MINUTES
Southern Nevada HIV Prevention Planning Group
October 7, 2026, 2:00 PM - 4:00 PM
SNHD/ Lone Mountain Conference Room/ 280 S. Decatur Blvd./ (TEAMS)

MEMBERS/VISITORS/PUBLIC ATTENDANCE

Please see attached sign-in sheet for further information on attendance. This meeting was solely an informational meeting, and no voting took place.

I. CALL TO ORDER - NOTICE OF POSTING AGENDA

SoNV HPPG Co-chair Cheryl Radeloff confirmed this was an informational meeting only. Stated the meeting will be recorded.

II. WELCOME AND INTRODUCTIONS OF MEMBERS AND GUESTS

This meeting was recorded. Cheryl Radeloff reviewed meeting etiquette. All participants introduced themselves.

III. ESTABLISHMENT OF QUORUM – This meeting is solely informational. Attendance did not meet quorum guidelines; no voting took place.

IV. PUBLIC COMMENT

Public comment is a period devoted to comments by the public on items appearing on the agenda. All comments are limited to five (5) minutes. Cheryl Radeloff apologized to and informed the group that the link to the agenda on the State Posting site was incorrect. "It was brought to our attention that there was a typographical error on our website; however, the shared agenda date was correct. Additionally, we are not voting on any action items today; therefore, we can proceed with the meeting without posting being a concern." It was corrected and the post was updated. No public health information was shared during the meeting.

V. CONSENT AGENDA

No consent will be given for this meeting as it is solely for informational purposes.

VI. INFORMATIONAL ITEMS/ DISCUSSION ONLY

A. "From Evidence to Action: Applying U=U Throughout the EHE Pillars" – C. Todd Fuqua, CPP, #Celebrate UU (see presentation *"From Evidence to Action: Operationalizing in Routine HIV Care and Counseling"*

- Integrate U=U in routine HIV care and counseling as a clinical mechanism
- Communicate U=U – people living with HIV have more favorable health outcomes when informed of U=U as compared to those who were not informed of U=U
  - 76% treatment satisfaction compared to 57%
  - 80% optimal adherence compared to 68%

  - 77% self-reported virologic control compared to 69%
  - Increases uptake of HIV testing services
  - 67% report informed by HCP, 21% informed by other communication, 12% uniformed
- 5 Clinical touchpoints to integrate U=U into care
  - Testing – pre-diagnosis – reduces fear, conveys benefit, lessens stigma/shame
  - Reactive Test/ diagnosis – reduces catastrophic thinking; gives hope
  - Treatment initiation – outlines personal benefit, treatment goals, positive reinforcement
  - Viral load monitoring – U=U reinforces progress and goal
  - Routine follow-up and adherence – reduces stigma and fear, reinforces belief, sustains engagement
- Public spaces and social media – see page 9 for resources
  - Signage in medical offices
  - Urinal cakes
  - Bell ringing
- From conversation to workflow
  - Is U=U scripted at diagnosis? Add to reactive result script.
  - Is U=U reinforced at viral load review? Add reinforcement to viral load template.
  - Does the entire team use consistent language? Train full team.
  - Is documentation built into workflow? Audit chart for documentation.
  - Tools – see page 12
- Adapting U=U model
  - Where does U=U fit? – lab review, follow-ups, counseling, case management
  - Documentation – SmartPhrase, template field, standard note language
  - Champions – clinical lead, nurse educator, QI coordinator, case management
- Resources and handouts – see page 13 for information
- U=U improves viral suppression because behavior changes because patients believe in their future and have hope.

Q: When you have shared the presentation to providers who don't work with HIV, what is their response?
A: This presentation is only shared with HIV providers, and they aren't familiar with it or ECHO.
Q: Is this available to the school district?
A: Yes. I'm working with some programs and discussed teaching U=U and disclosure. Most are good with the U=U presentation, but not the disclosure piece.
Q: What jurisdictions are you in and what is the difference between rural and non-rural?
A: I'm based in Indiana, an urban setting. When the presentation was shared to the ECHO program, it was statewide which included rural programs, and I have received invitations to present to some of the more rural health departments.
C: Thank you, and also, we really loved the signage that you developed and some of your suggestions, like the idea of ringing the bell when somebody becomes virally suppressed. I think that's a really interesting idea to consider because it really echoes it and normalizes it.
Q: Regarding all points of the care continuum, has there been any research on the U=U messaging that shows it helps with missed appointments? Do you think the U= messaging helps to give them hope or to want to come into their treatments and get their viral loads?
A: I'll have to dig into the studies because there's a lot of data in terms of the way they ask questions, but I think it would help with, because what we saw obviously was an increase in overall adherence to treatment and that includes making appointments.
C: I love your idea for quality improvement. Concentrate on one area, put it into practice and see how it's working. I also liked that you were saying to use consistent language.

B. "Sober Sex is Great Sex" – Ron J. Schnese, The LGBTQ+ Center of Las Vegas

- Certified peer recovery support specialist, supervisor, and a person in long-term recovery

- In recovery from chem sex addiction - have used any substance or drink since December 24, 2014
- Disclaimer stated: The views and opinions expressed in this presentation are completely mine. They do not represent my employer, any other parties I'm associated with, any boards that I sit on, coalitions, any of that. These are my concepts, things I've studied and from papers that I've studied, and just my own lived experience.
- Objectives for participants
  - Describe the neurobiological and relational impacts of chemsex on intimacy, desire, and bonding
  - Identify common post-chemsex sexual and relational experiences and normalize them in a clinical or peer setting
  - Demonstrate communication strategies that reduce shame and support relapse-prevention planning related to sexual activity
- Chemsex is the intentional pairing of substances with sexual activity. This is more than just getting high and having sex. The act of, the rituals, all of those things associated with getting high are commingled with the act of and rituals of sex. The reason chemsex differs from general substance use is because it conditions our arousal, our intimacy, and pleasure to a substance, to a setting, to a piece of paraphernalia.
- The brain on chemsex
  - Dopamine flooding and reward amplification
  - Reduced inhibition and impulse control
  - Conditioned arousal to substances and environments
  - Disruption of natural pleasure pathways
  - Impact on oxytocin (bonding hormone)
  - Altered attachment responses
  - Intimacy becomes chemically mediated
  - Sober sex may feel unsafe or flat
- Relational impacts
  - Changes in normal boundaries/consent
  - Emotional distancing outside of chemsex
  - Vulnerability of being desired
  - Confusion after between sex, validation and connection
- Post-chemsex experiences
  - Reduced libido/desire – not chemically driven
  - Fear of sober intimacy/ avoidance of dating/sex – what do I bring without drugs?
  - Sexual shame/grief – what did I do/consent to?
- Post-chemsex support
  - Assume trauma without disclosure – offer trauma informed care
  - Prioritize safety, choice, and empowerment
  - Avoid moralizing language or abstinence only assumptions
  - Respect client's pace and readiness for change and recovery – meet them where they are
- Sex positivity
  - Context is important
  - Autonomy over compliance
  - Pleasure is a valid recovery topic – discover the need for the pleasure
  - Sex is not the problem – the problem is substances, power dynamics, safety, loss of control
  - Support
- Behavior change – reduce shame to increase honesty and engagement
  - Language use – positive structure
  - Relapse prevention planning

