



NEBRASKA INTEGRATED HIV PREVENTION AND CARE PLAN 2017-2021

Nebraska Department of Health and Human Services

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Acronyms

ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Centers
AIDS	Acquired Immune Deficiency Syndrome
ANAC	Association of Nurses in AIDS Care
ART	Anti-Retroviral Therapy
ASO	AIDS Service Organization
CAPWN	Community Action Partnership of Western Nebraska
CBO	Community-Based Organization
CCH	Chadron Community Hospital
CDC	Centers of Disease Control and Prevention
CHC	Community Health Centers
CMA	Crystal Meth Anonymous
CTR	HIV Counseling, Testing, and Referral
DIS	Disease Investigator Specialist
eHARS	Enhanced HIV/AIDS Reporting System
EIS	Early Intervention Services
ERMA	Emergency Rent and Mortgage Assistance
FDA	U.S. Food and Drug Administration
HCV	Hepatitis C
HIPEP	HIV Interprofessional Education Project
HIV	Human Immunodeficiency Virus
HIVMA	HIV Medical Association
HOPWA	Housing Opportunities for Persons With HIV/AIDS
HRSA	The Human Resources Service Administration
HUD	US Department of Housing and Urban Development
ID	Infectious Disease
IDU	Injection Drug User
MATEC	The Midwest AIDS Training and Education Center
MSM	Men who have Sex with Men
NA	Narcotics Anonymous
NAP	Nebraska Aids Project
NDHHS	Nebraska Department of Health and Human Services
NIR	No Indicated Risk
OAHC	Outpatient Ambulatory Health Care Services
PEP	Post-Exposure Prophylaxis
PLWHA	People Living with HIV/AIDS
PrEP	Pre-Exposure Prophylaxis
PTAC	Policy Training Advisory Council
RW	Ryan White
RWHAP	The Ryan White Part B Program
SCSN	Statewide Coordinated Statement of Needs
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TBRA	Tenant Based Rental Assistance
UNMC	University of Nebraska Medical Center
VL	Viral Load

WCHR
YMSM

Western Regional Health Resources
Young Men who have Sex with Men

Introduction

“The United States will become a place where new HIV infections are rare and when they do occur, every person regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.”

National HIV/AIDS Strategy Vision Statement

The Nebraska Department of Health and Human Services (NDHHS) shares the vision of the United States National HIV/AIDS Strategy. The development of new strategies and tools to aid in the prevention of new HIV infections and to support people living with HIV/AIDS through strengthened systems for treatment and care shows new promise in addressing HIV both nationally and in Nebraska. Although substantial progress has been made along the HIV care continuum, challenges remain.

Since the beginning of the HIV epidemic, Nebraska has remained a low incidence state. Over the past five years, the number of new HIV infections remained relatively stable with a range of 81-88 cases in a given year. In 2015, 81 persons were newly identified as living with HIV. Trends in HIV infections in Nebraska are similar to those observed throughout the United States. In 2015, the greatest number of new HIV infections were reported among persons 15-24 years of age, while decreases were observed among all other age groups. Disparities by race and ethnicity also existed in 2015. White persons accounted for 58% of new cases of HIV in 2015. However, when compared to the rate of new infections among white persons, the rate for Black/African American persons was over 8 times greater, and the among Hispanic persons was double.

The majority of new HIV cases were among men, who accounted for over three-fourths of new cases in 2015. Among men, nearly one-third of infections were attributed to men who have sex with men, and 8.2% were attributed to heterosexual transmissions. Among women, the greatest number of new infections between 2011-2015 were attributed to heterosexual exposure. There continues to be a challenging in collecting data for indicated risk; in the past five years, risk was not identified for 20.1% of cases among men and 35.9% of cases among women.

HIV prevalence patterns in Nebraska are similar to those of incidence. At the end of 2015, a total of 2,217 persons were living with HIV (PLWH). The prevalence rate for men was nearly 5 times that for women, while the prevalence rate for Black/African Americans was over nine times that of whites. Geographically, the majority of PLWH resided in Douglas (58%) or Lancaster (15.5%) County.

Nebraska supports PLWH through a variety of mechanisms, including Ryan White Parts B and C and HOPWA. In 2015, medical case management services were provided for 474 clients, of whom 70% were men, 64% were white, and 53% were over the age of 45 years. The majority of service recipients were below the federal poverty level. The AIDS Drug Assistance Program (ADAP) supported medications for 993 people in 2015. A total of 235 clients accessed Emergency Financial Assistance (EFA), the majority of which was used to support housing assistance and transportation. Ryan White Part C services were provided by the University of Nebraska Medical Center (UNMC) and the Community Action Partnership of Western Nebraska (CAPWN). In 2015, the Part C program served 512 clients, which represented a slight increase from the previous year. Additional support to 83 PLWH was provided through the

Housing Opportunities for People with AIDS Program (HOPWA). UNMC also received support from Ryan White Part D.

Challenges remain to HIV prevention, treatment, and care in Nebraska. In 2015, among PLWH in Nebraska, 42.4% were currently in care, and 75.4% were virally suppressed. In 2015, 63% of new PLWH were linked to care. There are opportunities for system strengthening across the HIV care cascade, particularly in the areas of linkage to care. Further, the current plan supports retention in care, which will likely result in a greater percentage of people who are virally suppressed.

The SCSN process was valuable for NDHHS; it provided an opportunity to assess the needs, gaps, and barriers in the community from multiple perspectives. Further, the development of the Integrated Plan provided an opportunity to prioritize unmet needs and gaps in services to increase efforts to address the HIV Care Continuum. This plan was developed through a collaborative process with local prevention, treatment, and care providers and other stakeholders, and it provides a framework for meeting the goals of the National HIV/AIDS Strategy. The NDHHS is committed to implementing new, innovative strategies and methods to prevent new cases of HIV in Nebraska, as well as to supporting PLWH with access to medical care and other support services to ensure an enhanced quality of life. Through collaboration and coordination with clinical and community partners, the NDHHS looks forward to continuing to make great strides in addressing HIV in Nebraska.

Section I: Statewide Coordinated Statement of Need/Needs Assessment

Part A: Epidemiologic Overview

Description of State of Nebraska

Population Distribution

Nebraska is a primarily rural state where the majority of the population resides in the eastern third of the state. The top two population centers, Omaha and Lincoln, are located in Douglas and Lancaster counties. According to the US Census Bureau, the population of Nebraska in 2015 was estimated at 1,896,190, a 3.8% increase from the population in 2010 (1,826,341). The two largest counties in Nebraska, Douglas and Lancaster, had estimated populations of 550,064 and 306,468, in 2015, respectively. The smallest county is Arthur county, located in the western part of the state, with a population of 460 (2010).¹ Table 1 shows the population for the 10 most populated counties in Nebraska.

Table 1: Largest Counties in Nebraska, 2010²

County	Population
Douglas	517,110
Lancaster	285,407
Sarpy	158,840
Hall	58,607
Buffalo	46,102
Scotts Bluff	36,970
Dodge	36,691
Lincoln	36,388
Madison	34,876
Platte	32,237

Race and Ethnicity

In 2014, racial minority populations represented 13.6% of the total population of Nebraska. The white population accounted for 86.4%, while the Black/African American population accounted for 4.9%; the Asian population for 2.2%; the American Indian/Alaska Native for 1.4%; and the Native Hawaiian/Other Pacific Islander population for 0.1%. The Hispanic/Latino population accounted for 10.2% of the population.³ Table 2 provides a summary of population by race and ethnicity.

Table 2: Nebraska population by race and ethnicity, 2014 US Census estimates

Race/Ethnicity	Total Percentage of the Population, 2014
White Alone	86.4%
Black/African American Alone	4.9%

Race/Ethnicity	Total Percentage of the Population, 2014
American Indian/Alaska Native Alone	1.4%
Asian Alone	2.2%
Native Hawaiian or Other Pacific Islander Alone	0.1%
Two or More Races	2.0%
Hispanic or Latino	10.2%

Table 3 shows the percent population change among racial and ethnic population groups in Nebraska from 2010-2014. Increases were seen in each population group, with the majority of population increase among racial and ethnic minority populations.

Table 3: Percentage population change, Nebraska, 2010-2014

	2010	2014	Percent Change
Total Population	1,826,341	1,896,190*	3.8%**
White	1,572,480	1,682,064	6.97%
Black/African American	82,125	92,164	12.22%
American Indian/Alaska Native	18,263	26,341	44.23%
Asian	32,874	41,393	25.91%
Native Hawaiian/Other Pacific Islander	1,826	1,881	3.01%
Hispanic/Latino	168,023	191,913	14.22%
Non-Hispanic/Latino	1,499,426	1,514,610	1.01%

*2015 data, 2014 population was 1,881,503; **Percent change 2010-2015

Note: Numbers were calculated from percentages reported by the US Census Bureau. The base population for 2010 was 1,826,341 and for 2014 was 1,881,503.

Age and Sex

According to population estimates from the US Census Bureau, the distribution of males and females in Nebraska is almost equal, with females comprising 50.2% of the population in 2014.⁴ Table 4 shows the Nebraska population by age and sex.

Table 4: Population of Nebraska by age and sex, 2014⁵

	Males n (%)	Females n (%)	Total Population n (%)
All	936,863 (49.8)	944,640 (50.2)	1,881,503 (100)
Under 18 years	238,635 (25.5)	227,974 (24.1)	466,609 (24.8)
18 – 24 years	98,197 (10.5)	93,421 (9.9)	191,618 (10.2)
25 – 44 years	244,160 (26.1)	234,239 (24.8)	478,399 (25.4)
45 – 64 years	235,731 (25.2)	238,157 (25.2)	473,888 (25.2)
65 years and older	120,140 (12.8)	150,849 (16.0)	270,989 (14.4)

Poverty Level

According to the 2014 US Census, the median household income in Nebraska was \$52,400, which represented an increase of 6.3% from 2010. Approximately 12.9% of the population lived in poverty.

While the median household income increased between 2010 and 2014, the percentage of the population who lived in poverty also increased. Poverty rates in Nebraska demonstrated pronounced disparities by race and ethnicity. Table 5 shows poverty rates by selected racial and ethnic categories for 2014.

Table 5: Poverty rates in Nebraska by selected racial and ethnicity categories, 2014⁶

Race/Ethnicity	Percent living below poverty level
White	11.0%
Black or African American	33.0%
American Indian and Alaska Native	43.2%
Asian	16.7%
Two or more races	22.0%
Hispanic or Latino	26.2%

The statewide unemployment rate among those in the labor force aged 16 years or older was 5.4% in 2014, representing an increase from 2010 when the unemployment rate was 4.7%. Similar to the poverty rate, unemployment affected certain racial and ethnic groups more than others; notably, unemployment was highest among American Indian or Alaska Natives (21.0%), Black or African Americans (14.5%), those of two or more races (10.5%), and person of Hispanic or Latino origin (9.8%).⁷

Among Nebraska residents aged 25 years and older, 89.7% reported educational attainment of a high school diploma (or equivalent) or higher in 2014. The poverty rate was greatest among those with less than a high school diploma (24.7%) when compared to those with a high school diploma or higher.⁸

Health Insurance

In 2014, 14% of Nebraska adults aged 19-64 years reported being uninsured. However, 26% of those residents between the ages of 19 and 64 years who were living below 200% of the federal poverty rate reported being uninsured. It is notable that the number of uninsured adults increased by 4.5% between 2010 and 2014.⁹ Table 6 shows insurance coverage by source and income level.

Table 6: Distribution of adults in Nebraska by health insurance coverage source and income level, 2014

Source	All Income Levels		Low Income (<200% of FPL)	
	Nebraska %	US %	Nebraska %	US %
Employer	64%	59%	32%	26%
Non-Group	9%	8%	10%	10%
Medicaid	8%	14%	8%	32%
Other Public	5%	5%	9%	6%
Uninsured	14%	14%	26%	26%

Current HIV Epidemic

In 2015, 81 cases of newly identified HIV infections were reported in Nebraska. The five-year average was 83 cases per year for the 2011 to 2015 reporting period, and was 107 for the previous five-year period (2006 to 2010). Figure 1 shows trends in HIV/AIDS incidence for Nebraska from 2006 – 2015.

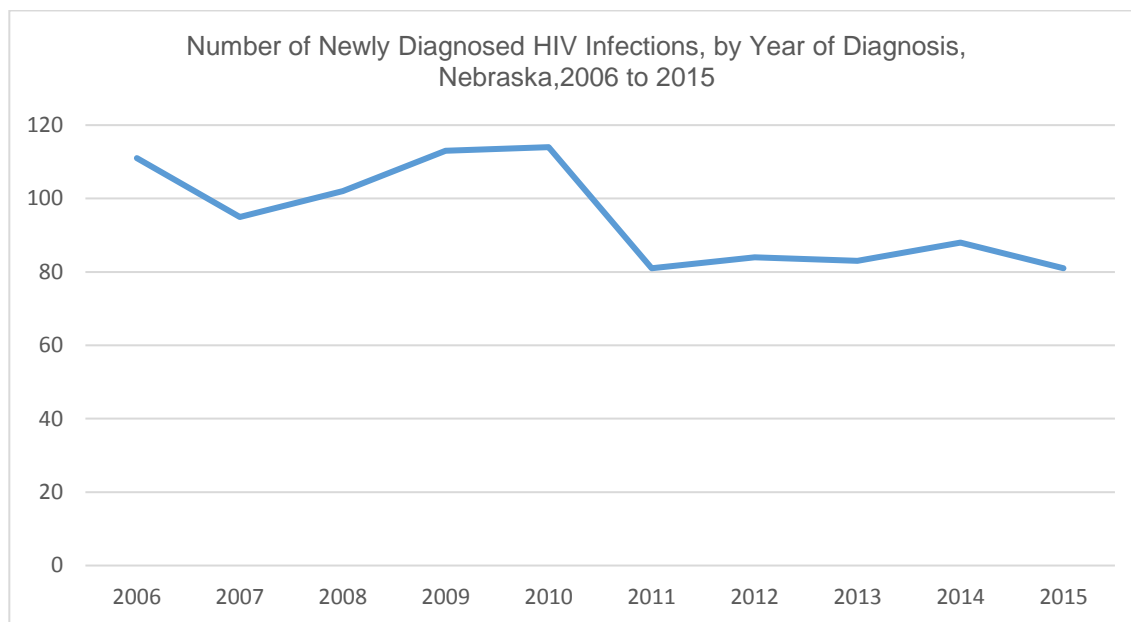


Figure 1: Trends in HIV/AIDS incidence, 2006-2015.

The incidence rate of HIV/AIDS in Nebraska was 4.27 persons per 100,000 population in 2015, compared to 6.23 person per 100,000 in 2011. Compared to 10 years ago, the number of newly diagnosed HIV infections decreased by 27% in 2015. While the number of new cases has dropped since 2006, the number has remained relatively stable for the past five years, with a range 81 to 88 newly reported infections per year.

Age

Between 2006 and 2015, the age group most affected was 25 to 34 years followed by 35-44 years. Infections in males were significantly higher than in females (85% of newly identified cases were male during the report period). The mean age of infection for 2015 was 33 years, which slightly declined from 10 years ago (34 years), and the mean age of infection in 2015 in males was slightly lower than females (33 years vs 35 years). Table 7 shows HIV/AIDS diagnoses by age group.

Unlike previous years, the number of new cases of HIV was greatest among those aged 15-25 years in 2015.

Table 7: HIV/AIDS diagnoses by age group, Nebraska, 2006-2015

Age in years	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
12 or less	3	1	1	2	1	1	1	1	0	0	11
13-14	0	0	1	0	1	0	1	0	0	0	3
15-24	15	17	12	24	28	12	14	18	15	25	180

Age in years	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
25-34	38	33	30	34	35	32	24	22	30	21	299
35-44	36	26	33	32	25	15	24	22	25	17	255
45 or greater	19	18	25	21	24	21	19	20	18	18	203
Total	111	95	102	113	114	81	84	83	88	81	952

Figure 2 shows diagnoses of HIV infection by age group for the years 2006 through 2015. Figure 2 demonstrates the change in the ages of persons newly diagnosed over time. Over time, the highest incidence has typically been among persons aged 25-34 years, with the notable exception of 2015. As the figure shows, new infections were highest among persons 15-24 years of age for the first time in 2015.

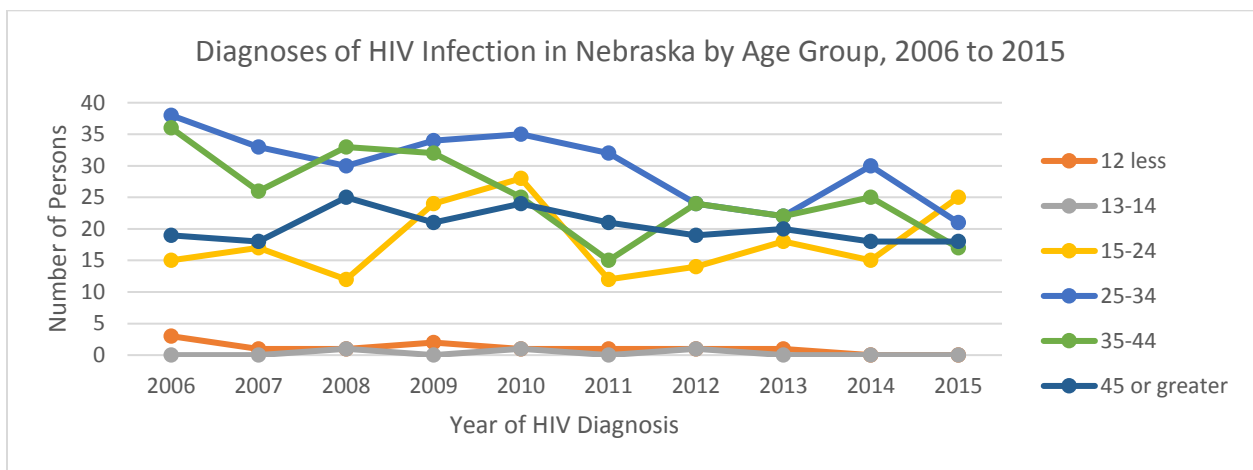


Figure 2: HIV infection by age group, Nebraska, 2006 – 2015.

Race and Ethnicity

The greatest percentage of new HIV/AIDS cases in 2015 were among white, non-Hispanic persons (58.0%), followed by Black, non-Hispanic persons (21.0%), and Hispanic persons (all races) (13.6%). Table 8 shows both cumulative and new cases reported in 2015.

Table 8: HIV cases, cumulative and 2015, Nebraska

Race/Ethnicity	All diagnosed HIV cases through 2015		New HIV/AIDS cases, 2015*	
	N	%	N	%
White, Non-Hispanic	1793	59.7	47	58.0
Black, Non-Hispanic	740	24.6	17	21.0
Hispanic, all races	343	11.4	11	13.6
Asian/Pacific Islander	33	1.1	0	0.0
American Indian/Alaska Native	48	1.6	5	6.2
Multiple Races	43	1.4	1	1.2
Unknown	4	0.1	0	0.0
Missing	1	0.0	0	0.0

*Includes both new HIV diagnoses and AIDS diagnoses made at the time of HIV diagnosis.

Figure 3 shows new HIV infections by race and ethnicity between 2006 and 2015. Over time, trends have remained relatively stable among all racial and ethnic groups in Nebraska. New infections among Hispanic persons showed a slight increase in recent years while new infections among white and Black persons showed a slight decline.

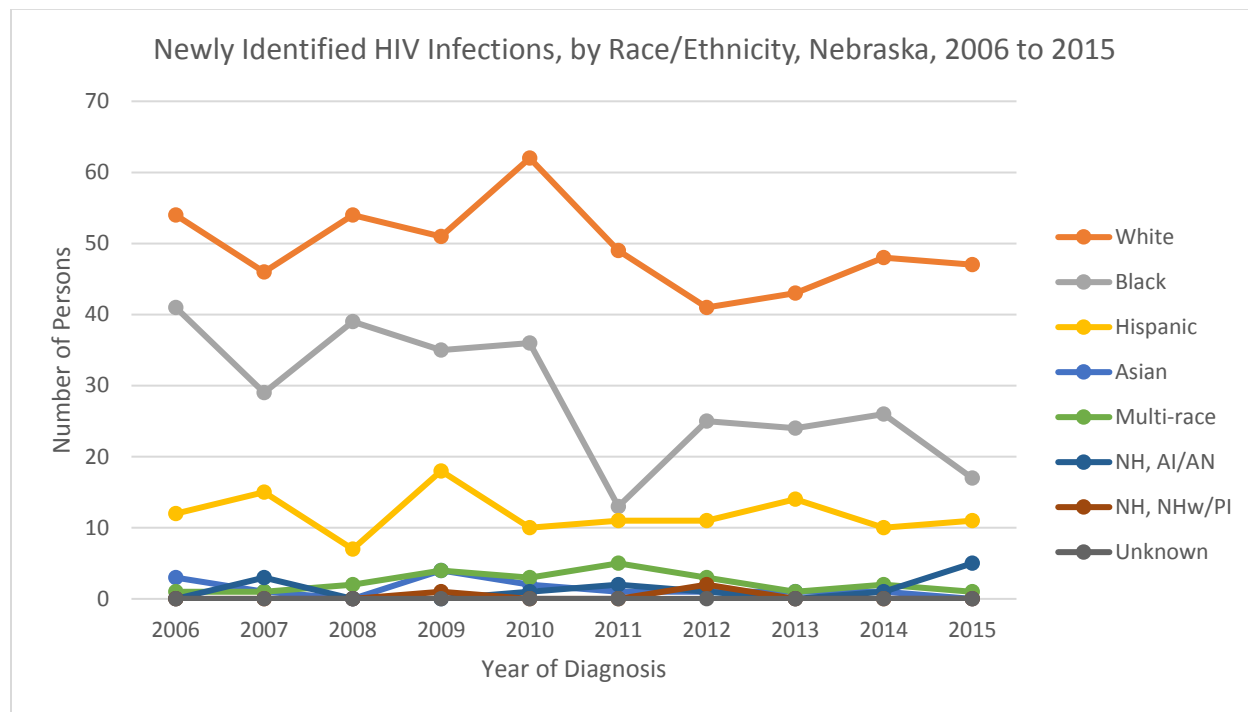


Figure 3: New HIV Infections by Race/Ethnicity, Nebraska, 2006 – 2015.

Data for HIV/AIDS diagnoses by race and ethnicity showed pronounced disparities, particularly for Black Nebraskans. Although Black residents represented only 4.7% of the total population in 2015, they accounted for over 21% of new infections in 2015. Table 9 presents a comparison of percentages of population and HIV diagnoses.

Table 9: Comparison of new HIV/AIDS diagnoses with population rates, 2015

Race/Ethnicity	% Population	% HIV/AIDS diagnoses, 2015
White, Non-Hispanic	80.0%	58.0%
Black, Non-Hispanic	4.7%	21.0%
American Indian/Alaska Native	0.8%	13.6%
Asian/Pacific Islander	2.3%	0.0%
Multiple Races	1.7%	1.2%
Hispanic or Latino	10.4%	6.2%

Rates for HIV infection over the past five years also showed notable disparities in HIV diagnoses by race and ethnicity. The rate of infection for Black persons was over 8 times that of white persons. Likewise, the infection rate for Hispanic persons was over twice that of white persons. Similarly, rates of diagnosis among males were substantially higher than those among females for all racial/ethnic categories between 2011 and 2015. Table 10 presents rates of diagnosis by sex and race/ethnicity.

Table 10: HIV diagnoses per 100,000 population, by race/ethnicity and gender, Nebraska, 2011-2015

	Males			Females			Total		
	N	%	Rate	N	%	Rate	N	%	Rate
White	205	58.07	5.48	23	35.94	.6	228	54.68	3.01
Black	75	21.25	34.12	30	46.88	14.36	105	25.18	24.5
Hispanic	51	14.45	10.47	6	9.38	1.62	57	13.67	6.15
Asian	3	.85	3.38	1	1.56	1.02	4	.96	2.14
Multi-Race	12	3.40	15.85	0	0	0	12	2.88	7.8
NH, AI/AN	7	1.98	18.68	2	3.13	5.15	9	2.16	19.66
NH, NHw/PI	0	0	0	2	3.13	72.86	2	.48	35.78
Total	353		8.48	64		1.5	417		4.46

Sexual Orientation

Diagnoses among the MSM population have increased in recent years. MSM remain the predominant risk category. In 2015, 78% of all males diagnosed with HIV reported having sex with other males. Researchers at Emory University partnered with CDC to estimate the MSM population in the United States.¹⁰ The estimate for Nebraska is that 1.9% of the adult men had sex with another man in the past five years with an estimate of 13,198 MSM in Nebraska in 2013.

Time of Diagnosis

The percentage of late diagnoses in Nebraska has steadily declined since 2010, with 31% of all new infections classified as late diagnosis in 2015. Overall, between 2010 and 2015, there was also a decline in the percentage of concurrent diagnoses, with 23% of diagnoses in 2015 being concurrent. Table 11 shows the time of diagnosis for HIV/AIDS cases in Nebraska from 2006 through 2015. Figure 4 provides an overview of total HIV diagnoses, late diagnoses, and concurrent diagnoses in Nebraska from 2000 – 2015.

Table 11: Time of HIV/AIDS diagnosis, Nebraska, 2006-2015

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
Total Infections	111	95	102	113	114	81	84	83	88	81	952
Total Late Dx	38	31	45	42	44	31	30	30	29	25	345
Concurrent Dx	29	28	43	35	41	30	27	30	28	23	314
Percent Late Dx	34	33	44	37	39	38	36	36	33	31	36
Of Late, % concurrent	76	90	96	83	93	97	90	100	97	92	91

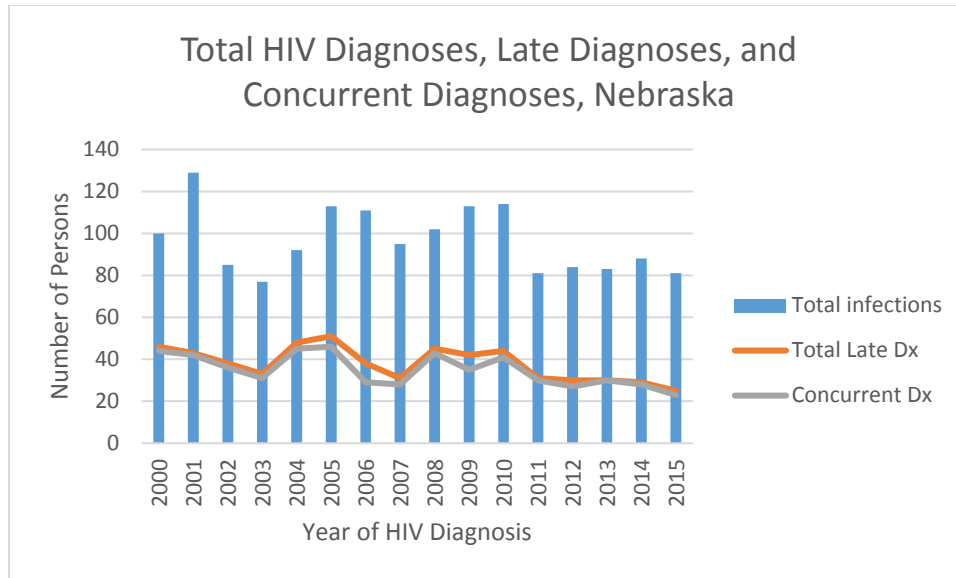


Figure 4: HIV diagnoses: total, late, and concurrent, Nebraska, 2000-2015

CD4+ and Viral Load

Between 2011 and 2015, the first reported CD4+ ranged from 300 to 341. Across the reporting period, first CD4+ has remained stable. During the same period, all CD4+ ranged from an average of 441 to 525. Since 2012, all CD4+ has steadily declined. First viral load counts ranged from a low of 167,501 in 2015 to a high of 392,026 in 2014, while most recent viral load counts ranged from a low of 7,452 in 2013 to a high of 82,469 in 2015. Most recent viral load counts increased steadily between 2013 and 2015. Table 12 shows CD4+ and viral load averages.

Table 12: CD4+ and viral load averages, Nebraska, 2011-2015.

Year	1st CD4	all CD4	1st VL	Most Recent VL
2011	306	504	241543	63406
2012	341	525	338259	57100
2013	339	524	187584	7452
2014	300	471	392026	35458
2015	314	441	167501	82469

Geography

Geographically, the greatest number of people living with HIV resided in Douglas County (n = 1301, 58%) in 2015, followed by Lancaster County (n = 348, 15.5%). Although the major burden of HIV was in the counties, the epidemic extends throughout the state. Table 12 shows the number of persons living with HIV by public health district. Figure 5 shows persons living with HIV/AIDS as of December 31, 2015, by Nebraska public health district.

Persons Living with HIV/AIDS, as of December 31, 2015, Nebraska

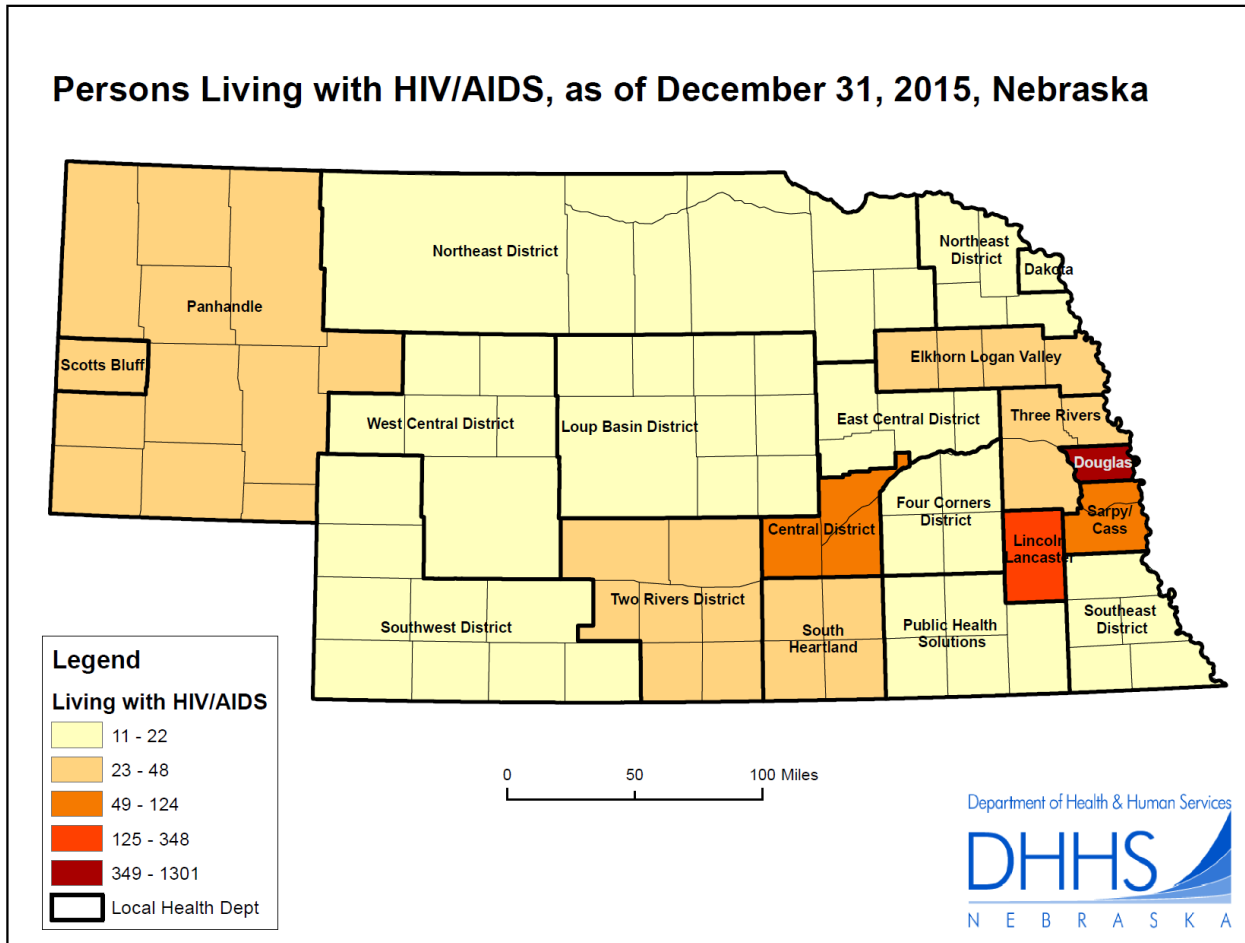


Figure 5: persons living with HIV/AIDS as of December 31, 2015, by Nebraska Public Health District

Table 13 shows the number and percentage of persons living with HIV/AIDS by public health department in 2015.

