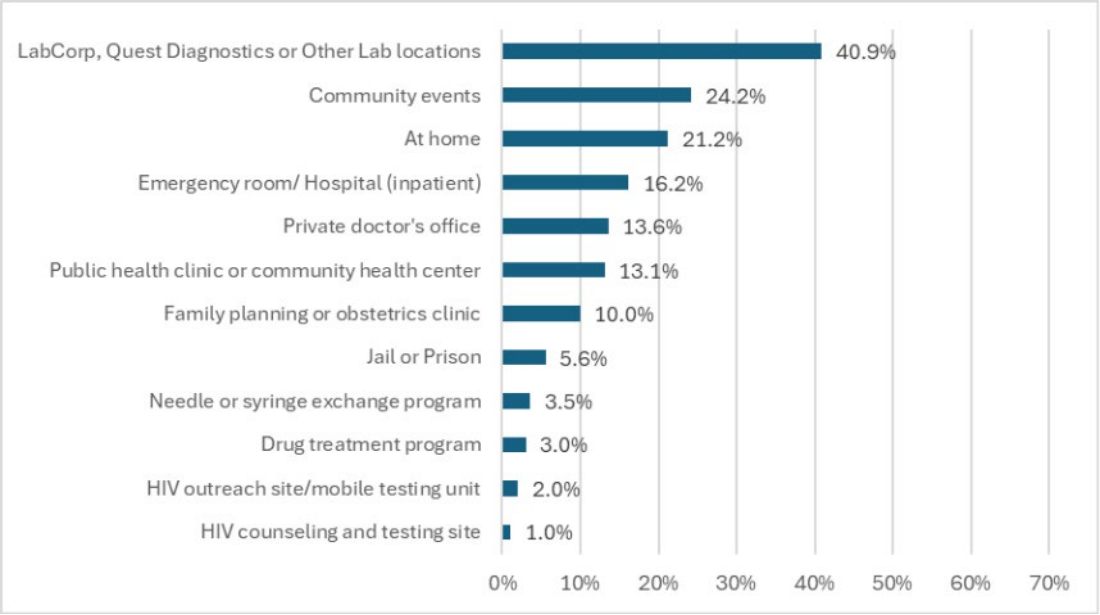
months. Of the three measured infections, respondents were least likely to report being tested for HIV, with 28% reporting no lifetime testing.

Figure 6. History of testing for HIV, Hepatitis C Virus, and syphilis (n=250).



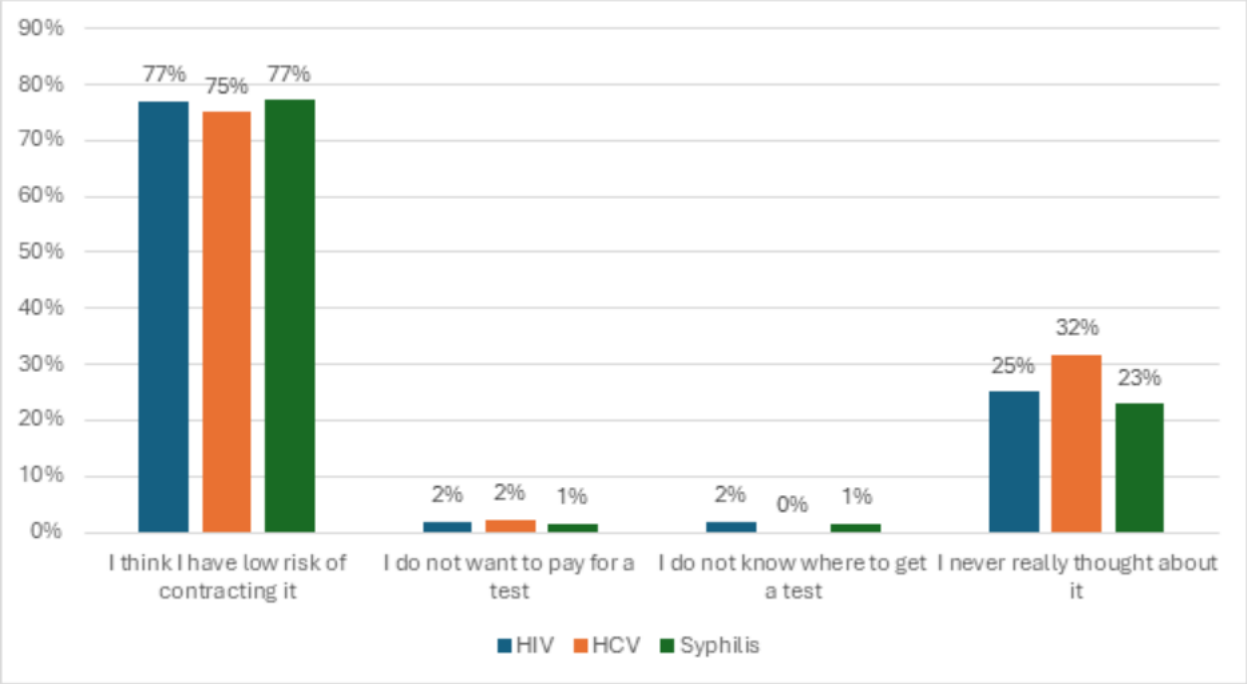
Over half of HIV tests were administered at outpatient laboratories (40.9%) or community events (24.2%). Other common testing locations included at-home testing (21.2%) and emergency rooms or hospitals (16.2%).

Figure 7. Testing locations for HIV (n=198).



Among the subset of participants who had never had an HIV test, main reasons for not having ever received an HIV test included low perceived risk of contracting HIV (76.9%), never having thought about it (25%), not wanting to pay for an HIV test (1.9%) and not knowing where to get a test (1.9%). Similar findings were observed for hepatitis C and syphilis testing.

Figure 8. Reasons for not having HIV (n=52), Hepatitis C (n=44), or syphilis (n=70) testing, among community survey respondents.



Note: HIV missing n=4; HCV missing n=3; Syphilis missing n=7.

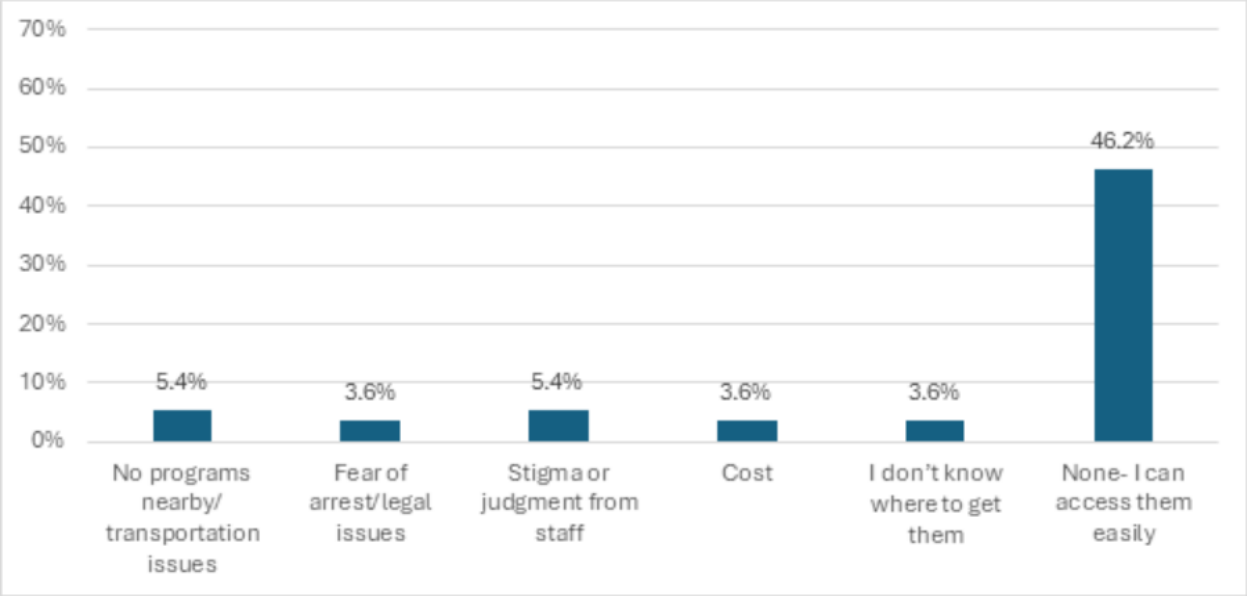
About 70% of syndemic community survey participants had heard of pre-exposure prophylaxis (PrEP) prior to completing the survey. Further, 7.7% of participants had spoken to a doctor or provider about PrEP and 4.6% of participants were using PrEP or had used PrEP at some point in the past. Among those who did not use PrEP, 100% were willing to use PrEP in the future.

In the syndemic Community survey, nearly 75% of participants reported being sexually active in the last 12 months. Over 80% of sexually active participants reported having sex without condoms in the last 12 months. Although, 87% reported feeling confident or very confident with convincing their partners to use condoms. Participants also reported feeling confident talking about safer sex with partners (90.4%) and asking partners about other sexual partners they have (86.2%).