        - Identify patterns (apps, venues, emotional status)
        - Plan for discomfort with sober intimacy – suggest slowing down, setting boundaries; the nervous system needs time to recalibrate
        - Normalize setbacks as learning opportunities
- Recovery – not a one size fits all plan
    - Separate abstinence from substance from abstinence of sex
    - Autonomy
        - Decisional – what to do
        - Practical – acting on the decision of what to do
    - Honor client's definition of healthy sex
    - Revisit goals during recover
    - Talking about sex is harm reduction

Q: How does chemsex impact physiological responses; for instance erectile dysfunction?
A: Enough pairing of chemicals during sex, men tend to get ED issues more often. It's because the chemicals mess with blood flow. Discuss it with your partner, have them discuss with a friend, normalize erectile dysfunction.
C: There is an organization called Impulse, which is a subsidiary organization of AIDS Health Care Foundation. And they have a chapter in San Francisco that not only spoke directly to this conversation, but Playboy took it up and had it published in some of their publications. The drug interaction chart helps inform people about not only chemsex, but which substances to avoid given some of the lethal outcomes that come with those drug interactions. Link: impulse_sf Official: TikTok, Instagram | Linktree
♀Do you know your limits when it comes to mixing substances? Understanding them now could help you…
C: Ron created a Safer Chemsex Practices booklet that has a QR code that links to the drug and interactions. If anyone would like one, please contact Ron.
Q: How does this activity relate to HIV prevention?
A: Depending on what substances are being used and how they're using them increases risk for acquisition of HIV. The behaviors that are being engaged in. People will engage in certain behaviors wild at a high, but normally would never engage in, or certain boundaries dissolve. Have open conversations about protecting yourself. Using PrEP is optimal; however, we have to consider what interactions there could be with those medications as well. There is an unofficial drug on drug interaction with drugs for PrEP
C: Tarrah Kilgore can get a copy to anyone who is interested.
C: Street drugs not only an interaction with PrEP, but they actually lower the efficacy of once-a-day daily PrEP somewhat. Tarrah, could you share that with us? There's also the London drug guide where you actually can put in the substance and then the medication and it will tell you if there's any interaction at all. They have one for HIV also.
C: We're finding there are people that are using substances not to just get high and then have sex but using substances because of trauma they have had in their past so they can now be able to be intimate.
Q: How might we bring in discussion of chemsex when discussing U=U?
A: Those who are practicing chemsex need to be monitored a lot closer by their HIV doctor because the drug-on-drug interactions between common chemsex drugs and their ART, whether that is once daily pill or long-acting injectable. That does have an effect on U equals U. Also, these drugs do have an effect on our immune system and can make us more vulnerable to the virus replicating even on ART.

C. "Meeting Providers Where They Are: Hospital Huddles for Community Collaboration and Perinatal HIV Prevention Education in Southern Nevada" –Cheryl Radeloff, PhD and Raychel Holbert, MPH; SNHD ODS

- SNHD Perinatal HIV Program History
    - 2017-2022 – SNHD's Ryan White nurse case managers (NCM) educate hospitals, providers and staff
        - C-sections performed even when the viral load was low/non-detectable

        - Infants were not evaluated with appropriate tests before discharge; no heel sticks or cord blood, must be venipuncture
    - 2023-Present – Perinatal HIV Prevention Education Team formed
        - Multi-divisional effort (Ryan White NCM, Office of Disease Surveillance, Office of Communications)
        - Educate maternity and emergency department (ED) staff in preventing perinatal HIV transmission
            - Provide a binder insert with resources and pharmacies that stock
            - Breast/chest feeding information
            - Correct tube type
            - Ask evaluation type questions to improve the education presentation
                - ❖ Information on testing laws for all STIs
                - ❖ Pamphlet to person who is tested – Healthy Mom Equals Healthy Baby brochure
            - Discuss PEP and PrEP
        - Developed a unit binder with reference information; recommended algorithms, actions for at risk infants, resources for staff and patients
    - USCHA Conference
        - Organized by National Minority AIDS Council (NMAC)
        - Largest national conference for community mobilization and public health education for HIV/AIDS
        - Purpose to advance public health practices to end the HIV epidemic
        - 30-year anniversary
        - https://www.nmac.org/uscha/
    - iPoster Presentation at USCHA – see slide 6
        - iPoster link: https://uscha26.ipostersessions.com/Default.aspx?s=2B-3E-5D-5A-6C-C7-DF-A5-63-55-B3-12-41-E7-F5-85
            - Background
            - Methods
            - Results
            - Evaluation
            - Lessons Learned and Recommendations
            - Conclusions and Future Directions
            - Conference responses
                - ❖ Consider working with doulas
    - References and Resources
        - NMAC 2026 – https://www.nmac.org/about/
        - SNHD ODS online perinatal HIV materials https://lp.constantcontactpages.com/cu/niZYEBH/perinatalhiv

Q: Now that you have been doing this awhile, what do you think is still the barrier to us to get to 0?
A: Prenatal care. I think that's why we have that algorithm because when you go through the law, ideally you should be tested your first trimester, first visit, and then they recommend third if you've not been tested. And also based on risk, because we're a high morbidity jurisdiction. Also at birth, because if there hasn't been any testing and the person does come back, and the mom tests positive, then there are specific things that have to happen with that. Another reason is a transient community, and sometimes there is a lag in getting that care. Knowledge of the laws for providers is a barrier as well. Finally, not testing the dads/partners.
C: The lack of insurance is also a barrier. Most women can't afford to pay for prenatal care.
Q: In the pamphlet, does it have information if you're giving the child the injection or the oral for ART when they're babies? Does it have side effects or what the client should look out for.
A: Currently that information is not in the pamphlet, but such a great suggestion. We could also include information about retesting, and U=U.