Table 13: Persons Living with HIV by Nebraska Health Department, 2015

Local Health Department	N	%
Central District	84	3.7%
Dakota County	22	1.0%
Douglas County	1301	58.0%
East Central	20	0.9%
Elkhorn Logan Valley	35	1.6%
Four Corners	19	0.8%
Lincoln-Lancaster County	348	15.5%
Loup Basin	17	0.8%
North Central	11	0.5%
Northeast Nebraska	14	0.6%
Panhandle	28	1.2%

Local Health Department	N	%
Public Health Solutions	18	0.8%
Sarpy/Cass	124	5.5%
Scotts Bluff County	39	1.7%
South Heartland	32	1.4%
Southeast	15	0.7%
Southwest	15	0.7%
Three Rivers	36	1.6%
Two Rivers	48	2.1%
West Central	15	0.7%
Missing	3	0.1%
	2244	

Country of Birth

Over 91% of persons diagnosed with HIV between 2011 and 2015 were born in the United States or in a dependent territory. During the same time period, 8.4% of diagnoses were among people born in other countries.

Among foreign born cases in Nebraska, persons born in Africa represented approximately 43% of cases, while persons from Mexico/Central America/South America and persons from Asia or other geographic areas represented 28.6% of cases each. Table 14 provides data for HIV diagnoses by country of birth.

Table 14: HIV/AIDS diagnoses by place of birth, Nebraska, 2011-2015

Place of Birth	N	%
US born/US dependency	382	91.6
Foreign born	35	8.4
Total	417	
Africa	15	42.9
Mexico/Central America/South America	10	28.6
Asia/Other	10	28.6
Total	35	

Source: eHARS

Exposure Category

Since 2006, the majority of HIV infections in Nebraska have been attributed to men who have sex with men (MSM). MSM represented 47.8% of all infections during this time period. In 2015, MSM represented 63% of newly diagnosed cases of HIV. Heterosexual transmission accounted for 15.7% of new infections between 2006 and 2015, and for 8.6% of new infections in 2015. Table 15 provides an overview of HIV infection by risk category. Table 15 shows infections by risk category.

Table 15: HIV infection by risk category, Nebraska, 2006-2015

Risk Category	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
MSM	53	47	37	42	52	44	37	42	50	51	455
IDU	9	3	5	7	7	1	3	3	2	1	41
MSM/IDU	4	4	4	2	5	4	6	4	4	2	39
Heterosexual	13	9	23	23	17	7	14	21	15	7	149
NIR	29	31	31	36	32	24	21	12	17	20	253
Pediatric exposure	3	1	2	3	1	1	3	1	0	0	15
Total	111	95	102	113	114	81	84	83	88	81	952

Figure 6 shows new HIV infections by risk factor between 2006-2015. As the figure demonstrates, it is notable that among defined risk categories, the only increase since 2013 has been among MSM.

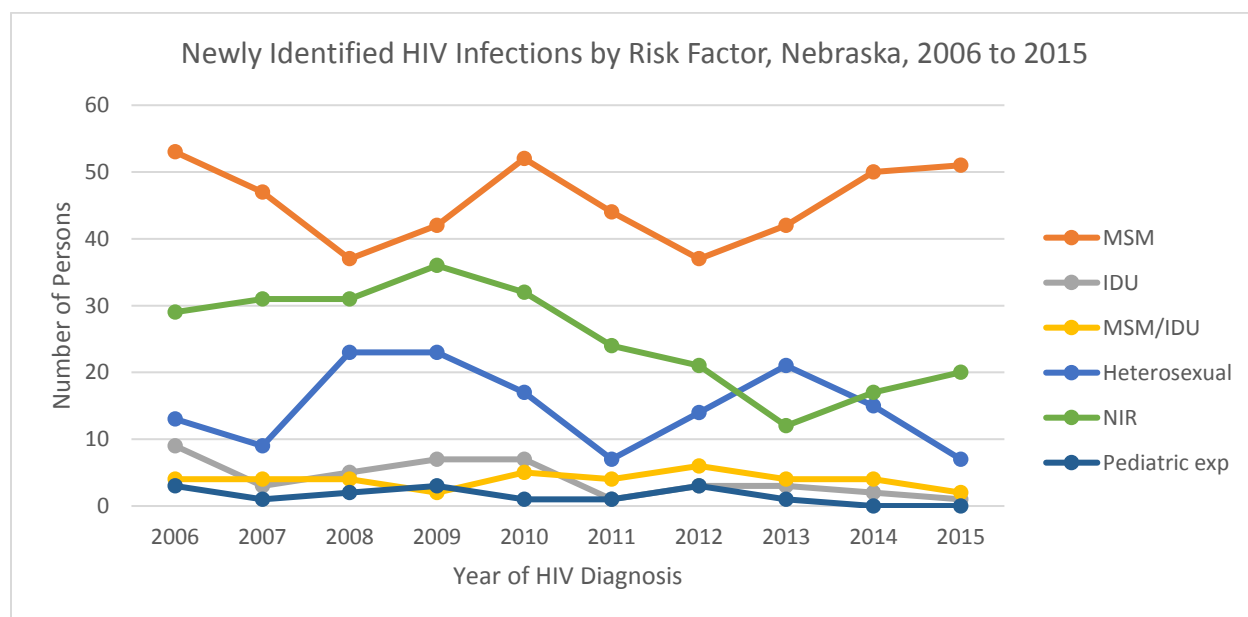


Figure 6: HIV infections by risk factor, Nebraska, 2006 - 2015

Sex

Males

Among males only, the greatest number of new infections between 2011 and 2015 resulted from MSM exposure across all racial and ethnicity categories. MSM exposure accounted for 63.5% of all new infections among males during the time period. The second most prevalent mode of reported exposure was through heterosexual activity, which accounted for 8.2% of infections across all races and ethnicities. Heterosexual exposure was higher for Black males (18.7%) than males of other racial or ethnic groups. Table 16 shows male adult/adolescent HIV/AIDS diagnoses by exposure category and race/ethnicity.

Table 16: Male adult/adolescent HIV/AIDS diagnoses by exposure category and race/ethnicity, Nebraska, 2011-2015

Exposure Category	Males													
	White		Black		Hispanic		Asian		NH, AI/AN		Other		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
MSM	140	68.3	37	49.3	33	64.7	3	100	4	57.1	7	58.3	224	63.5
IDU	4	2	1	1.3	0	0	0	0	0	0	0	0	5	1.4
MSM/IDU	18	8.8	2	2.7	0	0	0	0	0	0	0	0	20	5.7
Heterosexual	8	3.9	14	18.7	5	9.8	0	0	1	14.3	1	8.3	29	8.2
NIR	33	16.1	20	26.7	12	23.5	0	0	2	28.6	4	33.3	71	20.1
Pediatric	2	1	1	1.3	1	2	0	0	0	0	0	0	4	1.1
Total	205		75		51		3		7		12		353	

Figure 7 shows HIV diagnoses by exposure for adult and adolescent males between 2006 and 2015. This figure demonstrates that in recent years, exposures in each risk category have decreased with the exception of MSM.

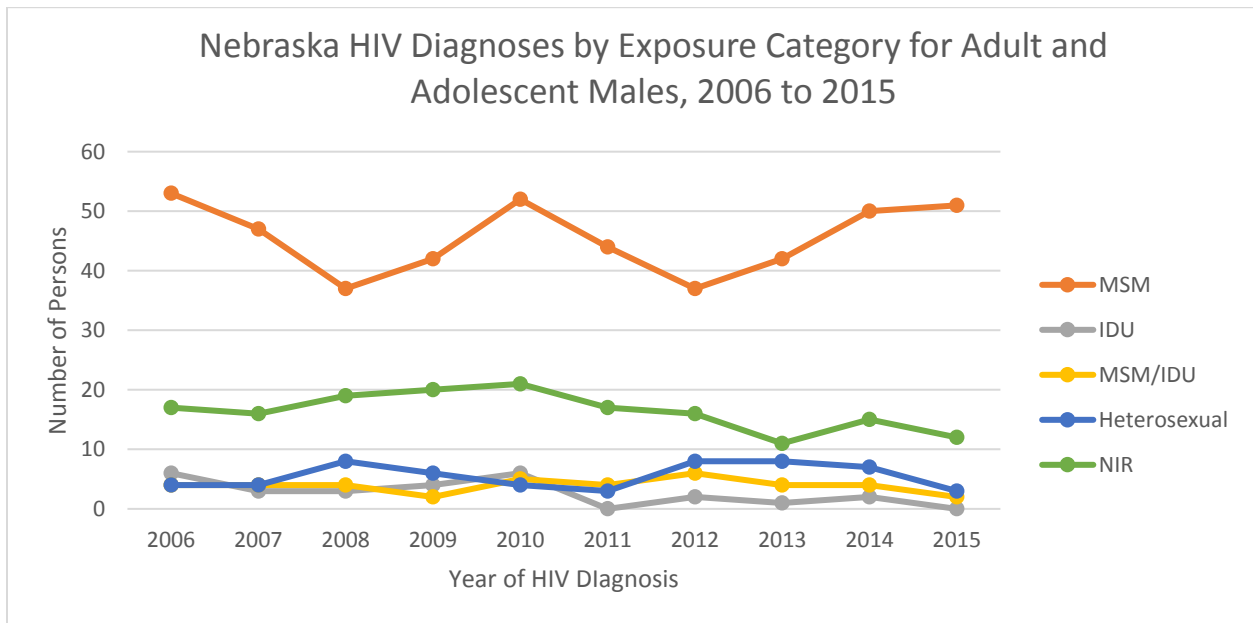


Figure 7: HIV diagnoses by exposure/ category for adult and adolescent males, Nebraska, 2006-2015.

Females

Among females only, the greatest number of new infections between 2011 and 2015 resulted from heterosexual exposure across all racial and ethnicity categories. Heterosexual exposure accounted for 54.7% of all new infections among females during the time period. The second most prevalent mode of reported exposure was injection drug use (IDU), which accounted for 7.9% of infections across all races

and ethnicities. Table 17 shows female adult/adolescent HIV/AIDS diagnoses by exposure category and race/ethnicity.

Table 17: Female adult/adolescent HIV/AIDS diagnoses by exposure category and race/ethnicity, Nebraska, 2011 – 2015

Females														
Exposure Category	White		Black		Hispanic		Asian		NH, AI/AN		Other		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
IDU	3	13.04	1	3.3	0	0	0	0	1	50	0	0	5	7.8
Heterosexual	12	52.17	17	56.7	5	83.3	0	0	0	0	1	50	35	54.7
NIR	8	34.78	12	40	1	16.7	1	100	1	50	0	0	23	35.9
Pediatric	0	0	0	0	0	0	0	0	0	0	1	50	1	1.6
Total	23		30		6		1		2		2		64	

Figure 8 shows HIV diagnoses by exposure for adult and adolescent females between 2006 and 2015. As the figure demonstrates, there have been declines among each reported exposure category with the exception of IDU, which increased slightly between 2014 and 2015.

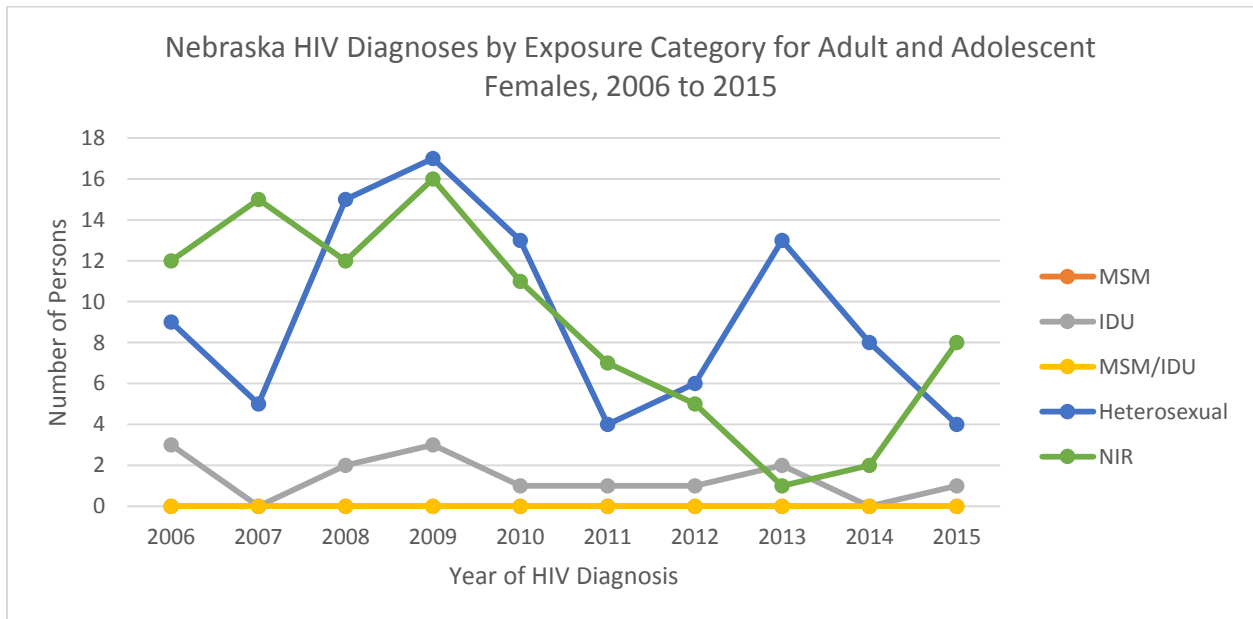


Figure 8: HIV diagnoses by exposure for adult and adolescent females, Nebraska, 2006-2015

Cumulative HIV Disease

Persons Living with HIV/AIDS

At the end of 2015, there were a total of 2,247 persons living with HIV/AIDS in Nebraska. HIV disproportionately affected males, who had a rate of 253.8 when compared to females, who had a rate of 53.9. By race/ethnicity, Black persons living in Nebraska had a rate of 710.3, which was over 9 times greater than the rate for white persons. Table 18 shows PLWHA rates by gender and race/ethnicity. Table 18 shows rates of persons living with HIV/AIDS by sex and race/ethnicity.

Table 18: PLWHA rates by sex and race/ethnicity, Nebraska, 2015.

Race/Ethnicity	Males		Females		TOTAL	
	N	Rate	N	Rate	N	Rate
White	1005	133.83	186	24.27	1191	78.51
Black	395	866.77	235	544.88	630	710.26
Hispanic	265	256.71	59	62.63	324	164.12
Asian	19	91.4	14	62.96	33	76.7
Multi-race	25	153.65	8	40.28	33	99.61
NH, AI/AN	22	283.39	9	113.46	31	197.51
NH, NHw/PI	2	308.16	2	338.98	4	322.84
Unknown	0		1		1	
TOTAL	1733	253.81	514	53.87	2247	118.5

Figure 9 shows the rates of HIV and AIDS by race, ethnicity, and sex. The figure demonstrates the disproportionate number of Black persons living with HIV/AIDS in Nebraska at the end of 2015.

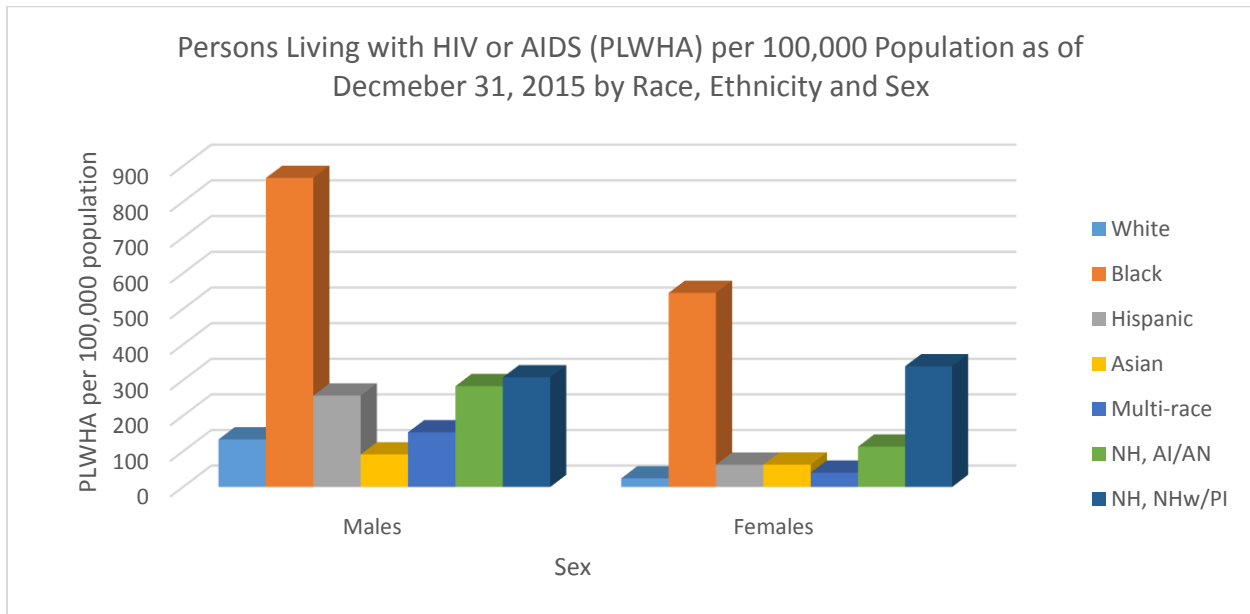


Figure 9: PLWHA rates per 100,000, Nebraska, 2015

HIV/AIDS Diagnoses, 1983-2015

Since the first diagnosis of HIV in Nebraska, a total of 3005 cases were reported through 2015, 3003 of which occurred in 1983 or later (when the first cases were tracked). Since 1983, 80% of cases have been reported among males. The number of cases of HIV and AIDS increased through the early 1990s, when antiretroviral medications became more widely available. Since the mid-1990s, the number of AIDS cases has gradually declined overall. The number of HIV cases has fluctuated since that time, peaking in 2001 with 129 cases. Since 2011, the number of HIV cases has remained stable. Figure 10 shows HIV and AIDS diagnoses since 1983.

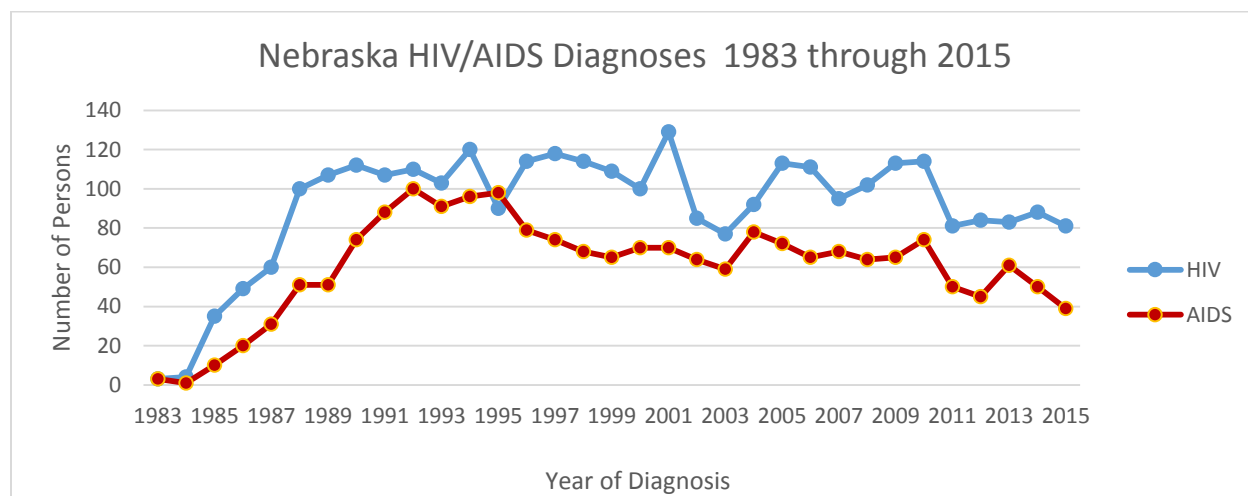


Figure 10: HIV and AIDS diagnoses, Nebraska, 1983-2015

AIDS

A total of 2,001 persons have been diagnosed with AIDS since the first reported cases in Nebraska. Approximately 82% of AIDS diagnoses have been among males. Among males, MSM exposure accounted for approximately 59% of AIDS cases with a reported category, and MSM/IDU and heterosexual exposure each accounted for approximately 9% of cases. Table 19 shows cumulative AIDS diagnoses for males by exposure category and race/ethnicity.

Table 19. Cumulative AIDS diagnoses, males, by exposure category and race/ethnicity, Nebraska, 1983-2015

Exposure Category	White		Black		Hispanic		Asian		NH, AI/AN		Other		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
MSM	722	67.5	141	42.7	78	42.4	7	70.0	9	56.3	10	52.6	967	59.4
IDU	59	5.5	29	8.8	13	7.1	0	0.0	1	6.3	1	5.3	103	6.3
MSM/IDU	110	10.3	29	8.8	7	3.8	0	0.0	2	12.5	0	0.0	148	9.1
Heterosexual	34	3.2	53	16.1	20	10.9	0	0.0	2	12.5	1	5.3	110	9.1
NIR	100	9.4	71	21.5	64	34.8	3	30.0	2	12.5	5	26.3	245	15.0
Hemophiliac/Clotting factor	32	3.0	2	0.6	1	0.5	0	0.0	0	0.0	1	5.3	36	2.2
Transfusion/Transplant	10	0.9	1	0.3	1	0.5	0	0.0	0	0.0	0	0.0	12	0.7
TOTAL	1069		330		184		10		16		19		1628	

Among females, the majority of AIDS cases for which an exposure category was reported resulted from heterosexual exposure, which accounted for approximately 42% of cases. Injection drug use accounted for 22.1% of cases among females. Table 20 shows cumulative AIDS diagnoses for females by exposure category and race/ethnicity.

Table 20. Cumulative AIDS diagnoses, females, by exposure category and race/ethnicity, Nebraska, 1983-2015

Exposure Category	White		Black		Hispanic		Asian		NH, AI/AN		Other		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
IDU	42	26.9	25	17.6	4	10.5	0	0.0	8	57.1	2	20.0	81	22.1
Heterosexual	71	45.5	54	38.0	17	44.7	2	33.3	3	21.4	5	50.0	152	41.5
NIR	33	21.2	60	42.3	16	42.1	4	66.7	3	21.4	2	20.0	118	32.2
Pediatric	5	3.2	3	2.1	0	0.0	0	0.0	0	0.0	1	10.0	9	2.5
Hemophiliac/Clotting factor	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Transfusion/Transplant	5	3.2	0	0.0	1	2.6	0	0.0	0	0.0	0	0.0	6	1.6
Total	156		142		38		6		14		10		366	

Since the mid-1990s, the number of AIDS diagnoses has shown an overall decline, with a few exceptions (2005 and 2011). Likewise, the number of AIDS deaths have declined since the mid-1990s. Figure 11 shows trends in AIDS diagnoses and deaths.

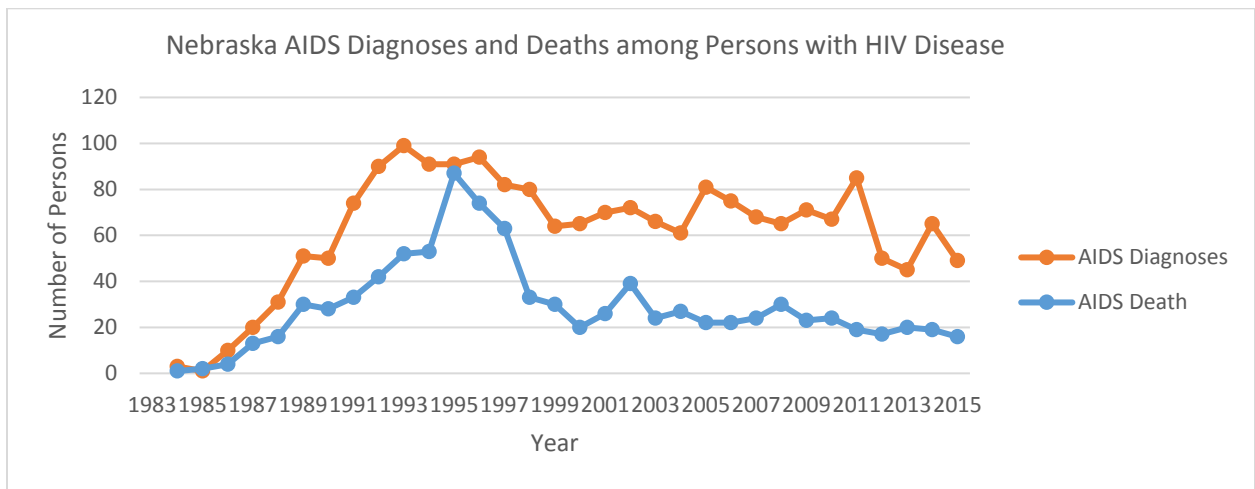


Figure 11: AIDS diagnoses and deaths, Nebraska, 1983-2015

Ryan White Program

The state of Nebraska receives support for Ryan White Parts B and C.

Ryan White Part B

The Ryan White Part B program (RWHAP) is located within the Nebraska Department of Health and Human Services, Division of Public Health, Infectious Disease Prevention and Care Unit in Lincoln, Nebraska. The Program Administrator is responsible for program oversight for HIV Prevention, Ryan White, HOPWA, Hepatitis C, STD, TB, and HIV Surveillance programs. The Program Manager is responsible for direct oversight and day-to-day operations of the Ryan White Program. The Quality Manager is responsible for the quality improvement of services to all RWHAP sub-recipients. Quality improvement reviews must occur at least twice annually per federal guidance. The purpose of the Ryan White Part B program is to provide access to core medical (including life-saving medication therapies) and supportive service for HIV positive consumers. The RWHAP provides funding for the following program areas:

1. AIDS Drug Assistance Program (ADAP)—provides therapeutic medications for the treatment of HIV infection.
2. Emergency Financial Assistance—provides support services including emergency short-term housing assistance utilities, transportation, food, and insurance premium payment assistance.
3. Comprehensive Medical and Social Case Management Services—provides access to Ryan White funded services and assistance in accessing other eligible services for qualified clients.
4. Outreach – reaches out to individuals who are newly positive, have been lost to care and follow-up or who present with newly diagnosed sexually transmitted diseases. Includes refugee populations.
5. Mental health – telehealth outreach to rural Nebraskans with HIV disease to ensure confidential, mental health therapy.
6. Psychosocial support – meets the local needs of individuals with health education and risk reduction information as well as other personal, psychosocial needs.

Services are provided to individuals who reside in Nebraska, meet financial eligibility requirements, and meet all other eligibility requirements.

Core Services

A total of \$2,366,091 was allocated for Ryan White Part B core services in 2015. The majority of funds for core medical services supported ADAP and medical case management. A total of \$167,501 was allocated for support services, the majority of which supported minority outreach and housing assistance. Table 21 shows the expenditures for each core component, including core medical services and support services.

Table 21: Ryan White Part B Allocations, Nebraska, FY2015

Ryan White Part B Allocations: Fiscal Year 2015			
Core Medical Services (\$2,366,091)			
	ADAP	\$1,766,038	
	Mental Health	\$18,713	
	Medical Case Management	\$463,944	

Ryan White Part B Allocations: Fiscal Year 2015			
	Oral Health	\$40,000	
	Home Health	\$0	
	Outpatient Ambulatory Services	\$77,396	
Support Services (\$167,501)			
	Direct Client Services		
	Housing Assistance	\$56,098	
	Utility Assistance	\$7,812	
	Insurance Premium Payment Assistance	\$0	
	Transportation	\$16,213	
	Food/Non-Food Items	\$8,008	
	Translation	\$0	
	Medical Transportation	\$0	
	Minority Outreach	\$65,108	
	Psychosocial Support	\$14,262	
	HERR	\$0	

ADAP

The ADAP program is operated through a sub-grant to the University of Nebraska Medical Center. The program is directed by Dr. Susan Swindells. Physicians across the state access ADAP through a mail order system with the UNMC pharmacy. Clients in the Omaha area access the UNMC outpatient pharmacy directly, while clients in other parts of the state received medications via mail. In 2015, there were 143 medications in the formulary, which included all FDA approved medications for the treatment of HIV, medications for the treatment of opportunistic infections, and medications for the treatment of mental health issues.

Since 2011, the number of unduplicated clients served by ADAP has steadily increased. A total of 993 clients were served in 2015 by ADAP, which represented a 36% increase from the previous year. State funding for ADAP remained consistent throughout the five-year period. Table 22 shows ADAP funding by year.

Table 22: ADAP funding by year, Nebraska, FY 2011-2015

Source	2011	2012	2013	2014	2015
N unduplicated clients/year	562	623	720	732	993
N medications in formulary	130	132	138	140	143
Federal funds allocated	\$1,632,633	\$2,505,306	\$2,520,611	\$2,166,690	\$2,083,483
Rebate funds allocated	\$124,945	\$0	\$480,760	\$1,412,444	\$1,100,000
State funds allocated	\$900,000	\$900,000	\$900,000	\$900,000	\$900,000
Total funds allocated	\$2,657,758	\$3,405,306	\$3,901,371	\$4,479,134	\$4,083,483

Since 2011, overall funding for ADAP increased for the state of Nebraska. However, there was a 24% decline in funding in FY 2015 when compared to the previous year. Table 23 shows the variance in ADAP funding.