Regarding injection substance use, about 16% of syndemic community survey participants had injected a substance in the past year, including medications or drugs. Among those who injected a substance, only 59% always used a clean syringe. Some participants (39.3%) felt it would be easy or very easy to access

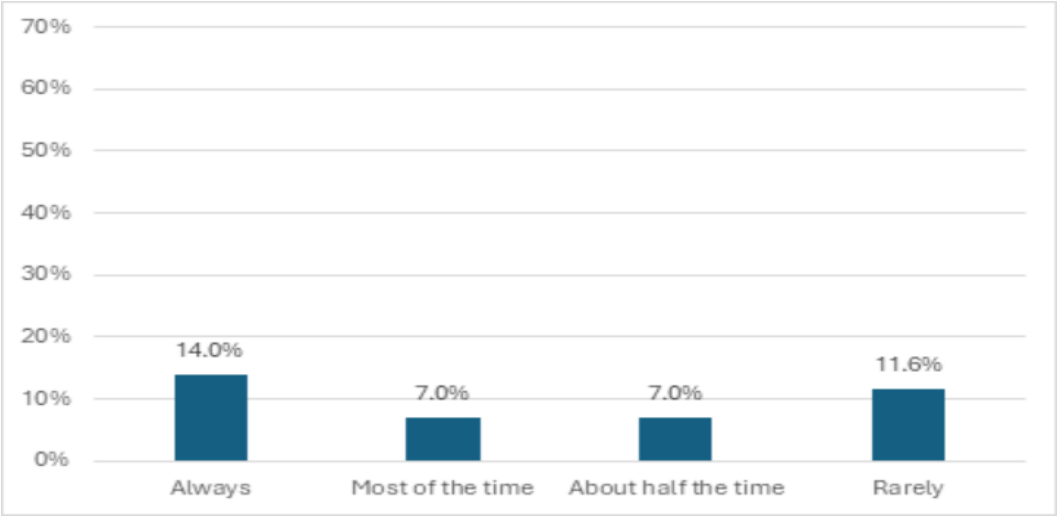
syringes from a syringe service program. Nearly half (46.2%) reported having no barriers to accessing clean syringes. Figure 9 shows the variety of barriers participants reported.

Figure 9. Barriers to accessing clean syringes among people who inject drugs, substances, or medications (n=56).



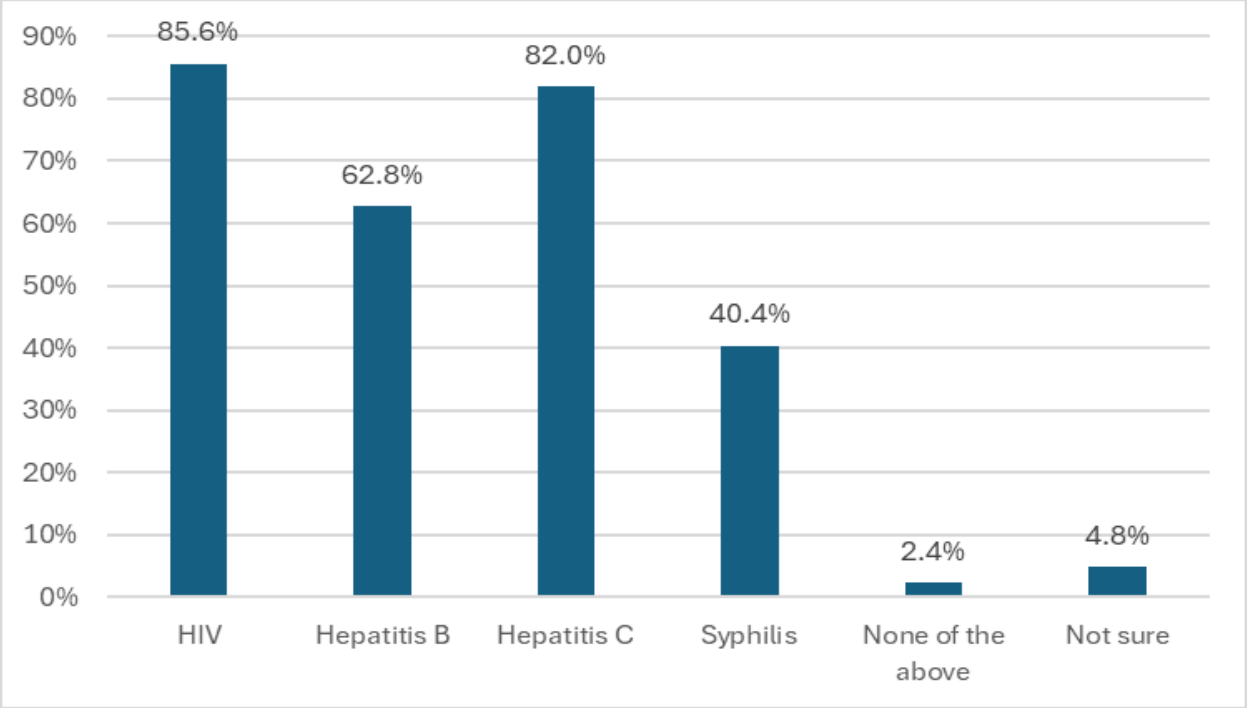
In terms of overall services for people who use drugs, most participants (50.8%) thought services were somewhat accessible in their community. Among all participants, 9.2% reporting using illicit drugs or misusing prescription medications in the last 12 months. Of these, 28% reporting taking drugs alone at least half the time in the last year, and 11.6% had a lifetime history of drug overdose. Figure 10 shows participant frequency of taking drugs while alone.

Figure 10. Past 12-month history of using drugs while alone (n=43).



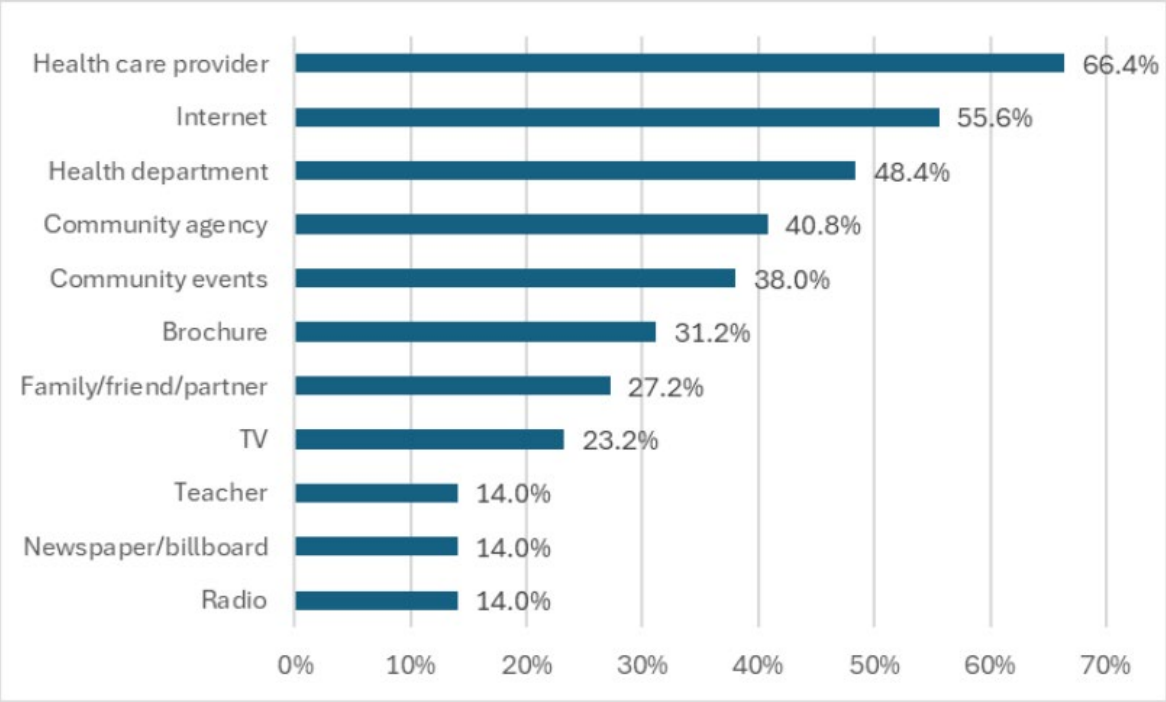
Over 40% of participants who reported illicit drug use or medication misuse had not heard of drug testing strips before the survey. Of all participants, there was a variety of perceptions on which infections could be spread while using injection drug equipment. Most participants (85.6%) were knowledgeable of the potential of spreading HIV.

Figure 11. Respondent opinions on which conditions can be spread by sharing needles or other injection equipment (n=250).



Most participants were interested in receiving sexual health information from a healthcare provider, on the internet, or from a health department or agency.

Figure 12. Desired sources for accessing sexual health information among community survey participants (n=250).



Syndemic Needs Assessment – Focus Groups

In addition to the community survey, a series of 12 syndemic focus groups and 6 individual interviews were conducted between December 7, 2025, and April 14, 2026, with a total of 88 participants. All 12 focus groups and one individual interview were conducted in person, while the remaining five individual interviews were conducted virtually through Zoom/Teams. Audio from all focus groups and interviews were recorded and auto transcribed and thoroughly reviewed for accuracy by members of the Office of State Epidemiology team. The Larson Institute team analyzed the data using a condensed inductive thematic analysis approach.