C: As a group we share resources, and where to test, but can a client get a copy of those results from a mobile testing unit or small clinic to show they have been tested.
Q: Will you be modeling this across state lines into other counties, since this is like a bigger region, you know, Las Vegas, San Diego, LA, Las Vegas.
A: Thank you. I think this initiative has been very successful in Southern Nevada, and this could be replicated in other parts of Nevada to our rural partner, also to our northern. This information is part of the iPoster, and it is available online. https://uscha26.ipostersessions.com/Default.aspx?s=2B-3E-5D-5A-6C-C7-DF-A5-63-55-B3-12-41-E7-F5-85
C: I see this being a global framework, especially since it's not really being valued in other countries either. There are global organizations like WHO and AIDS Health Care Foundation, that really could reinforce this and really bring it beyond the scope of state counties or states.

- SoNV HPPG – next meeting Wednesday, February 3, 2027; 2pm – 4pm, 280 S Decatur Blvd (2027 schedule attached) If you have suggestions on presentations for HPPG 2026, contact: radeloff@snhd.org
  - Elections will be held at the February meeting to replace the co-chair elect. Albert will move into the co-chair position which will open the co-chair elect position. If you would like to run, you must be a member of SoNV HPPG. Email Chris Reynolds for an application.

VII. **PUBLIC COMMENT:** 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. No action may be taken upon a matter raised under this item on this Agenda until the matter itself has been specifically included on the agenda as an item upon which action may be taken pursuant to NRS 241.020. Comments will be limited to five (5) minutes per speaker. If any member of the general public wishes to make a public comment, either in person or via MS Teams, request time from a SoNV HPPG co-chair, clearly state your name and address, and spell your last name for the record. Please state whether you have any direct or indirect interest in or relationship with any individual or organization that proposes to enter any transaction with Southern Nevada HIV Prevention Planning Group. If any member of the Southern Nevada HIV Prevention Planning Group wishes to extend the length of a public comment, this may be done by the Co-Chairs or the Southern Nevada HIV Prevention Planning Group by majority vote.

Organizational Activities

- Southern Nevada Health Consortium
  - National Latinx AIDS Awareness Day; October 15, 2026 at Chicanos Por lo Casa at 555 N Maryland Pkwy; 5pm-8pm; offering vendors, flu and COVID vaccines, HIV testing with incentives, and a dinner program
  - World Aids Day – planning is in progress with an HIV awareness week
    Email Chris Reynolds for additional information.
  - Consortium Community Calendar – if your organization has an event, you can submit it to the calendar page and it will be posted; SNVhealthconsortium.org
- SNHD
  - Let's Talk About Chemsex Training – October 20, 2026; 9am – 12pm; 280 S Decatur Blvd
  - Empower Change – next training is November 9-10, 2026; 280 S Decatur Blvd
  - HDAD – Food Systems & the Federal Dietary Guidelines - October 8, 2026; 4pm-6pm at Dignity Health on Sahara
    Registration: https://bit.ly/3TmvB3B
- The Center
  - Building Bridges to Help – November 22, 2026; 8am-4:30pm

VIII. ADJOURNMENT

Meeting adjourned at 4:11pm.



From Evidence to Action: *Operationalizing in Routine HIV Care and Counseling*



How can I intentionally integrate U=U messaging into routine clinical care in ways that measurably improve patient engagement, adherence, and viral suppression?

SoNV HPPG
October 2026

Todd Fuqua (They/them)
aka Professor Peacock
Community Artivist & Health Educator
Person living with HIV since 2012
todd@ctoddcreations.com

Content adapted from U=U University, Prevention Access Campaign.

1



Learning Objectives



- Describe U=U as a clinical intervention
- Summarize behavioral impact evidence
- Identify 5 integration touchpoints
- *Apply workflow integration strategies*
- *Use tools to standardize messaging*

Clarity changes belief.
Consistency changes outcomes.
Workflow sustains both.



Reused with permission from U=U University, Prevention Access Campaign

2

2

Why this session exists?

- Evidence alone does not change behavior
- U=U must be delivered consistently to influence care outcomes
- This session translates science into routine practice



Operationalize U=U as standard clinical practice

3

3

U=U Is Not a Message
It Is a Clinical Mechanism

- Accurate U=U communication
- Reduced fear & internalized stigma
- Improved adherence
- Higher viral suppression
- Health & prevention benefit

4

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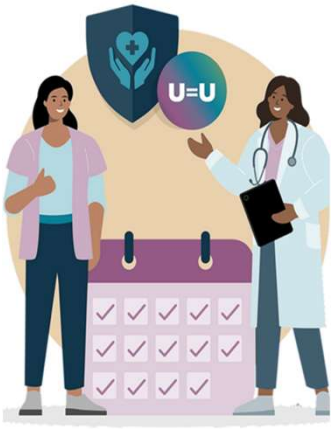
Evidence That Messaging Changes Behavior

- Providers are encouraged to discuss U=U with all patients[1]
- U=U awareness is associated with
  - Improved ART adherence[2]
  - Higher viral suppression[2]
  - Improved sexual health[2]
  - Reduced shame and stigma[2]



1 Calabrese & Mayer, https://preventionaccess.org/wp-content/uploads/2021/05/The-Lancet-Providers-should-discuss-UU-with-all-patients-living-with-HIV.pdf
2 Okoli et al 2021, https://pubmed.ncbi.nlm.nih.gov/32732335/

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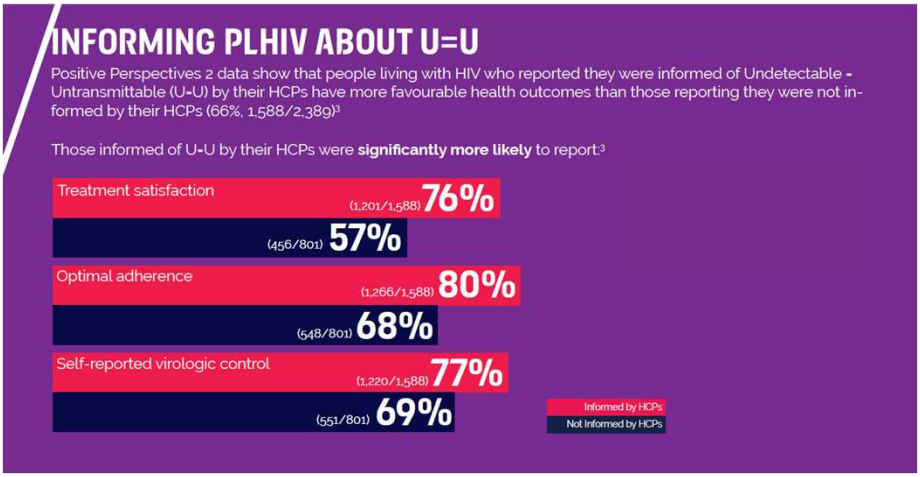
Evidence That Messaging Changes Behavior



Source: Okoli C, Van de Velde N, Richman B, *et al.* Undetectable equals untransmittable (U = U): awareness and associations with health outcomes among people living with HIV in 25 countries *Sexually Transmitted Infections* 2021;**97:**18-26.