Table 23: ADAP funding history, Nebraska, FY 2011-2015

Fiscal Year	Funding Amount*	Variance
FY 2011	\$2,657,758	-
FY 2012	\$3,405,306	+28%
FY 2013	\$3,901,371	+15%
FY 2014	\$4,479,134	+15%
FY 2015	\$4,083,483	-24%

*Includes \$900,000 in state funding

Emergency Financial Assistance

Emergency Financial Assistance provides assistance to clients who experience financial difficulties due to HIV/AIDS. Services include financial assistance for emergency short-term rent assistance, utilities, food and medical transportation. Case managers initiate requests for assistance through the Provide Case Management Software system, which links the RW program, case management, HOPWA, and clients. Each request is reviewed by the Compliance Coordinator, and if approved a check is mailed within 1-2 business days.

A total of \$45,201 was used to provide direct emergency assistance in 2015. Housing assistance accounted for 38% of this amount, followed by transportation, which accounted for 25%. Other assistance services included utility assistance, food, and insurance premium assistance. Table 24 shows direct emergency assistance expenditures for 2015.

Table 24: Emergency Financial Assistance expenditures by category, Nebraska, FY 2015

Category	Number served (Duplications occur)	Units of Service	Amount	% of funds
Housing assistance	32	48	\$17,195	38%
Utility assistance	49	87	\$8,336	18%
Transportation	132	914	\$11,285	25%
Food	141	291	\$5,817	13%
Insurance premium payment assistance	1	4	\$2,568	6%
Total			\$45,201	100%

In 2015, the Emergency Financial Services component of the program provided a total of 1,344 services for 235 unduplicated clients. The number of clients decreased minimally from the previous year; however, the number of services increased. Table 25 shows the number of clients and services, along with funds expended each year.

Table 25: Emergency Financial Assistance clients and services provided by year, Nebraska, 2011-2015

	2011	2012	2013	2014	2015
N unduplicated clients served	235	185	192	240	235
N services provided	1592	1049	1267	915	1344
Total funds expended	\$31,083	\$28,881	\$29,416	\$31,335	\$45,201

Comprehensive Medical Case Management Services

Medical case management services are provided to clients through a sub-grant with the Nebraska AIDS Project (NAP). NAP provides services in five offices located in Omaha, Lincoln, Norfolk, Kearney, and Scottsbluff. In addition to Part B funding, NAP also receives Part C funding (Western Nebraska Part C program funds) for medical and social case management, bilingual services, HIV outreach/education, and counseling and testing. With funding from both Parts B and C, NAP coordinates services offered by each program for clients in need.

In 2015, medical case management services were provided for 474 people, the majority of whom were male (70%), white (64%), non-Hispanic (82%), and over the age of 45 years (53%). Sixty-two percent of service recipients were below 100% of the federal poverty level. Table 26 shows recipients of case management services by demographic characteristics.

Table 26: Ryan White Part B Medical Case Management Services, Nebraska, 2015

Demographic Characteristic	N	%
Gender		
Male	333	70%
Female	133	28%
Transgender	3	1%
Missing data	5	1%
Race/Ethnicity		
White	312	64%
Black	143	30%
American Indian/Alaska Nat.	14	3%
Asian	6	1%
Native Hawaiian/PI	1	0%
Missing data	8	2%
Ethnicity		
Hispanic/Other	85	18%
Non-Hispanic	389	82%
Age Group		
0-12	1	0%
13-24	18	4%
25-44	191	40%
45-64	231	49%
65+	19	4%
Invalid or missing age	14	3%
Federal Poverty Level		
Below 100% of the FPL	292	62%
100%-138% of the FPL	65	14%
139%-200% of the FPL	73	15%
201%-250% of the FPL	27	6%
251%-400% of the FPL	12	3%
401%-500% of the FPL	5	1%

Ryan White Part C

The Nebraska Ryan White Part C program is administered through sub-grants with the University of Nebraska Medical Center (UNMC) and Western Community Health Resources/Chadron Community Hospital. In FY 2015, 512 clients were served by the Part C program.

University of Nebraska Medical Center

The UNMC Ryan White Part C program provides early intervention services (EIS) to clients who reside in the eastern three quarters of the state, as well as to persons from part of southwest Iowa. The mission of the program is to provide comprehensive services to those who are at risk for or infected with HIV disease. EIS services are provided through the UNMC Specialty Care Center HIV Clinic and associated services at UNMC. These EIS services include: primary HIV healthcare (outpatient visits and lab services), ophthalmology, mental health care, oral health care, nutritional consultation, papanicolaou tests, and annual tuberculosis skin testing. The program also provides services through contracted dentists and mental health/substance abuse providers located in Omaha. The Omaha clinic offers evening hours to increase access for clients who are unable to attend during the day. An outreach clinic is held in Grand Island every eight weeks to provide services to rural clients.

Eligible clients are persons who are at risk or infected with HIV disease who have an income below 200% of the federal poverty level and who are ineligible for Medicaid or private insurance coverage by a third-party payer.

In FY 2015, UNMC was allocated a total of \$575,986 for Part C services. Most of the funding supported primary health care (\$519,921), while other funds supported dental health (\$36,202) and mental health/substance abuse services (\$19,863). Table 27 shows expenditures for FY 2015.

Western Community Health Resources/Chadron Community Hospital

Part C services for the Western Nebraska (i.e., the “panhandle”) are administered through a sub-grant to Chadron Community Hospital (CCH) and a health department, Western Regional Health Resources (WCHR). Sandy Rose, WCHR director, also serves as the Ryan White Part C director. The partnership, the Community Action Partnership of Western Nebraska (CAPWN), is coordinated by Jeff Tracy, who is responsible for overall program operations. Dr. Margaret McLees from the Denver Public Health Infectious Disease Clinic serves as the CCH medical director. Dr. McLees conducts clinics at the CAPWN Health Center, located in Gering, Nebraska, on a quarterly basis. The program also contracts with providers in the region for additional health care related services.

Eligible clients must reside in the region to qualify for services. Currently, there are no income-eligibility limitations. A staff member from the Scottsbluff office of the Nebraska AIDS Project conducts enrollment, as well as provides medical and social case management services. The NAP staff person is funded jointly by the Nebraska Ryan White Part B program and the WCHR Part C program.

In FY 2015, WCHR was allocated a total of \$62,736 for Part C services. Funding supported primary health care (\$33,914) and medical case management (\$28,822). Table 28 shows expenditures for FY 2015.

Table 27: Ryan White Part C Allocations, Nebraska, FY 2015

Services	UNMC	Western Nebraska
Primary Health Care (includes diagnostic testing)	\$519,921	\$33,914
Dental Health	\$36,202	\$0
Mental Health/Substance Abuse	\$19,863	\$0
Translation Services	\$0	\$0
Medical Case Management	\$0	\$28,822
Vision Services	\$0	\$0
Nutritional Consultations	\$0	\$0
TOTAL	\$575,986	\$62,736

Clients Served by Part C

In FY 2015, a total of 512 clients were served by the Nebraska Ryan White Part C program. The UNMC program provided services for 451 clients, which represented an increase of 17% when compared to the number of clients served in FY 2014. Chadron Community Hospital provided services for 61 clients in FY 2015, which represented an increase of 21.3% when compared to the number of clients served in FY 2014. The total number of clients served by the Part C program decreased between FY 2011 and FY 2014; however, there was an increase between 2014 and 2015. Table 28 shows the number of clients by provider.

Table 28: Comparison of number of clients served yearly by Nebraska Ryan White Part C Program, 2011-2015

Fiscal Year	Number of Clients		
	UNMC Part C Program	Chadron Community Hospital	Total
2011	554	52	606
2012	492*	50	542
2013	381*	45	426
2014	374*	48	422
2015	451	61	512

*Reductions are due to the number of consumers who accessed insurance through the ACA.

HOPWA

The Housing Opportunities for People with AIDS program (HOPWA) is a federal program administered by the US Department of Housing and Urban Development (HUD). HOPWA has three goals, which are:

1. Increase housing stability through housing assistance and supportive services;
2. Prevent homelessness; and
3. Increase access to care and support services.

The HOPWA program compliments and enhances assistance which is funded through other programs, including the Ryan White Parts B and C Program, ADAP, Section 8, and other funding resources. HOPWA is designed to fill current gaps in housing assistance for people living with HIV or AIDS. The assistance available through the Ryan White Part B program remains a last resort for funding housing needs for clients.

The HOPWA program provides assistance in four key areas:

1. Emergency Rent and Mortgage Assistance (ERMA): available for clients in situations where they face a housing crisis which may result in homelessness; limited to 21 weeks out of a 52 week period.
2. Tenant Based Rental Assistance (TBRA): available for clients who require long-term monthly assistance with housing needs; clients in TBRA are required to apply for Section 8 housing assistance, which replaces TBRA if awarded.
3. Supportive Services: available for clients with multiple support resources, which may include case management, mental health and substance abuse counseling, self-sufficiency courses, or transportation.
4. Permanent Housing Placement: available to help clients secure permanent housing through assistance with first/last month rent, security deposit, or rental application fee.

Clients apply to the HOPWA program through case managers at Nebraska AIDS Project. Case managers request assistance from NDHHS following verification of client eligibility. ATP assists NAP case managers in locating housing and supportive services or other resources throughout the state. Case managers also work with clients to create housing plans and alternative options for housing to ensure that client needs are met with long-term, permanent strategies.

To be eligible for assistance through HOPWA, clients must meet three requirements:

1. The household must be low income, which is defined as a household income at or below 80% of the median income for the area.
2. The person must be diagnosed with HIV or AIDS, and the diagnosis must be documented by a physician or health care provider.
3. Assistance is provided on a need-basis; total funding is limited to the grant funding to the NE HOPWA program by HUD.

In FY 2015, a total of \$362,364 was allocated for the HOPWA program, of which \$162,389 (45%) was expended. Of the expenditures, support services accounted for 39%, while administrative costs accounted for 33%, housing information/counseling accounted for 11%, and rental/mortgage and tenant-based housing assistance accounted for 11%. Table 29 shows HOPWA utilization and expenditures.

Table 29: HOPWA expenditures, Nebraska, FY 2015

Service	% Utilization	Expenditures
Housing information/counseling	11%	\$2,905
Rental/mortgage and tenant-based housing assistance	11%	\$2,905
Supportive services*	39%	\$40,038
Permanent housing placement	0%	\$0
Administrative cost	33%	\$12,061
Total	45%	\$162,389

*Includes case management, security deposits, first month rent, transportation, self-sufficiency/life skills training courses, mental health/substance abuse services.

The HOPWA program served a total of 83 clients in FY 2015. The majority of the clients were male (68%), white (48%), Hispanic (76%), and 25 years of age or older (97%). Table 30 shows demographic characteristics for HOPWA clients.

Table 30: Demographic characteristics of HOPWA assisted clients, Nebraska, 2015

Characteristic	HOPWA (N = 83)	
	N	%
Gender		
Male	56	68
Female	25	30
Transgender MTF	2	2
Race		
White	40	48
Black/African American	35	42
American Indian/Alaska Native and White	5	6
Asian	1	1
Asian and White	0	0
Native Hawaiian/Pacific Islander	0	0
Black/African American and White	0	0
Other Multi-Racial	2	2
Ethnicity		
Hispanic	63	76
Non-Hispanic and Other	20	24
Age		
0-12 years	0	0
13-24 years	2	2
25-44 years	40	48
45+ years	41	49
Unknown	0	0
Risk Category		
MSM	39	47
IDU	7	8
MSM/IDU	3	4
Heterosexual contact	30	36
Adult hemophilia	0	0
Transfusion	1	1
Pediatric	0	0
Undetermined, unknown, or not available	3	4

Risk Indicators for HIV Infection

This section focuses on risk indicators for HIV infection in Nebraska, unless a specific geographic area is indicated. Data in this section include behavioral surveillance data as well as data on other infectious diseases that may be indicative of HIV infection or share risk factors with HIV infection.

Youth Risk Behavioral Survey

In 2015, 32.5% (n=1,365) of the Nebraska high school students who completed the YRBS indicated that they had sexual intercourse in their lifetime, while 24.9% (n=1,359) of the high school students indicated that they were currently sexually active. Eight percent (n=1,360) of students shared that they had sexual intercourse with four or more persons. Of the female and male high school students who were currently sexually active, 43% (n=314) did not use a condom during their last sexual intercourse experience. Before their last sexual intercourse, 17.9% (n=314) of participants had consumed alcohol or used drugs. The majority of the students had never been tested for HIV (90.7%, n=1,438).

Among the Nebraska high school students, 8.3% (n=1,538) indicated that they had been physically forced to have sexual intercourse, 8.1% (n=983) had experienced physical dating violence, and 8.8% (n=972) had experienced sexual dating violence. More than half of the students had ever consumed alcohol (51.7%, n=1,629). It was reported that 26.6% (n=1,613) of students had used marijuana in their lifetime, 5.3% (n=1,626) had used cocaine, 5.1% (n=1,641) had used ecstasy, 2.5% (n=1,641) had used heroin, 4.2% (n=1,612) had used methamphetamines, and 3.5% (n=1,644) had taken steroids without a doctor's prescription. Students shared that 4.0% (n=1,638) of them had injected an illegal drug in their lifetime.

Sexually Transmitted Diseases

The number of identified cases of chlamydia and gonorrhea have increased since 2011. In 2015, a total of 7,858 cases of chlamydia were reported, and 1,673 cases of gonorrhea were reported. Since 2011, the number of syphilis cases has not been stable, with the number of new cases peaking in 2014 (n = 70). A total of 47 syphilis cases were identified in 2015. When combined, these three STDs have shown a steady upward trend since 2011. Table 31 shows trends in STD cases from 2011 – 2015.

Table 31: Trends in STD cases, Nebraska, 2011-2015

Year	STD			
	Chlamydia	Gonorrhea	Syphilis	Total
2011	6398	1328	13	7739
2012	6790	1441	17	8248
2013	7459	1404	58	8921
2014	7611	1479	70	9160
2015	7858	1673	47	9578
Total	36116	7325	205	43646

Chlamydia

In 2015, 7,974 cases of chlamydia were reported in Nebraska, representing an increase from previous years. Since 2011, the number of chlamydia cases has shown a steady increase in Nebraska, with 1,460 more cases in 2015 than in 2011. Although the number of cases has steadily increased for both males

and females, chlamydia was more commonly reported among females in each year between 2011 and 2015. In 2015, 68% of chlamydia cases were reported in females. Table 32 shows chlamydia cases by sex from 2011-2015.

Table 32: Chlamydia cases by sex, Nebraska, 2011-2015

Sex	Year					
	2011	2012	2013	2014	2015	TOTAL
Male	1986	2061	2218	2331	2545	11141
Female	4776	4636	4969	5091	5429	24901
TOTAL	6762	6697	7187	7422	7974	36042

Figure 12 shows chlamydia cases by sex for 2011-2015.

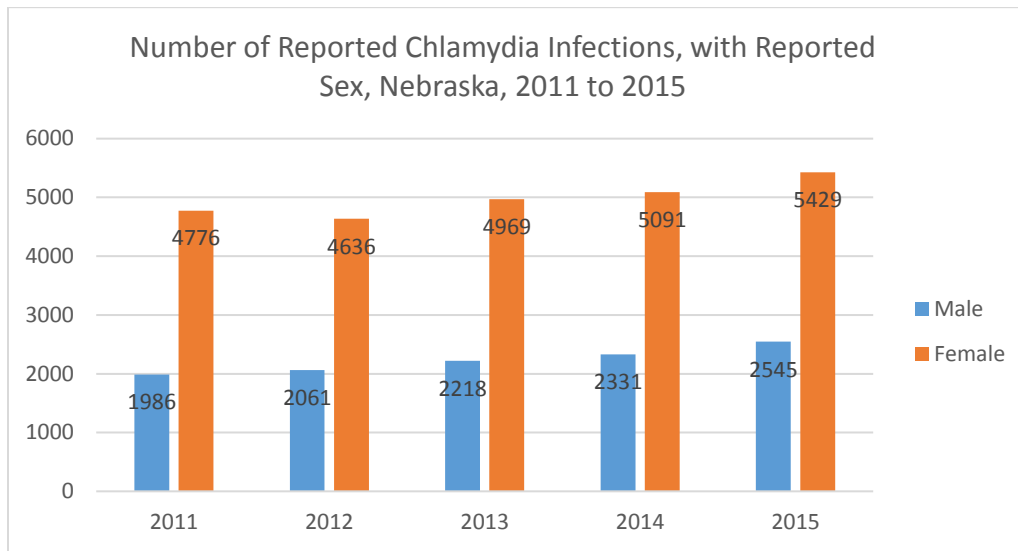


Figure 12: Chlamydia cases by sex, Nebraska, 2011 – 2015

Between 2011 and 2015, persons between the ages of 20 – 24 years were the most impacted by chlamydia infection. In 2015, this age group accounted for 40% of all reported cases. Persons aged 15 – 19 years represented the second highest percentage of infections in 2015 (25%), followed by persons aged 25 – 29 years (19%). Together, persons aged 15 – 29 years represented 84% of all reported cases of chlamydia in 2015. Table 33 shows chlamydia cases by age for years 2011 – 2015.

Table 33: Chlamydia cases by age, Nebraska, 2011-2015

Age Group (years)	Year									
	2011		2012		2013		2014		2015	
	N	%	N	%	N	%	N	%	N	%
<10	4	0.06	6	0.09	9	0.12	6	0.08	3	0.05
10-14	35	0.55	35	0.52	33	0.44	29	0.38	57	0.73
15-19	1588	25	1626	24	1651	22	1654	21.75	1943	25

Age Group (years)	Year									
	2011		2012		2013		2014		2015	
	N	%	N	%	N	%	N	%	N	%
20-24	2661	42	2869	42	3188	43	3234	43	3143	40
25-29	1198	19	1307	19	1487	20	1533	20	1481	19
30-34	501	8	529	8	615	8	672	9	716	9
35-44	308	5	319	5	374	5	365	5	388	5
45+	97	2	88	1	87	1	111	1	120	2
Total	6392		6779		7444		7604		7851	

Figure 13 shows chlamydia cases by age for 2011 – 2015 in Nebraska.

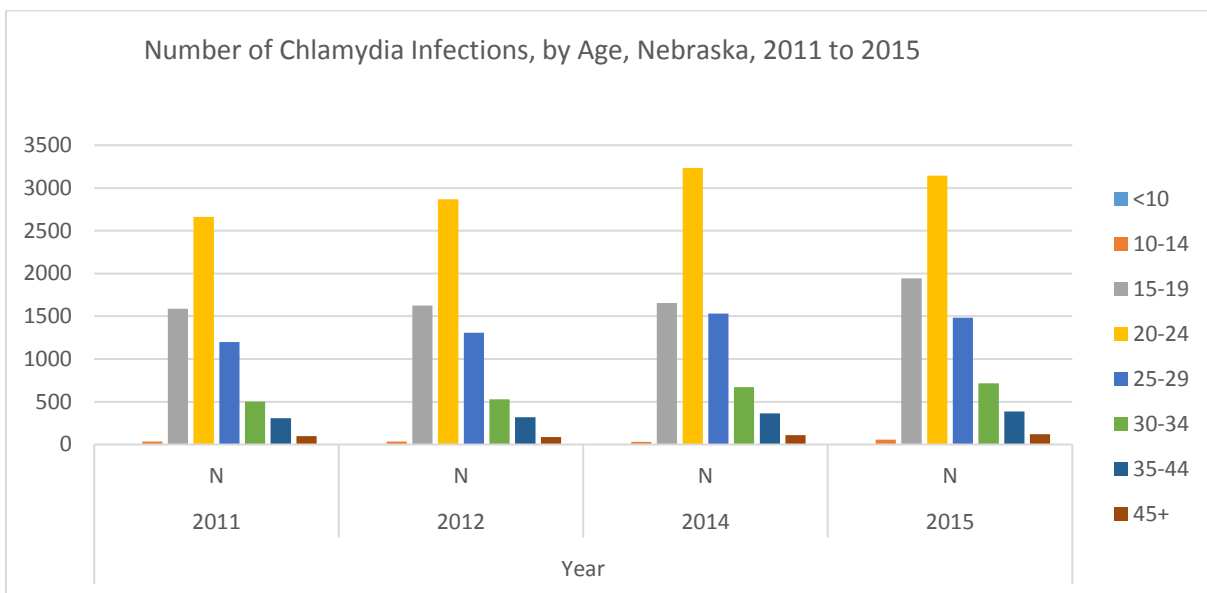


Figure 13: Chlamydia cases by age, Nebraska, 2011-2015

By race and ethnicity, the greatest number of chlamydia cases reported in each year was among Whites, who accounted for 43% of all reported cases in 2015. This percentage rose from 34% in the previous year. Black persons represented 19% of all newly reported cases in 2015, which represented a slight decline from 20% of cases in the previous year. Table 34 shows chlamydia cases by race and ethnicity from 2011-2015.

Table 34: Chlamydia cases by race and ethnicity, Nebraska, 2011-2015

Race/ Ethnicity	Year									
	2011		2012		2013		2014		2015	
	N	%	N	%	N	%	N	%	N	%
AI/AN	122	2	94	1	111	1	142	2	170	2
Asian	41	1	63	1	660	1	87	1	80	1
Black	1633	26	1570	23	1487	20	1548	20	1503	19

Race/ Ethnicity	Year									
	2011		2012		2013		2014		2015	
	N	%	N	%	N	%	N	%	N	%
Hawaiian/PI	2	0	14	0	13	0	16	0	21	0
Hispanic	476	7	452	7	579	8	602	8	762	10
Multiple	7	0	25	0	23	0	14	0	20	0
White	2278	36	2210	33	2301	31	2560	34	2733	43
Other	80	1	75	1	91	1	104	1	296	4
Refused	0	0	0	0	158	2	185	2	0	0
Unknown	1759	27	2287	34	2594	35	2319	31	2273	29
Total	6398		6790		7415		7577		7858	

Figure 14 shows trends in chlamydia infections by race, Nebraska, 2011-2015.

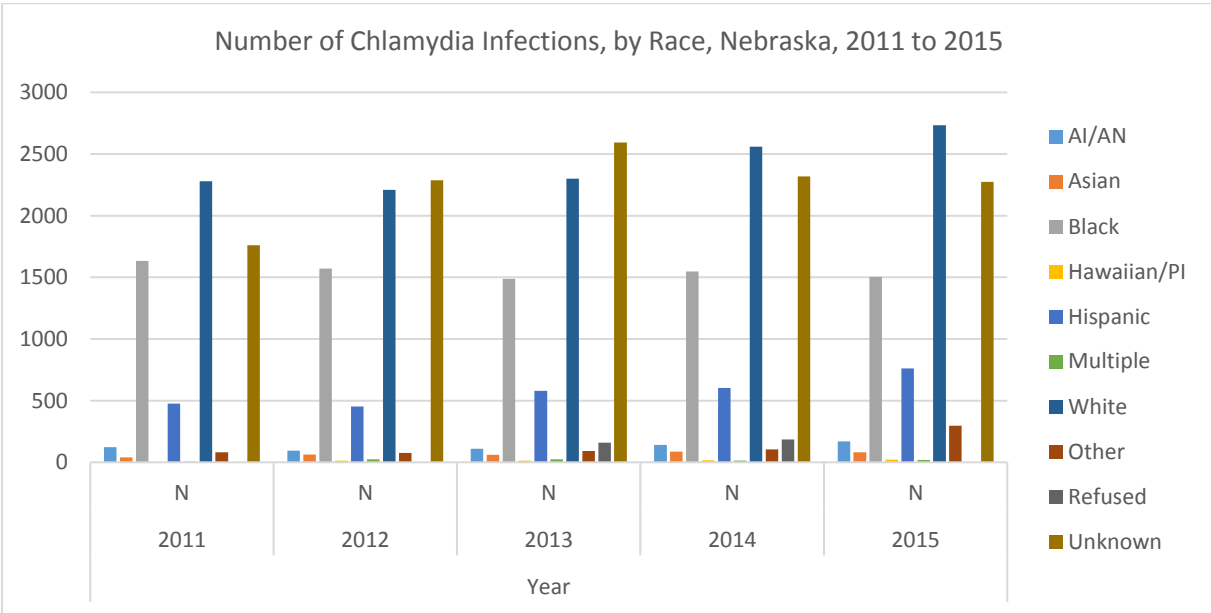


Figure 14: Chlamydia infections by race, Nebraska, 2011-2015

Gonorrhea

Between 2011 and 2015, a total of 7,278 cases of gonorrhea were reported in Nebraska. The number of cases increased each year between 2013 and 2015. Infections among females were greater in each year than among males; however, the number of infections reported among males showed a greater increase over time than infections among females. In 2015, the number of cases reported in females was only 17 greater than the number of cases reported in males; whereas in 2011, females accounted for 290 more cases than males. Table 35 shows gonorrhea infections by sex from 2011-2015.

Table 35: Gonorrhea infections by sex, Nebraska, 2011-2015

Sex	Year					
	2011	2012	2013	2014	2015	TOTAL
Male	529	633	685	684	841	3372
Female	819	775	691	763	858	3906
TOTAL	1348	1408	1376	1447	1699	7278

Like chlamydia, gonorrhea was most common among persons aged 20-24 years between 2011 and 2015. This age group represented 32% of all reported cases in 2015. Between 2014 and 2015, the number of cases increased in two age groups; the percentage of new cases among persons aged 15-19 years increased from 14% to 17%, and the percentage of new cases among persons aged 30-34 years increased from 12% to 15%. Table 36 shows gonorrhea infections by age group for 2011-2015.

Table 36: Gonorrhea infections by age group, Nebraska, 2011-2015

Age Group (years)	Year									
	2011		2012		2013		2014		2015	
	N	%	N	%	N	%	N	%	N	%
<10	1	0.08	0	0	0	0	1	0.07	1	0.06
10-14	6	0.45	2	0.14	7	.5	8	0.54	8	0.48
15-19	332	25	292	20	234	17	212	14	281	17
20-24	527	40	521	36	463	33	520	35	540	32
25-29	241	18	309	21	331	24	337	23	363	22
30-34	94	7	161	11	162	12	182	12	246	15
35-44	96	7	101	7	144	10	147	10	168	10
45+	29	2	55	4	59	4	72	5	59	4
Total	1326		1441		1400		1479		1672	

Figure 15 shows trends in gonorrhea infection by age, 2011-2015.

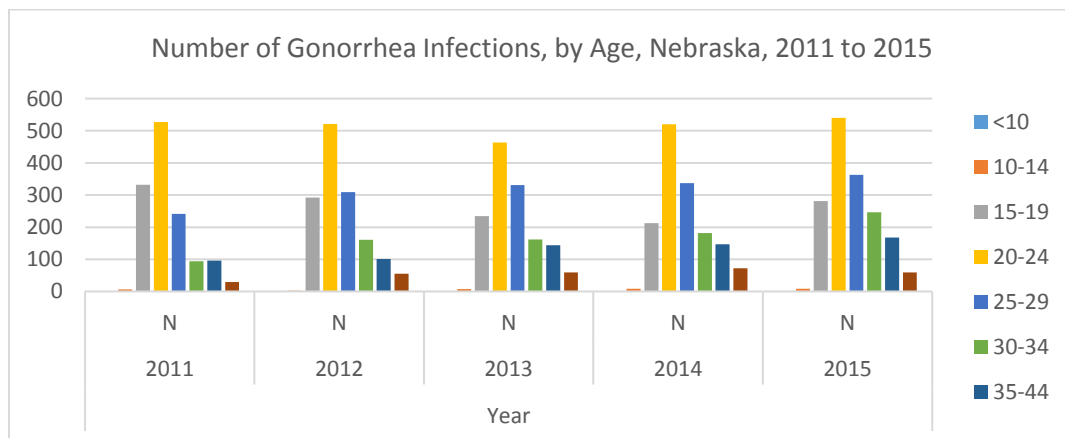


Figure 15: Gonorrhea infections by age, Nebraska, 2011-2015

Between 2011 and 2015, gonorrhea disproportionately affected Black persons in Nebraska, who accounted for 39% (n=652) of new infections in 2015. However, it is notable that the proportion of new infections among Black persons has decreased over the past five year period, while the proportion of new infections among White persons has increased steadily over the same period. Whites accounted for 34% (n=570) of new infections in 2015. There was a small increase in the proportion of cases reported among Hispanics, from 4% in 2014 to 6% in 2015. Table 37 shows gonorrhea infections by race and ethnicity.

Table 37: Gonorrhea infections by race and ethnicity, Nebraska, 2011-2015

Race/ Ethnicity	Year									
	2011		2012		2013		2014		2015	
	N	%	N	%	N	%	N	%	N	%
AI/AN	24	2	22	2	21	2	33	2	39	2
Asian	9	1	10	1	7	1	5	0	6	0
Black	668	50	596	41	547	39	595	40	652	39
Hawaiian/PI	0	0	0	0	2	0	3	0	2	0
Hispanic	51	4	60	4	51	4	53	4	99	6
Multiple	2	0	8	1	4	0	8	1	6	0
White	274	21	406	28	389	28	465	32	570	34
Other	13	1	13	1	11	1	17	1	62	4
Refused	1	0	0	0	22	2	31	2	0	0
Unknown	286	22	326	23	343	25	262	18	238	14
Total	1328		1441		1398		1472		1672	

Figure 16 shows trends in gonorrhea infection by race/ethnicity, Nebraska, 2011-2015.

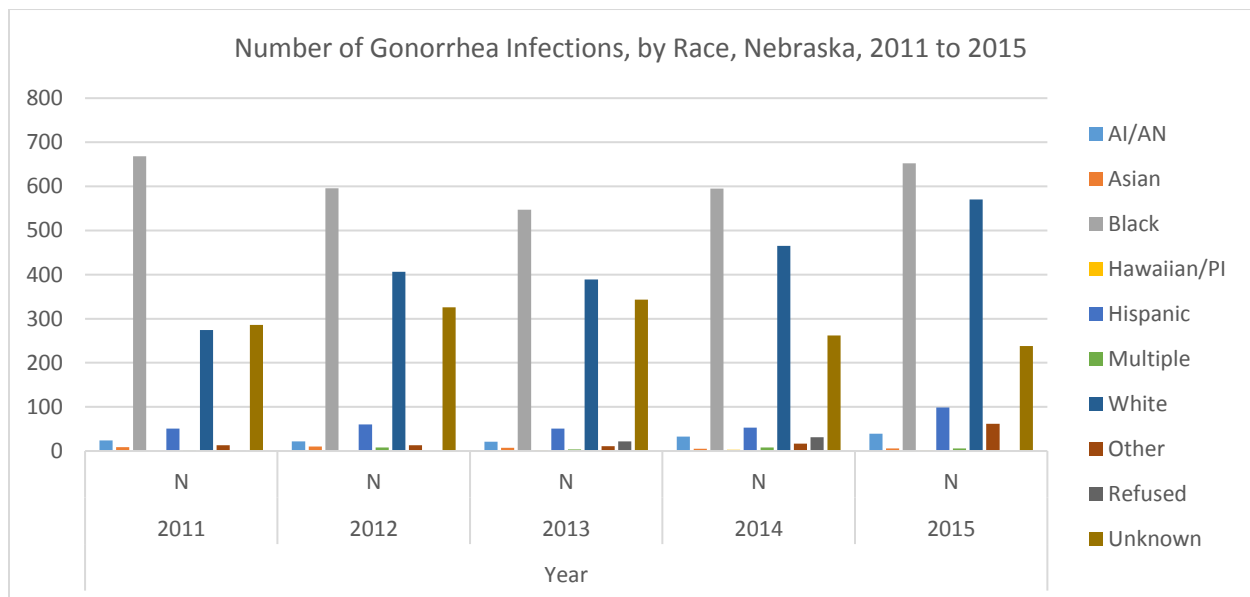


Figure 16: Gonorrhea infection by race/ethnicity, Nebraska, 2011-2015.