Table 8. Sociodemographic characteristics of focus group participants, Nevada Syndemic Plan Community Assessment (n=88).

Demographic Characteristics	N	%
County of Residence		
Clark County	46	52.3
Washoe County	14	15.9
Quad Counties (Carson, Douglas, Storey, Lyon)	22	25.0
Other Rural Counties	6	6.8
Total	88	100.0
Age		
18-24	6	6.8
25-34	13	14.8
35-44	15	17.0
45-54	14	15.9
55-64	18	20.5
65 and older	21	23.9
Missing	1	1.1
Total	88	100.0
Primary Race or Ethnicity		
American Indian or Alaska Native	3	3.4
Asian/ Native Hawaiian or Pacific Islander	2	2.3
Black or African American	18	20.5
Hispanic/ Latinx/o/a	15	17.0
White, non-Hispanic	41	46.6
Multi-race/ethnicity	6	6.8
Other and missing	3	3.4
Total	88	100.0
Gender		

Demographic Characteristics	N	%
Male	49	55.7
Female	38	43.2
Total	88	100.0
Educational Attainment		
Some high school (no diploma)	12	13.6
High school graduate (or equivalent, such as GED)	23	26.1
Some college, no degree	27	30.7
Technical school degree (such as cosmetology or computer technician)/ Associate degree (AA, AS, etc.)	12	13.7
Bachelor's degree (BA, BS, etc.)	13	14.8
Master's degree (MA, MS, MSW, etc.)/ Doctorate or professional degree (PhD, MD, JD, etc.)	1	1.1
Total	88	100.0
Identification Groups		
Sexually active individuals	52	59.1
People living with HIV	34	38.6
Individuals with a history of incarceration	26	29.5
Men who have sex with men	25	28.4
Former use of opioids or stimulants*	24	27.3
Currently using opioids or stimulants*	9	10.2
Current diagnosis or history of hepatitis C	5	5.7
Currently or previously engaged in sex work	4	4.5
Individuals who did not identify with any listed groups	8	9.1

* Non-medical use or used in a manner not prescribed.

Source: 2027-2031 Syndemic Plan focus groups demographic survey.

Focus group participants were asked to select one or more populations they identify with from a list of groups disproportionately impacted by syndemic conditions (Table 8). Among the 88 focus group respondents, 50.0% identified as non-White, 6.8% were between the ages of 18–24 years, and 1.1% identified as transgender or gender non-conforming. The most frequently selected identification group was sexually active individuals (59.1%), followed by people living with HIV (38.6%), individuals with a history of incarceration (29.5%), men who have sex with men (28.4%), and individuals in recovery from non-medical opioid or stimulant use (27.3%). Smaller proportions of respondents identified as currently using opioids or stimulants in a manner not prescribed (10.2%), having a current diagnosis or history of hepatitis C (5.7%), or currently or previously engaging in sex work (4.5%). Additionally, 9.1% of respondents did not identify with any listed priority population.

Key Findings

Nevada has several strong foundations for HIV testing and prevention, including community awareness of testing locations, trusted outreach through community events, rapid testing programs, syringe service programs, and alternative testing options such as home test kits and vending machines. Participants also identified strong peer networks, community-based naloxone distribution, and Ryan White-funded services as important strengths supporting prevention and linkage to care. The Rapid stART program, trusted providers, and outreach workers with lived experience were viewed as especially important for helping people quickly enter and remain engaged in HIV care.

At the same time, participants described ongoing barriers that continue to affect HIV prevention, testing, and treatment access. Stigma, fear of disclosure, low perceived HIV risk, immigration-related concerns, and distrust of healthcare systems were commonly identified challenges. Rural and frontier communities face additional barriers due to limited testing options, shortages of HIV specialty care and mental health services, transportation challenges, and fragmented systems of care. Participants also noted gaps in awareness of PEP and Doxy PEP, limited syringe service access in some areas, and concerns about funding instability and insurance-related barriers. Overall, stakeholders emphasized the need for more integrated care models, expanded peer-led outreach, broader and more inclusive prevention messaging, telehealth and mobile services, transportation support, and stronger mental health services to improve access and long-term engagement in care.

HIV Treatment and Care Needs Assessment

An HIV treatment and care needs assessment was conducted by Collaborative Research in partnership with the State of Nevada RWHAP Part B, the Las Vegas TGA, and the Clark County EHE teams.[6] The needs assessment consisted of a community survey among PLWH in Nevada.

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

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

Key Findings

Early intervention services are a critical component of providing newly diagnosed PLWH an opportunity to rapidly achieve viral suppression. Among PLWH who completed the treatment and care needs assessment, a little over one-third of participants (37.6%) reported that they needed early intervention services and were able to access them, while 21.5% of participants needed early intervention services and were not able to access them. Further, over two-thirds of participants felt early intervention services were very or extremely important for achieving and maintaining viral suppression and for ending the HIV epidemic.

Over half of participants left their medical visit with questions (55.1%) and 36.8% of participants whose HIV care provider did not speak their language felt their provider did not always use an interpreter. However, 82.0% of participants felt their provider spent enough time with them during visits. Over half of participants left their HIV case manager visits with questions (53.4%). Regarding potential language barriers, 34.3% of participants identified their HIV case managers not always using an interpreter. However, most participants felt their provider sometimes or always spent enough time with them (81.4%).

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

Outpatient ambulatory health services, early intervention services, and medical case management were the top three ranked service needs, although more than 44% of participants expressed that all service categories are extremely important.

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

3.4.a: Priorities

Syndemic Needs Assessment - Community Survey

Four major themes synthesized across survey responses:

- Health Behaviors and Perceived Risk
- Knowledge and Education
- Importance of Primary Care Settings

- Violence and Discrimination

1. Health Behaviors and Perceived Risk

- More than half of respondents engaged in at least one form of condomless sexual contact (e.g. oral sex, receptive or insertive vaginal or anal sex)
- Most respondents perceived they had low risk of being exposed to HIV, HCV, or syphilis at 76.9%, 75.0%, and 77.1% respectively. Which was the predominant reported reason for not having ever been tested for those infectious conditions
- Most participants reported they are somewhat or very confident they can speak with a casual partner about safer sex, ask a sexual partner about their other sexual partners, and/or convince a partner that they should use a condom
- Among those who reported having ever injected drugs, none indicated they had shared a syringe and most reported it is easy to obtain clean syringes through a pharmacy

2. Knowledge and Education

- Survey respondents were more knowledgeable about HIV testing and potential risk factors compared to other conditions such as syphilis or HCV
- More respondents reported they had heard about HIV PEP (70.4%) compared to Doxy PEP (50.8%)
- Less than half of survey respondents were aware syphilis could be transmitted through sharing of syringes
- The most frequently identified preferred source for receiving sexual health education was from a provider, followed by internet, health departments, and other community agencies

3. Importance of Primary Care Settings

- Among those tested for HIV, HCV, or syphilis, the most frequently identified setting for testing was through a primary care office/private provider (40.9%, 44.7%, and 49.4% respectively)
- Although respondents were not evaluated for individual risk, 17.5% indicated a healthcare provider has a discussion with them about taking Doxy PEP in the past 12 months

4. Violence and Discrimination

- Over one in four (26.8%) reported they had experienced discrimination in the past 12 months
- Overall, very few participants reported physical (4.0%) or sexual (2.8%) violence in the past 12 months

Syndemic Needs Assessments - Focus Groups

Eight major themes synthesized across all focus groups:

- Stigma and Shame as a Pervasive Barrier
- Gaps in Knowledge and Awareness — Uneven Across Populations
- Intersection of Substance Use and Sexual Health
- Fragmented, Inequitable Care
- Structural Barriers and Social Determinants of Health
- Rural-Specific Gaps
- What Works — Facilitators and Bright Spots
- What Participants Want — Recommendations

1. Stigma and Shame as a Pervasive Barrier Stigma emerged across every focus group as the most consistent barrier, cutting across HIV, STIs, and substance use.

- Fear of testing positive, shame around disclosing status or risky behaviors, and reluctance to discuss sexual health with providers were nearly universal
- Stigma is compounded for BIPOC, Latino, and LGBTQ+ communities, and is greater in rural and tribal settings where these topics are less openly discussed
- Internalized stigma around SUD — including shame when seeking basic care like detox or treatment for an abscess — deters help-seeking
- The emotional toll of living with HIV and not being able to talk openly about it was described as significant; building community was identified as essential
- Concern that naloxone and PrEP enable risky behavior reflects lingering stigma and misconceptions that complicate prevention messaging

2. Gaps in Knowledge and Awareness — Uneven Across Populations Awareness of prevention tools, transmission routes, and available services varied widely by population, geography, and age.