6

6

Increases the Uptake of HIV Testing Services

- Smith et al. (2021)[1] investigated the impact of a **peer-delivered U = U message on men's HIV testing uptake** at a mobile testing clinic.
- On standard of care (SOC) days, peer promoters informed men about the availability of HIV testing at the mobile clinic. On intervention days, peer promoters delivered U = U messaging.
- 1,048 adult-aged males participated.



[1] Smith et al. U = U Messaging Increases Uptake of HIV Testing Among Men https://pubmed.ncbi.nlm.nih.gov/34057659/

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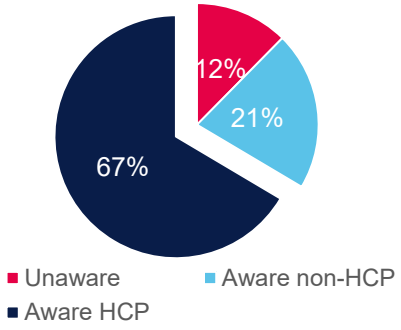
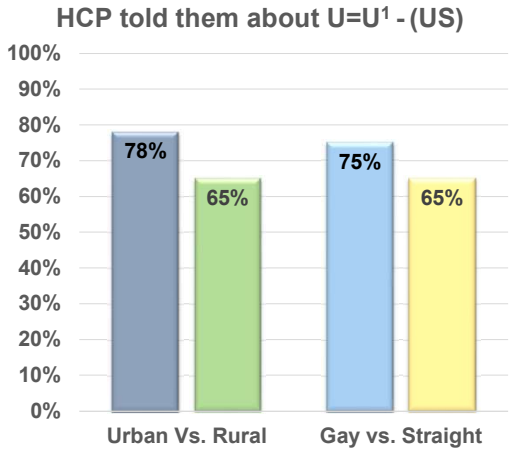
1/3 of PLHIV were not told about U=U by their HCP

- Many PLHIV report U=U is never discussed in clinical visits[1]





1 Positive Perspectives 2 Survey https://pubmed.ncbi.nlm.nih.gov/33026574/ https://www.poz.com/article/uu-important-hiv-health-us-providers-less-consistent-sharing 8

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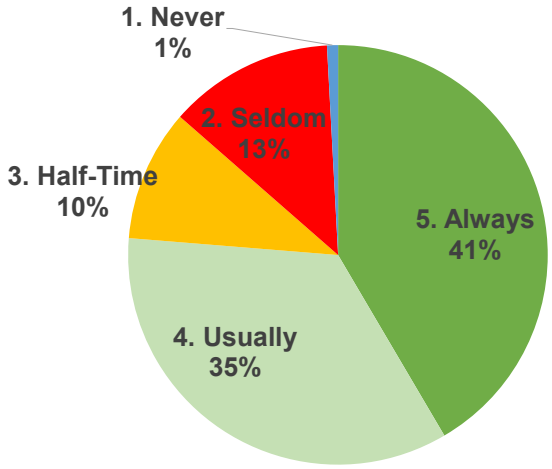
How often do you discuss U=U with your patients living with HIV?



From my four workshops' pre-survey (n=130) w/avg of 3.8:

- **41% answered always**
- 35% answered usually
- 24% answered half time or less
- Was that a one-off or on-going conversation?

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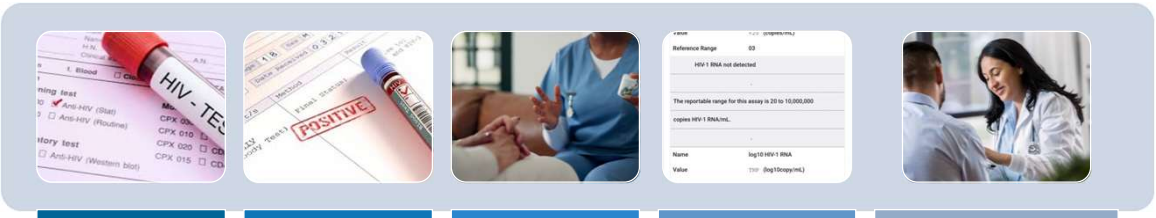
The 5 Clinical Touchpoints for U=U Integration into Care Continuum



Testing (Pre-diagnosis framing)	Reactive Test / Diagnosis	Treatment Initiation	Viral Load Monitoring	Routine Follow-up & Adherence Conversations

Testing → Diagnosis → ART Initiation → Retention → Viral Suppression

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1. Testing (Pre-Diagnosis Framing)



"Get tested, know the facts. If someone has HIV and starts treatment, they can reach a point where they cannot pass HIV to partners. U=U."

Reduces fear. Conveys benefit. Lessens shame.

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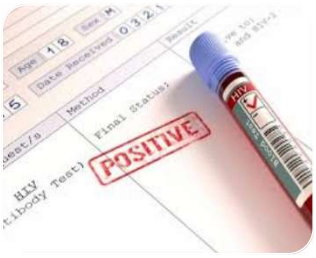
2. Reactive Test / Diagnosis



"I know this feels overwhelming. Treatment today is simple and effective. Once you're undetectable, you can't pass HIV to your partner – and it keeps you healthy. We can get you there."

Reduce catastrophic thinking.

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3. Treatment Initiation



"Starting treatment now helps you reach undetectable quickly. That protects your health and means you can't pass HIV to others."

Clear personal benefit. Shared goal with loved ones. Positive reinforcement.