Syphilis

A total of 196 cases of syphilis were reported in Nebraska between 2011 and 2015, the majority of which occurred in males (n=176, 90%). The number of reported cases dramatically increased between 2012 and 2013, and the number of new cases has remained consistently elevated since that time. Table 38 shows syphilis infections by sex.

Table 38: Syphilis infections by sex, Nebraska, 2011-2015

Sex	Year					
	2011	2012	2013	2014	2015	TOTAL
Male	12	13	46	59	46	176
Female	1	3	8	6	2	20
TOTAL	13	16	54	65	48	196

The age groups affected most by syphilis changed between 2011 and 2015. In 2011 and 2012, most new cases were reported among persons aged 45 years and older. However, in 2013 and 2014, most new cases were reported among persons aged 25-29 years. In 2015, the greatest number of cases were reported among persons aged 30-34 years; however, it is notable that the distribution of new infections by age was fairly consistent for those above 20 years of age. Table 39 shows syphilis infections by age group.

Table 39: Syphilis infections by age group, Nebraska, 2011-2015

Age Group (years)	Year									
	2011		2012		2013		2014		2015	
	N	%	N	%	N	%	N	%	N	%
15-19	1	8	0	0	1	2	0	0	1	2
20-24	3	23	3	18	12	21	17	24	10	20
25-29	1	8	4	24	20	34	16	23	10	20
30-34	1	8	3	18	11	19	8	11	11	22
35-44	3	23	2	12	7	12	14	20	8	16
45+	4	31	5	29	7	12	15	21	9	18
Total	13		17		58		70		49	

Figure 17 shows syphilis infections by age group in Nebraska.

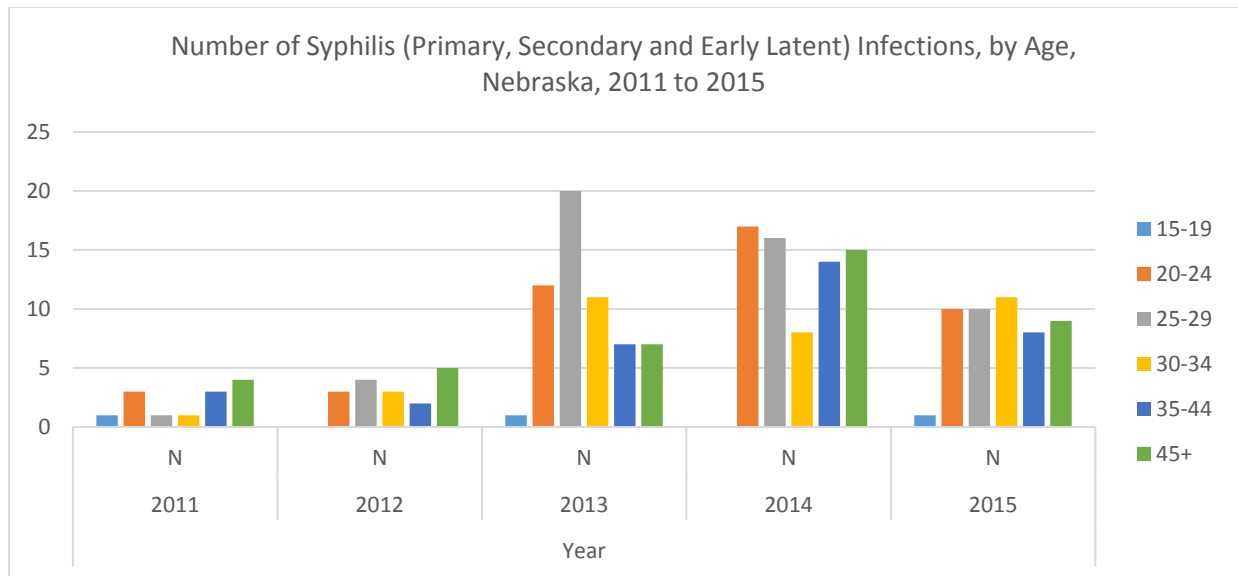


Figure 17: Syphilis infections by age group, Nebraska, 2011-2015

Nearly half of all syphilis infections reported in 2015 were among whites (46%), and 20% of new infections were among Black persons. The overall trend in new syphilis infections by race and ethnicity for 2011 through 2015 has been a decrease in new cases among Black persons and an increase among white persons. Table 40 shows syphilis infections by age race and ethnicity.

Table 40: Syphilis infections by race and ethnicity, Nebraska 2011-2015

Race/ Ethnicity	Year									
	2011		2012		2013		2014		2015	
	N	%	N	%	N	%	N	%	N	%
AI/AN	0	0	0	0	1	2	2	3	3	6
Asian	0	0	0	0	2	3	2	3	1	2
Black	5	38	6	35	15	26	24	34	10	20
Hispanic	0	0	2	12	2	3	1	1	2	4
Multiple	0	0	0	0	1	2	0	0	0	0
White	4	31	7	41	28	48	30	43	23	46
Other	0	0	0	0	0	0	1	1	0	0
Unknown	4	31	2	12	9	16	10	14	10	20
Total	13		17		58		70		49	

Figure 18 shows syphilis infections by race and ethnicity in Nebraska.

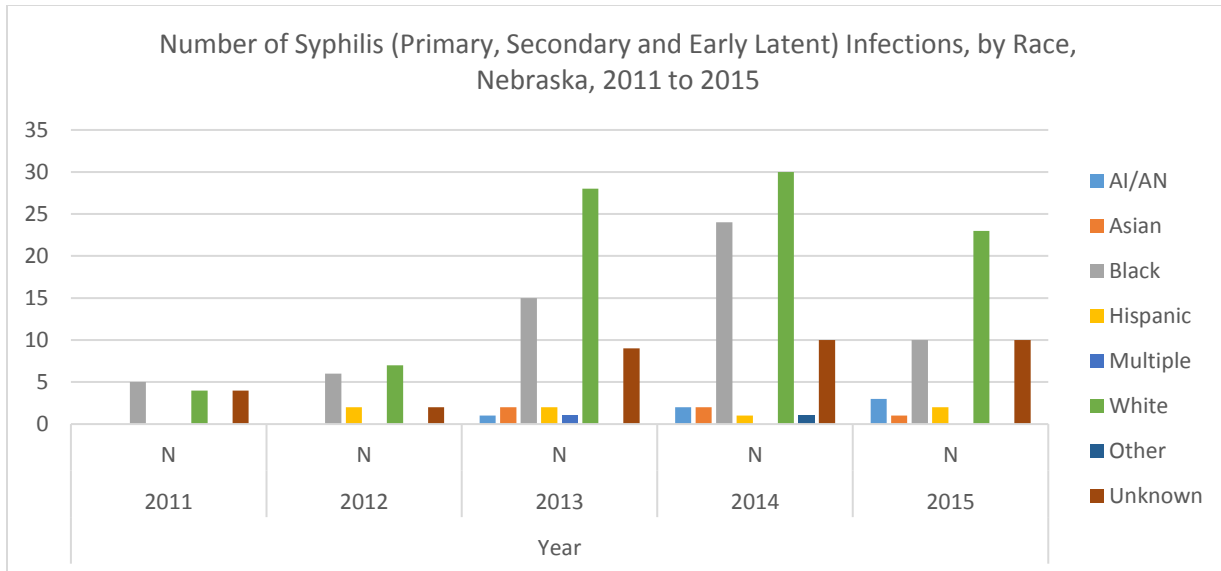


Figure 18: Syphilis infections by race and ethnicity, Nebraska, 2011-2015

Tuberculosis

Between 2011 and 2015, at least one case of tuberculosis was reported in each health district in Nebraska. The majority of cases were reported in Douglas County (n=67) and Lancaster County (n=18) during the five-year period. The number of reported cases was fairly consistent over time, with a notable increase in cases in Douglas County between 2013 and 2014. The overall case rate for tuberculosis in Nebraska in 2015 was 1.8 per 100,000 persons. Table 41 shows reported cases of tuberculosis by county and district health departments.

Table 41: Reported TB Cases by County and District Health Departments, Nebraska, 2011-2015

Health Department or District Name	2011	2012	2013	2014	2015	5 Year Totals
Central District HD	0	1	1	2	4	8
Dakota County HD	1	1	1	3	2	8
Douglas County HD	11	13	9	18	16	67
East Central HD	2	1	0	0	1	4
Elkhorn Logan Valley HD	1	0	1	2	1	5
Four Corners HD	0	0	0	1	0	1
Lincoln/Lancaster County HD	3	4	3	5	3	18
Northeast District HD	0	0	0	1	2	3
Panhandle HD	2	0	0	0	1	3
Public Health Solutions	1	0	1	1	0	3
Sarpy/Cass County HD	1	0	1	0	1	3
South Heartland HD	0	0	0	1	0	1
Southeast District HD	0	0	0	1	0	1

Health Department or District Name	2011	2012	2013	2014	2015	5 Year Totals
Three Rivers	0	0	0	0	2	2
Two Rivers HD	0	2	3	2	0	7
West Central HD	1	0	1	1	0	3

In 2015, the distribution of tuberculosis cases was nearly evenly distributed between males and females, with males accounting for 18 cases and females accounting for 15 cases. The case rate per 100,000 persons was 1.9 for males and 1.6 for females.

The majority of cases were reported among persons aged 25-44 years in 2015. Figure 19 shows the distribution of tuberculosis cases by age group.

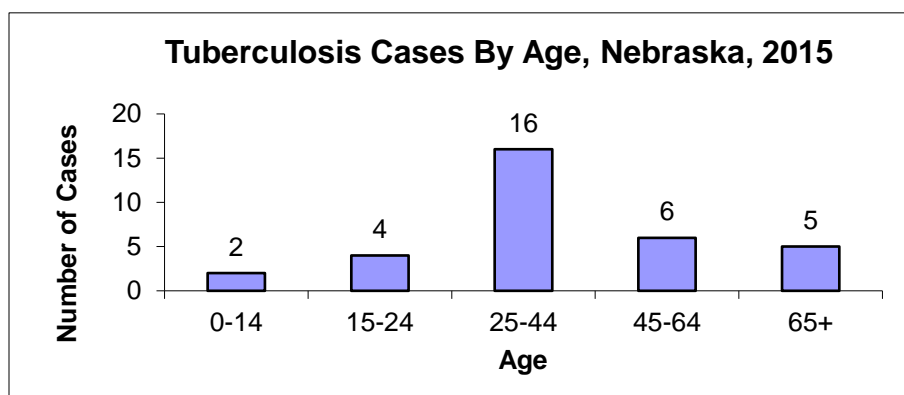


Figure 19: Tuberculosis cases by age, Nebraska, 2015

The majority of tuberculosis cases in 2015 were among whites (n=15, rate 0.9). However, the case rate for Black persons was over six times greater for Black persons (6.5) and nearly 30 times greater for Asian persons (29.0). When comparing cases among Hispanic persons to cases among non-Hispanic persons, most new cases of tuberculosis were reported among non-Hispanic persons. However, the case rate for Hispanic persons was nearly 4 times that of non-Hispanic persons (5.2 vs. 1.4), which demonstrates a disproportionate burden of disease among Hispanic persons. Table 42 shows cases and rates for tuberculosis by race/ethnicity.

Table 42: Total cases and rates for tuberculosis by race/ethnicity, Nebraska, 2015

	White	Asian	NH/PI	American Indian	Black	Hispanic	Non-Hispanic
Total cases	15	12	0	0	6	10	23
Case Rate	0.9	29	0	0	6.5	5.2	1.4

For each year between 2011 and 2015, most cases of tuberculosis in Nebraska were attributed to foreign born individuals. Since 2012, no cases of tuberculosis have been diagnosed among persons living with HIV. Figure 20 shows tuberculosis cases in by risk factor.

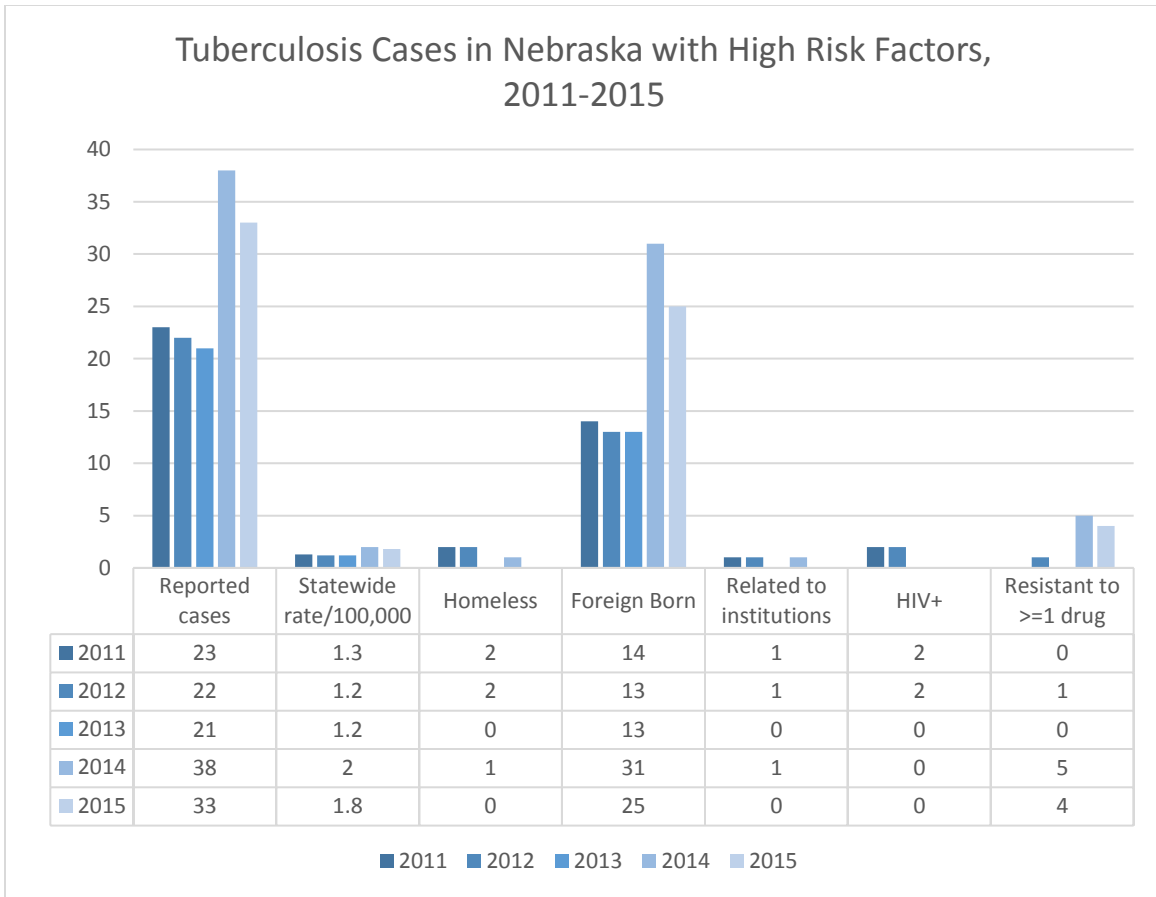


Figure 20: Tuberculosis cases by risk factor, Nebraska, 2011-2015

Hepatitis C

The number of new cases of Hepatitis C increased each year between 2011 and 2015, peaking in 2015 with a total of 1,178 cases. By age, the greatest number of cases were reported among persons aged 45-54 years over the five-year period, closely followed by persons aged 55-64 years. Table 43 shows the number of reported Hepatitis C infections by age group.

Table 43: Number of Reported Hepatitis C Infections by Age Group, Nebraska, 2011-2015

Age Group (years)	Year					Total
	2011	2012	2013	2014	2015	
0-12	5	4	5	9	4	27
13-14	0	0	1	1	0	2
15-24	35	59	78	71	81	324
25-34	121	119	143	163	142	688
35-44	149	156	196	156	170	827
45-54	341	292	299	281	269	1482
55-64	210	255	274	336	378	1453
65<	45	59	65	107	134	410
Total	906	944	1061	1124	1178	5213

The majority of reported cases of Hepatitis C between 2011 and 2015 were among whites. Between 2013 and 2014, there was a notable increase in the number of reported infections in among both Black and white persons. Trends for race should be interpreted with caution, however, due to the high number of cases among persons of unknown race. Table 44 shows the number of reported Hepatitis C cases by race and year.

Table 44: Number of Reported HCV Infections by race, Nebraska, 2011 through 2015

Race	Year					Total
	2011	2012	2013	2014	2015	
American Indian or Alaska Native	12	9	9	15	12	57
Asian	2	0	5	5	0	12
Black or African American	5	5	7	25	30	72
Native Hawaiian or Other Pacific Islander	0	1	2	1	0	4
Unknown/Missing	797	831	948	927	915	4418
White	90	98	90	151	221	650
TOTAL	906	944	1061	1124	1178	5213

DIS Interviews

Interviews were conducted with disease investigator specialists (DIS) from the two largest counties in Nebraska in July 2016. DIS reported that they observed continued HIV-related stigma, particularly regarding HIV testing. Further, outdated or misinformation, as well as beliefs in myths about HIV, were reported. One DIS pointed out that a barrier for many people is a misunderstanding of the testing procedure. The DIS further noted an increase in the number of people who return for repeat testing; after the first test, fears about testing subsided. DIS also reported observing that many people are coming for the “testing package,” which includes testing for HIV and other sexually transmitted diseases. One DIS stated that for many people presenting for a test resulted from learning that an acquaintance tested positive, or from “word on the street” that a sexual partner was infected.

DIS reported that their most frequent contact was with MSM. Both DIS firmly believed that the use of smartphone or internet-based applications contributed to recent infections. Specific applications included Grindr, Tinder, Adam4Adam, and Craigslist. Further, DIS commented that non-gay identified MSM were likely to seek sexual encounters through applications or the internet, particularly on Craigslist. DIS also reported that sexual encounters with anonymous partners presented challenges for partner identification. One DIS noted a recent increase in testing among women, particularly those in middle age.

Both DIS reported that they had recently worked with more cases where oral sex was likely to have contributed to STD or HIV transmission. One DIS hypothesized that this linkage may be related to drug use among MSM, which may compromise oral health and result in more efficient vectors for transmission.

DIS discussed that they have received more requests for information about PrEP recently. However, they also noted that finding providers to support PrEP was difficult. One DIS reported that a client was provided with misinformation about the use of PrEP by a prescribing provider; the client was told that PrEP could be used immediately before sex, immediately after sex, and for two days following the sexual

encounter and remain effective. DIS indicated the PrEP education is needed for both providers and consumers.

Intimate Partner Violence

According to the National Intimate Partner and Sexual Violence Survey (NISVS) conducted by the CDC in 2010, an estimated 263,000 Nebraska women and 172,000 Nebraska men have reported a lifetime prevalence of rape, physical violence, and/or stalking by an intimate partner in Nebraska¹¹. In 2013, the National Domestic Violence Hotline documented 483 calls from Nebraska residents, which ranks 39th in Hotline call volume as a state. Out of the 483 callers, the victim ages were 2% as 18 and under; 13% as 18-24; 31% as 25-35; 23% as 36-45; 25% at 46-54; and 6% as 55 and over. The victims identified as 69% white, 13% Black or African American, 11% Hispanic, and 7% other. 42% of the calls were from Omaha, 15% Lincoln, and 43% from smaller communities throughout Nebraska¹².

Nebraska domestic violence programs in Nebraska served 401 domestic violence victims on September 10, 2014 according to the 2014 National Census of Domestic Violence Services. Out of 401 victims served in one day 173 domestic violence victims (94 children and 79 adults) found refuge in emergency shelters or transitional housing, while 228 adults and children received non-residential assistance and services, including counseling, legal advocacy, and children's support groups¹³.

Substance Use

Currently, approximately 134,000 adults in Nebraska were reported to have a substance use issue by the Division of Behavioral Health of the Nebraska Department of Health and Human Services. For each year between 2006 and 2010, an average of 543 deaths in Nebraska were attributed to alcohol¹⁴, and 36.9% of all fatal motor vehicle crashes in Nebraska resulted from the use of alcohol¹⁵. In 2014, alcohol was listed as the primary drug of choice for 52.9% of treatment admissions, followed by methamphetamine (13.9%), marijuana (10.1%), and opiate drugs (5.0%)¹⁶. In 2013, alcohol accounted for 23.0% of all arrest offenses in Nebraska, and drug abuse violations accounted for 14.6%¹⁷. Over the past decade, the drug induced death rate has increased 55%, primarily due to the rise on opioid overdose deaths. The rate in Nebraska, however, remains half of the US rate¹⁸.

In 2014, 30% of female prison admissions were due to drug-related offenses, while male prison admissions for drug-related offenses were just under 12%. However, the number of males admitted for drug offenses was more than 4 times greater for males than females in 2014 (530:119).

Mental Health

The Division of Behavioral Health of the Nebraska Department of Health and Human Services reported that approximately 62,000 adults in Nebraska were living with a serious mental health disorder. According to the BRFSS, 17.7% of adults in Nebraska reported ever being diagnosed with a mental health disorder in 2014, and 8.2% of adults reported frequent mental distress in the same year. However, 38.1% of those who reported frequent mental distress did not report being diagnosed with depression¹⁹. Among high school students, 24.1% reported symptoms of depression within the past year in 2015 according to the YRBS²⁰. Between July 2013 and July 2014, 41,125 mental health services were provided to 22,579 Nebraska residents¹⁶.

Spotlight on Social Determinants in Douglas County:

The Poverty rate in Douglas County was an estimated 28.6% for individuals 25 years and older with less than a high school diploma in 2014. Individuals with a high school diploma (includes those with GEDs) had an estimated poverty rate of 13.8%. Employed females (8.8%) had a higher poverty rate than employed males (6.1%). Further, unemployed females (43.5%) had a higher poverty rate than unemployed males (35.5%).²¹

Educational Attainment for 18 to 24 year olds is 13.4% for those with less than a high school diploma, and 26.3% for those with high school diplomas (including those with GEDs). For the 25 year olds and over, 21.9% have high school diplomas (including those with GEDs), and 23.7% had some college with no degree. For 25 to 34 years old, 88.9% had a high school diploma or higher and 41.7% had a Bachelor's degree or higher²².

The total median earnings in the past 12 months for all 25 year olds and over was \$36,274. For those who had less than a high school diploma, earnings were \$21,149. Males with less than a high school diploma earned more than females, \$23,017 compared to \$17,841. The total for those who had a high school diploma was \$26,846. Males earned more than females in this group. The median earnings for males in this group were \$30,745 and for females were \$23,281.²³

Race/ethnicities: According to the 2014 estimates, the population for Douglas County is primarily White (394,936), then Black (62,377), and Hispanic (64,924)²⁴.

Employment Status: For individuals 16 years and over, an estimated 71.9% were in the labor force, 67.1% were employed, and the unemployment rate was 4.6%. The percentage of Whites who were in the Labor Force was 72.6%, while for Blacks, the percentage was 66.7%. For those employed, 68.6% were White, while 56.6% were Black. Black individuals (15.2%) had a higher unemployment rate than White individuals (5.3%).²⁵

Fertility: In 2014, 3,128 births were unmarried mothers. Poverty rates in unmarried mothers data was not available.²⁶

Characteristics of Teenagers, 15 to 19 years old: A total of 32,001 teenagers in Douglas County were enrolled in school, while 3,516 were not enrolled in school. More white teenagers (1,757) were not enrolled in school than Hispanic teenagers (849) or Black (714). In 2014, an estimated 1.8% of females between 15 to 19 years old had given birth in the past 12 months. By race, in the past 12 months 3.3% of Hispanic females, 2.8% of Black females, and 1.2% of White females between the ages of 15 to 19 years old had given birth.²⁷

Part B: HIV Care Continuum

A diagnosis-based HIV Care Continuum was created for 2015, and included the following steps on the continuum:

1. Diagnosed: people who have been diagnosed with HIV and currently live in Nebraska
2. Linked to care: people who had a lab test (CD4 and/or viral load) within 3 months of diagnosis within the last year
3. Currently in care: people who have had at least 2 lab tests (CD4 and/or viral load) within the last year
4. Last viral load less than 200: of those currently in care the number of people whose last viral load was less than 200

Figure 21 presents the HIV Care Continuum for Nebraska, 2015.

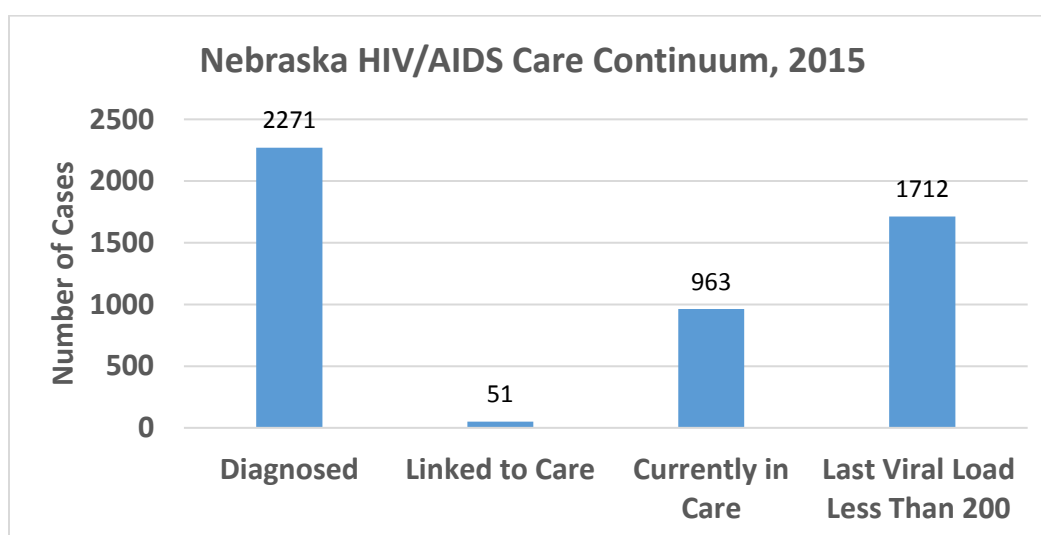


Figure 21: HIV Care Continuum, Nebraska, 2015

In 2015, there were a total of 2,271 people in Nebraska living with HIV. Of those persons living with HIV, 42.4% (n=963) were currently in care, and 75.4% (n=445) were virally suppressed. In 2015, 81 new cases of HIV were diagnosed, of which 63% (n=51) were linked to care.

Race and Ethnicity

An HIV Care Continuum was created for the three racial and ethnic groups with the highest prevalence of HIV in Nebraska: white, Black, and Hispanic. Figure 22 shows the continuum by race and ethnicity.

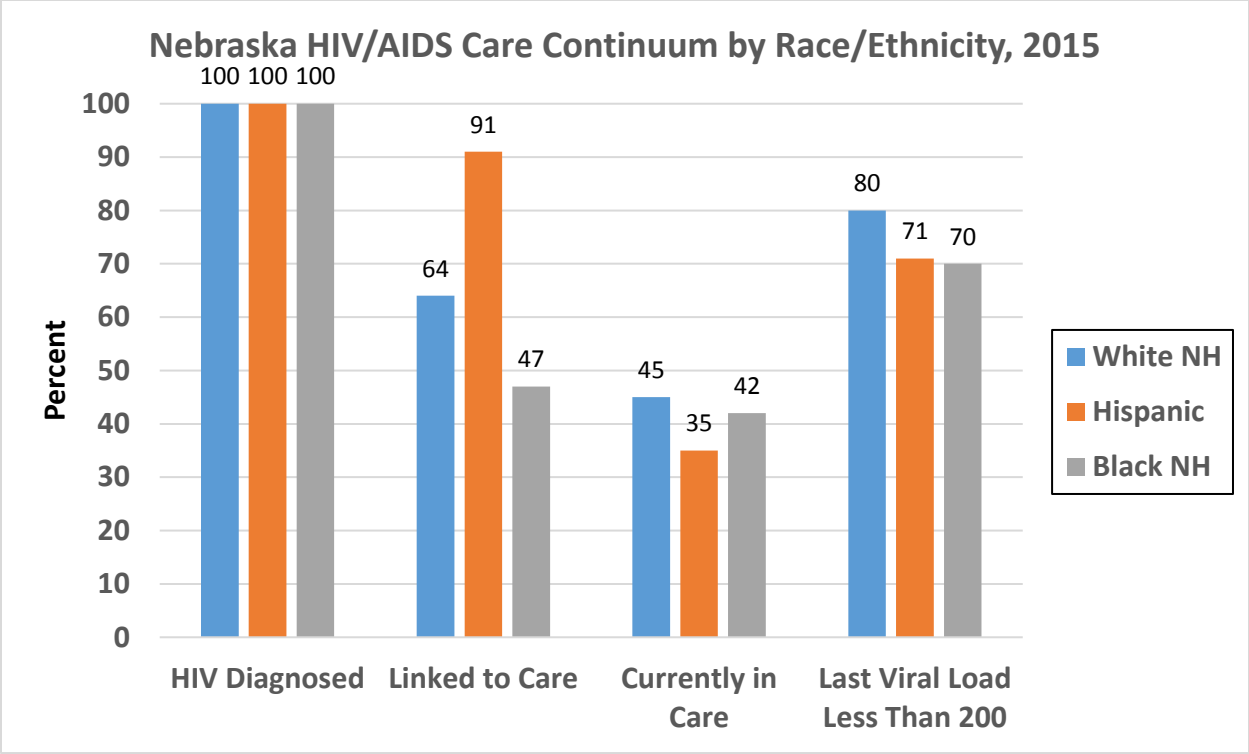


Figure 22: HIV/AIDS Care Continuum by race/ethnicity, Nebraska, 2015

By race and ethnicity, Hispanic persons who were living with HIV were more likely to be linked to care in 2015 than persons of other races or ethnicities. However, Hispanic persons were less likely to be currently in care when compared to other races or ethnicities, and less likely to be virally suppressed than white persons.

Of diagnosed white, non-Hispanic persons, 64% were linked to care in 2015, 45% retained in care, and 80% virally suppressed. Among all races and ethnicities reported here, white persons living with HIV were most likely to be currently in care or virally suppressed.