- Naloxone awareness was relatively strong; PrEP awareness was moderate but uneven; PEP and Doxy PEP were largely unknown across most groups
- Persistent misconceptions remain — that HIV is a "gay disease," that it is curable, and that modern medications eliminate the need for prevention behaviors
- Prevention advertising was seen as too narrowly targeted, reinforcing stereotypes and excluding heterosexual men, Black cis women, elderly populations, and rural communities
- Seniors, tribal communities, and youth were consistently identified as under-reached populations with distinct awareness gaps
- Outdated views on HIV transmission persist broadly, including misinformation about mother-to-child transmission and casual contact

3. Intersection of Substance Use and Sexual Health Participants consistently described substance use and sexual risk as deeply intertwined.

- Drug use and sexual behavior frequently co-occur, with substances influencing decision-making, medication adherence, and engagement in higher-risk behaviors
- Sex work intersects with both substance use and HIV/STI risk across multiple communities
- Substance use was described as a coping mechanism for trauma, pain, isolation, and stress — with addiction often intergenerational
- Withdrawal symptoms were identified as a direct barrier to safer use practices

4. Fragmented, Inequitable Care Participants described a healthcare system that is inconsistent, fragmented, and frequently failing those who need it most.

- Care is siloed — patients navigate multiple providers and locations for HIV, SUD, mental health, and primary care, creating gaps and burden
- Provider quality varies widely; some providers listen and screen comprehensively while others turn patients away, don't read charts, or perpetuate stereotypes
- Providers outside specialty settings are less educated on transmission, at-risk populations, and how to communicate a positive diagnosis
- High provider turnover disrupts continuity of care, particularly damaging for PLWH managing long-term treatment
- Insurance barriers — excessive documentation requirements, forced provider changes, and Ryan White bureaucracy — were described as exhausting and a driver of disengagement
- The cumulative burden of simultaneously attending multiple required programs while maintaining employment was identified as unsustainable (e.g., IOP, NA, etc.)
- Fear of funding cuts and losing access to life-saving medication was prominent among PLWH

5. Structural Barriers and Social Determinants of Health Structural conditions consistently compound health risks and limit access to care.

- Homelessness creates cascading barriers — no address for results, no phone for callbacks, medication loss or theft, and unsafe living conditions
- Transportation is a major barrier across settings — long bus routes, inability to reach services, and difficulty getting to pharmacies
- Cost of medications, insurance, food, and rent creates compounding financial strain that deprioritizes health
- Immigration status prevents some individuals from seeking care due to fear of legal repercussions

- Lack of cultural and familial connection was named as a driver of substance use, suggesting social belonging is a protective factor current services don't adequately address

6. Rural and Frontier-Specific Gaps Rural, frontier, and tribal communities represent a distinct and acute level of need.

- HIV, STIs, and substance use are not openly discussed in rural and tribal communities, and awareness of available resources is extremely low
- Specialty HIV care, SUD treatment, mental health providers, and stocked pharmacies are largely absent outside urban centers
- Frontier areas were described as having essentially no resources
- LGBTQ+ individuals in rural settings face compounded stigma with fewer support structures
- Telehealth and medication mail delivery were identified as needed solutions but are not yet widely accessible

7. What Works — Facilitators and Bright Spots Despite significant barriers, participants identified conditions and approaches that support engagement.

- Staff and outreach workers with lived experience were the most consistently cited facilitator - building trust and rapport quickly
- Established provider relationships were identified as a key driver of retention in care
- Walk-in, low-barrier service models and one-stop-shop care settings were praised where available
- Peer support groups and a sense of community were identified as protective factors, particularly for PLWH
- Incentives such as gift cards and bus passes for attending appointments or getting tested were identified as effective engagement tools
- Non-fear-based, normalizing social media messaging and community event outreach were seen as the most effective communication approaches

8. What Participants Want — Recommendations Participants offered concrete, actionable recommendations across all pillars.

- A one-stop-shop care model integrating HIV, SUD, mental health, and primary care was the most frequently cited recommendation
- Care navigators or CHWs embedded in clinical appointments, particularly for people with infectious disease
- Mental health support and peer community spaces specifically for PLWH to address the emotional burden of living with HIV
- Expanded funding for Certified Peer Recovery Support Specialists, particularly in rural and frontier areas

- Mobile medical services, telehealth, and medication mail delivery for rural populations
- 24/7 SSP access and community-based distribution of naloxone, condoms, and fentanyl test strips
- Diversified, inclusive prevention messaging across all media channels representing the full range of affected populations
- Transportation support and appointment incentives as standard components of care engagement

HIV Treatment and Care Needs Assessment

1. Conduct Follow-Up Focus Groups

- Conduct additional focus groups on the top unmet service needs identified in the survey.
- Use findings to better understand barriers to accessing services.
- Help inform future planning and funding priorities for HIV programs statewide.

2. Strengthen Case Management Services

- Increase regular contact between clients and case managers.
- Develop a statewide acuity scoring system for case management.
- Use case management to reduce barriers to care and improve viral suppression outcomes.

3. Strengthen Patient Navigation and Support Services

- Improve navigation support for medical care, mental health, and social services.
- Increase access to support groups, counseling, and case management.
- Address communication and language barriers between providers and clients.

4. Expand Housing Support

- Increase access to stable and affordable housing for people with HIV.
- Develop stronger partnerships with municipalities and healthcare providers.
- Address housing instability as a major barrier to HIV care and retention.

5. Implement Intensive Medical Case Management

- Increase frequency of client follow-up and appointment monitoring.
- Provide more intensive support for medication adherence and retention in care.
- Focus on clients who are at risk of falling out of care or not achieving viral suppression.

6. Improve Service Delivery Systems

- Strengthen coordination between providers, testing sites, outreach programs, and case management agencies.
- Improve follow-up systems for clients who miss appointments.
- Expand transportation assistance, housing screening, and culturally responsive staffing.
- Ensure services are coordinated, accessible, and consistent across Nevada.

3.4.b: Actions Taken

After completion of the Syndemic needs assessment, the findings were shared with Syndemic Workgroup members and were used to support discussions of priorities, needs, barriers, and gaps. The summary of findings and emergent priorities were used to inform the development of Section 4: Situational Analysis and Section 5: 2027 – 2031 Goals and Objectives.

3.4.c: Approach

The Nevada Syndemic Planning process used a collaborative, community-informed approach to complete the needs assessment. Building on findings from the 2021 HIV Needs Assessment, the jurisdiction expanded the survey tool into a broader syndemic framework to better understand the interconnected impacts of HIV, HCV, syphilis, substance use, violence, and access to prevention and care services across Nevada communities. Survey development and revisions were conducted collaboratively with community partners and public health stakeholders to ensure the instrument was clear, non-stigmatizing, and relevant to priority populations.

People with HIV (PLWH), people with lived and living experience (PWLE), and communities disproportionately impacted by HIV were incorporated throughout the recruitment and engagement process. Recruitment strategies included focus groups with priority populations, coordination with community leaders from nonprofit organizations and local government programs, and outreach through email invitations to PLWH and PWLE. Additional recruitment occurred through outreach to individuals participating in other relevant statewide assessment and community engagement processes. To broaden community participation, a statewide community survey was distributed electronically using snowball sampling methods and QR code flyers linked to the online survey. The teams engaged entities and stakeholders through participation in Syndemic Planning meetings, survey dissemination, focus groups, and collaborative review processes. A summary of Syndemic Planning members and participating organizations is provided in Table 2.

SECTION 4: SITUATIONAL ANALYSIS

This section presents a summary of how the goals and objectives address the needs of people and communities that have been disproportionately impacted with respect to syndemic conditions. The situational analysis summarizes themes that emerged from the community engagement and planning process, epidemiologic snapshot, resource inventory, and needs assessments.

4.1: Situational Analysis

Pillar One: Diagnose

Strengths

- Communities who are adversely impacted by HIV were generally knowledgeable about testing locations and resources
- Community events and trusted spaces were identified as effective venues for testing outreach
- Availability of quality training and certification to provide rapid testing
- Increase in alternative methods to acquire testing (e.g., Collect 2 Protect program), home test kits in vending machines, etc.
- High levels of partner screening and partner services

Challenges

- Stigma is a consistent barrier — fear of being outed, shame around a positive result, and reluctance to discuss sexual health with providers
- Providers outside specialty clinics rarely conduct sexual health histories or offer routine HIV screening
- Lower awareness of available testing and limited local access to services in rural and frontier areas
- Fear of legal repercussions due to immigration status prevents some individuals from seeking testing
- Jail represents a missed opportunity — some screening occurs but with no linkage to care upon release
- Low perceived risk for HIV and HCV
- Less than half of Nevadans have received an HIV test
- Nearly half of HIV diagnoses occur at late stage (45% of new diagnoses in 2025)
- For a quarter of new diagnoses, no identified risk for transmission is ascertained because some individuals can be difficult to locate for interviews
- No accurate way to capture amount of testing done in general, including negative results

Needs

- Normalize testing by integrating it into routine care and bringing it to trusted community spaces and events
- Availability of after-hours and weekend testing
- Peers and trusted community members as messengers for normalizing testing, particularly in communities where stigma is highest