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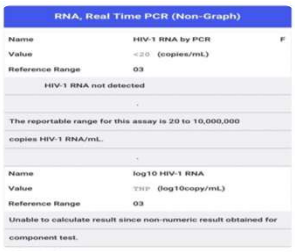
4. Viral Load Monitoring



RNA, Real Time PCR (Non-Graph)

Name	HIV-1 RNA by PCR	F
Value	<20 (copies/mL)	
Reference Range	03	
HIV-1 RNA not detected		
The reportable range for this assay is 20 to 10,000,000 copies HIV-1 RNA/mL.		
Name	log10 HIV-1 RNA	
Value	THP (log10copy/mL)	
Reference Range	03	
Unable to calculate result since non-numeric result obtained for component test.		

"Today's viral load shows how treatment is working. Every step toward undetectable protects your health and your partners."

U=U reinforces progress. Shared goal with loved ones.

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5. Routine Follow-up / Adherence Conversations

"Every dose counts. Staying on your HIV treatment keeps you healthy and when you're undetectable, you can't pass it on. What helps you stay on track?"



Reduces stigma & fear. Reinforce belief. Sustain engagement.

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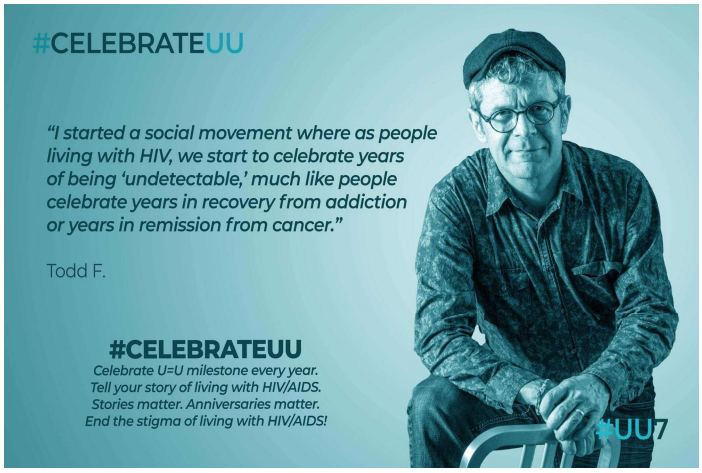
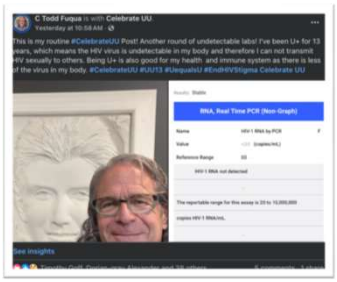
5. Routine Follow-up / Adherence Conversations







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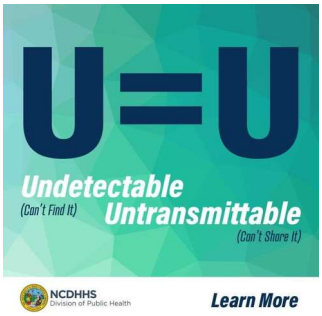
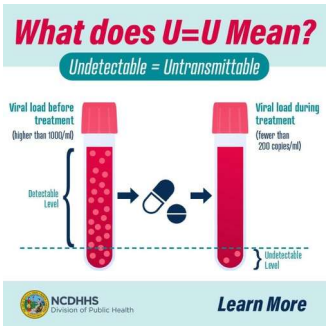
Public Spaces & Social Media















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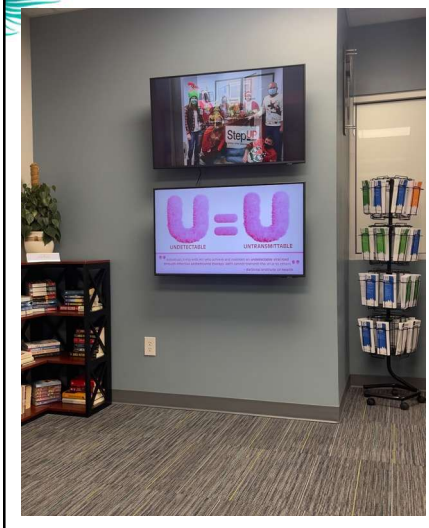
Public Spaces & Social Media









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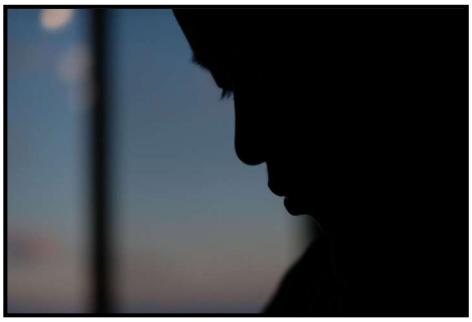
From Conversation to Workflow



Ask yourself:

- Is U=U scripted at diagnosis?
- Is it reinforced at viral load review?
- Does the entire team use consistent language?
- Is documentation built into workflow?

If not, it depends on personality.
That is not sustainable care.

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Example EMR = Integration

Reactive Result Template:

- "Discussed U=U and viral suppression as prevention. Patient verbalized understanding."

Viral Load Visit Template:

- "Reinforced U=U and importance of maintaining suppression."

Team Training Checklist:

- Nurses reinforce U=U
- Case managers reinforce U=U
- Providers document U=U discussion

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Micro-Implementation Checklist

PICK ONE!

- Add U=U line to reactive result script
- Add U=U reinforcement to VL template
- Train full team (Professor Peacock is available!)
- Audit charts quarterly for documentation



"Small changes done consistently beat ambitious plans that never happen."
– Professor Peacock

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ECHO Case Consultation Model for U=U

- Add one set of questions
  - Was U=U discussed?
    - At which touchpoint?
    - Was it documented?
- Discussion includes
  - Where in the care continuum was the strongest opportunity?
  - What exact language would you use?
  - What system change could reduce this gap in the future?
- Key Distinction
  - The goal is not only clinical management.
  - The goal is strengthening consistent U=U delivery across the team.

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Tools Provided

Team Training Model



U=U Team Training Model

A Flexible Framework for Clinic Implementation

Communicating that sustained viral suppression prevents sexual transmission of HIV is evidence-based clinical care.

This model can be adapted to clinics of any size. I would recommend identifying a sponsor (why not you?). This Sponsor should take both of the courses at U=U University.

- Course 1: Understanding and Communicating U=U
- Course 2: Implementing and Evaluating U=U

There are options for self-guided (4 hour) and leader-led/live instruction (4 weeks / 10 hours) for each course. These courses are based on the *Implementing and Scaling Up U=U Resource Guide*, and offer valuable tools and real-life examples for different situations.