Black, non-Hispanic persons were least likely to be linked to care when compared to other races or ethnicities. However, 42% were currently in care and 70% were virally suppressed.

For 2015, the care continuum was fairly consistent when interpreted by race and ethnicity. The most notable inconsistency was among Hispanics, who were more likely to be linked to care, yet less likely to be retained in care or virally suppressed when compared to other racial and ethnic groups. Another notable inconsistency was that Black persons were least likely to be linked to care; however, the percentage of those who were virally suppressed was not significantly different.

Gender

When viewed by sex, there was little variation in the HIV care continuum between males and females in terms of being currently in care or being virally suppressed. A slightly greater percentage of females were linked to care when compared to men (65% vs. 59%).

Figure 23 shows the HIV care continuum by sex.

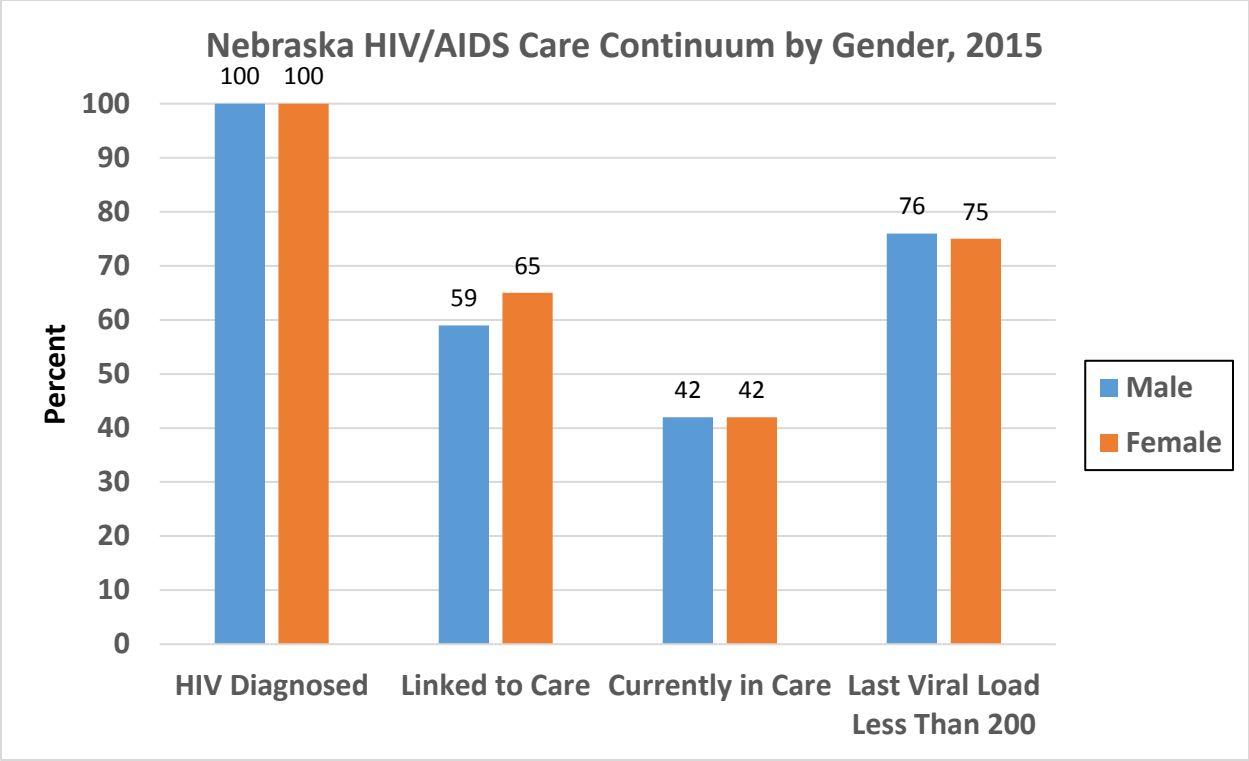


Figure 23: HIV/AIDS Care Continuum by sex, Nebraska, 2015

Exposure

Among persons for whom exposure category was reported, heterosexual contact showed the greatest percentage of persons who were virally suppressed (80% each), followed by MSM (78%) and NIR (67%).

Persons who were exposed through MSM contact were the most likely to have been linked to care when compared to other exposure categories. The greatest disparities existed in linkage to care for persons who reported NIR when compared to other exposure groups. Most persons who were infected through MSM transmission (73%) and heterosexual transmission (71%) were linked, while only 53% of the NIR category were linked to care.

Interestingly, only 31% of those who reported NIR were currently in care when compared to people who reported transmission through heterosexual and MSM contact (44%).

It should be noted that data for sub-group analyses may be unstable due to a low number of cases. Results for IDU and IDU/MSM should be interpreted with extreme caution; in 2015, only one IDU case was reported, and two IDU/MSM cases were reported.

Figure 24 shows the HIV Care Continuum by exposure.

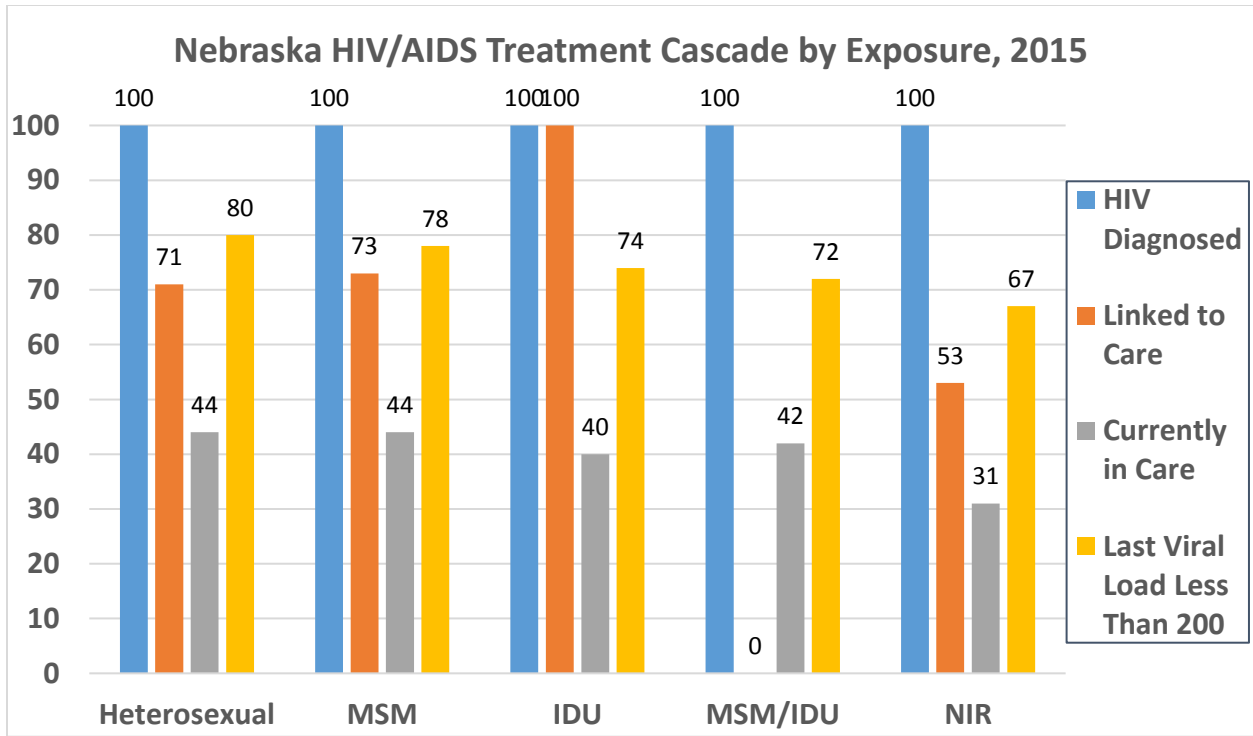


Figure 24: HIV/AIDS Care Continuum by exposure category, Nebraska, 2015

Note-excluded IDU and MSM/IDU from narrative

Part C: Financial and Human Resources Inventory

Funding for HIV Services and Care

Federal and State Funding

The Centers of Disease Control and Prevention (CDC) provides funds to support the HIV prevention program of the Nebraska Department of Health and Human Services. HIV prevention funding is managed by staff at the NDHHS, which provides both direct and contracted services across the state. CDC also supports STD prevention and HIV surveillance. Additional funding for prevention is provided through a PHHS block grant.

The Human Resources Service Administration (HRSA) provides funding for Ryan White programs, and Housing and Urban Development (HUD) provides funding for HOPWA. These funds are managed by the NDHHS.

The state of Nebraska supports Medicaid, which contributes substantially to alleviating the costs associated with HIV-related services for many PLWHA. In addition to Medicaid support, the state also provides funding for the AIDS Drug Assistance Program (ADAP).

In 2015, the federal government provided a total of \$4,914,257 for HIV prevention and care services in Nebraska. In the same year, the state of Nebraska provided a total of \$4,401,037. Table 45 shows the funding amount by source and the percentage of total funding represented by each source.

Table 45: HIV prevention and services funding, Nebraska, FY 2016

Source	Funding Amount (\$)	Percent of Total
HIV Prevention: CDC HIV Prevention	755,416	8.0
STD Prevention: CDC STDAPPS	24,585	0.3
PHHS Block Grant: CDC	10,000	0.1
HIV Surveillance: CDC	193,216	2.0
Medicaid: State funds	3,501,037	38
HIV Care/Support: HRSA Ryan White (All Parts) FY 2015	3,568,676	38
HIV Care/Support: HUD/HOPWA (all jurisdictions)	362,364	3.9
ADAP: State funds	900,000	9.7
Total Federal Funds	4,914,257	53
Total State Funds	4,401,037	47
Prevention and Care Total	9,315,294	100

Resources Inventory

The following tables present the resources inventory by funding source and include the responsible agencies, services, and HIV care continuum steps impacted.

Table 46: HIV Prevention - PS-1201 Funding, Nebraska

Agency	Services Provided	HIV Care Continuum Step Impacted
Nebraska AIDS Project	Routine HIV Testing Partner Services Disease Intervention Services Condom Distribution Prevention Counseling Community Outreach and Education	HIV – Diagnosed, Linkage to Care
Community Action Partnership of Western Nebraska	Routine HIV Testing Prevention Counseling Condom Distribution Partner Services	HIV – Diagnosed, Linkage to Care
Charles Drew Health Center	Routine HIV Testing Prevention Counseling Condom Distribution Partner Services	HIV – Diagnosed, Linkage to Care
Central Health Center	Routine HIV Testing Prevention Counseling Condom Distribution Partner Services	HIV – Diagnosed, Linkage to Care
Douglas County Health Department	Routine HIV Testing Partner Services Disease Intervention Services Prevention Counseling Condom Distribution	HIV – Diagnosed, Linkage to Care
East Central District Health Department	Routine HIV Testing Prevention Counseling Condom Distribution Partner Services	HIV – Diagnosed, Linkage to Care
Family Health Services, Inc.	Routine HIV Testing Prevention Counseling Condom Distribution Partner Services	HIV – Diagnosed, Linkage to Care
Lincoln/Lancaster County Health Department	Routine HIV Testing Partner Services Disease Intervention Services Prevention Counseling Condom Distribution	HIV – Diagnosed, Linkage to Care
North Omaha Area Health Inc.	Routine HIV Testing Prevention Counseling Condom Distribution Partner Services	HIV – Diagnosed, Linkage to Care
OneWorld Community Health Centers, Inc.	Routine HIV Testing Prevention Counseling Condom Distribution	HIV – Diagnosed, Linkage to Care

Agency	Services Provided	HIV Care Continuum Step Impacted
	Partner Services	
Western Community Health Resources	Routine HIV Testing Prevention Counseling Condom Distribution Partner Services	HIV – Diagnosed, Linkage to Care

Table 47: Ryan White Part B, including ADAP, Nebraska

Agency	Services Provided	HIV Care Continuum Step Impacted
University of Nebraska Medical Center	AIDS Drug Assistance Program, Dental/oral health services, Medical Transportation	HIV Diagnosed Linkage to Care Engaged/Retained in Care Prescribed ART Achieved Viral Suppression
Nebraska AIDS Project	Medical case management, housing, psychosocial services, linkage to care	HIV Diagnosed Linkage to Care Engaged/Retained in Care
Lutheran Family Services	Linkage to care/outreach	HIV Diagnosed Linkage to Care
Lincoln/Lancaster County Health Department	Linkage to care and re-engagement	HIV Diagnosed Linked to Care
Western Community Health Resources	Outpatient ambulatory services	HIV Diagnosed Linked to Care Engaged/Retained in Care Prescribed ART Achieved Viral Suppression
University of Nebraska Lincoln	Mental health services	HIV Diagnosed Linkage to Care Engaged/Retained in Care Prescribed ART
Calico Spirit Group	Psychosocial services	HIV Diagnosed Linkage to Care Engaged/Retained in Care Prescribed ART

Table 48: Ryan White Part C, Nebraska

Agency	Services Provided	HIV Care Continuum Step Impacted
University of Nebraska Medical Center	Early Intervention Services (medical care), mental health services, substance abuse	HIV Diagnosed Linkage to Care Engaged/Retained in Care Prescribed ART

Agency	Services Provided	HIV Care Continuum Step Impacted
	services, dental/oral health services	Achieved Viral Suppression
Chadron Community Hospital/Western Community Health Resources	Early Intervention Services (medical care), mental health, dental	HIV Diagnosed Linkage to Care Engaged/Retained in Care Prescribed ART Achieved Viral Suppression

Table 49: Ryan White Part D, Nebraska

Agency	Services Provided	HIV Care Continuum Step Impacted
University of Nebraska Medical Center	HIV medical care to Women and Children	HIV Diagnosed Linkage to Care Engaged/Retained in Care Prescribed ART Achieved Viral Suppression

Table 50: HOPWA, Nebraska

Agency	Services Provided	HIV Care Continuum Step Impacted
Nebraska AIDS Project	Housing, Supportive Services	HIV Diagnosed Linkage to Care Engaged/Retained in Care

Table 51: Sexually Transmitted Disease Program, Nebraska

Agency	Services Provided	HIV Care Continuum Step Impacted
Nebraska AIDS Project	Disease Intervention Specialist Partner Services	Linkage to Care

Appendix B presents a HIV/AIDS Resource Guide for Nebraska.

Capacity

The Midwest AIDS Training and Education Center (MATEC) at the University of Illinois—Chicago, completed a workforce capacity assessment in August 2016 for submission with the integrated plan. This report, entitled, “Needs and gaps that may affect the overall capacity to provide HIV clinical care in Nebraska,” begins on the following page.

INTRODUCTION

The Midwest AIDS Training + Education Center (MATEC) is a federally-funded training center, providing AIDS and HIV clinical training and support to health care professionals in Illinois, Iowa, Indiana, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio and Wisconsin. MATEC is part of the AIDS Education and Training Centers (AETC) Program (funded under Part F) of the Ryan White HIV/AIDS Program. The AETC Program increases the number of health care providers who are educated and motivated to counsel, diagnose, treat, and medically manage people living with HIV and to help prevent behaviors that lead to HIV transmission.

This report was prepared for the Nebraska Department of Health and Human Services, for the purpose of their 2017-2021 Integrated HIV Prevention and Care Plan. It describes MATEC's findings regarding the needs and gaps that may affect the overall capacity to provide HIV clinical care in Nebraska.

This report was prepared in response to the *Guidance for the Development of a Regional AIDS Education and Training Center (AETC) Needs Assessment* provided by the Health Resources and Services Administration (HRSA) in November 2015. In accordance with HRSA's Guidance, the AETC's findings regarding clinical workforce needs and gaps were to be provided to Part A and B programs for them to use when preparing their integrated prevention and care plans. To this end, at MATEC's 2016 Policy Training Advisory Council (PTAC) meeting, representatives from all Part A and B programs in MATEC's region were invited to discuss (among other issues) MATEC's plans to approach the assessment of the HIV workforce and to reach consensus regarding the definition of "workforce". At the PTAC meeting, the group agreed to define the HIV workforce: Physicians, Physician Assistants, Nurse Practitioners, Registered Nurses, Dental Providers and Clinical Pharmacists. For the purpose of this report, workforce is also referred to as the *clinical workforce*. However, given the nature of the data sets used to describe the findings, in some cases other HIV professionals (e.g., social workers, case managers, public health providers, etc.) were also taking into consideration.

Any questions pertinent to this report may be directed to Ann Fitzgerald (MATEC-NE Director) at anfitzgerald@nebraskamed.com.

DATA SOURCES

At the 2016 PTAC meeting, Part A and B representatives agreed to provide to MATEC the following data sets:

- Most recent HIV prevalence data by counties, city/town, or zip codes
- Most recent list of providers reporting CD4 counts and viral load by zip codes, otherwise by county
- Any other lists by zip codes or by county (e.g., CTR test sites, linkage to care personnel, etc.)

From the Nebraska Department of Health and Human Services, the following data sets were received which were used in this report:

- HIV Prevalence data by Public Health Jurisdiction
- List of Providers Reporting CD4 and Viral Load By Zip Code

Additional data sets utilized for the purpose of this report include:

- AETC's trainees data:
 - Needs Assessment data collected during 2013-2014 by Mountain Plains AETC showing priority Training and Technical Assistance topics for Nebraska.
 - No participant data from the Participant Information Forms for Nebraska were used in this report, as Nebraska was not part of the MATEC region prior to September 1, 2015.
- The Black AIDS Institute HIV Work Survey: *When We Know Better, We Do Better: The State of HIV/AIDS Science and Treatment Literacy in the HIV/AIDS Workforce in the United States*. Black AIDS Institute, 2015 (<https://www.blackaids.org/reports/when-we-know-better-we-do-better>).

The Black AIDS Institute, in collaboration with the CDC, the Latino Commission on AIDS, and the National Alliance of State and Territorial AIDS Directors, conducted the US HIV Workforce Survey between 2012 and 2013. The 62-question web-based survey was completed by more than 3,600 workers in the HIV field and assessed the knowledge, attitudes and beliefs of the HIV workforce in the United States. Data were reported for three knowledge categories: 1) basic knowledge and terminology, 2) treatment, 3) clinical knowledge (biomedical interventions). The survey report describes the results of the HIV Workforce Survey and includes fact sheets for 16 states and 14 major metropolitan areas with knowledge scores for each of the three knowledge categories, attitudes towards biomedical interventions, and demographic data of the respondents including a work profile. For the Midwest region, the states included in the state fact sheets were Illinois, Michigan, Missouri, and Ohio. Chicago was the only Midwestern metropolitan area included in the fact sheets for major metropolitan areas.

- Data Warehouse, Health Resources and Services Administration. Data extracted on June 15, 2016. (<https://datawarehouse.hrsa.gov/tools/dataPortal.aspx>)
- County-level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections among Persons who Inject Drugs, United States. *JAIDS Journal of Acquired Immune Deficiency Syndromes* Publish. (June 2016, Ahead of Print.) (<http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=ovft&AN=00126334-900000000-97209&PDF=y>)

Several maps were created to visualize and analyze data across Nebraska. ArcInfo version 10.2.2. was used to develop the maps and geospatial data were downloaded from the U.S. Census Bureau, and included TIGER/Line 2010 Decennial Census files.

FINDINGS

The findings described in this section are based on the analysis and interpretation of the existing data listed in the introduction. These data begin to inform us on current needs and gaps that may affect the overall capacity to provide HIV clinical care in Nebraska.

1. GEOGRAPHIC GAPS OF HIV CLINICAL WORKFORCE

1.1 Prevalence data *(See Map 1/page 10)*

- i. Although HIV cases have been reported in every public health jurisdiction in Nebraska, it is important to highlight the following jurisdictions with an HIV prevalence between 15 and 182 people living with HIV (non-AIDS): **Two Rivers, Central District, Elkhorn Logan Valley, Three Rivers, Lincoln-Lancaster, and Sarpy/Cass** districts. The public health jurisdiction of **Douglas** with 1500 reported cases is an outlier in Nebraska where the highest HIV prevalence rate is found.

1.2 Providers/Facilities who reported CD4 and Viral Load (VL) values in 2015.

(See Map 2/page 11)

- i. A total of 121 providers/facilities reported CD4 and VL values. Most of these providers are located in high prevalence areas, with 76 providers located in Omaha (**Douglas** district) and 20 providers in Lincoln (**Lincoln** district).
- ii. The following public health jurisdictions (with a prevalence between 8 and 13 people living with HIV) do not show up in the list of providers/facilities reporting CD4 and VL values: **Southwest NE, Public Health Solutions, Northeast NE, and Dakota** districts.
- iii. Some of these providers/facilities reporting CD4/VL values are not on MATEC's distributions lists and may not be aware of the training and TA services available through MATEC.

1.3 Community Health Centers currently providing HIV clinical care *(See Table 1/page 9 and Map 3/page 12)*

- i. A total of 6 Community Health Centers (CHCs) are currently providing HIV clinical care according to HRSA's Data Warehouse. None of these 6 CHCs currently receive Ryan White funding.
- ii. In addition to the 6 CHCs, two Ryan White Part C funded clinics are providing HIV clinical care.
- iii. All 6 CHCs are in or close to public health jurisdictions with high reported prevalence of HIV.
- iv. The following public health jurisdictions with high prevalence data, as indicated by the number between brackets, do not have a CHC within their boundaries that is currently providing HIV clinical care services: **Two Rivers (29), Three Rivers (17), and Sarpy/Cass (57)**.
- v. Some of these CHCs are not on MATEC's distributions lists and may not be aware of the training and TA services available through MATEC.

- vi. The following health care center in Nebraska is the current recipient of intense assistance from MATEC under its HIV Practice Transformation Project: One World Community Health Center in Omaha (**Douglas** district).

2. NEEDS OF THE HIV CLINICAL WORKFORCE

2.1 Based on MATEC's Data

- i. High volume clinicians who provide HIV care (most frequently, clinicians in urban and/or Ryan White settings) have the highest level of knowledge and low-volume clinicians (frequently rural and private practice clinicians) have the lowest level of knowledge.
- ii. As low volume providers are more likely to refer HIV-positive patients for HIV care, there is an opportunity for MATEC to increase their knowledge and skill levels so that they are able to provide more advanced HIV care and retain HIV positive patients in their practices. The data from Figure 1 suggest that trainings of low volume providers need to focus on initiating Anti-retroviral treatment (ART), monitoring adherence, and treating drug resistance.
- iii. Priority topics for training and technical assistance in Nebraska are Testing, Prevention, Occupational Exposure, Adolescents, and Primary Care
- iv. According with new HRSA guidelines for funding allocations for the AETC grantees, a significant proportion of funds have to be allocated to new projects (i.e., HIV Practice Transformation and HIV Interprofessional Education). Hence, the funding level for AETCs to fulfill other training and technical assistance needs has significantly decreased for Fiscal Years 2016 through 2019.

2.2 Based on The Black AIDS Institute HIV Work Survey (See Table 2/page 9)

Although no fact sheet was included in the report for the state of Nebraska, several of the national findings are worth mentioning here. At the national level, over 3,600 HIV workers scored an average of 61% of the questions correct. Broken down by question category, these percentages correspond to 73% correct for basic knowledge questions, 54% correct for treatment questions, and 45% correct for clinical knowledge questions. It is noted in the report that the Midwest fared better than the national average, and that HIV workers from Nebraska who were included in the survey scored an average of 70% of all questions correct, making Nebraska one of the top scoring states in the country.

At the national level, there is an 8-11 percentage point gap between Whites and African Americans across all categories. This indicates the need for all states to focus its training and capacity building assistance on increasing the HIV science, treatment, and prevention knowledge among African Americans clinicians.

A number of studies have examined issues of racial concordance in clinical care and training programs. A multicenter study that examined the role of cultural distance

between HIV-infected patients and providers in perceived quality of care found that patients who rated lower perceived cultural similarity with their providers rated significantly lower quality of care and lower trust in their providers. Cultural concordance was assessed in terms of speech and language, reasoning, communication style, and values, which, based on the findings of the study, indicated the importance of positive patient-provider interactions and cultural competency in provision of HIV care (Saha et al., 2011). Given these realities, the need for culturally competent clinicians, particularly from the communities most affected by HIV, is crucial.

Based on data from the report on familiarity with and belief in biomedical interventions, HIV workers are less familiar with the topics of Topical Microbicides and HIV vaccines; only 37% indicate that they are familiar with PrEP, and 42% are familiar with Treatment as Prevention, suggesting a need for training in these topics.

3. Retirement Creating Workforce Gaps

The Institute of Medicine in examining workforce needs for *HIV Screening and Access to Care* (2011) acknowledged that the HIV/AIDS workforce is aging. They estimated nationally that 33 percent of physicians, 24 percent of pharmacists and 45 percent of nurses will likely reach retirement age by 2020. Meanwhile the population is increasing and the age of the population is increasing, both of which place greater demands on health professionals. A survey of HIV Medical Association (HIVMA) members, a physician group specializing in HIV care, found in 2010 that at least 45% of its members were 51 years and older, with 17% over the age of 61. In 2010 60% of nurses with the Association of Nurses in AIDS Care (ANAC), the HIV/AIDS nursing association, were between the ages of 40 and 50, and only 7% were between the ages of 20-29, indicating young nurses were not choosing HIV/AIDS as their specialty. The National Alliance for HIV Education and Workforce Development made recommendations regarding this issue: “The early cohort of experienced HIV-care clinicians, who brought passion and commitment to patients early in the epidemic, entered the field 20 or more years ago and are nearing retirement. As they leave, a service gap will be created, and these providers will need to be replaced with well-educated, skilled clinicians who are able to provide comprehensive HIV care” (NAHEWD, 2014, p. 8). Further investigation into retirement and its affects upon the Illinois workforce need to be carried out.

MATEC efforts such as the HIV Interprofessional Education Project (HIPEP) and the Clinician Scholars Program are programmatic activities which specifically aim to prepare the next generation of skilled and dedicated HIV practitioners.

HIPEP is a regional collaborative that includes six University-based Inter Professional Education programs to develop, implement and evaluate interprofessional team-based training programs for health professions students to prepare a workforce which is ready and able to optimize care and outcomes for persons living with HIV/AIDS.

The MATEC Clinician Scholars Program is a 12-month training program specifically designed for minority or predominately minority serving, front line clinical care providers (Physicians, Physician Assistants, Nurse Practitioners, and Pharmacists), who are interested in the diagnosis, treatment, medical management, and prevention of HIV/AIDS.

4. Counties Vulnerable for Rapid Dissemination of HIV or HCV Infections among Persons who Inject Drugs in Illinois

The recent HIV outbreak in Scott County, Indiana, prompted MATEC to explore the literature about rural counties in our region which may be vulnerable to similar outbreaks. In doing so, we found an article (recently accepted to be published in the *Journal of Acquired Immune Deficiency Syndrome* cited above) in which the authors identified “U.S. counties potentially vulnerable to rapid spread of HIV, if introduced, and new or continuing high rates of hepatitis C virus (HCV) infections among persons who inject drugs”. In Nebraska, there were no counties identified in this article. However, counties were identified in six other Midwestern states, and it might be worthwhile for the Nebraska Department of Health and Human Services and MATEC to further explore vulnerability and target interventions to prevent transmission of HIV and HCV among persons who inject drugs.

SUMMARY

This report summarizes findings related to the HIV clinical workforce in Nebraska. The focus includes the need for additional training and technical assistance to enhance the current and future workforce. Specific findings include:

- a. HIV cases have been reported in every public health jurisdiction in Nebraska. Additional efforts to enhance the workforce should target jurisdictions with high prevalence, with Douglas district showing the highest prevalence.
- b. Four public health jurisdictions do not include providers who report CD4 and Viral Load values, indicating the need to ensure providers/facilities are available to cover these jurisdictions. Specific concerns include Southwest NE, Public Health Solutions, Northeast NE, and Dakota districts.
- c. Several public health jurisdictions with high prevalence do not have a CHC within their boundaries that is currently providing HIV clinical care. The following districts may need attention due to a lack of CHCs: Two Rivers, Three Rivers, and Sarpy/Cass jurisdictions.
- d. Given shifting national priorities for the AETCs, close collaboration and resource sharing may be needed to expand programs, especially in rural areas.
- e. Topics needing attention include Testing, Prevention, Occupational Exposure, Adolescents, Primary Care, PrEP, and Treatment as Prevention.

Table 1. Community Health Centers Providing HIV Care in Nebraska

Health Center Name	City	Zip code	HIV
Charles Drew Health Center, Inc.	Omaha	68111	0.07%
Community Action Partnership Of Western Nebraska	Gering	69341	1.19%
Heartland Health Center, Inc.	Grand Island	68803	0.12%
Midtown Health Center, Inc.	Norfolk	68701	0.10%
One World Community Health Centers	Omaha	68134	0.05%
Peoples Health Center	Lincoln	68503	0.06%

Source: Data Warehouse, Health Resources and Services Administration.

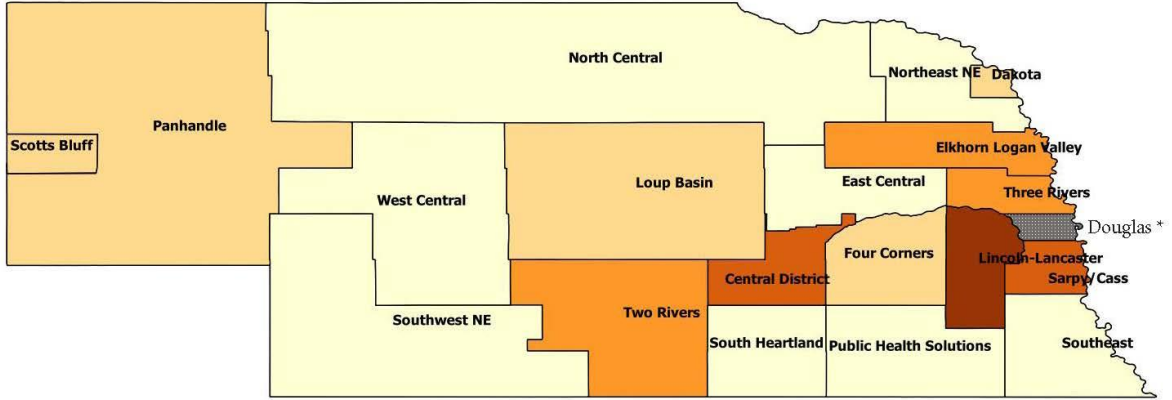
Table 2. Knowledge Scores by Question Category, Whites and African Americans, 2012-13 HIV Workforce Survey

		All Questions	Basic Knowledge and Terminology	Treatment	Biomedical Interventions
USA	All respondents	61%	73%	54%	45%
	Af Am (n = 68)	57%	69%	51%	41%
	White (n = 69)	67%	80%	59%	49%

Source: The Black AIDS Institute HIV Work Survey: When We Know Better, We Do Better: The State of HIV/AIDS Science and Treatment Literacy in the HIV/AIDS Workforce in the United States. Black AIDS Institute, 2015

Map 1.