- Diversify prevention messaging to reach heterosexual men, Black cis women, elderly populations, and rural communities
- Provider training on sexual health screening and communicating a positive diagnosis, ideally delivered by people with lived experience
    - Most frequent place for receiving an HIV, HCV, or syphilis test is through a primary care office/provider

Pillar Two: Treat

Strengths

- Patients of trusted HIV specialist and primary care provider described significantly better care experiences
- Staff and outreach workers with lived experience were identified as key to building trust and supporting retention in care
- Peer support groups and community spaces for PLWH are meaningful facilitators of treatment engagement and emotional wellbeing
- Generally, percentage of persons newly diagnosed with HIV in Nevada who are linked to care is high
- RWHAP Part A is a strength for getting PLWH into care and keeping them in care
- Rapid stART program

Challenges

- Care is fragmented — PLWH navigate multiple providers and locations for HIV, SUD, mental health, and primary care
- Fear of funding cuts and losing access to life-saving medication was prominent among PLWH
- Provider quality varies widely; high turnover disrupts continuity of care
- Rural and frontier residents face acute shortages of HIV specialty care, SUD treatment, and mental health providers
- Insurance barriers — excessive documentation, forced provider changes, and Ryan White bureaucracy — are an exhausting and a driver of disengagement

Needs

- Integrated one-stop-shop care model covering HIV, SUD, mental health, and primary care
- Care navigators or CHWs embedded in clinical appointments for people with infectious disease
- Telehealth and medication mail delivery for rural and frontier populations
- Culturally and linguistically appropriate treatment options, including Spanish-speaking SUD programs
- The emotional toll of living with HIV is significant and not well addressed, therefore dedicated mental health support and support groups specifically for PLWH are needed

Pillar Three: Prevent

Strengths

- Naloxone awareness is strong, attributed to distribution through SSPs and community-based settings
- Community events and social media identified as trusted, effective channels for prevention outreach and supply distribution
- Preferred sources for receiving sexual health education was from a provider, internet, health departments, and other community agencies
- Healthy peer networks and a sense of community connection were identified as protective factors against substance use initiation and risky sexual behavior
- High confidence in speaking with a casual partner about safer sex, asking a sexual partner about their other sexual partners, and/or convincing a partner that they should use a condom

Challenges

- Persistent misconception that PrEP, PEP, and Doxy PEP are for gender-discordant identities; PEP and Doxy PEP awareness is low
- Prevention advertising seen as too narrowly targeted, reinforcing stereotypes and excluding heterosexual men, Black cis women, and elderly populations
- PrEP has created a false sense of security among some groups, reducing condom use and perceived risk
- Retail cost of naloxone is a barrier for those without another source; 24/7 SSP access is unavailable in many areas
- Withdrawal symptoms and SSP access gaps lead to needle reuse
- Condomless sexual contact is frequent among many sub-populations
- Many are not aware syphilis could be transmitted through sharing syringes

Needs

- Diversified, inclusive prevention messaging representing the full range of affected populations across all media channels
- Community event distribution of naloxone, condoms, and fentanyl test strips
- Non-fear-based, normalizing social media campaigns as a primary outreach channel

Pillar Four: Respond

Strengths

- Staff and outreach workers with lived experience are a trusted model for community engagement
- Walk-in, low-barrier service models and one-stop-shop settings are praised where available
- Appointment incentives such as gift cards and bus passes were identified as effective tools for supporting engagement

Challenges

- Structural barriers — transportation, housing instability, lack of phone or address — prevent engagement even when services exist
- Distrust of systems among BIPOC, rural, and unhoused populations, driven by programs being started and then cut
- Frontier areas have very little infrastructure, relying heavily on urban areas
- Low Medicaid reimbursement, funding cuts, and eliminated positions threaten continuity and quality of services
- Criminalization of homelessness and immigration-related fears create additional barriers to engagement

Needs

- CHWs and Certified Peer Recovery Support Specialists embedded in clinical settings and deployed for community outreach, with expanded funding particularly in underserved areas
- Sustained, consistent investment in programs to rebuild community trust
- Transportation support as a standard component of care, including ride services to appointments
- Mobile medical services and medication mail delivery for rural and frontier populations
- Support groups and community spaces — particularly for PLWH and PWUD — to address mental health, reduce isolation, and build connections are still needed

4.1.a: People and Communities Disproportionately Impacted by HIV

In 2025, the Northern and Southern Nevada HPPGs identified the following groups as people and communities disproportionately impacted by HIV in Nevada: PLWH, MSM, people who are sexually active, people who use substances, youth and young adults, and communities of color, these populations have not shifted from the previous HIV Integrated Plan. Whenever possible, the community engagement and planning process and assessments focused on these populations to ensure that information presented in Section 4: Situational Analysis and Section 5: 2027 – 2031 Goals and Objectives were based on the needs of these populations.

SECTION 5: 2027 – 2031 GOALS AND OBJECTIVES

5.1: Goals and Objectives Description

The goals, objectives, and activities presented below were developed based on the needs and priorities identified through the community engagement and planning process, development and review of the epidemiologic snapshot, resource inventory, and needs assessments, and development and review of the situational analysis. All goals, objectives and activities were developed within the four EHE Pillars to align with other national, state, and local initiatives and will be evaluated, updated, and improved across the planning period, as needed.

Diagnose and Detect

Goal 1: Diagnose all individuals with HIV, syphilis, chlamydia, gonorrhea, and viral hepatitis as early as possible after infection.

Obj 1.1 From 2027 to 2031, reduce the number of new HIV stage 3 diagnoses by 10%.

Source: eHARS annual reported data
Baseline: 226 new HIV stage 3 diagnoses in 2025

Activities

a. Increase awareness of Southern Nevada Health District's (SNHD) at-home HIV screening program, "Collect2Protect".
   - Suggested metric(s): Number of website impressions; Number of social media posts about program.
b. Increase testing among people of color
   - Suggested metric(s): Proportion of tests provided to key populations for late-stage diagnoses (LHAs report total number and race/ethnicity).

Obj 1.2 Annually, 20,000 federally funded HIV tests will be conducted within the state of Nevada.

Source: CDC-required performance metrics; RWPA performance metrics.
Baseline: 23,463

Activities

a. Increase community awareness about location of testing sites and at-home testing.
   - Suggested metric(s): Number of website impressions on the End HIV Nevada website for testing locations and the SNHD Collect2Protect. Add the link on End HIV website to Consortium website for calendar of events in Clark County.

b. Implement targeted HIV testing strategies among MSM, people living with HIV, youth (ages 13 – 17), young adults (ages 18 – 24), and persons who use injection drugs
   - Suggested metric(s): Number of tests provided to the identified target populations.
c. SNHD provider education about rapid HIV testing
   - Suggested metric(s): Number of providers trained on rapid HIV testing per calendar year.
d. Increase HIV prevention events and testing opportunities.
   - Suggested metric(s): Number of impressions on websites (e.g., End HIV Nevada website and Rethink HIV Nevada website); Number of testing opportunities.

Obj 1.3 Annually, increase the number of rapid or point-of-care (POC) tests conducted for syphilis by 5%.

Source: LHAs, LifeCare Partners
Baseline: 1,222 (SNHD) + 100 (LifeCare Partners) + 164 (CCHHS) + 1,027 (NNPH) = 2,513 total

Activities

a. Identify funding sources to acquire additional rapid tests for partners to utilize.
   - Suggested metric(s): Number of test kits distributed to partner organizations
b. Annually update syphilis hotspots (by zip code) and distribute information to partners.

Obj 1.4 Annually, increase the number of rapid or point-of-care tests conducted for HCV by 5%.

Source: LHAs, LifeCare Partners
Baseline: 788 (SNHD) + 300 (Life Care Partners) + 711 (The Center) = 1,088 total

Activities

a. Identify additional funding sources to acquire additional rapid tests for partners to utilize.
   - Suggested metric(s): Number of test kits distributed to partner organizations
b. Identify acute HCV hotspots for potential community outreach and testing.
   - Suggested metric(s): Annually update acute HCV hotspots (by zip code) and distribute information to partners.

Obj 1.5 From 2027 through 2031, increase the proportion of people with a positive HCV antibody test receiving a viral load, PCR, or genotype test from 50% to 60%.

Source: Office of Analytics HCV Clearence Continuum data, second column
Baseline: 9,880 new HCV diagnosis from 2021-2023, only 4,927 (49.8%) received a viral test

Activities

a. Conduct a laboratory assessment to identify barriers to running the reflex HCV RNA test if antibody positive.
b. Determine patterns associated with gaps in reflex testing and determine if a policy issue or workflow challenges exist.

Obj 1.6 Annually, 95% of clients testing HIV-positive will be informed of their test result within 7 business days from report to health authority.

Source: PS24-0047 performance metric.
Baseline: 77.8% in 2025

Activities

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

Obj 1.7 Identify at least 3 substance use treatment organizations willing to implement opt-out screening for HIV and HCV by 2031.

Source: Syndemic Plan evaluation
Baseline: 0

Activities

a. Conduct theoretical modeling to identify estimate of number of people to be impacted by these screenings. Use modeling to identify the parameters for defining a pilot site (volume of testing goals suggested by model).
b. Identify pilot sites, at least one in an urban county and one in a rural/frontier county.
c. Work with sites to identify the barriers and potential successful actions to implement opt-out testing.