1. Align Leadership

Goal: Agree on shared language and expectations.

Options:

- 30-minute leadership huddle
- Email consensus with brief follow-up
- Incorporate into existing QI meeting

Outputs:

- Agreed threshold (<200 copies/mL)
- Standard phrasing
- Documentation approach
- Re-audit timeline

Adaptation tip:
Small clinics may do this informally. Larger systems may require formal approval.

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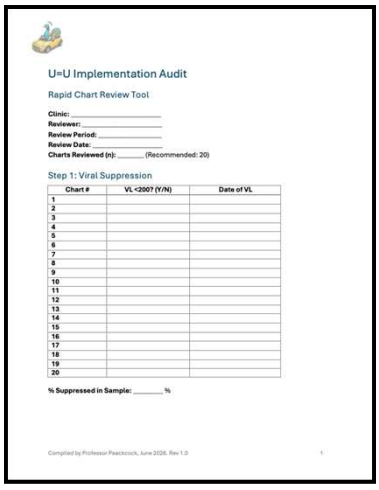
Chart Audit Template



U=U Implementation Audit

Rapid Chart Review Tool

Clinic: _____
Reviewer: _____
Review Period: _____
Review Date: _____
Charts Reviewed (n): _____ (Recommended: 20)

Step 1: Viral Suppression

Chart #	VL <200? (Y/N)	Date of VL
1		
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% Suppressed in Sample: _____ %

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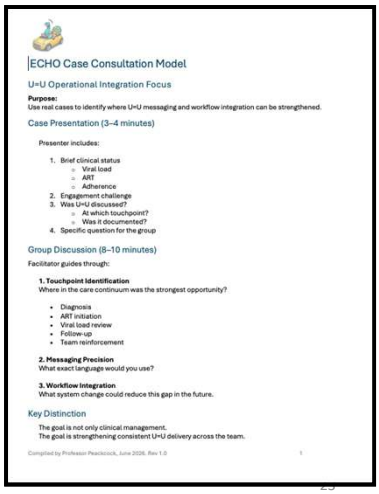
ECHO Case Consultation



ECHO Case Consultation Model

U=U Operational Integration Focus

Purpose:
Use real cases to identify where U=U messaging and workflow integration can be strengthened.

Case Presentation (3–4 minutes)

Presenter includes:

1. Brief clinical status
   - Viral load
   - ART
   - Adherence
2. Engagement challenge
3. Was U=U discussed?
   - At which touchpoint?
   - Was it documented?
4. Specific question for the group

Group Discussion (8–10 minutes)

Facilitator guides through:

1. Touchpoint Identification
Where in the care continuum was the strongest opportunity?

- Diagnosis
- ART initiation
- Viral load review
- Follow-up
- Team reinforcement

2. Messaging Precision
What exact language would you use?

3. Workflow Integration
What system change could reduce this gap in the future.

Key Distinction

The goal is not only clinical management.
The goal is strengthening consistent U=U delivery across the team.

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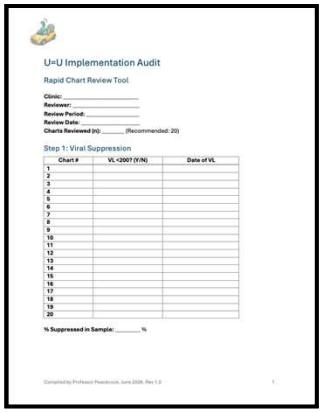
Adapting This Model to Your Setting

1. Where does U=U fit in your workflow?
   - Lab review
   - Follow-up visits
   - Prevention counseling
   - Case management
2. What makes documentation easiest?
   - SmartPhrase (“dot phrase”)
   - Template field
   - Standard note language
3. Who can champion this?
   - Clinical lead
   - Nurse educator
   - QI coordinator
   - Case management



U=U Implementation Audit

Rapid Chart Review Tool

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Implementation requires clarity, consistency, and one workflow decision.

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Resources & Handouts

- U=U University Training
  - Implementing and Evaluating U=U

Join Course 2: Implementing and Evaluating U=U [SELF-GUIDED]

Join Course 2: Implementing and Evaluating U=U [LIVE INSTRUCTION]

SCAN FOR RESOURCES

- Tools to Support Standardization
- U=U University Service Delivery Scripts
  - Provider FAQ Sheet
  - **Team Training Model**
  - **Chart Audit Template**
  - **ECHO case consultation model**
- U=U Key Messages_UU UNI.pdf
- Common U=U Questions and Concerns.pdf

Handouts for entire series available at https://bit.ly/PeacockUU
Look at Module 2 for today's content

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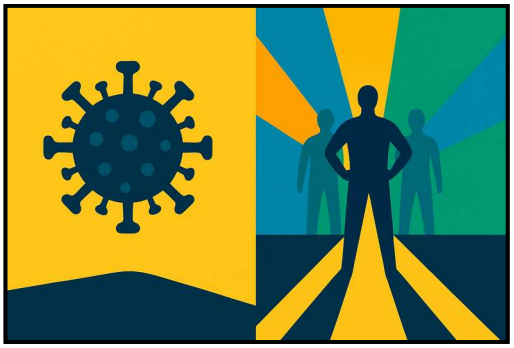
Closing

U=U improves viral suppression not because the virus changes.

It improves suppression because behavior changes.

Behavior changes when patients believe their future is intact.



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Other Sessions in this Series





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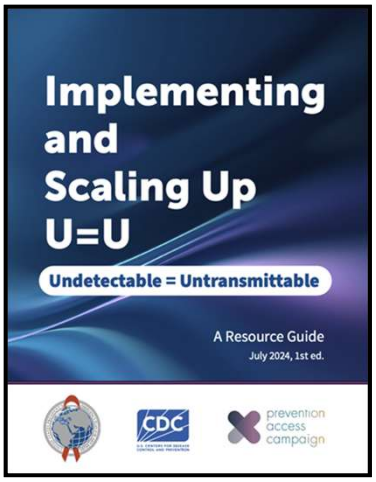
Thank you and acknowledgments







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SOBER SEX IS GREAT SEX!