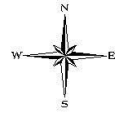
Nebraska HIV Prevalence by Public Health Jurisdiction



Legend

Nebraska Prevalence by jurisdiction

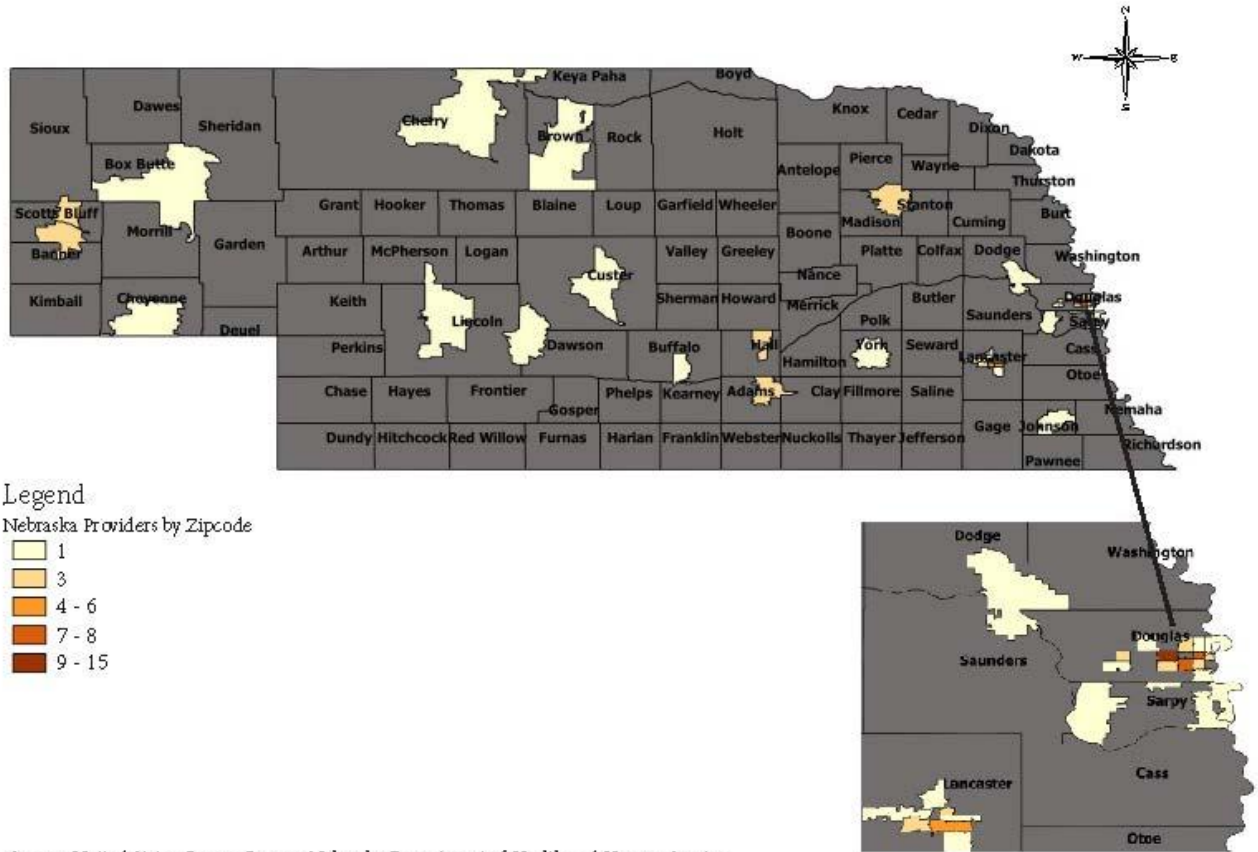
- 6 - 9
- 10 - 14
- 15 - 29
- 30 - 57
- 58 - 182
- *Douglas Jurisdiction Frequency - 1500



Source: United States Census Bureau, Nebraska Department of Health and Human Services.

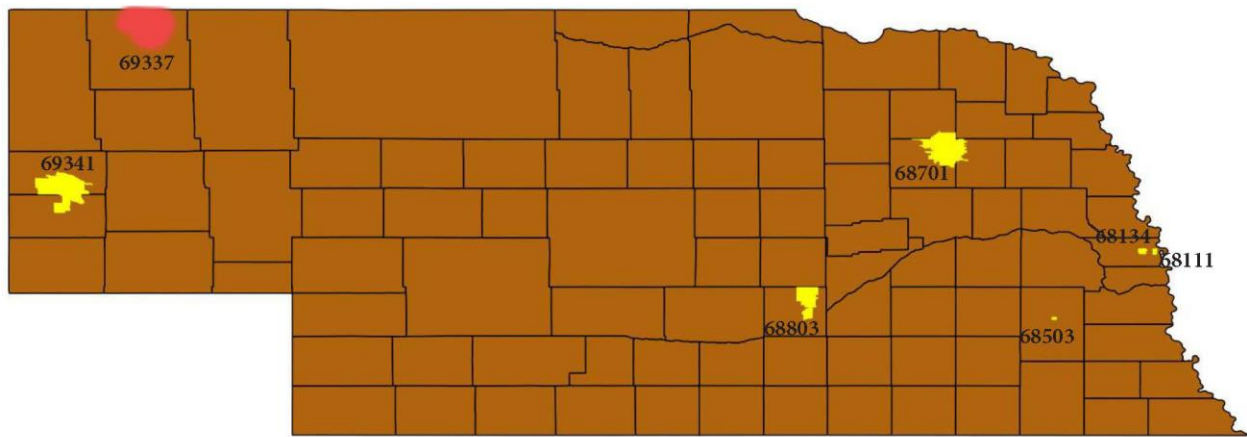
Map 2.

Nebraska Providers Reporting CD4/Viral loads by Zipcode



Map 3. Community Health Centers currently providing HIV clinical care and Ryan White Clinical Sites

(Nebraska) Zipcodes Containing
Community Health Centers
Ryan White Centers



Source: Health Resources and Services Administration (HRSA)

Interaction of Funding Sources

Nebraska's HIV Prevention, Ryan White, Hepatitis, Housing Opportunities for People Living with AIDS, HIV Surveillance, Tuberculosis, and Sexually Transmitted Disease Prevention Programs are all housed within the Division of Public Health, Health Promotions Unit. This structure supports the collaborative efforts between programs to meet the needs of individuals living with or at risk of acquiring HIV. The Health Promotions Unit provides services and coordinates HIV/AIDS prevention and care activities to maximize funding resources that impact the greatest number of individuals in an effort to decrease the spread and transmission of HIV/AIDS and encourage HIV positive individuals to access appropriate services.

It has been a focus of Nebraska's Health Promotions Unit to ensure that services are driven by needs rather than by funding. Individuals needing information on HIV/AIDS or seeking services have the option to enter the state's system through any of these programs. Program personnel meet regularly to share internal and external resource information and assist in negotiating the needs of individuals in care or requesting preventative services. With a decrease in program resources in all prevention programs, this structure is important to maintain the services that are provided and increase preventative care.

In addition, program contracts provide multi-tiered funding for external partners to support both preventative and direct care to individuals living with or at risk of acquiring HIV/AIDS. Counseling and Testing (C/T) sites throughout Nebraska are supported by program funds provide HIV testing, preventative care and partner service assistance. The AIDS Drug Assistance Program is provided external to the Nebraska Department of Health & Human Services by the University of Nebraska Medical Center. Medical case management is provided by Nebraska AIDS Project. All other core medical and supportive care services are also contracted to community-based agencies and organizations. The provision of ADAP by a community-based clinic is unique to Nebraska. This structure facilitates collaboration between community-based organizations and the ADAP.

Needed Resources in the Jurisdiction

The need for funding to support an increase in prevention services was identified during multiple Nebraska HIV Care and Prevention Consortium (NHCP) planning group meetings. Preventative services focused on targeting online social websites continues to be significant area of need. The high cost of marketing on social websites and the influx of new social websites makes it expensive and difficult to maintain an online presence. The HIV Prevention Program has increased its online presence by advertising contact information for HIV testing and information on both social sites that allow free advertising and through the use of paid advertising.

In addition, as stated in the Statewide Coordinated Statement of Needs section of this document, transportation continues to be an obstacle throughout Nebraska but specifically more problematic in the central and Western areas of Nebraska. Individuals accessing services may have to travel several hours to see a HIV care provider. The Ryan White Program and HIV Prevention Program utilize the NHCP planning group to assist in developing and updating a Health Services Community Resource Directory that lists transportation services.

Accessible and affordable housing continues to be a need in all areas of Nebraska. With the restrictions and waiting lists for Section 8 and other government housing programs, the ability for individuals utilizing Housing Opportunities for Persons with AIDS (HOPWA) to obtain suitable housing is limited.

Part D: Assessing Needs, Gaps, and Barriers

Addressing Needs, Gaps, and Barriers

Subpart 1: Community “Town Hall” Meetings

Description of Procedures

The assessment included the planning and implementation of one statewide stakeholder meeting, followed by six regional meetings. NDHHS contracted a team from the University of Nebraska at Omaha, led by Dr. Jason D. Coleman, to coordinate and conduct this process. The meetings used a focus group, “town hall” format conducive to the elicitation of needs across stakeholder groups. Stakeholders included, but were not limited to, HIV-related prevention, care, and treatment providers; persons living with HIV; representatives of local, state, and federal entities that support HIV-related services; persons at higher risk of HIV infection (e.g., men who have sex with men, racial minorities); and other parties.

Statewide Stakeholder Meeting

A statewide stakeholder meeting was held in Lincoln, Nebraska in October 2015 at the Cornhusker Hotel. The meeting lasted approximately 6 hours, with 41 individuals attending the meeting. The purpose of this meeting was to engage stakeholders to identify HIV-related prevention, service, and treatment needs at the state level.

Regional Meetings

Regional meetings used a “town hall” format and lasted approximately 90 minutes each. Meeting locations for each city were identified following the October HIV Statewide Stakeholder meeting. Cities were chosen based on urban and rural population hubs, in addition to places with CTR and case management services. Regional meetings occurred during April and May 2016. One additional meeting was implemented at the May 2016 Community Planning and Nebraska HIV CARE and Prevention Consortium (NHPC) meeting. Regional meetings were held in public locations, including libraries, colleges, and health departments.

Locations included:

1. Scottsbluff
2. Kearney
3. Lincoln
4. Sioux City
5. Norfolk
6. Omaha
7. NHPC

The UNO team led recruitment for the regional meetings and utilized NDHHS and other sexual health organizations to help assist recruiting participants. Recruitment was conducted by the UNO team with the assistance of staff from the NDHHS staff and local organizations. Recruitment flyers were distributed in paper format and via social media. When possible, local media organizations were also asked to promote meetings in each location. Case managers were asked to invite their clients and other consumers.

The regional meetings were facilitated using a semi-structured format; i.e., when discussion led to salient topics or ideas not included in the original regional meeting guide, the facilitator followed the lead of the participants. During each regional meeting, data was recorded in written or audio format. At the conclusion of all regional meetings, all recordings were transcribed, and data were analyzed by the UNO team using qualitative data analysis methods.

Focus groups were facilitated using a semi-structured format; i.e., when discussion led to salient topics or ideas not included in the original focus group guide, the facilitator followed the lead of the participants.

Regional Meetings Participants

A total of 56 participants attend the regional meetings. Participants represented 11 Nebraska towns/cities (Scottsbluff, Harrisburg, Gering, Columbus, Lincoln, Omaha, Grand Island, Hastings, Norfolk, Bennet, Kearney) or 7 Nebraska counties (Scottsbluff, Banner, Platte, Lancaster, Douglas, Hall, Madison). Most participants reported being Caucasian (n=44, 78.6%). Other participants identified as African American or Black (n=5; 8.9%), Hispanic (n=3; 5.3%), Asian (n=2; 3.5%), Mixed (1; 1.9%), and American Indian (n=1; 1.9%). 6 participants reported an ethnicity of Latino or Hispanic. The age range was 21 to 65 years, and the mean age of participants was 45.1 years. Thirty participants were women (54.7%), 24 were men (43.6%), one participant was transgender (1.8%), and one participant was genderqueer (1.8%). A total of 9 participants (16.1%) who attended the town hall meetings reported living with HIV.

Data Analysis Plan

The guiding analytical strategy included using a qualitative, community based participatory-research (CBPR) approach to data analysis and interpretation. Each focus group was audio recorded and transcribed verbatim. Transcripts were then loaded into QSR NVivo qualitative data management and analysis software for detailed coding. Codes were based on the areas of interest from the Statewide Coordinated Statement of Needs town hall meeting guide. After coding, the project team reviewed the codes and transcripts to ensure accurate interpretation of the data. Notes from post-focus group project team meetings were also reviewed to ensure accurate interpretation of the data.

Outcomes

Outcomes are grouped by the previously identified themes of importance for the Statewide Coordinated Statement of Needs town hall meetings: HIV Service Barriers, HIV Service Gaps, and HIV Service Needs. Within each theme, data was synthesized to determine salient and key sub themes across the 7 town hall meetings. Outcomes are reported at the aggregate level.

HIV Service Barriers

Participants in the regional meetings discussed service barriers related to HIV prevention and care. HIV-related barriers were defined as obstacles to HIV prevention in the community. HIV-related service barriers were identified across multiple domains that included: social and structural, service providers, program, legislative or policy, and client.

Social and Structural

Regional meeting participants discussed social and structural barriers, which included stigma, fear, being ostracized, and cultural practices and perspectives.

Stigma

Participants most frequently discussed stigma towards HIV prevention and care in terms of denial—the perception that HIV is not an issue that impacts people in Nebraska. Many participants shared that Nebraska residents believe that contracting HIV is nearly impossible, especially in rural Nebraska, or that HIV does not exist at all in Nebraska.

One participant stated, “It’s [HIV] just something that they heard about and happens in big cities I guess. It’s not so much a concern here in rural Nebraska.” Another participant added, “I’ve heard people say that there’s not HIV or AIDS in the Panhandle [Western Nebraska]. They think we don’t have that here.” Denial creates a context of “not my problem” for many, which facilitates HIV-related stigma.

Some participants also shared the belief that HIV exclusively affects gay men. One described the perception around HIV only occurring in among gay men by stating, “Well, we’re not them [gay men]. We’re not going to get it.”

Some participants noted that the younger generation is not concerned with contracting HIV because of medical and treatment advances. Further, participants discussed that HIV is not often discussed among younger people. One reflected that, “there will be people saying HIV is on its way out... Everybody says that they can treat it and it’s no big deal.” Another participant shared his clinical experience with youth: “We have gotten a few of the younger clients that they just don’t realize what it is. It’s kind of like any other infectious disease. Give me a pill and I will be okay. It’s not that kind of a thing; it’s more difficult.”

Participants in several regional meetings specifically discussed HIV-related stigma among members of racial minority populations. Participants noted that “those communities [racial minority]... are very small so the stigma is just so much higher.” Further, participants believed that HIV-related stigma among minority populations directly contributed to a lack of service seeking, which further led to a decreased likelihood of having a controlled or undetectable viral load.

Other participants believed HIV-related stigma among some primary care providers was a major barrier for minorities seeking HIV prevention and treatment. One participant stated, “We have even have had some experiences where we have purchased insurance for undocumented individuals, but they [providers] still do not want to provide care because they do not think it is fair that they [PLWHA] have insurance.” Another participant followed that comment by stating minorities were, “...in absolute fear of the medical system.”

Fear or Shame

In every regional town hall meeting, participants discussed fears and situations that induced shame, and ultimately, prevented individuals from seeking screenings, receiving treatment, or staying in care.

The most frequently discussed fears were in regards to PLWHA disclosing their status to family, friends, or medical providers. One participant noted, “There is still so much fear about not knowing what to do or where to go. Fear of disclosure to my family. We’ve had people lay in the hospital and die [from HIV] who said, ‘No, don’t contact my family.’” Participants also noted that due to the small community sizes

across Nebraska, including Omaha, “people won’t go into their primary care provider to do screenings or talk to their primary care provider [about HIV].” Even if individuals have been living with HIV for years, participants noted that they “...are still hesitant to walk into the infectious disease doctor office [because] they might see someone they know;” may “...not feel safe;” or trust the confidentiality of the doctors because, “in the past... there is a problem with confidentiality at times.”

These fear-based barriers are amplified in rural communities. One participant reflected that “if they [local doctor] find out about that personal information about me, they will stop coming to my business or they won’t want to support me with what I do in the community because they will know too much about me.” A case manager noted that his client “...just quit a job recently because news of his diagnosis was spread throughout [the workplace] and he was ostracized.” Individuals also discussed fear as being a reason for the limited number of PLWHA who serve as community speakers. A participant noted, “In my heart, I wish that people who are HIV positive could speak out. I think that if somebody knew that they knew somebody that was HIV positive, it would break down a lot of barriers.”

Participants also discussed individuals who receive PrEP are being shamed by providers or other community members. One participant noted that, “providers think that if people are using it [PrEP], it is clearly that they are... making bad choices.” Multiple participants agreed with this statement and added that the use of PrEP leads to “slut shaming.”

Cultural Perspectives or Practices

Regional meeting participants discussed four main barriers that were attributed to Nebraska’s cultural perspectives or practices:

1. The political and religious landscape towards sexual health and HIV;
2. Lack of education and awareness of sexual health and HIV;
3. Increase in social media use; and
4. Inadequate resources for minorities living in Nebraska with HIV.

Participants discussed the impact that Nebraska’s political and religious perspectives have on sexual health and HIV. Participants described Nebraska as being “...abstinence only in public” and that they were “afraid to talk about it [sexual health or HIV] because young people may hear it.” Multiple participants believed that Nebraska’s traditional religious views prevented HIV testing and treatment, which one characterized: “I am wondering if there is a reluctance to engage in HIV treatment or prevention because of their religious views about sex?” Other participants believed that HIV prevention was not practiced in smaller communities due to cultural practices, stating, “I think cultural norms that you talk about in the smaller communities, it is seen as some of that thing that we shouldn’t do it [HIV prevention] here.” Another participant state, “We can’t even talk about sex ed in general.... so when you want to talk about HIV, it gets even worse.”

Limited exposure to HIV education or awareness was another barrier for HIV prevention and treatment. Participants believed that HIV education or awareness was not widespread throughout the State of Nebraska due to the perception that HIV is not a concern for educators or Nebraska residents. One participant stated, “There is a lack of awareness that HIV is still a concern. So, a lot of times people put it on the back burner and forget that it really exists... I worked with teachers recently that are not concerned at all.” Another participant stated, “They don’t think about it. They don’t think they’re at risk

so they don't even think about testing because they don't think they're behavior puts them at risk." Going further in regards to HIV not being taught thoroughly in the Nebraska education system, one other participant stated, "When talking to my nursing students, I ask them what they got in high school, and it is still so little. We're 30 years into this illness, and they still don't really know the basics [about HIV] coming into nursing school, and that's really sad."

Social media dating/hook up applications throughout Nebraska, like Grindr, were also discussed as rapidly growing facilitators of the HIV epidemic in Nebraska. One participant stated, "I do think it is increasing the potential for HIV in Nebraska with the increase of social media, especially in these smaller areas." Similarly, another participant described how social media impacts the spread of HIV in rural Nebraska when he noted, "The social media has opened up so many doors to these smaller areas to be able to go somewhere, meet up with somebody, and go home that night without anybody in town knowing about it... so you're going to somewhere, bringing something back to your town and spreading it as you go."

Some providers and educators raised the concerns about the inability to provide HIV prevention messages on social media applications that are intended for dating or sex seeking. One participant stated, "The web masters do not, at least on Grindr are not interested in having us on there [HIV prevention messages]." Continuing this conversation, another participant noted about his experience trying to advertise HIV prevention messages on similar social media applications when he reflected: "They'll sue you to then end of the earth if you put your stuff on there, even if you pay them... It's a tough sell... So I think that a huge barrier for us is the access to the social media and being able to advertise on social media."

Other participants discussed the intersection of Nebraska's limited resources for minorities and cultural beliefs within different minority groups being barriers for HIV treatment and retention in care. One participant stated, "Even internally, in our state, in our large division, we do not have anyone with the background and can't reach out to people [minorities]." Another stated that, "I think it is cultural too. Especially with the Sudanese and Somalians. They have beliefs that if they are feeling well, they should stop taking the meds [antiretrovirals] because you are doing ok."

Service Providers:

Regional meeting participants noted the following barriers when asked about HIV service providers:

1. Not qualified to work with PLWHA;
2. Limited locations of infectious disease doctors;
3. Retirement of devoted staff working in HIV prevention and care; and
4. Language barriers with minorities.

Not qualified to work with PLWHA

In multiple regional meetings, participants reflected that a large majority of primary care providers in Nebraska do not receive adequate education and training about HIV, which makes Nebraska primary care providers less experienced and skilled to implement evidence-based HIV services to patients. One participant stated, "I think a little bit of the education that providers get, doesn't really put them in a place where they are skilled to do sexual histories and talking with patients [about HIV]." Similarly, another participant noted, "Coming from an educational perspective, I don't know that the people that

we want to be the [HIV] providers are getting enough information about it in their training.” Specifically, in regards to primary care providers working with PLWHA, one participant stated, “We don’t have a lot of primary care providers that are experienced with working with HIV positive patients or HIV.” Another participant questioned the education that is provided in Nebraska medical schools when they said, “Along those same lines, just educating our medical school... Are they teaching about those things [HIV]?”

Further, even if providers are educated around HIV and new treatment options like PrEP, their clinics often reach maximum capacity due to the limited number of providers who prescribe or offer PrEP services. One participant stated, “There are few doctors in town or ID doctors or doctors willing to prescribe PrEP... as soon as people know someone prescribed PrEP, that person instantly has a flood of new patients.” Another participant echoed that statement, by noting that, “They [providers] are not taking new patients. They are completely full.”

Outside of primary care providers, participants discussed that there are limited providers in different supportive health sectors, like dental, eye, and mental health who are educated in HIV, or who will treat PLWHA. One participant stated, “Specifically with the Ryan White Part C funding—that is a great concern. Central Nebraska... has two dentists that are Ryan White-Part C. Eye is the same, we have one in Kearney and one in Grand Island... same with mental health.” Similarly, another participant stated, “Another barrier that a lot of consumers face is that there are very few providers that will provide dental services to the consumers that we work with.” A participant who self-disclosed that he is living with HIV, reflecting on consumer experiences with dental and eye care, stated, “Then the concern is always how other care like dentist and eye doctors and finding somebody who is a little knowledgeable about the issues of being positive. That they have to watch for things in the eyes. In general, that is a huge concern.”

Limited locations of infectious disease doctors or HIV specialists

The limited number and locations of infectious disease doctors and HIV specialists around Nebraska was considered a barrier for HIV prevention, care, and treatment. Multiple participants discussed the need for infectious disease doctors to be more accessible and available throughout Nebraska. One participant stated, “It would be nice to have more infectious disease doctors in Western Nebraska.” Another participant noted, “I find it very interesting that we have NAP here in Kearney, but the closest infectious disease doctor is an hour away.” Conversely, if individuals are able to receive HIV services from an infectious disease doctor, the client may not receive the level of care that an HIV specialist provides. One participant reflected on past conversations with clients who are living with HIV and stated, “There is a big difference between infectious disease doctor and HIV specialist. Most people would like to have an HIV specialist. Someone who understood them, understood their care... they feel the infectious disease doctor is not interested in them.”

Retirement of devoted staff working in HIV prevention and care

Regional meeting participants discussed the future retirement of devoted infectious disease doctors, case managers, or other individuals as being a barrier for HIV prevention, treatment, and care. One participant expressed her immediate concern about retirement when she stated, “One of the barriers is that in a 5, 6, 7 year period probably most of the folks who have most active with the HIV agency and IDS program in Western Nebraska will retire.” Another participant noted that he knew infectious

disease doctors who were going to retire this year and stated that, “Replacing ID docs is not easy... it gets tough... not a lot of people from out of state that want, or have the background are going to move to Western or Central Nebraska....What’s going to happen when some of these ID docs start retiring? That’s going to be huge!”

Language barriers with minorities

Participants also discussed the limited number of medical interpreters and influx of minorities in Nebraska who do not speak English as their primary language as barriers for HIV provider services. One participant noted, “The refugee population is just skyrocketing in Central Nebraska. Many different languages that NAP [Nebraska AIDS Project] is working with now.” Another participant stated, “Huge disparity. So many providers will get some support staff to do the interpreting, instead of medical interpreters [trained], and we deal with barriers then.”

Client

Regional meeting participants noted the following barriers for clients receiving HIV services:

1. Transportation (expense, time, distance);
2. Inability to navigate the system;
3. Lack of awareness about HIV resources;
4. Substance use and mental health issues; and
5. The cost of co-pays with insurance or no insurance for HIV treatment.

Transportation (expense, time, distance)

The expense, time, and distance that clients have to travel to HIV treatment appointments was one of the most frequent barriers that regional meeting participants discussed. Multiple participants noted that clients have to drive upwards of 45 to 60 miles to reach their nearest HIV testing or treatment center. One participant stated, “I have a number of people who call me, who might be 60 miles from Kearney and looking for a testing site that is close to them that offer similar services like NAP... they may not be comfortable going to a local doctor.” Another participant discussed the frequent appointments clients must attend as contributing transportation barriers when they noted, “The consumer’s appointments are in this group, this group, or that group, instead of the combination from general care and the interlinking of care. So they have to take more trips, which creates more problems – time, travel, cost and the whole works.” When describing his personal experience and experiences of other HIV positive individuals in regards to transportation, one participated stated, “For folks without a car, it is a nightmare. It really is.”

Inability to navigate the system

Regional meeting participants discussed that clients often have a difficult time navigating through the health care system, which creates barriers for clients accessing HIV services. One participant stated, “The health care system for anybody new, and just finding out what has happened to them is overwhelming in itself and then now trying to navigate and go through the system... that is a huge barrier.” Another participant noted, “The system can be so complex that I’ve got clients I’ve worked with for 16 years who can’t tell you the difference between Ryan White, Part B, ADAP.” A case manager

believed that clients had to be in contact with NAP if they would be successful in navigating through the system when he stated, “I think once you get outside of the Omaha/ Lincoln area... It’s imperative to be in contact with the NAP office because you have the barrier of distance and timeliness... If you can find us [NAP], if you can get into the system, it’s great. There’s a multitude of things we [NAP] can do in each of those areas, but it is making sure you are able to find that system because you might be 200 miles from the office.”

Lack of awareness about HIV resources

Participants throughout the regional meetings believed that clients were unaware about HIV resources, as well as misinformed about the cost of HIV. One participant, when reflecting through clients perspectives, noted, “People are like it is too expensive; I can’t afford it... There is just a lot of misinformed information out there about what it is, how it works, and sort of like, not like enough people talking [about HIV].” Another participant stated, “We start to see people in the rural area say that it is going to cost too much. I do not want to do this.” Participants also were concerned that clients are simply not aware that HIV services exist in Nebraska. One participant stated, “As far as Kearney, most people don’t know that Nebraska AIDS Project exists.” Another participant concluded that clients lack the, “Awareness of the fact that service is here and that early intervention is key... I don’t think anybody should be entering care in late stage anymore, but we still see it.”

Substance use and mental health issues

Mental health and substance use were also discussed as contributing barriers for clients not seeking or sustaining HIV services. A participant stated that, “Depression has a huge impact for consumers getting lost to care.” Another participant, discussing why participants get lost to care noted that it was due to, “Substance and mental health issues or just lack of support systems.” One participant also brought up the limited locations for social support groups, specifically for young person living with HIV. The participant stated, “They [young PLWHA] want to talk about other interests, than just HIV. They don’t want to go to a meeting in that area because the people in that area are older and they are young... so they end up driving 2 to 3 hours to Omaha or Lincoln groups and not going as much as they want or stop going.”

Cost of co-pays with insurance or no insurance for HIV treatment

Several participants in the regional meetings also discussed the impact of clients either not having insurance or clients having to cover the co-payment costs as barriers for receiving HIV services. One participant stated, “If you don’t have insurance, you essentially don’t have access at all.” Another participant, reflecting on the cost of co-payments stated, “To try and come up and pay for the co-pay and then the mental health part of becoming positive. It is kind of a shock. Because it’s just something else that can really burden someone that does not need this mental anxiety to help lower, say their counts, because stress can really relate to HIV.”

Program

Program-related barriers to HIV services in Nebraska identified by regional meeting participants included:

1. Limited funding;
2. Staff capacity; and

3. The distance it takes case managers travel in Central and Western Nebraska to access clients.

Limited funding

Regional meeting participants discussed that one of the largest barriers that HIV service organizations faced was the scarcity of funding for prevention, education, and advocacy, both in local communities and state-wide. A participant passionately said, “These programs at CAPWN and NAP have given so much of their own funding to these programs, they can’t do it anymore. All of their budgets have been cut so dramatically that they just can’t give anymore.” Other participants were angered and questioned the current distribution of HIV program funding, which is not disseminated to locations across the entire state. One participant, referring to funding not reaching all locations equally, stated, “Woah, there is the wall of Nebraska.” Another participant noted, “But a lot of our resources for prevention end up in Omaha because of the way some organizations are structured and their resources do not always make their way to Lincoln or other locations.”

Staff capacity

Due to budget cuts and limited funding, regional meeting participants believed that current HIV organizations were at staff capacity. One participant stated, “The problem is there is no funding for them to do the work they do every day... If we had that funding to be able to give them what they need, to be able to expand the programs, and to do the outreach—do the programs the way they are intended to be ran—it would be phenomenal!” Multiple other participants firmly stated that an increase in case managers was needed. A participant reflected on the current job requirements for a NAP case manager: “One of NAP’s case managers is supposed to be a part-time case manager and a part-time fundraising, education, outreach person. Well at this point, that position’s caseload is pretty close to 30, so they can’t do the prevention, education, and the outreach the way he needs to do it because of the caseloads that they have. So they can’t abandon the clients to prevent. And they can’t prevent without more staff.” Another participant believed, “one of the other barriers is that we used to be able to fund community health educators to go out and educate the community. Now there is no longer funding for the specific education piece, so we are lacking in the education around HIV.”

Participants also were concerned that their limited funding supports costly language services. Due to the limited presence of medical transcribers throughout Nebraska, a participant stated, “We deal with barriers for accessing pharmaceutical assistance for them [non-English speakers]. The case managers become the entity that calls in their meds every month or they are calling NAP and NAP has to utilize language support services, which is expensive.”

Traveling Distance

Several regional meeting participants also discussed the distance that HIV service providers had to drive to reach all of their clients. A participant, reflecting on the territory where her clients live, stated, “We have them scattered throughout all 11 counties and trying to see all of those people and meet all of their needs that is very difficult. The miles we have to put on trying to meet the needs of everyone in the Panhandle; it’s very difficult to do that.” Similarly, another participant also said, “I just have one more barrier... throughout the Panhandle, the vast area we have to travel to provide services or for those seeking services.”