Obj 1.8 Identify at least 3 organizations to partner with overdose prevention and street outreach programs to offer screening for HIV and HCV by 2031.

Source: Syndemic Plan evaluation
Baseline: 0

Activities

a. Coordinate with Syndemic Planning partners who provide street outreach and rapid testing to identify new partnership organizations across urban and rural/frontier counties.
b. Identify barriers and solutions for facilitating testing for HIV and HCV in non-traditional locations and/or with organizations not already conducting testing in-house.

Obj 1.9 By 2028, engage with at least 5 hospital systems to facilitate the development of policy to test all pregnant persons for syphilis in accordance with Nevada Revised Statutes (NRS) 442.010, and other STI's in accordance with NRS 441A.315.

Source: Syndemic Plan evaluation
Baseline: 0

Activities

a. Identify 5 hospital systems with high volume testing for the region/county (at least 2 will be in rural or frontier counties) and assess whether policies exist for testing in accordance with 442.010 and 441A.315.
b. Meet with hospital leadership to identify major barriers to implementing best-practice testing and screening methods.
c. Determine if major barriers can be resolved and engage with other organizations that have successfully implemented these changes to help communicate the value.

Obj 1.10 Annually, identify at least 1 primary care practice in high-risk counties not following the CDC's syphilis screening recommendation (to test all sexually active persons aged 15-44 years in counties with morbidity rates > 4.6 per 100,000) to implement protocol changes to screening in alignment with the recommended practices.

Source: Syndemic Plan evaluation
Baseline: 0

Activities

a. Conduct analyses utilizing all-payer and Medicaid databases to identify primary care providers with highest volume of female patients between 15 to 44 years, then among those the providers with the highest proportion of patients not being screened for syphilis.

b. Engage with providers identified through analysis and determine what best approach for implementing screening recommendations might be.
c. Provide resources or address concerns to increase screening rates.

Obj 1.11 Annually, promote awareness of the STD Clinical Consultation Service for healthcare professionals https://www.stdccn.org/render/Public as well as afterhours call lines for Nevada's respective LHA STD Programs, by providing information to at least 10,000 healthcare professionals in Nevada.

Source: Syndemic Plan evaluation
Baseline: 1,200 providers engaged with the QR code on a sexual health one-pager sent to providers during 2025.

Activities

a. Continue to promote a sexual health one-pager through medical licensure email listservs.
b. Partner with medical licensure boards, Nevada Hospital Association, Nevada Rural Hospital Partners, and Nevada Primary Care Association to increase reach and reinforcement of messaging.
c. Identify provider materials that can have a QR code sticker to scan to education and other resources.

Treat

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

 Indicates an objective as a Las Vegas TGA EHE-specific objective and will be measured among the TGA region only.

Linkage to Care

Obj 2.1 Annually, 85% of newly diagnosed HIV-positive individuals will be linked to care, as measured by a CD4 or a viral load test conducted within 30 days from earliest specimen collection date.

Source: eHARS data measured in days from (time 0) earliest specimen collection date to a CD4 or viral load test.
Baseline: Among those newly diagnosed with HIV, 79% were linked to care within 30 days after diagnosis in 2024.

Activities

a. Review regional flow chart (resource map) of services/activities for persons newly diagnosed with HIV and for providers and update it regularly.

- Suggested metric(s): Documentation that flow chart was reviewed annually

b. Utilize referral systems to coordinate new patient intakes between organizations.
   - Suggested metric(s): Number of referrals being scheduled and lost to follow up

Obj 2.2 Annually, 85% of newly diagnosed HIV-positive individuals will be referred to a healthcare provider within 30 days from initial CDC-funded test collection date.

Source: EvalWeb, date from CDC-funded initial HIV test specimen collection date to referral to a healthcare provider.
Baseline: 84.9% in 2025.

Activities – Same as Objective 2.1

Obj 2.3 Annually, among individuals engaged in the Las Vegas TGA EHE Rapid stART program, 90% of newly diagnosed HIV-positive individuals, those new to care, and/or persons returning to care will be linked to HIV care within 7 days of time zero date.
Source: Rapid stART module CAREWare RWPA specific
Baseline: 88.9% in 2025

Activities

a. Expand partnerships with CBOs, healthcare providers, testing sites and nontraditional partners to facilitate the identification, diagnosis, and rapid linkage of newly diagnosed and out-of-care PWH. This includes an emphasis on building partnerships that reflect the identities of populations of focus.
b. Disseminate Rapid stART protocols that expedite and streamline ART initiation for newly diagnosed and out-of-care PWH.
c. Provide orientation on Rapid stART protocols to new Rapid stART partners and refresher training to existing partners.
d. Implement first-year-in-care guidance (community developed in 2024) which includes tiered medical case management, improved client-centered treatment adherence counseling, expanded psychosocial support, mental health services, and strengthened collaboration between healthcare facilities & support services to ensure a comprehensive, coordinated approach to care.
e. Increase access to Rapid stART data portal (RWISE Viewer) to improve the monitoring and reporting of Rapid stART performance measures/metrics and re-engagement efforts.

Antiretroviral Therapy (ART)

- Obj 2.4 Annually, among individuals engaged in the Las Vegas TGA EHE Rapid stART program, 90% of newly diagnosed HIV-positive individuals, persons new to care, and/or persons returning to care will have initiated ART within 7 days of first medical appointment.

  Source: Rapid stART module CAREWare RWPA specific
  Baseline: 90.4% in 2025

Activities - Same as Objective 2.3

Viral Suppression

Obj 2.5 Annually, 75% of HIV-positive individuals will have achieved viral suppression (less than 200 copies/ml at last viral load) within 12 months of initial diagnosis among those who are newly diagnosed.

Source: eHARS, Continuum of Care

Baseline: Among those newly diagnosed in 2024, 63% of persons had achieved viral suppression (≤200 copies) within 12 months of diagnosis.

Activities – Same as Objective 2.1

- Obj 2.6 Annually, among individuals engaged in the Las Vegas TGA EHE Rapid stART program, 90% of newly diagnosed HIV-positive individuals, those new to care, and/or persons returning to care will have achieved viral suppression by 90 days after initiation of ART.
  Baseline: 78.19% in 2023; 79.90% in 2024

Activities - Same as Objective 2.3

Goal 3: Develop medication assisted treatment (MAT) network for persons with opioid-use disorder.

Obj 3.1 By 2028, develop and implement an evaluation plan to assess impacts of the expansion of mobile MAT for rural and frontier communities.

Source: Syndemic Plan evaluation
Baseline: N/A

Activities

a. Determine if any entity outside of required grant reporting is set up to evaluate the expansion of mobile MAT.
b. If these are underway, can we evaluate the reach of these types of programs and how it is impacting the cascade of care for people living in rural and frontier communities.

c. Implementation evaluation to be used to identify barriers and facilitators.

Obj 3.2 By 2029, develop a statewide network map for telehealth for treatment and recovery services and promote (or support) a pipeline for telehealth.

Source: Syndemic Plan evaluation
Baseline: 0

Activities

a. Identify telehealth organizations to determine their existing networks.
b. Explore inclusion of a linkage to care network starting with drug courts and their referrals, then add MCO providers.
c. System map of what is available where and the access points, including physical location and provider contact information, then add telebup coverage.
d. Determine a strategy to maintain a dynamic system map, including internships, and organizational partnerships such as the Nevada Opioid Center of Excellence.

Prevent

Goal 4: Prevent new HIV and STI transmissions by using proven interventions, including condom use, post-exposure prophylaxis (PEP), Doxy PEP, pre-exposure prophylaxis (PrEP), and proven prevention methods among those who use substances.

Obj 4.1 By 2031, reduce by 10% the rate of new HIV diagnoses.

Source: eHARS annual data
Baseline: 502 new HIV diagnoses in 2025

Activities

a. Improve access to partner services for people newly diagnosed with HIV.
- Suggested metric(s): % of newly diagnosed HIV-positive individuals interviewed for partner services within 30 days.

b. Reduce barriers to successful completion of partner service interviews and referrals.
- Suggested metric(s): Summary of barriers and strategies for improvement.

c. Improve access to risk reduction services for people testing positive and negative for HIV.
- Suggested metric(s): % of persons tested for HIV (HIV-positive and HIV-negative) screened for risk reduction intervention who are provided intervention.

Obj 4.2 Increase the number of providers receiving training or education about expedited partner therapy (EPT), Doxy PEP, PrEP, PEP, or 3-site STI testing annually, by 5% each year.

Sources: LHA trainings, AETC trainings, Rapid stART trainings
Baseline: ~1,200 providers trained per year through AETC and SNHD combined

Activities

a. Increase number of provider education sessions conducted by local health authorities and the AIDS Education and Training Center (AETC) within clinics, ERs, hospitals, and other healthcare organizations that are screening for HIV.
b. Updated one-pagers for providers regarding sexual health advocacy to include ordering labs for 3-site testing, taking a sexual history, laws, and recommendations.