SEX, INTIMACY, AND PLEASURE AFTER CHEMSEX

A Trauma-Informed, Sex-Positive Recovery Workshop

ABOUT ME



Ronald Schnese, CPRSS-S (NV)

Linkage to Care Coordinator Lead
The LGBT Center of Southern Nevada

"How wonderful it is that no one has to wait even a minute to start gradually changing the world."
~Anne Frank, 26 March 1944

Disclosure of conflict of interest

No conflict of interest to disclose

Disclaimer

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Overview and objectives

By the end of this workshop, participants will be able to:

- Describe the neurobiological and relational impacts of chemsex on intimacy, desire, and bonding.

- Identify common post-chemsex sexual and relational experiences and normalize them in clinical or peer settings.
    - Apply trauma-informed, sex-positive, and harm-reduction language when discussing sex and intimacy with clients.

- Demonstrate communication strategies that reduce shame and support relapse-prevention planning related to sexual activity.
    - Develop sex-specific recovery support strategies aligned with client autonomy and recovery goals.

Why This Workshop Matters

- Chemsex changes how people experience desire, intimacy, and connection
- Recovery often focuses on substances and a person's health....but not sex or pleasure (which is a pillar of health)
- Silence and shame increase relapse risk
- Providers often feel unprepared to talk about sex

Chemsex, intimacy, and the recovery process

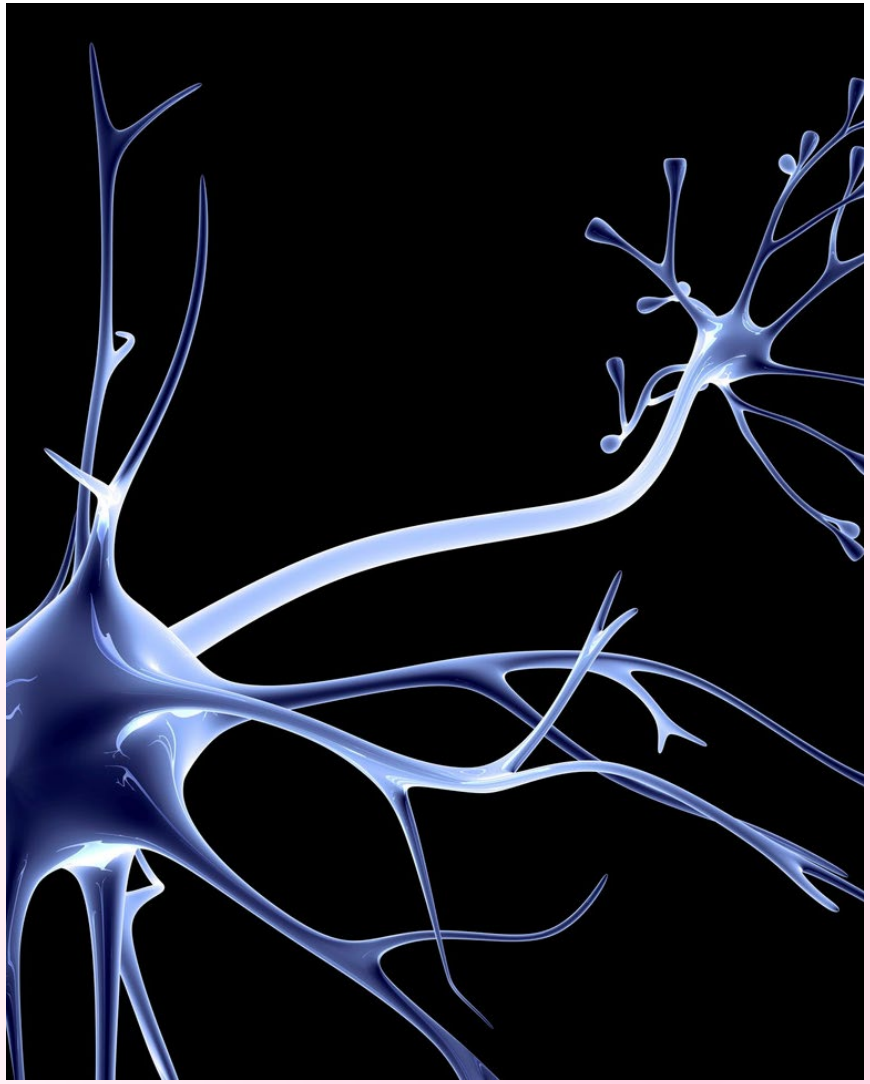
Defining chemsex or “Party and Play”

chemsex:
noun: informal • British English
sexual activity engaged in while under the influence of stimulant drugs such as methamphetamine or mephedrone, typically involving several participants.

- Use of specific substances to enhance sexual experience
- Often associated with extended sessions, disinhibition, and intensity
- Distinct from general substance use due to **sexual conditioning**

The brain on chemsex

- Dopamine flooding and reward amplification
- Reduced inhibition and impulse control
- Conditioning of arousal to substances + environments
- Disruption of natural pleasure pathways





Neurobiology of Desire & Bonding

- Impact on oxytocin (bonding hormone)
- Altered attachment responses
- Intimacy becomes chemically mediated
- Sober sex may feel “flat,” unsafe, or anxiety-provoking



Relational Impacts of Chemsex

- Shifts in boundaries and consent norms
- Increased emotional distancing or avoidance
- Fear of vulnerability without substances
- Confusion between sex, validation, and connection

Common Post-Chemsex Experiences

Normalize, don’t pathologize!



- Reduced libido or desire
- Fear of sober intimacy
- Sexual shame or grief
- Difficulty orgasming without substances
- Avoidance of dating or sex altogether

“The absence of immediate pleasure does not mean something is broken, it means the system is healing.”

- Assume trauma exposure rather than requiring disclosure
- Prioritize safety, choice, and empowerment in all interactions
- Avoid moralizing language or abstinence-only assumptions
- Respect pacing and readiness for change and recovery





Let’s Talk About









Context matters

Autonomy over compliance

Sex positivity

Pleasure is a valid recovery topic

Sex is not the problem



Reducing shame increases honesty, engagement, and long-term behavior change.