Legislative or Policy

Regional meeting participants discussed four main legislative or policy barriers:

1. Cost of care for PLWHA who do not meet income thresholds for public assistance;
2. Medicaid expansion;
3. Comprehensive sex education; and
4. Support for PLWHA who relocate to Nebraska.

Cost of care for PLWHA who do not meet income thresholds for public assistance

Regional meeting participants discussed the auxiliary service expenses associated with HIV as a detrimental burden for clients seeking and sustaining HIV services, particularly for those PLWHA living above the threshold for public support, yet who cannot afford services. One participant stated, “There are no resources currently in our area to assist people with the cost of doctor’s visits, initial consultation, the lab work they need to have, and we then refer them to specialist. But as soon as they get the first bill for \$1000 or more, they’re freaking out and calling me going, ‘I can’t afford this. How can I afford this?’” Other participants perceived the system as being a cost burden for individuals who do not receive assistance. One participant, expressing his frustrations with this legislative barrier, reflected: “We are discouraging them from getting a job and insurance. If they don’t have a job, they don’t have insurance, we’re like, ‘Don’t worry. We’ll pay for it.’ But, if you have a job and you’re working on whatever you need to do for your family or whatever, we want you to pay. Then we want you pay for your deductible and your out of pockets. To me that makes no sense.” Another participant also noted, “Most insurance lacks dental and eye care.”

Medicaid Expansion

The State of Nebraska opted not to expand Medicaid, which is a contributing barrier for those living with HIV. One participant stated, “I think we need Medicaid expansion to have better access to health care so people can get in care, get tested, and then have access to PrEP if they need it through Medicaid.” Another participant, when discussing why more people are not seeking or sustaining HIV treatment, noted, “A lot of people need Medicaid expansion.” Similarly, another participant said, “If Medicaid could be expanded, we really need that.”

Comprehensive sex education

Regional meeting participants also discussed the lack of uniformity of school guidelines in Nebraska for providing comprehensive sex education or sexual health education. One participant stated, “Even if it is comprehensive, each school has it own way of teaching it. Each teacher puts [his or her] own spin or who knows what actually gets instructed.” Another participant, when discussing why Nebraska did not conduct more HIV education and prevention in schools, noted, “I think the political climate has a lot to do with keeping people from instructing it.”

Support for PLWHA who relocate to Nebraska

Some participants noted that the federal regulations which dictate funding based on newly diagnosed individuals within a jurisdiction negatively affects Nebraska due to people who have been diagnosed in other jurisdictions moving into the state. One participant stated, “The new population that we see moving here are typically not diagnosed here. A lot of them were diagnosed either prior to coming to

the US or right after entry into the US. Again, we're not seeing those dollars." A PLWHA who recently moved to Nebraska from California, noted, "I want to make sure that the money that San Francisco is getting is coming back here to Nebraska... I think that it is important because the amount of money that is spent on me through Nebraska is now from Nebraska pocket's not from California's." Similarly, a participant stated, "Sadly, the diagnosis state is the state that receives the finances."

HIV Service Gaps

Regional meeting participants discussed service gaps related to HIV services. HIV service gaps were included discussions about how HIV prevention, care, and treatment services fall short in the community. HIV service gaps were expressed across three areas: HIV prevention, HIV care, and HIV support services.

HIV Prevention Gaps

HIV prevention gaps included:

1. Funding limitations;
2. Education, communication, and partnerships among health sectors; and
3. Limited education and awareness about PrEP.

Funding Limitations for Prevention

According to the regional meeting participants, the limited funding that is available for HIV prevention efforts greatly determines that amount and type of prevention activities that are facilitated throughout Nebraska. One participant stated, "As far as funding for outreach and education, it is limited to testing and screening so we don't do a good job."

Similarly, some participants believed Nebraska does not provide enough education or awareness about HIV to all health sectors and residents of Nebraska. One participant stated, "We see a few activities throughout Nebraska on HIV Awareness Day, but nothing really after that." Another participant, when reflecting on prevention efforts in rural Nebraska, noted, "On a scale of 1-10 in rural areas it is about half a point. I don't think it quite makes it up to one."

Due to the limited funding and current HIV organizations nearing or at staff workload capacity, one participant noted, "I would say the prevention efforts have dropped off as a result of it being the responsibility of the agencies and entities that already have a ton of other responsibilities." Another participant responded by saying, "As far as funding for outreach and education, it is limited testing and screening so we don't do a good job." One participant, when discussing the difference between past and current prevention efforts in Nebraska, stated, "We used to have radio and TV advertisements, but I don't hear or see them anymore." Another participant, commenting in this same discussion, stated that, "HIV educational speakers are less likely to occur at different civic organizations and schools."

Education, Communication, and Partnerships among Different Health Sectors

Regional meeting participants identified a gap in HIV prevention in regard to the education that providers in different health sectors receive and the communication that occurs between providers, as well as communication between providers and patients. One participant stated, "There is not enough education for mental health and substance use professionals [about HIV]." Along with the lack of

education about HIV in other health sectors, another participant discussed that HIV education and access to testing is not being completed in substance abuse centers and programs, when he noted, “The substance abuse programs provided HIV education and access to testing and that used to be very well done in this area with the mental health centers and a few of the other specialty programs and the detox centers, however... in the last couple years, it has sort of fallen off as not a priority to them and we’re short on man power to go and do it... so it’s kind of a mutual falling away.”

Other participants were concerned that communication about HIV testing was not being facilitated by primary care providers adequately and the lack of partnerships between organizations created a gap for HIV prevention efforts. One participant noted, “I don’t know if doctors or providers are not doing good screenings or just the stigma of HIV. I think that’s one reason we still have it [HIV transmission] is because folks aren’t knowing until they’re very, very sick and they’re infectious and possibly infecting other folks. The cycle continues.” Another participant, when discussing partnerships between HIV organizations and other health sectors, stated, “I do not think there is any conscious effort group wise.” Similarly, a participant also noted, “We have the NAs [Narcotics Anonymous], the CMAs [Crystal Meth Anonymous], there are those kinds of groups, but we do not even partner with them that I know of. I do not hear anyone partnering with those groups or offering some testing options.”

Awareness and Education about PrEP

Regional meeting participants discussed awareness and education about PrEP among both Nebraska residents and providers as a gap that currently existed in HIV prevention across the state. One participant, when discussing the education level about PrEP stated, “That is a very uneducated topic in Central Nebraska.” A participant also reflected: “PrEP is new coming, FDA approved it in 2012, but as you see like everything here [in Nebraska] it takes time to slowly spread out to the more rural parts of the country and I think also on perspective wise, helping people understand what it is and how it works.”

Other participants believed that access to PrEP was a gap, even if patients and providers were educated and understood how to implement PrEP, it may not be accessible in pharmacies or due to not having insurance. One participant stated, “I think access to PrEP is a gap.” Another participant, discussing access to PrEP being a gap, noted, “I think we can write prescriptions for it and do the medical care around it, but we are not going to stock it in our pharmacy.” A participant, discussing Nebraska residents, stated, “They’re hearing about and hearing this is an option and this is available, however if you don’t have insurance you don’t have access to it.”

HIV Care Gaps

Participants highlighted multiple service gaps related to HIV care in Nebraska. These gaps characterized how HIV care and treatment fall short. Regional meeting participants believed that the limited number of HIV medical specialists and HIV services across Nebraska was the primary gap in HIV care across Nebraska, as well as an incongruence among providers for patients. One participant, when reflecting about the need for holistic needs of a client, stated, “He [client] wanted to make sure he was going to something where’d he could eat lunch and talk about dentist and dental [care] and not just a mental health support group.” Another participant continued by noting, “The need to get all services connected... Our hope at some point is that we have a primary care doctor who is dealing with everything instead of it being a doctor in Omaha and doctor over here, doctor over there.” Similarly,

one other participant stated, “Not everybody that comes in to test is from this area...I am not familiar with who to connect them with in their home community.”

Even if patients are receiving care from an infectious disease doctor, participants believed they did not have adequate options for determining who cared for them and feared the worst if they lost their provider. One participant, reflecting on his own personal experience, stated, “You ain’t finding nobody else who knows you even if you don’t like your ID doc. You won’t probably leave if things are a little shaky because you can’t trust the next guy is even going to care of you as much as this person. Consumers are extremely worried about losing the providers that have been there from the get-go for them.”

HIV Support Service Gaps

HIV support service gaps reported by participants included limited social and mental health support systems and transportation.

Limited Social and Mental Health Support Systems

Regional meeting participants discussed the gap in social groups and mental health services that existed throughout Nebraska. Multiple participants discussed the limited opportunities for social support engagements for PLWHA, their families, and their friends. One participant stated, “As far as mental health goes, there are not mental health support groups in my opinion.” Another participant noted, “We do not have support groups like we used to.” Similarly, another participant said, “One thing I am concerned about is support for people and their families that are HIV positive—just social, emotional stuff.” A participant also believed that social workers in Nebraska communities did not receive adequate HIV training or education when they stated, “We have social workers in every gamut. Throughout our community... anyone working in social services arena should have some sort of education. You should have on a variety of things. It is something [HIV] that is not ever really mentioned.”

Transportation

Transportation was also discussed a gap for clients being able to access HIV services by regional meeting participants. Participants discussed the limited amount of public transportation or transportation assistance to reach services that are needed, but not located within their community. One participant, when reflecting on Central and Western Nebraska, stated, “We do not have access to really anything. There is no public transportation in those areas.” Another participant, when discussing transportation as a gap, noted, “I think that transportation to that true specialist care that cares about unique patients... is limited in general... the geography makes it a challenge.”

HIV Service Needs

Regional meeting participants believed that a variety of HIV prevention and care services were needed to improve HIV services throughout Nebraska. HIV service needs were defined as resources that would improve HIV prevention, treatment and care services in Nebraska. Primarily, participants discussed needs around HIV prevention and HIV care.

HIV Prevention

HIV prevention needs discussed by regional meeting participants included:

1. Increased condom distribution and HIV testing;
2. Greater HIV awareness and education throughout all health sectors in Nebraska;
3. Statewide coordinated efforts between substance use, mental health, and HIV/STI providers;
4. Unified statewide HIV prevention message; and
5. Utilizing social media for HIV prevention.

Participants expressed that residents of Nebraska would benefit from increased HIV and STI education and prevention efforts throughout the state. Prevention efforts named included both structural strategies (e.g. condom distribution and testing) and awareness and education activities.

Increased Condom Distribution and HIV Testing

In every regional meeting, participants discussed the need to increase in the number of locations that offer condom distribution and HIV testing throughout Nebraska. Multiple participants stated that condoms or HIV testing were needed at more public locations, other than just at health departments. One participant stated, "I think if condoms were more available at places... and not just at health departments... condoms just need to be around at more places. Even just more free condom spaces." Other participants discussed specific locations for HIV testing or condoms to be facilitated that included: Boys and Girls State, Prisons, Rotary Clubs, Alternative Schools, Youth Rehabilitation Centers, YMCA, YWCA, and Churches. One participant, when reflecting on what he believed was needed for new locations to be successful at implementing HIV testing, stated, "I just think that rapid testing is super important for people... people come in they want their test results immediately... not by a letter in the mail, phone call. So easy testing, affordable testing, confidential testing, is important!"

In addition to needing more public HIV testing and condom locations, multiple participants also described the need for in-home testing due to the stigma in Nebraska that exists around HIV. One participant stated, "I think that if you're dealing with a population that wants to [get tested], but they don't. Especially in smaller communities where they know folks and they don't want to go where everybody goes. Then the in home testing is a great way." Another participant, when asked why in-home testing would be beneficial for a state like Nebraska, noted, "It just takes away that step of having to go somewhere and dealing with who's going to see you and having to say, 'Can I have an HIV test?' Then you also have the risk of your doctor saying, 'We don't really do that here' or 'You need to go to the Health Department.'"

Greater HIV Awareness and Education

Regional meeting participants frequently discussed that Nebraska would benefit from an increase in HIV awareness and education campaigns throughout all health sectors in Nebraska. One participant, when discussing Nebraska HIV prevention needs stated, "Spreading awareness but also encouraging that broader education standpoint of knowing your risks and not being afraid of talking to someone about it. Whether it is a publication, a poster, or something on their wall. Maybe they won't get tested in their provider's office because they don't feel comfortable doing it there but if they see a sign that says here is a list of places I can go get tested." Another participant, noted, "I think before we can have a voice in prevention, we have to educate first." Participants were worried about HIV prevention education

occurring more frequently in the future, as numerous participants stated that they did not receive adequate HIV prevention funding and current, passionate HIV staff workers are on the verge of retirement with no replacements in sight. One participant stated, “We don’t get that funding. It’s a real challenge and is needed.” Another participant, specifically discussing Central and Western Nebraska noted, “Most of us in this room are aging now... what we need are a new group of folks with commitment and passion.” One other participant contributed a solution to the Central and Western Nebraska HIV future employment needs when she reflected: “Maybe the next generation one of the things we need is training for that next generation. Not just training for providers but for that next frontline.”

Participants throughout the regional meetings also believed that one of the missing prevention pieces was statewide comprehensive sexual health education. One participant stated, “I would say if we can find a bridge that can close a gap from the political side so that we can have a universal form of educating people, it would probably decrease the amount of time we spend treating gonorrhea, chlamydia, syphilis, and also HIV.” Multiple other participants discussed their fear of Nebraska youth not viewing HIV as a concern anymore with the recent advancements in HIV medication, and thus, needed education around HIV. One participant stated, “It goes back to that someone needs to have the education at the youth level... it is not a big deal to a lot of youth anymore.” Similarly, another participant noted that the youth needed, “general awareness... what their risk are... and more open conversations.”

Regional meeting participants also believed that Nebraska communities, residents, and providers needed increased PrEP awareness and education. One participant stated, “Well I think everyone needs to be educated more about PrEP. Every single community member needs to know more about it [PrEP], so they can help tell people.” Multiple other participants were concerned that providers in Nebraska did not have adequate education around PrEP or PEP and therefore were less likely to implement these treatment options to patients. One participant stated, “You need to get in the information out there that it [PrEP and PEP] exists. For PEP, you need to let them [providers] know it is intended for emergencies.” The same participant continued by discussing the type of education that providers may need towards PrEP and PEP treatment when they stated, “I think you would also have to work on the social dimensions... correcting the misperceptions about the long term use... a lot of myth busting, like around if it is bad for someone to take and a lot of myth busting around the shame and compensation.” Similarly, another participant noted, “I have been looking at and trying to follow or at least get the information on PrEP. We need to get providers on board with this PrEP.”

Statewide Coordinated Efforts between Substance Use, Mental Health, and HIV/STIs.

Regional meeting participants were highly concerned that Nebraska did not coordinate efforts adequately between substance use, mental health, and HIV/STIs providers. One participant stated, “We need a better collaboration between substance abuse and mental health providers.” Another participant, discussing her perception in regards to the current collaborative efforts throughout different health sectors in Nebraska, noted, “Our mental health and substance abuse, HIV prevention/AIDS, don’t collaborate very well together. That includes Medicaid too.” Likewise, another participant discussed the dichotomy of HIV services related to intravenous drug users and stated, “We do not partner with the treatment providers very well.” Several other participants believed funding was needed to help expand the collaboration between HIV and different health sectors. One participant

noted, “We need funding and expanding that comes under specialty care like neurology, psychiatry, mental health, ophthalmology.”

Other participants believed that new HIV prevention services needed to be extended and partnered with HIV services outside of Omaha and Lincoln. One participant stated, “What we need then is for programs in the Omaha and Lincoln as they are developing and innovation is occurring to think of us [Central and Western Nebraska organizations]. Another participant perceived that there was a loss of connection between different HIV service organizations that are available throughout the state for HIV efforts when they noted, “Here is this overall thing that we should know about HIV or AIDS, but then there is no connection, like here are the services that are available.”

Unified statewide HIV prevention message

Regional meeting participants described the necessity for a unified statewide HIV prevention message. One participant stated, “We do not have a statewide message and I think that is something that we could work on. We have talked about it and everyone should be saying the same thing. No matter how it is funded, it should all be one statewide message.” Similarly, another participant noted, “I think a unified message is definitely missing.”

Participants also discussed more specific messaging strategies that they believed were needed to include in the statewide message. One participant stated, “It needs to be the right message. Concerted, coordinated, uniformed implementation strategy and message.” Other participants believed that HIV sub-messages specific to certain populations were also needed. A participant noted, “I wonder if there just needs to be a multi-pronged approach where maybe we have one overall message, but then we have sub-messages and sub-target populations.” Likewise, another participant stated, “It’s the balance between finding a message, but also from the feedback we’ve heard, having relatable messengers specific to populations.”

Utilizing social media in HIV prevention

In every regional meeting, participants described the need for HIV prevention messages to be disseminated through social media. Participants believed that social media was the most effective outlet for reaching and connecting with different populations throughout the state. One participant, describing the reach of social media, stated, “That is what the young people are into. With Facebook you can hit a large group. And you can show them locations for testing in their local area.” Another participant noted, “We need a better strategy, or a strategy, using modern technology that is something that people relate to and how they get their messages now.” Other participants believed that HIV prevention messages utilizing social media would be more visible and resonate with Nebraska residents. One participant stated, “There’s so much leverage you might have in social networking that you’re not going to get anywhere else. Just the massive amount of people by one click that you can impact.” Similarly, another participant discussed the importance of social media in Nebraska when he noted, “I don’t think that it’s something that people talk about [HIV prevention]. It is something that is pushed aside... more social media... I don’t want to say constant reminders, but kind of.”

HIV Care

Regional meeting participants described several important HIV care needs, including:

1. Increased HIV staff capacity;

2. HIV education for consumers and providers; and
3. Easy access to services.

Increased HIV staff capacity: case managers and HIV specialists

Participants frequently discussed needing more HIV case managers and HIV specialists throughout Nebraska, especially in Central and Western Nebraska. One participant stated, “I think support for the AIDS project and to have case managers... Kearney needs an additional case manager it sounds like.” Another participant discussed the benefits of having an adequate amount of case managers when she noted, “It’s nice to have someone... follow up on medication adherence and things like that.” One other participant, discussed her concerns about committed case managers and other HIV staff reaching retirement age in Western Nebraska and what solutions were needed to remedy the situation, noted, “The point being, trying to figure out some sort of secession... how do we engage other folks in our clinic, in our networks, who are going to start cross training and going to be able to take over some of this work. The point being, there is a real committed group of folks here, it’s what makes us strong, and it’s also one of the biggest weakness in terms of care.”

Specific to the accessibility and number of HIV specialists in Nebraska, several participants discussed Nebraska residents needing more options or locations of HIV specialists throughout Nebraska. One participant stated, “There is a dearth of providers, so you can’t be picky and chose. But in Omaha, there is possibilities.” Another participant, when reflecting through his own experiences navigating through the system, discussed what HIV consumers needed in Nebraska when he noted, “To make sure that people know where to get care and that there is choices on where they can go for care... Choices in services matter. If there is only one person who does it, or even two people who do it... that would be a serious barrier.” Similarly, another participant stated, “There is just one infectious disease doctor around here, I know there was a doctor from Omaha going to Columbus.”

HIV education for consumers and providers

Regional meeting participants believed HIV consumers were in need of increased HIV education opportunities, in order for them to navigate through the system more effectively. One participant noted, “We need people to help navigate the systems. It is so difficult to try to figure out where they need to go, what they need to do and what paperwork they need to fill out and what hoop they need to jump through.” Similarly, a participant stated, “A huge barrier is the lack of dumbing down the system for people who really need it.” Another participant, discussing the difficulty for HIV consumers to understand and utilize insurance correctly, noted, “You can give them [HIV consumers] insurance and give them a Blue Cross Blue Shield card... but it will not do them a whirl of good if they do not know how to use insurance... One of the biggest things is meeting people where they are at [in the system] and to fill in those gaps.” One solution that participants believed would benefit consumers would be the creation of HIV community support groups. One participant noted, “If we could have community or advisory groups that is made up of consumers... people would be able to find out where others go, where they go for treatment, what does it cost; it’s just a good way of networking, too.”

Regional meeting participants also believed that Nebraska would benefit from creating and facilitating training opportunities for all providers who may work with HIV consumers. One participant stated, “We need to incorporate more into training of at least healthcare people... social work, education, or case

management... but definitely in healthcare... nursing doesn't get that much exposure [HIV] in general." Likewise, another participant proposed a solution for increasing provider trainings in Western Nebraska when she noted, "If we had something at the hospital or regional conference for medical providers, nurses, and dieticians, at maybe the Civic Center and bring in some speakers maybe a day or day and half meeting. Most people come from Chadron and towards from Wyoming and talk about the progress we've made and it wouldn't take much money to do that. If we could get that on an annual or semiannual or even two-year basis we could get that education out there. You know you have new doctors and new nurses out there."

Easy access to services

Regional meeting participants, outside of Omaha and Lincoln, commonly mentioned that statewide transportation services were needed in order for HIV consumers to access and sustain in HIV treatment or care more easily. One participant stated that Nebraska needed to, "identify statewide transportation providers." Similarly, another participant noted, "We cannot lose our transportation service moneys, because we have so many people traveling... If we don't keep ahould of that... they just can't afford to travel." Other participants believed that centralizing locations of different health sectors would reduce several barriers that often occur in HIV consumers. One participant reflected, "Having everything right here will definitely make things a whole lot easier for people, because if they could have all of their care in one place instead of working with 5 doctors... a central location... would eliminate the issue of traveling and having to take a day off of work just to go to a five-minute appointment."

Other participants believed that providing or paying for transportation from Western Nebraska communities to access services in Lincoln or Omaha was not the most conservative way to utilize the already limited resources. Instead, several participants discussed alternative ways to access services that are closer for providers and patients. One participant noted, "We're so much closer to Denver than we are to Omaha. I don't know if we look at regional efforts... but it makes more sense to use the AIDS Patient Training Center out of Denver. It's half the distance to come and half the time than Omaha." Similarly, another participant, when discussing closer places to access HIV treatment or care services, stated, "There's population base and bigger population bases in Cheyenne, Rapid City, Casper, Denver, and Fort Collins, all of those are closer than Omaha or Lincoln. So if there's ways for us to make more natural use of those maybe we should."

Summary

Stigma permeates the environment surrounding HIV in Nebraska, which contributes to continued challenges for the engagement of people in the HIV prevention, treatment, and care systems. Continued challenges are the determination to not expand Medicaid and resistance to the adoption of comprehensive sexuality education curricula in schools across the Nebraska. Salient cultural and religious beliefs further stigmatize behaviors that may lead to HIV transmission or people who are living with HIV, which foster an environment of testing avoidance, fear of disclosure, and shame.

More HIV awareness and education are needed throughout the state, particularly in areas outside of Omaha. Lack of knowledge about HIV is not uncommon in Nebraska, and this lack of knowledge likely drives stigma and policy development that is not supportive of HIV prevention, treatment, or care. Traditional educational approaches, along with structural approaches like condom distribution, must be strengthened. New challenges, particularly in the area of social media and biomedical prevention,

present new opportunities for new strategies for addressing HIV. Support must be provided for staff to learn to use new media. Most medical providers in Nebraska will not prescribe PrEP, so there is a great need for provider education.

For people living with HIV, challenges in navigating the treatment and care system continue to be a reality. For many, access to medical or other services is difficult due to the geographic distance from providers or case managers. Transportation remains a barrier to care for many. The lack of providers creates additional challenges for consistent care, particularly in Western Nebraska. The aging and forthcoming retirements of current providers is a concern that must be acknowledged. The rapid influx of immigrants who bring diverse cultural practices and languages is a growing concern for service provision.

Needs exist across all ecological domains in Nebraska. Systems and organizations would benefit from strengthening services, expanding access, and focusing on services coordination. Communities would benefit from increased, culturally appropriate engagement by well-trained staff. People living with HIV and their support networks would benefit from increased psychosocial support, easier access to care, and better knowledge of support services. A unified, strategic approach that includes intervention at all ecological levels will ultimately address HIV-related stigma, which is among the greatest challenges to HIV prevention, treatment, and care.

Subpart 2: Ryan White Provider Surveys

Description of Procedures

A survey instrument was developed based on a review of provider surveys from states in the region. Providers advised staff that electronic administration was the preferred method. The survey was uploaded into the online platform, and the survey link was disseminated to providers in January, 2016. The survey remained available to providers for one month.

Results

The current findings reflect results of the 2016 Ryan White Statewide Coordinated Statement of Need (SCSN) provider survey to assess the needs of Ryan White providers in Nebraska. Providers representing various organizations responded to the survey. Significant heterogeneity was found in the number of years their organizations have provided HIV/AIDS-related services (range: 1 to 30 years) and the number of clients/patients served each month (10 to 1000+). The majority of respondents were medical providers providing care at a health clinic.

Half of the (n=12) providers indicated their organization works with specific populations (i.e., race/ethnicity, gender, age groups, special needs, etc.). Listed below are the specific populations:

- MSM (4)
- People of color (3)
- Newly diagnosed
- Transgender women
- People living with HIV (3)
- Refugees (2)
- IDU
- Women

Table 52 Provides a summary of providers by type. Table 53 provides a description of the agencies by type, and Table 54 provides an overview of most frequently provided services.

Table 52: Providers by type, Nebraska, 2016

Practitioner Level (check all that apply)	n
Medical Provider (physician, nurse, etc.)	12
Part C Provider	3
AETC Provider	2
Member of a Federally Recognized Indian Tribe	0
Case Manager	8
Consumer of Ryan White Services (Client)	0
Other Provider	1
Advisory Board Member, Non-Service Provider (NHCP)	2
Health Department Staff	0
Other	3

Table 53: Agency description, Nebraska, 2016

Agency Description (Choose one response only)	% (n)
AIDS Service Organization	25.0% (6)
Health Clinic	45.8% (11)
Hospital	12.5% (3)
Community-Based Organization (not AIDS specific)	4.2% (1)
Multi-Service Agency, including HIV/AIDS services	8.3% (2)
Treatment Facility	4.2% (1)
Dentist	0
Other	0

Table 54: Most frequently provided services, Nebraska, 2016

Most often provided services*	n
Medical care	17
Dental care	3
Case management	17
Substance abuse	3
Counseling/mental health	5
Food distribution/nutrition	5
Access (e.g. child care, transportation)	9
House	5
Benefits/financial assistance	11
Family services (e.g. respite care, kinship care, legal assistance)	0
Other	1

*Check all that apply, no percent calculated

A little over one third (n=8) providers indicated their organization had training in trauma informed care. The majority (n=18, 78.3%) were interested in opportunities for training/cross-training with other HIV provider organizations or forming an HIV Care Collaborations Team, however, three respondents were “not sure” and two responded “no”.

Providers ranked 18 services 1 to 18 in the order of importance necessary to support consumers in the state of Nebraska (1 is highest, 18 least high). Provider rankings varied considerably, therefore the top 5 services are presented below with the percent of providers who chose the service in their top 5 most important services.

1. Access to care (n=15, 71%)
2. ADAP (n=13, 62%)
3. Insurance health premiums (n=10, 53%)
4. Prescription costs (n=9, 45%)
5. Mental health (n=7, 35%) and Housing (n=7, 35%)

Several of the providers (n=13, 65%) indicated there are needs not currently being met by the RW Part B and C programs in Nebraska. Listed below are the specific unmet needs:

- Clients do not qualify for certain medications (2)
- Actual transportation services (3)
- Access to Case Manager services
- Pet services/ animal care
- Client education opportunities
- Translators
- Car repairs
- Primary care for diabetes and other reoccurring issues
- Substance abuse treatment
- Housing assistance
- Coverage for medical appointments for preventative care
- Furniture assistance
- Dental coverage
- Hormone Replacement Therapy coverage
- HIV testing
- High deductibles/ Co-pay assistance for those using employer's insurance (3)
- Hepatitis C treatment coverage
- More comprehensive care

The following barriers to care come to the provider's mind for persons living with HIV/AIDS?

- Substance use (3)
- Stigma (6)
- Unemployment
- Homelessness/ Housing (2)
- Mental health issues (2)
- Transportation/Distance (4)
- Child care
- Financial barriers
- Telecommunications
- Language
- Limited providers (2)
- Fears of treatment
- Poor primary health care access
- Limited insurance coverage
- Inefficiency of mail order pharmacies

A few providers (n=3, 14.3%) indicated there is not an effective process in place linking care for HIV+ individuals. Listed below are suggestions on how to improve this process:

- Linkage between testing sites/ state EPI program and care providers
- Have Ryan White applications at testing sites

- Referral to doctors at testing sites
- Trained counselors to give results to clients
- Better communication between UNMC and NAP
- More referrals made to NAP
- More supportive services
- Better linkage between UNMC and patients outside of their care, especially for those outside of Omaha across the state
- More training
- More collaboration
- Resource Development

Providers were asked to rank methods of implementing Early Identification of Individuals with HIV/AIDS (EIIHA):

1. Peer outreach
2. Minority outreach
3. Intensive case management
4. Other
5. Contractual agreement

“Other” was specified as:

- Comprehensive sexual health education reform in public schools
- Education in non-traditional settings in order to reach high risk populations
- I don't have an answer
- Internet/website interface

Two providers indicated effective collaboration and coordination of care does not exist between the RW Part B, Part C and other HIV-related service providers in Nebraska? Listed below are suggestions on how to improve:

- Stream-lined process and tiered like Iowa
- Better communication (3)
- Periodic visits

Providers rated the effectiveness of components of the Ryan White program. Overall, 45% of providers rated the education provided to case managers on new issues as “good,” “effective,” or “very effective,” while 40% rated the program as “fair,” or “poor.” Thirty percent of providers were unsure.

Thirty percent of providers believed that the program did a “good” or “effective” job of educating or ensuring that education was provided to consumers about RW program services. Forty percent rated this service as “fair” or “poor,” and 30% percent were unsure.

Forty-five percent of providers indicated that the Ryan White program does a “good,” “effective,” or “very effective” job in dealing with the gap coverage in rural areas, while 20% believed that the program

did a “fair” job. Forty percent were unsure. Table 55 provides a summary of provider perceptions of program services.

Table 55: Program effectiveness, Nebraska, 2016

	Very Effective	Effective	Good	Fair	Poor	Not sure
How effectively is the NE RW program educating or ensuring that education is provided to case managers on new issues related to case management and consumer care and treatment?	5.0% (1)	20.0% (4)	20.0% (4)	25.0 % (5)	15.0% (3)	30.0% (6)
How well is the Nebraska Ryan White educating or ensuring that education is provided to consumers of RW services?	0	15.0% (3)	15.0% (3)	25.0% (5)	15.0% (3)	30.0% (6)
How effectively is the Nebraska Ryan White Program dealing with gap coverage in rural areas?	5.0% (1)	20.0% (4)	15.0% (3)	20.0% (4)	0	40.0% (8)

Additional feedback

- ADAP/ RW service mostly used for medication access and medical bill coverage
- There is apathy among those living with HIV in Nebraska making it difficult to get people to participate in education and advocacy
- Happy with the support their clients currently receive
- NAP case manager educates clients
- Always room for improvement

Subpart 3: Ryan White Client Surveys

Description of Procedures

Client surveys were developed after a review of surveys used by other states in the region. The final survey was provided to case managers from the Nebraska AIDS Project and the University of Nebraska Medical Center for distribution to clients. A total of 245 surveys were mailed to case managers for distribution, along with self-addressed, stamped envelopes for survey submission. An electronic version of the survey was also created. The survey was available in both English and Spanish. Surveys were completed between January and February, 2016.