Obj 4.3 Increase number of healthcare professionals educated about NRS 441A.315, regarding testing for sexually transmitted infections in emergency services settings and primary care clinics by 5% each year.

Sources: Rapid stART tracking on number of contacts made, MOUs signed with clinics, number of Rapid stART testing sites/medical care clinics. AETC provider education by number of sessions, number of staff trained. Potential to obtain data by provider type on tests ordered, to measure increase.
Baseline: TBD

Activities

a. Providers reached through passive outreach (i.e. sending out materials).
b. Rapid stART Response team partnerships.
c. SNHD SB211 “road show”, positive screening tests for congenital syphilis, syphilis, and HIV through nursing huddles/shift changes in ED and L & D.
d. LifeCare Partners to expand to the north and will help to spread the message to primary care providers.

Obj 4.4 Increase the number of people who have access to overdose prevention services, health recovery supplies, counseling, and education annually by 10%.

Source: Trac-B

- Suggested metrics for engaged with services baseline to include: Number of educational materials distributed, number of clients engaged via in person education or counseling encounters, number of mail orders, number of prevention supplies distributed, number of people accessing vending machines, number of clients visiting storefront.

Baseline: TBD
Partner organizations: Trac-B, SNHD, LHAs, LifeCare Partners, SOR, RISE

Activities - TBD

Obj 4.5 Increase the number of new zip codes receiving mail-based overdose prevention and health recovery supplies annually by 10 zip codes.

Source: Trac-B data by zip code to determine the expansion patterns geographically and will include number of new individuals as well.
Baseline: TBD

Activities

a. Engage with substance use prevention coalitions and social services to increase knowledge and awareness, specifically in rural and frontier communities.
b. Determine what is preferred from an outreach perspective within each community and actively engage with various priority populations to provide information on overdose prevention program options.

Obj 4.6 Annually update an accessible resource for general public regarding sexual health advocacy designed to take to providers.

Source: Syndemic Plan evaluation
Baseline: 0

Activities

a. Develop a webpage, linked resources, and an app.
b. Create an STI/HIV one-pager for patients.

Obj 4.7 Maintain condom distribution in Nevada.

Source: HIV Program performance metrics
Baseline: 370,000 condoms distributed in 2025

Activities

a. Maintain number of agencies distributing free condoms.

Obj 4.8: Syndemic team to promote awareness of the NSIP-SOR partnerships to increase hepatitis A, hepatitis B, HPV, and other vaccinations including, but not limited to, among people who are living with HIV and HCV in high overdose and high VPD zip codes, by engaging with all three tiers of VFC, 317, and other NSIP providers serving these zip codes while funding is available.

Sources

a. Analysis through NSIP IIS (WebIZ) data in 2027 (matched with eHARS and EpiTrax data for PLWH and PLW HCV) to look are reach specifically to populations of focus for the syndemic plan and key populations.

b. Number of NSIP vaccinating partners ordering SOR vaccines per calendar year.

Baseline: TBD

Activities

a. Partner with NSIP and SOR to identify hot-spot zip codes and determine which providers may be eligible but have not yet become an NSIP provider.

Goal 5: Prevent the initiation of use and reduce regular use of substances.

Obj 5.1 By 2028, identify at least three partnerships with existing initiatives to provide parents information and education focused on healthy youth development, prevention strategies, and risk factors associated with substance use.

Source: Syndemic Plan evaluation
Baseline: 0

Activities

a. Possible partnerships include Substance Use Prevention Coalitions, EMS, law enforcement, PWLE delivering messages, PRSS, and EfC D2A Program.
b. Focus on delivery of fact-based information.
c. Tailored to the group(s) receiving the message (community-specific).
d. Opportunities to increase information in Back-to-School Nights for parents.

Obj 5.2 By 2029, build an interactive webpage to illustrate which evidence-based substance use prevention programs are being delivered to youth across Nevada.

Source: Substance Use Prevention Coalition data reported to WITS (DPBH)
Baseline: 0

Activities

a. Partner with SNOAC, DPBH, and possibly Office of Analytics to pipeline the data into a dynamic and interactive mapping tool.
b. Develop a webpage to host the information including program descriptions and testimonials, as appropriate. This site would include program descriptions, proportion of students in each county receiving evidence-based programs, and program evaluation data, to inform the statewide reach and promote possible peer-to-peer conversations among school administrators.

Obj 5.3 By 2028, 30% of Syndemic Plan Partner organizations' leadership will receive a presentation to learn more about Foundation for Recovery (FFR) programs, to increase the number of Recovery Friendly Workplaces (RFW).

Source: Syndemic Plan evaluation
Baseline: 0

Activities

a. Send email communications to Syndemic Partner members to encourage reaching out to FFR.
b. Provide descriptions about FFR and RFW to help leadership better understand the presentation intentions and purpose.

Obj 5.4 By 2031, at least half of Syndemic Plan Partner organizations will make a connection between FFR and at least one non-behavioral health organizational or business contact to encourage becoming RFW certified.

Source: Syndemic Plan evaluation
Baseline: 0

Activities

a. When a syndemic partner organization provides training or tabling of an event, share FFR resources with other entities.

Goal 6: Prevention of unwanted harm among those who use substances.

Obj 6.1 By 2029, establish at least 10 connections between naloxone distribution partnerships between substance use prevention coalitions sites, behavioral health sites, primary care offices and community-based support groups including local Narcotics Anonymous and faith-based programs.

Source: Syndemic Plan evaluation
Baseline: 0

Activities

a. Identify NA groups, faith-based programs and other community-based gatherings for people who use drugs.
b. Connect organizations distributing Narcan including substance use prevention coalitions sites, behavioral health sites, primary care offices with the contact people who host or organize the community-based gatherings for people who use drugs.

Obj 6.2 By 2028, increase awareness of naloxone distribution by encouraging naloxone/Narcan to be offered in a visually obvious location and/or display of obvious signage, as appropriate.

Source: Syndemic Plan evaluation
Baseline: 0

Activities

a. Include promotion of clear advertising/knowledge at places where it is available, if not free (e.g. pharmacies).
b. Low barrier, 24-7 naloxone access in more places.
c. Mapping locations for distribution sites.

Respond

Goal 7: Respond quickly to potential HIV, STI, and HCV outbreaks and sudden increases in overdoses to get necessary prevention and treatment services to people who need them.

Obj 7.1 Annually, local and state health authorities and community stakeholders will review and update the existing HIV/STI and Hepatitis Outbreak Response Plans, as necessary.

Source: Syndemic Plan evaluation
Baseline: 0

Activities

a. Engage in semi-annual reviews and update of Nevada's HIV Cluster and Outbreak Detection and Response Plan.
b. Engage in annual review and update of Nevada's Hepatitis Outbreak Detection Plan.
c. Share statewide Outbreak Response Plan which can be adopted by Local Health Authorities, as needed for responding to an increase in STIs.

Obj 7.2 Maintain capacity for infectious disease cluster detection at state and local health departments.

Outcomes: Number of trainings received annually; Number of educational opportunities shared with LHAs and community partners.
Source: Logs of training, educational opportunities, and agenda topics.
Baseline: NA

Activities

a. Identify and document potential training and educational opportunities for state and local surveillance and investigation staff, including through AETC.
b. Engage with Nevada's HIV Prevention Planning Groups to determine how to partner with community organizations to identify and address prevention gaps.
c. Identify opportunities for implementing advanced scientific methods (i.e. molecular sequencing data, time-space analyses) to identify and connect people with prevention and treatment services.

Obj 7.3 By 2030, assess capacity for overdose increase "spike" detection response in each county.

Outcomes: Number of counties (out of 17) contacted; Number of counties with monitoring entity(ies) identified; Number of counties with response entity(ies) identified.
Source: NA
Baseline: 0

Activities

a. Determine which entities are responsible for monitoring county-level data for early detection of drug-related overdoses.
b. Determine which entities are involved in a response if/when increases "spikes" occur.
c. Assess if there are gaps that need to be addressed at the local level and whether state-level monitoring would be helpful via ESSENCE and OD Maps data.

Obj 7.4 Perform timely analysis of case surveillance data to identify possible transmission clusters each month.

Outcome: Monthly cluster analysis completed.
Source: NA
Baseline: Ongoing

Activities

a. Review alerts, analysis, and response as needed during Quarterly Surveillance Data Quality/Cluster Detection and Response meetings.
b. Consult with CDC regarding capacity to implement Secure HIV-TRACE in Nevada in Nevada by 2031.

5.1.a: Updates to Other Strategic Plans Used to Meet Requirements

Not applicable.

SECTION 6: 2027-2031 INTEGRATED PLANNING IMPLEMENTATION, MONITORING, AND JURISDICTIONAL FOLLOW-UP

6.1: 2027-2031 Integrated Planning Implementation Approach

The Office of State Epidemiology will lead implementation, monitoring, evaluation, improvement, reporting, and dissemination of the plan, in partnership with the Larson Institute staff. An online tracking instrument will be developed in REDCap that will be shared with all partners and stakeholders that outlines the goals, objectives, and activities, and will provide a document outlining roles, responsibilities, and expectations for reporting. Data will be collected from stakeholders and partners responsible for reporting at minimum annually, although many objectives in the 2027-2031 Syndemic Plan are ongoing or sequential, therefore reporting will be as frequent as possible. A website will be created, with an online dashboard designed to provide close to real time visual communication of progress being made towards objectives and related activities.