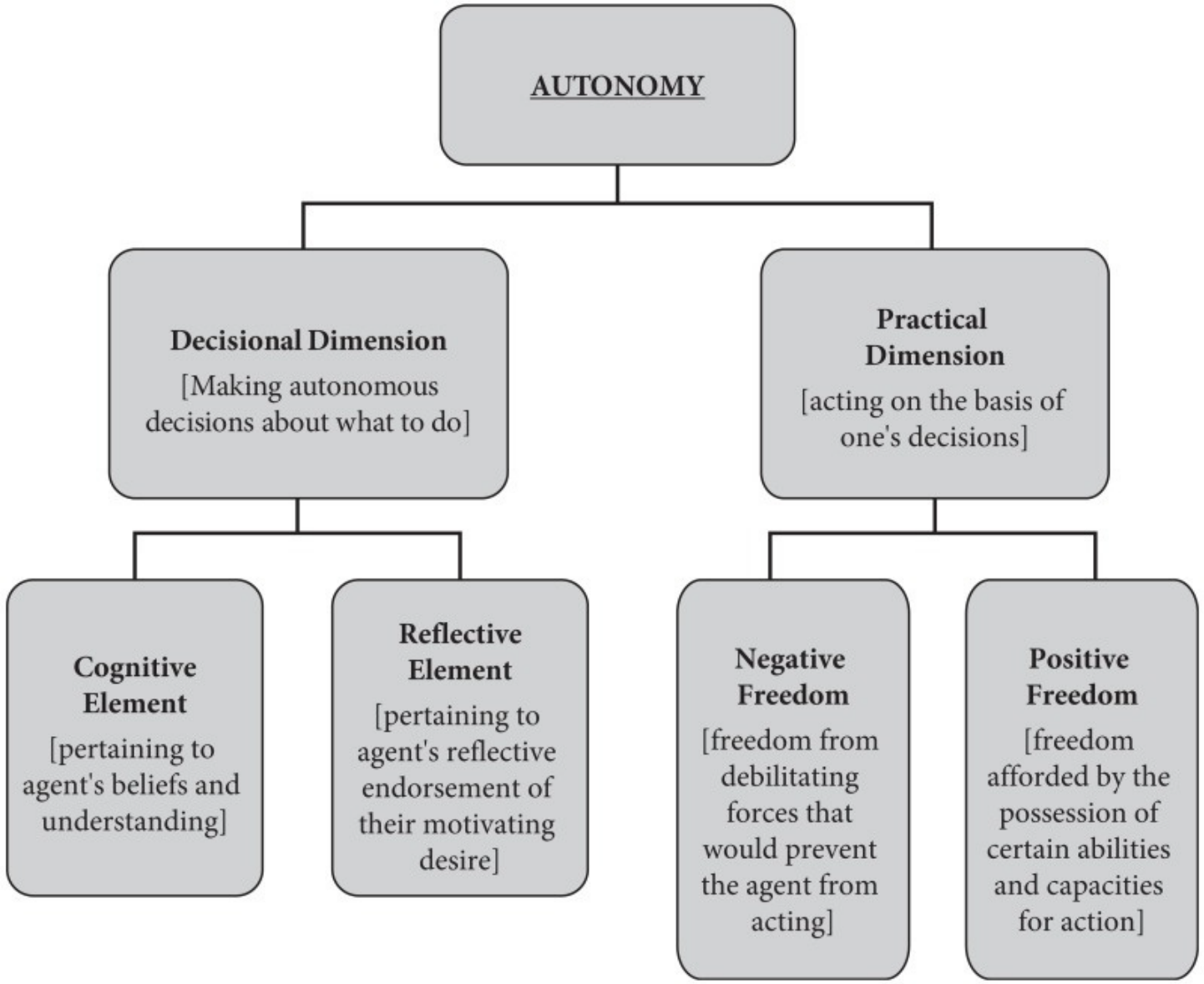
Instead of	Try using
• “Risky behavior”	• “Conditioned responses”
• “Sex addiction”	• “Learned coping strategies”
• “Poor choices”	• “Adaptive behaviors that no longer serve”

Sex & Relapse-Prevention Planning

- Sexual activity can be a relapse trigger
- Identify patterns (apps, venues, emotional states)
- Plan for discomfort with sober intimacy
- Normalize setbacks as learning opportunities







- Recovery goals are not one-size-fits-all
- Abstinence from substances ≠ abstinence from sex
- Honor client definitions of "healthy sex"
- Revisit goals as recovery evolves

Recovery strategies to help

- Gradual exposure to sober intimacy
- Mindfulness-based pleasure retraining
- Boundaries around apps or environments
- Peer or therapeutic sexual processing spaces

Common pitfalls

- All-or-nothing rules around sex
- Moralizing or pathologizing desire
- Pushing exposure faster than readiness
- Ignoring pleasure or intimacy needs
- Assuming relapse equals failure



What to Remember

- Chemsex recovery includes sex, intimacy, and pleasure
- Normalization reduces shame and relapse risk
- Language matters
- Client autonomy is central
- Talking about sex is harm reduction



QUESTIONS?

Sources:

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NAVIGATING OUR COMMUNITY SN health CONSORTIUM

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CPLC CHICANOS POR LA CAUSA

MEETING	SoNV HPPG	DATE	October 7, 2026
FACILITATOR	Dr. Cheryl Radeloff	TIME	2:00pm - 4:00pm
LOCATION	SNHD/ 280 S Decatur Blvd/ Lone Mtn Conf. Rm		

Southern Nevada Health District

NO.	NAME (PLEASE PRINT)	PROGRAM/AGENCY/AFFILIATION	EMAIL	PHONE	SIGNATURE
1	Albert Sedano	The Center	[illegible]		
2	Ron Schnese	The Center	rschnese@thecenterlv.org	702-574-4276	
3	CHARLIZ LACCAO	SNHD LZA	LACCAO@SNHD.org	702-668-2160	
4	Bethany Reyes	SNHD LZA	delosreyes@snhd.org	702-759-0766	
5	Jocelin Bravo Rosas	SNHD	bravo-rosas@snhd.org	702-759-0090	
6	Brennen O'Toole	SNHD	otoolcb@snhd.org	702-759-1043	
7	Chris Reynolds	SNHC			
8	Rachel Holbert	SNHD/ODS	holbert@snhd.org	702 2341449	
9	Sandi Santos	SNHD/ODS			
10	Cheryl Radeloff				
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21	VIRTUAL	ATTENDEES			
22					
23	Professor Peacock (M. Todd Figueroa)				
24	Xavier Foster				
25	Hope Wright				
26	Tonia Atencio	SNHD - RN			
27	Belen Campos-Garcia				
28	Gina Schuster	Comm. Outreach Medical Ctr			
29	Heather Kerwin				
30	Leena Ramirez	- Gilead			
31	Anayensi Alvarez	- CAN			
32	Eric Matesen				
33	Sara Ruiz				
34	Jarrah Kilgore				
35	Dominic Calhoun				
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