Results

The current findings reflect results of the 2016 Ryan White Statewide Coordinated Statement of Need (SCSN) survey to assess the needs of Ryan White clients in Nebraska.

Socio-Demographic Characteristics

A total of 107 individuals completed the client survey. Majority of participants identified their sex as male (n=80, 75.5%) and 24.5% as female. No participants identified as transgender. Age of participants ranged from 24 to 87 years with a median age of 52 years. Over half (55 of 93) of the zip codes in NE were represented. Participants were racially and ethnically diverse with 55% (n=59) identifying as White/European American, 13% (n=14) Black/African American, 21.5% (n=23) Latino/Hispanic, and 10.3% as Native American, African refugee, multiracial, or other. Participants identified as heterosexual (n=44, 45.8%), homosexual (45, 46.9%), and bisexual (n=7, 7.3%). Approximately 10% of participants, however, did not respond to the question on sexual orientation. The vast majority of participants (n=94, 91.3%) reported an annual income of \$30,000 or less and about half were unemployed (n=52, 49%). In addition, table 56 provides additional information about issues that may impact clients.

Table 56: Issues that may impact clients, Nebraska, 2016

Item	Yes	No	Don't know
In the past 12 months, have you not seen the doctor because of the cost	11.4% (12)	87.6% (92)	1.0% (1)
In the past year, have you not taken medications because of the cost?	10.5% (11)	89.5% (94)	0
Have you spent time in prison/jail since you were diagnosed with HIV/AIDS?	19.6% (21)	80.4% (86)	0
During the past 12 months have you been homeless at any point?	6.7% (7)	93.3% (8)	0
During the past 12 months did you stay with friends or family because you didn't have your own place?	24.3% (26)	75.7% (81)	0
During the past 12 months did you use HOPWA funding to help pay mortgage, rent or other housing?	15.1% (16)	80.2% (85)	4.7% (5)

Health

Participants reported living with HIV for approximately 15 years on average with a range of 1 to 34 years and 36.2% (n=38) had ever been diagnosed with AIDS. The majority of participants rated both their current health and mental health as at least "good". Medicaid and Ryan White Services were utilized

the most frequently for healthcare coverage. Tables 57 through 59 provide additional details about the health status, coverage, and exposure history of clients.

Table 57: Self-reported health status, Ryan White clients, Nebraska, 2016

	Excellent	Very good	Good	Fair	Poor	Very Poor
How do you rate your current health status?	17.1% (18)	26.7% (28)	24.8% (26)	25.7% (27)	2.9% (3)	2.9% (3)
How do you rate your current mental health status?	13.3% (14)	23.8% (25)	28.6% (30)	27.6% (29)	5.7% (6)	1.0% (1)

Table 58: Types of health care coverage, Ryan White clients, Nebraska, 2016

	Medicaid	Medicare	COBRA	Private	Self	VA Benefits	Ryan White	None	Don't know
What kind of healthcare coverage do you have?*	49	14	2	26	2	1	48	1	2

*Check all that apply, no percent calculated

Table 59: HIV exposure, Ryan White clients, Nebraska, 2016

How do you think that you were first exposed to HIV?	% (n)
Having Sex With Men	61.3% (65)
Having Sex with Women	11.3% (2)
Occupational Exposure	0
Sharing Needles or Works	4.7% (5)
Born with HIV	0
Blood Products/Transfusion	3.8% (4)
Don't Know/Not Sure	14.2% (15)

Provider/Case Manager Satisfaction

Participants were asked several questions regarding their satisfaction with healthcare providers and case managers. The majority of participants were very satisfied with the care they received. Tables 60 and 61 provide survey responses regarding satisfaction with providers and case managers.

Table 60: Perceptions of case manager experience and knowledge

	Excellent	Very good	Good	Unsure/ Neutral	Fair	Poor	Very poor	N/A
How do you rate your overall experience with your case manager?	62.1% (64)	17.5% (18)	13.6% (14)	4.9% (5)	1.9% (2)	0	0	3.7% (4)
How would you rate your healthcare provider's knowledge of HIV/AIDS?	65.7% (69)	20.0% (21)	8.6% (9)	2.9% (3)	1.9% (2)	1.0% (1)	0	1.9% (2)

Table 61: Perceptions of case manager services, Ryan White clients

	Strongly agree	Agree	Somewhat agree	Unsure/ Neutral	Somewhat disagree	Disagree	Strongly disagree	N/A
I feel that my case manager respects me.	69.8% (74)	30.2% (26)	0.9% (1)	4.7% (5)	0	0	0	0.9% (1)
I feel that my case manager listens to and hears me/my concerns.	69.8% (74)	21.7% (23)	3.8% (4)	4.7% (5)	0	0	0	0.9% (1)
I feel that my case manager values my time.	71.2% (74)	21.2% (22)	2.9% (3)	4.8% (5)	0	0	0	1.9% (2)
My case manager clearly explains the services I am and am not eligible for.	57.3% (59)	30.1% (31)	2.9% (3)	9.7% (10)	0	0	0	1.9% (2)
I feel that I can tell my case manager when I am not happy with the services I receive.	60.4% (64)	27.4% (29)	2.8% (3)	7.5% (8)	0.9% (1)	0.9% (1)	0	0.9% (1)
When I need referrals to another doctor or service, my case manager helps me.	57.4% (54)	26.6% (25)	3.2% (3)	9.6% (9)	2.1% (2)	1.1% (1)	0	10.3% (11)

Services

On average, participants reported driving approximately 49 miles or an hour to their healthcare provider. Miles ranged from 0 to 230 and minutes ranged from 1 to 300. Tables 62 and 63 show the Ryan White services needed and accessed by survey participants in the past year. Case management and ADAP (medications) were reported as the most frequently needed and utilized services.

Table 62: Services needed, Ryan White clients, Nebraska, 2016

Which of the 12 services available to NE Ryan White clients have you needed in the past 12 months?*	n
Transportation	42
Mental health	15
ADAP (medications)	62
Dental services	44
Housing	24
Health insurance premiums	40
Emergency assistance (i.e., utilities, food, etc.)	31
Laboratory services	38
Translation/interpretation	6
Nutrition education	15
Support group	18
Case management	62

**Check all that apply, no percent calculated*

Table 63: Services used, Ryan White clients, Nebraska, 2016

Which of the 12 services available to NE Ryan White have you used in the past 12 months?	n
Transportation	35
Mental health	11
ADAP (medications)	63
Dental services	37
Housing	17
Health insurance premiums	40
Emergency assistance (i.e., utilities, food, etc.)	23
Laboratory services	39
Translation/interpretation	6
Nutrition education	13
Support group	20
Case management	59

**Check all that apply, no percent calculated*

Participants identified medical services received NOT through Ryan White. A total of 53 responses were obtained with podiatry/foot care followed by optometry/eye care as the most common medical services received outside of Ryan White eligible care.

- Podiatrist/foot care (n=11, 21% of responses)
- Optometry/Eye care (n=7, 13% of responses)
- Dermatologist/Skin Specialist (n=5, 9.4% of responses)
- Chiropractor/ Physical therapy (n=5, 9.4% of responses)
- Therapist/ Psychiatrist/Mental health care (n=4, 9.4% of the responses)
- Dental (n=3, 5.6% of responses)

Part E: Data: Access, Sources, and Systems

Data Sources, Policies, and Availability

The main sources of data for the epidemiologic profile are surveillance data. For HIV/AIDS incidence and prevalence, the main source of data is the HIV/AIDS surveillance data eHARS (Enhanced HIV/AIDS Reporting System) which is used to collect, manage and report Nebraska's HIV/AIDS cases surveillance data to CDC. Data in eHARS includes demographic, risk factor, illness history and laboratory data. These data are used to track the incidence and prevalence of HIV in Nebraska. The demographic information combined with the laboratory data are used to create the care continuum.

The Nebraska Department of Health and Human Services' STD program uses STD MIS to report STD morbidity to the Centers for Disease Control and Prevention (CDC). The database is also used to capture disease investigator efforts and assist in investigations. These reports are intended as a reference document for policymakers, program managers, health planners, researchers, and others who are concerned with the public health implications of these diseases.

The Nebraska Ryan White Program is required to collect data on all consumers accessing funded programs. Demographic and income data are collected at intake, at each service visit, and at the mandatory six-month and annual recertification period. All data is reported to the Nebraska Ryan White Program and subsequently the Health Services and Resource Administration (HRSA) annually through the Ryan White Services Report. The Nebraska Department of Health and Human Services utilizes Provide for the Ryan White Part B program.

Provide Case Management Software system was purchased in 2001 to allow the Ryan White Part B and later the Housing Opportunities for Persons with AIDS programs to collect and report client-specific data to the U.S. Department of Health and Human Services' Health Resources and Services Administration and HUD and the U.S. Department of Housing and Urban Development. The system is also used to track services and cost of services provided to clients. Client service plans and progress in reaching client goals are also entered into system.

HIV Prevention utilizes EvaluationWeb to collect data surrounding the activities of HIV counseling and testing. Data collected ranges from demographics, patient risk factors, agency activities, and co-infections. The purpose of EvaluationWeb is to provide data to better monitor and strengthen HIV prevention activities. Data are collected on forms that accompany the EvaluationWeb system and collected by agencies performing HIV Prevention funded and non-HIV Prevention funded HIV testing.

Agencies include: non-profit volunteer agencies, Title X Family Planning, local health departments, state correctional facilities, and Federally Qualified Health Centers.

Demographic data on persons who utilize the AIDS Drug Assistance Program (ADAP) was unavailable. While the assumption is that the overall demographics would be similar to the overall epidemic in Nebraska, demographic data on ADAP clients might indicate a population that is underserved and a potential source for further spread.

Section II: Integrated HIV Prevention and Care Plan

Part A: Integrated HIV Prevention and Care Plan

The following pages present the Nebraska Integrated HIV Prevention and Care Plan.

NHAS Goal 1: Reduce new HIV infections

National Objectives (2020 Targets)

- Increase the percentage of people living with HIV who know their serostatus to at least 90 percent.
- Reduce the number of new diagnoses by at least 25 percent.
- Reduce the percentage of young gay and bisexual men who have engaged in HIV-risk behaviors by at least 10 percent.

Objective 1: By the end of 2021, increase the percentage of individuals living with HIV who know their serostatus to at least 90% (Baseline: 82%, 2014).				
Strategy 1: Intensify targeted HIV testing among the highest risk populations for HIV				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	NDHHS	Identify communities with the greatest HIV-related disparities	People Living with HIV/AIDS (PLWHA)	Surveillance data
By the end of 2021:	NDHHS Funded HIV testing sites Primary Care Providers and other testing sites	Increase testing outreach among members of priority populations (Black MSM, Black women, YMSM, white MSM)	Priority populations	No. of HIV tests Positivity rate
By the end of 2021:	NDHHS	Increase early detection of new HIV infections	PLWHA	Number of HIV tests Positivity rate Early detection data

Strategy 2: Increase HIV testing among partners of PLWHA				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	NDHHS DIS	Work with state and local DIS to identify, contact, and test partners of people who are newly diagnosed with HIV	Partners of newly infected PLWHA	Number of partners identified Number of partners contacted Number of tests conducted with partners
By the end of 2021:	NDHHS Ryan White Providers	Reduce late testing by implementing or enhancing Outpatient Ambulatory Health Care Services (OAHC) at Ryan White sites	PLWHA Individuals at higher risk for HIV	No. of OAHC services reported
By the end of 2021:	NDHHS Ryan White Providers	Reduce late testing by implementing or enhancing high risk partner services at Ryan White sites, including testing and prevention activities	Individuals at higher risk for HIV	No. of services reported

Strategy 3: Support integrated HIV testing and related screening activities				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	NDHHS Funded Testing Sites	Support funded testing sites to conduct HIV testing	General population	Number of tests conducted Positivity rate
By the end of 2021:	NDHHS Funded Testing Sites	Ensure integrated HIV/STD testing at all funded testing sites	General population	Documentation of testing Number of tests conducted
By end of 2021:	NDHHS	Ensure that HIV testing is conducted in correctional settings	State and local correction institutions	Number of tests conducted

Objective 2: By the end of 2021, reduce the number of new HIV diagnoses in Nebraska by at least 25%.				
Strategy 1: Deliver evidence-based HIV prevention interventions				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2018:	NDHHS Funded agencies	Identify appropriate evidence-based behavioral interventions for individuals, groups, or communities at highest risk for HIV	Black MSM, YMSM, HRH women	Adoption of an evidence-based intervention

By the end of 2021:	NDHHS Funded agencies	Implement appropriate evidence-based behavioral interventions for individuals, groups, or communities at highest risk for HIV	Black MSM, YMSM, HRH women	Number of people enrolled in intervention
By the end of 2021:	NDHHS Community partners	Support community-based condom distribution programs	General population, PLWHA, persons at highest risk for HIV	Number of condoms distributed
By the end of 2021:	NDHHS Community partners	Provide evidence informed HIV prevention messages through social media or social marketing interventions	General population, PLWHA, persons at highest risk for HIV	Social media and marketing data Reach
Strategy 2: Provide accessible, medically accurate information about HIV and associated risks, prevention strategies, and transmission				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	NDHHS Community partners	Provide evidence informed HIV prevention messages through social media or social marketing interventions	General population, PLWHA, persons at highest risk for HIV	Social media and marketing data Reach
By the end of 2021:	NDHHS Community partners	Distribute HIV prevention materials (from CDC, other national partners, or locally developed)	General population, PLWHA, persons at highest risk for HIV	Number of materials distributed
By the end of 2021:	NDHHS Community Partners	Provide HIV educational materials in clinical, community, and educational settings.	General population	Number of materials distributed

Strategy 3: Expand access to Pre-Exposure Prophylaxis (PrEP) for HIV				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017:	NDHHS	Provide training to health care providers about prescribing and monitoring PrEP	Health Care Providers	Number of trainings conducted Number of providers who attend trainings
By the end of 2018:	NDHHS	Train HIV prevention education and testing providers to inform clients about PrEP as an option for prevention	HIV education and testing professionals	Number of materials distributed Reports from community partners
By the end of 2018:	NDHHS	Create and maintain a directory of PrEP providers	Testing sites General population	Directory of PrEP providers Schedule for updating directory
By the end of 2018:	NDHHS Community Partners	Deliver community-based education about PrEP	General population	Information dissemination tracking Reach

By the end of 2021:	NDHHS	Increase the number of PrEP providers in Nebraska, particularly in areas where the risk for HIV is greatest	Health Care Providers	Number of Providers Location of Providers
By the end of 2021:	NDHHS	Identify financial resources to support access to PrEP for consumers who cannot afford medication or related services (e.g., laboratory charges, medical visits)	PrEP users	List of resources
By the end of 2021:	NDHHS Community Partners	Train PrEP navigators to assist interested persons with PrEP education and guidance on access and adherence	PrEP users	Number of trained navigators Number of clients served

NHAS Goal 2: Increase access to care and improve health outcomes for people living with HIV/AIDS

- Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85 percent.
- Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90 percent.
- Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80 percent.
- Reduce the percentage of persons in HIV medical care who are homeless to no more than 5 percent.
- Reduce the death rate among persons with diagnosed HIV infection by at least 33 percent.

Objective 1: By the end of 2021, increase the percentage of newly HIV diagnosed persons linked to HIV medical care within one month of their diagnosis to at least 85%. (Baseline = 82%).				
Strategy 1: Facilitate systems to link people to care immediately after HIV diagnosis.				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2018 (and ongoing):	NDHHS Health Departments Partners	Develop partnerships with medical providers across Nebraska to ensure timely entry into care for persons who test positive for HIV.	Primary care providers CBOs	Number of Agreements/ Memoranda of Understanding (MOU)
By the end of the 2017 (and ongoing):	NDHHS Ryan White Providers	Conduct brief assessments at RW Part B sites for quicker benefit eligibility determination.	Ryan White Providers Newly diagnosed PLWHA	Time to first medical appointment/ Linkage to care data

By the end of 2021:	NDHHS Ryan White Providers Testing sites	Develop a notification system to inform NDHHS and support service providers every 30 days when a client is not linked to care	NDHHS Support Service Providers PLWHA	Number of notifications Number of contacts following notification
By the end of 2019:	NDHHS	Provide training for linkage to care staff on strategies to engage people from demographic groups most likely to be out of care	Linkage to Care Staff	Number of trainings Number of staff trained
Strategy 2: Implement evidence-based public health strategies to engage clients in care (e.g. ARTAS)				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing:	NDHHS	Increase opportunities for providers to be trained in public health strategies	Providers	No. of trainings provided No. of providers enrolled
By the end of 2018:	NDHHS	Implement an evidence-based public health strategy to engage clients in care (e.g., ARTAS, Project Connect)	HIV Providers	Adoption of an EBI Number of persons who complete EBI
By the end of 2021:	NDHHS Partnering agencies	Increase annually the number of PLWHA who receive public health strategies	PLWHA	No. of strategies offered No. of PLWHA enrolled

Strategy 3: Develop strategies to support enhanced linkage to care services.				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	NDHHS	Review and update policies and protocols related to enhanced linkage to care services.	NDHHS Partners	No. of policies reviewed and implemented
By the end of 2017:	NDHHS	Increase educational, marketing and capacity-building efforts related to the importance of early linkage and entry into care.	PLWHA Health Care Providers Partners Testing sites	No. of materials developed/ distributed No. of trainings offered

Objective 2: Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90%.				
Strategy 1: Assess client needs and align services with client need to reduce barriers to client retention.				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	NDHHS Ryan White Providers	Provide on-going opportunities for the input of PLWHA and other consumers into Ryan White services	PLWHA Other Consumers	Number of meetings/data collection points for input

By the end of 2017 (and ongoing):	NDHHS Ryan White Providers	Ensure the development of a care plan by medical care managers to address the client individualized needs and barriers to care.	PLWHA	Percentage of medical case management patients who have a medical care plan
By the end of 2019 (and ongoing):	NDHHS Ryan White Providers	Increase number of clinics with non-traditional hours to meet the needs of clients.	PLWHA	Clinics with non-traditional hours
By the end of 2021:	NDHHS Ryan White Providers	Increase the number of Ryan White providers who offer Part B psychosocial services to improve retention in care	Ryan White Part B providers PLWHA	Number of service providers Number of PLWHA enrolled
By the end of 2021:	NDHHS	Implement a seamless outreach plan to target individuals who are newly diagnosed with HIV or STDS, or who have been lost to care.	NDHHS	Number of individuals reached

Strategy 2: Support Ryan White services for PLWHA.				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	NDHHS Ryan White Providers	Monitor and improve RW eligible core and supportive services (e.g. housing, medical case management, transportation, food, mental health).	PLWHA Providers	No. of services provided through RW
By the end of 2017 (and ongoing):	NDHHS RW Providers	Continue the HOPWA program to support housing needs of eligible PLWHA	PLWHA Providers	No. of housing services provided through HOPWA
By the end of 2017 (and ongoing):	NDHHS RW providers	Collaborate with medical and social case managers to identify affordable housing while protecting client confidentiality	Case managers PLWHA	Number of housing services provided
By the end of 2020 (and ongoing):	NDHHS RW Providers	Establish collaborative relationships with Mental Health providers to provide services to Ryan White clients.	PLWHA	Sub-grants and fee-for-service contracts Number of services provided
By the end of 2017 (and ongoing):	NDHHS RW Providers	Ensure confidential mental health therapy to PLWHA in Western Nebraska through the use of telehealth.	PLWHA	Number of telehealth consultations Number of clients who access telehealth

By the end of 2017 (and ongoing):	NDHHS Ryan White Providers	Support the transportation needs of PLWHA	PLWHA	Number of clients who access transportation support Number of transportation providers
Strategy 3: Ensure medical visits using data-driven strategies to track retention.				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	NDHHS Ryan White Providers	Ensure that each PLWHA client has at least one medical visit with a provider with prescribing privileges within each 6 month period	PLWHA	No. of clients who have a medical visit within 6 month period
By the end of 2021:	NDHHS Ryan White Providers	Assess treatment readiness with clients to make referrals to appropriate services	RW Providers	Number of referrals Number of patients retained in care
By the end of 2021:	NDHHS Partners	Use eHARS data to coordinate reengagement of clients in care (coordination between surveillance, prevention, and Ryan White)	PLWHA	Number of clients reengaged in care

Objective 3: Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%				
Strategy 1: Provide public health strategies for medication adherence				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	NDHHS	Increase opportunities for providers to be trained in medication adherence strategies.	Providers	Number of trainings provided Number of providers enrolled
By the end of 2017 (and ongoing):	NDHHS Partners	Promote the use of the Nebraska Reminders web-based system for medical reminders (e.g., medication adherence, medical appointments)	PLWHA	Website metrics Number of system users
Strategy 2: Increase access to HIV medications				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	NDHHS RW Providers	Health Care providers will continue to prescribe Anti-Retroviral Therapy (ART) to clients as indicated.	PLWHA	Percentage of clients being prescribed ART
By the end of 2017 (and ongoing):	NDHHS	Ensure AIDS Drug Assistance Program (ADAP) resources are available to support needs of qualified PLWHA	PLWHA	Number of clients enrolled in ADAP programs
Strategy 3: Implement a web-based system for ADAP/Medical Case Management Services				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2018:	NDHHS Ryan White Program	Contract with a specified case management software company to provide a web-based application for online application for all Part B, C, & D and ADAP clients	PLWHA	Number of electronic applications filed

NHAS Goal 3: Reduce HIV-related disparities and health inequities

- Reduce disparities in the rate of new diagnoses by at least 15 percent in the following groups: gay and bisexual men, young Black gay and bisexual men, Black females, and persons living in the Southern United States.
- Increase the percentage of youth and persons who inject drugs with diagnosed HIV infection who are virally suppressed to at least 80 percent.

Objective 1: By the end of 2021, reduce by at least 15% the rate of new diagnoses among gay and bisexual men.				
Strategy 1: Engage gay and bisexual men in behavioral and biomedical prevention strategies				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	NDHHS Partners	Conduct targeted outreach to gay and bisexual men to increase HIV testing	Gay and bisexual men	Outreach Activities Number of HIV tests
By the end of 2021:	NDHHS Partners	Implement an evidence-based behavioral HIV prevention intervention for gay and bisexual men	Gay and bisexual men	Implementation of EBI Number of participants

By the end of 2021:	NDHHS Funded Testing Sites	Promote the use of PrEP through targeted social or other media campaigns	Gay and bisexual men	Implementation of campaigns
Strategy 2: Expand services to reduce HIV-related disparities experienced by Black gay and bisexual men				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	NDHHS	Train providers in culturally sensitive or aware practices and services for Black gay and bisexual men.	Clinical Providers CBOs	Number of trainings provided No. of providers participated
By the end of 2021:	NDHHS	Increase number of health and human service providers who deliver culturally sensitive services to Black gay and bisexual men.	Clinical Providers CBOs	Number of providers who have Black gay and bisexual men-friendly environmental conditions Number of providers with policies regarding cultural sensitivity and humility
By the end of 2021:	NDHHS Partners	Increase sexual health education and awareness among black gay men to reduce the number of new infections.	Gay, bisexual, and transgender individuals Partners	Implementation of sexual health and awareness campaigns

Strategy 3: Increase access to HIV prevention including HIV testing and other services.				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2021:	NDHHS	Increase the number of HIV testing opportunities in communities of racial and ethnic minority persons	Gay and bisexual men	Number of testing sites Number of tests at each site

Objective 2: By 2021, implement health communication messages to address HIV-related stigma				
Strategy 1: Increase web-presence, print, broadcast and other electronic media regarding HIV prevention and care messages				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	NDHHS	Develop messages or utilize National campaign to promote awareness and prevention of HIV/STIs/HCV (e.g., Act Against AIDS, “Ask me about AIDS”.) Promote recognition of national health observances (ex. World AIDS Day, National Testing Day)	Priority and general populations	Number of messages developed Number of published messages/materials distributed
By the end of 2017 (and ongoing):	NDHHS	Support web-based prevention strategies	Priority and general populations	Number of messages Number of page views

Strategy 2: Increase engagement with traditional and non-traditional community partners				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2017 (and ongoing):	NDHHS	Continue to work with traditional community partners (ASOs and CTR providers) to promote HIV communication messages	ASOs CTR sites	Number of messages promoted
By the end of 2018 (and ongoing):	NDHHS	Identify non-traditional (non-ASO) community partners that work with populations at higher risk for HIV infection (e.g., gay and bisexual men, Black women)	Partners	Number of partners identified
Strategy 3: Engage other populations through health communication strategies				
Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of 2020:	NDHHS	Develop a targeted strategy for engaging transgender persons	Transgender persons	Development of strategy

Anticipated Challenges or Barriers

HIV-related stigma continues to be a barrier to implementing HIV prevention programs, especially in communities where the greatest need has been documented (e.g., Black/African American communities). HIV also continues to dramatically impact gay, bisexual, and other men who have sex with men at highly disproportionate rates, both nationally and in Nebraska. It is anticipated that we will continue to encounter the outcomes of such stigma in implementing our HIV programs. Salient outcomes of this stigma may result in barriers to recruitment of those at highest risk for HIV infection into HIV prevention interventions or for HIV testing.

The State of Nebraska opted not to expand Medicaid, which is a barrier for supporting people living with HIV. Uncertainty about future federal funding for HIV prevention and care services creates a challenge for long-term planning for HIV prevention, care, and treatment. As documented in the present Statewide Coordinated Statement of Need, major challenges continue to exist for client services, including the need for transportation, mental/behavioral health services, other medical and ancillary services, housing, and drug assistance.

Although mentioned only briefly in this plan, the currently increasing national opiate epidemic may also create substantial challenges if an outbreak occurs in Nebraska.

Part B: Collaborations, Partnerships, and Stakeholder Involvement

Stakeholder Contributions

The process for the development of the SCSN and Integrated Plan was designed to maximize the input of stakeholders and key partners. Stakeholders attended a meeting in September of 2015 to learn about the new planning process. Ryan White providers and clients from across the state completed surveys to provide input for the SCSN between January and February 2016. A series of town hall style meetings/focus groups were held across the state in April and May of 2016 to solicit information from stakeholders. The town hall events were promoted through local Ryan White providers, testing clinics, case managers, health departments, NHCP members, social media, and local media when possible. An additional focus group was held with the NHCP in May of 2016.

The Integrated Plan was developed based on both CDC/HRSA guidance and the input of NDHHS officials, partnering agencies, and the NHCP. A draft of the goals and objectives was presented to the NHCP in September 2016 for discussion, review, and revision. Guidance from the NHCP was incorporated into the final plan.

Representation from PLWH is present in the NHCP. The categories that are present are Injecting Drug User, MSM Urban, MSM of Color, MSM Rural, Woman – HIV Impacted, Red Ribbon Community member, Person Living With HIV or AIDS, and Native American/American Indian. MSM of Color and Native American/American Indian are the two PLWH positions that are consistently missing from the table. Input from the community is solicited when we do not have those voices present.

Part C: People Living with HIV (PLWH) and Community Engagement

The Nebraska Department of Health and Human Services (NHHS) initiated a comprehensive community-based participatory planning process in February 1994. Currently, this statewide planning body is known as the Nebraska HIV Care and Prevention Consortium (NHCPC). The NHCPC includes representatives from all geographical regions of the state. It is a comprehensive planning body with representation from HIV prevention and care providers and consumers, STD, TB, and HCV programs, public health, behavioral health, substance abuse, corrections, education and members of populations at risk for HIV infection in Nebraska. Several members of the NHCPC are people living with HIV/AIDS. The NHCPC acts in an advisory capacity to the NHHS HIV Prevention and Ryan White Programs. Through this advisory relationship, the HIV Prevention and Ryan White Programs respond to the care and prevention issues affecting those at risk for HIV infection, as well as those who are currently living with HIV/AIDS. The NHCPC advised the NHHS on the development of the Integrated Plan.

Deliberate efforts were undertaken to ensure the inclusion of PLWH in the development of the plan. PLWH serve on the NHCPC, which provided guidance and advisement for the development of the plan. Ryan White client surveys were administered to PLWH through their case managers. Client survey respondents represented a cross-section of Nebraskans living with or at high risk for HIV: 75.5% of respondents were male; 13% were Black or African American, 21.5% were Hispanic or Latino; and 54% were gay or bisexual.

Recruitment efforts for town hall meetings were also targeted to PLWH, who represented 16% of participants. Similar to the client surveys, town hall participants represented a cross-section of Nebraskans living with or at high risk for HIV: 43.6% were men, 9% were Black or African American; and 5.3% were Hispanic or Latino. These processes allowed for a broad sample of PLWH and persons at high risk for HIV to contribute information which was used to develop the plan.

Care providers also participated in the development of the plan. Case managers and medical providers attended NHCPC meetings and participated in town hall meetings. Twenty-four providers participated in the provider survey.

Stakeholder engagement was critical to the success of the SCSN. Furthermore, the role of the NHCPC in the SCSN process, including their participation and input into the objectives was essential for the development of the Integrated Plan. Their experience and insight, including strategies for engaging other stakeholders and approaches to address barriers, led to a more robust and relevant plan.

The letter of concurrence from the NHCPC is appended as Appendix A.

Section III: Monitoring and Improvement

Stakeholder Updates and Feedback

The Ryan White and HIV Prevention Program managers will provide bi-annual updates on the progress towards the plan implementation and goals. The managers will solicit feedback on barriers to implementation and/or goal completion. Feedback from the participants will be incorporated as appropriate into the plan implementation. The quality management and improvement of the plan performance will be important to the overall process for successful implementation and execution of the plan.

Monitoring and Evaluation

Each goal and objective will be monitored to determine its feasibility as well as Nebraska's progress to implementation and completion. Nebraska will use Clinical Quality Management (CQM) standards to review the goals and objectives. If it is determined that a goal/objective is not feasible or is not producing the desired result, the CQM standards will be applied and input will be sought from stakeholders to determine the revised goal/objective. Evaluation of the plan will be completed in collaboration with HIV Surveillance/Epidemiology to ensure that the plan is impactful.

Data Utilization

The HIV Surveillance Program has been instrumental in the development of the plan. Utilization of the HIV Epidemiologist has ensured that data analysis is complete and that goals and objectives are developed with the greatest potential outcome. As Nebraska reviews progress to goals and objectives, HIV Surveillance will actively participate in the evaluation and analysis. The CQM process will incorporate all of the internal stakeholders. Data analysis is integral to the quality assessment prior to presenting progress to external stakeholders and requesting input. By incorporating HIV Surveillance data, the analysis will be more robust and all planning for health outcomes related to HIV prevention and care.

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Appendix A: Letter of Concurrence

See Attached

Appendix B: Resource Guide

See Attached