6.1.a: Implementation

The Syndemic Plan activities largely reflect initiatives which are already being conducted by a variety of partners, including new partners particularly those focused on substance use prevention, treatment and recovery, PLWH, people affected by and at-risk for syndemic conditions, and service providers and administrators from different funding streams. While there are limited additional funding streams, the Office of State Epidemiology staff are regularly applying for grant opportunities which may support or enhance syndemic partnership or efforts. For example, a one-time funding opportunity to link persons living with HCV to treatment was secured through the Office of State Epidemiology, and while the project funding will end as the Syndemic Plan starts, this grant opportunity provides direct linkage to care for persons living with untreated HCV as well as wraparound services, reflecting the Office of State Epidemiology's commitment to address issues through a syndemic approach. Another example is StreetReach, which is a new collaborative effort at the University of Nevada, Reno (UNR) between the School of Public Health and the Orvis School of Nursing, led by the Larson Institute, and is supported by a FOCUS award from Gilead Sciences. StreetReach brings wound care, blood-borne virus testing, and linkage to community care to persons who are unsheltered in Reno. StreetReach launched in early 2026, with a team comprised of a faculty nurse, a program coordinator, and a community health worker.

6.1.b: Monitoring

The Office of State Epidemiology in partnership with the Larson Institute staff will be in contact with key stakeholders regularly to check in on progress made towards objectives, as applicable and encourage regular reporting of any ongoing objective or activity measures. The Office of Analytics has been involved in the development of this plan and are aware of potential ancillary data matches and

annual requests to help monitor progress on plan goals, objectives, and activities. All objectives and suggested metrics that will be reported on by key stakeholders are outlined in Section 5: 2027 – 2031 Goals and Objectives.

While developing goals, objectives, and activities, the Syndemic Planning Members identified existing performance metrics from various programs within the state as indicators that will be used to track progress on goals and objectives whenever possible. Syndemic Planning Members were requested to raise awareness of any potentially duplicative plans at the state, local, or organizational level, to not directly duplicate efforts and determine how new partnerships could be formed to improve efforts already underway. Several meetings were held with individual organizations and programs to better understand the framework where syndemic planning efforts could fill existing gaps. The purpose of these efforts was to ensure that all goals, objectives, and activities are measurable and to reduce the burden placed on programs and organizations that are operating on limited resources. All updates and improvements made to the plan will be carefully documented and shared with the CDC and HRSA.

6.1.c: Evaluation

Objectives will be measured on a calendar year, unless otherwise noted. Many objectives are ongoing and measures will be accounted for as they occur, which will permit more frequent updates. Informal measurement will be conducted through regular communication from the Infectious Disease and Opioid Epidemiologist, so barriers and challenges for activities can be communicated prior to having a major impact on an objective without warning. Many of the measures will be able to be requested through the Nevada Office of Analytics, while other objectives are able to be analyzed by Office of State Epidemiology and Larson Institute staff.

The Internal Workgroup will be reconvened every quarter, while the Syndemic Planning Members will be invited to meet at least twice a year. During these meetings the Office of State Epidemiology will partner with the Larson Institute to present and discuss progress on the goals, objectives, and activities outlined in the plan and to ensure proper coordination of tracking and reporting efforts. At minimum, annual Syndemic Plan updates will also be provided to the HPPGs, the Las Vegas TGA Planning Council, and EHE groups during respective meetings at least once annually, and more frequently as requested.

6.1.d: Improvement

The Syndemic Plan is intended to be a living document that will be updated as goals and objectives are met, and when programmatic, legislative, and other important changes are made. It is expected that the Syndemic Plan will be improved, as needed, at regular intervals across the project period based on new epidemiological data, progress on objectives, activities, and feedback from community members/stakeholders. A “Parking Lot” of potential objectives was created during the Syndemic Planning meetings to capture the ideas considered but at the time were of lesser immediate priority or needed further research to

ensure if potential objectives were feasible and not duplicative. If a current objective is completed or if it is determined by Syndemic Planning Members an objective is no longer be feasible, the Parking Lot objectives will be revisited and considered for adoption into the Syndemic Plan.

At each quarterly Internal Workgroup meeting and the biannual Syndemic Planning Members meetings, progress on goals, objectives, and activities will be reviewed in relation to epidemiological data. All modifications to the plan will be implemented through input during meetings with the opportunity to weigh in via email. Any changes to the plan will be made public on the website, with explanations as to why objectives were modified or are no longer being pursued.

6.1.e: Reporting and Dissemination

A Syndemic Plan website will be developed to provide ongoing updates through visual platforms, including an online dashboard. The progress will be translated to a hardcopy template which will be provided to planning groups, community members, and other stakeholders, including CDC and HRSA. During the quarterly Internal Workgroup meetings, and the biannual Syndemic Planning Member meetings, the performance measures will be reviewed for each objective in progress. A report of progress will be provided beforehand, so meeting attendees can ask questions or provide updates as appropriate. PLWH are involved with these groups and decision making about changes will be done through discussion and written communication as needed.

6.1.f: Updates to Other Strategic Plans to Meet Requirements

This document serves as both the Nevada Syndemic Plan as well as the 2027-2031 HIV Integrated Plan and does not include portions of other existing planning documents, rather objectives mirror grant-funded programmatic performance measures as able.

SECTION 7: LETTERS OF CONCURRENCE

7.1: CDC Prevention Program Planning Body Chair(s) or Representative(s)

7.2: RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)

7.3: RWHAP Part B Planning Body Chair or Representative

7.4: Integrated Planning Body

7.5: EHE Planning Body

APPENDICES

Appendix 1: Completed Integrated Plan Checklist

CY 2027 – 2031 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

Requirement	New Material and/or Existing Material	Title/File Name of Materials	Page(s) for this Section
Section I: Introduction of Integrated Plan and SCSN			
1. Introduction	New Material	NA	4-10
a. Approach	New Material	NA	10
b. Documents submitted to meet requirements	New Material	NA	10
Section II: Community Engagement and Planning Process			
1. Jurisdiction Planning Process	New Material	NA	11-14
a. Entities involved in the process	New Material	NA	12-13
b. Role of the RWHAP Part A Planning Council/Planning Body (not required for state only plans)	New Material	NA	13
c. Role of Planning Bodies and other entities	New Material	NA	13

d. Collaboration with RWHAP Parts – SCSN requirement	New Material	NA	14
e. Engagement of People with HIV – SCSN requirement	New Material	NA	14
f. Priorities	New Material	NA	14
g. Updates to other strategic plans used to meet requirements	New Material	NA	14
Section III: Contributing Data Sets and Assessments			
1. Data Sharing and Use	New Material	NA	15
2. Epidemiologic Snapshot	New Material	NA	15-24
3. HIV Prevention Care and Treatment Resource Inventory	New Material	NA	24-41
a. Strengths and gaps	New Material	NA	26
b. Approaches and partnerships	New Material	NA	26
4. Needs Assessment	New Material	NA	42-53
a. Priorities	New Material	NA	53-59
b. Actions taken	New Material	NA	58
c. Approach	New Material	NA	58-59
Section IV: Situational Analysis			
1. Situational Analysis	New Material	NA	60-63
a. People and communities disproportionately impacted by HIV	New Material	NA	63
Section V: 2027-2031 Goals and Objectives			
1. Goals and Objectives Description	New Material	NA	64-76
a. Updates to other strategic plans used to meet requirements	New Material	NA	76
Section VI: 2027-2031 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow-Up			
1. 2027-2031 Integrated Planning Implementation Approach	New Material	NA	77-79

a. Implementation	New Material	NA	77
b. Monitoring	New Material	NA	77-78
c. Evaluation	New Material	NA	78
d. Improvement	New Material	NA	78-79
e. Reporting and dissemination	New Material	NA	79
f. Updates to other strategic plans used to meet requirements	New Material	NA	79
Section VII: Letters of Concurrence			
1. CDC Prevention Program Planning Body Chair(s) or Representative(s)	New Material	NA	80-81
2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)	New Material	NA	82-83
3. RWHAP Part B Planning Body Chair or Representative	New Material	NA	NA
4. Integrated Planning Body	New Material	NA	NA
5. EHE Planning Body	New Material	NA	NA

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[2] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Data Report 2024. https://ryanwhite.hrsa.gov/data/reports. Published December 2025.

[3] Howard L, Silva I, Powers M, Zhang F, Peek JCN, Yang W. Nevada High School Youth Risk Behavior Survey (YRBS) Comparison Report, 2023-2025. Published online March 19, 2026. Accessed May 5, 2026. https://scholarwolf.unr.edu/handle/11714/11786.

[4] Nevada's Ryan White Program Service Agencies. End HIV Nevada. https://endhivnevada.org/ryan-white-service-agencies/.

[5] The Planning Council. Las Vegas Transitional Grant Area (TGA). https://lasvegastga.com/planning-council/.

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