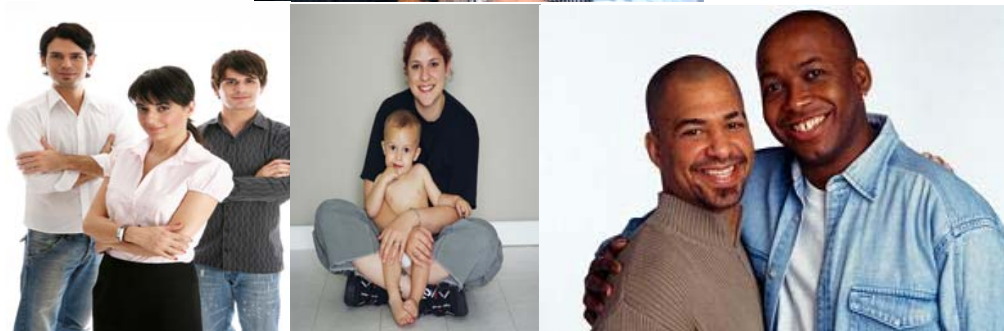


# Nebraska

## HIV Comprehensive Plan 2009 – 2013





# Nebraska HIV Comprehensive Plan 2009 – 2013

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- DHHS Ryan White/HOPWA Programs
- DHHS STD Program
- DHHS TB Program
- DHHS Tobacco Free Nebraska Program (YRBS)
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## ACRONYMS

**AAR** – Annual Administrative Reports  
**ACHA** – American College Health Association  
**ADAP** – AIDS Drug Assistance Program  
**AIDS** – Acquired Immunodeficiency Syndrome  
**AK** – Alaskan Native  
**ATP** – Assistive Technology Partnership  
**AVHPC** – Adult Viral Hepatitis Prevention Coordinator  
**BCG** – Bacille Calmette-Guerin  
**BRFSS** – Behavioral Risk Factor Surveillance System  
**CARE** – Comprehensive AIDS Resources Emergency  
**CBO** – Community Based Organization  
**CDC** – Centers for Disease Control and Prevention  
**CHN** – Community Health Nurse  
**CLEAR** – Choosing Life: Empowerment, Actions, Results  
**COBRA** – Consolidated Omnibus Budget Reconciliation Act  
**CPG** – Community Planning Group  
**CRCS** – Comprehensive Risk Counseling Services  
**CTR** – Counseling, Testing and Referral  
**DASH** – Division of Adolescent School Health  
**DHHS** – Department of Health and Human Services  
**DIS** – Disease Intervention Specialist  
**DOT** – Directly Observed Therapy  
**EIS** – Early Intervention Services  
**ELIRT** – Electronic Lab Information Reporting Technology  
**ER** – Emergency Room  
**ERMA** – Emergency Rent and Mortgage Assistance  
**FDA** – Food and Drug Administration  
**HAART** – Highly Active Antiretroviral Therapy  
**HARS** – HIV/AIDS Reporting System  
**HAV** – Hepatitis A Virus  
**HBV** – Hepatitis B Virus  
**HCV** – Hepatitis C Virus  
**HE/RR** – Health Education/Risk Reduction  
**HHRP** – Holistic Health Recovery Program  
**HIV** – Human Immunodeficiency Virus  
**HOPWA** – Housing Opportunities for Persons with AIDS  
**HRH** – High Risk Heterosexual  
**HRSA** – Health Resources and Services Administration  
**HUD** – US Dept of Housing and Urban Development  
**IDU** – Injecting Drug Use  
**IMB** – Information, Motivation and Behavioral Model  
**IPP** – Infertility Prevention Project  
**LTBI** – Latent TB Infection  
**MSM** – Men Having Sex With Men  
**NAP** – Nebraska AIDS Project  
**NCHA** – National College Health Assessment  
**NDE** – Nebraska Department of Education  
**NE** – Nebraska  
**NGU** – Non-gonorrheal urethritis  
**NHCPC** – Nebraska HIV CARE and Prevention Consortium  
**NHSDA** – National Household Survey on Drug Abuse  
**NHSDUH** – National Household Survey on Drug Use & Health  
**NIPP** – Nebraska Infertility Prevention Project

**NIR** – No Identifiable Risk  
**NPHL** – Nebraska Public Health Lab  
**NRPFSS** – Nebraska Risk and Protective Factor Student Survey  
**NRRC** – Nebraska Red Ribbon Community  
**OPA** – Office of Population Affairs  
**PCRS** – Partner Counseling and Referral Services  
**PCS** – Panhandle Community Services  
**PHS** – Public Health Services  
**PID** – Pelvic Inflammatory Disease  
**PIR** – Parity, Inclusion and Representation  
**PLWHA** – Persons Living With HIV/AIDS  
**POL** – Popular Opinion Leader  
**PPACT** – Panhandle Prevention Advocacy CARE Team  
**PRAMS** – Pregnancy Risk Assessment Monitoring System  
**RAC** – Regional Advisory Committee  
**RAPP** – Rural AIDS Prevention Project  
**RFA** – Request for Application  
**SAMHSA** – Substance Abuse and Mental Health Services Administration  
**SCSN** – Statewide Coordinated Statement of Need  
**SHEPS** – School Health Education Profile Survey  
**SE** - Southeastern  
**SISTA** – Sisters Informing Sisters on Topics and AIDS  
**SNAC** – Southeast Nebraska AIDS Coalition  
**STD** – Sexually Transmitted Disease  
**TB** - Tuberculosis  
**TBRA** – Tenant Based Rental Assistance  
**TEDS** – Treatment Episode Data Set  
**UNMC** – University of Nebraska Medical Center  
**YRBS** – Youth Risk Behavior Survey  
**YRBSS** – Youth Risk Behavior Surveillance System

# **SECTION 1**

## **NHCPC MEMBERSHIP/COMMUNITY PARTNERSHIP LISTS**



**SECTION 1**  
**Nebraska HIV CARE and Prevention Consortium**  
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Assistive Technology Partnership  
Behavioral Management Clinic, Inc.  
Caring People Sudan  
Central Health Center  
Charles Drew Health Center  
District Health Departments  
Douglas County Health Department  
Goodwill Industries  
Lincoln/Lancaster County Health Department  
Megan Smith Psychotherapy  
Nebraska AIDS Project (NAP)  
Nebraska Department of Correctional Services  
Nebraska Department of Education  
Nebraska Department of Health and Human Services  
    Hepatitis Program  
    Hepatitis Surveillance  
    HIV Prevention Program  
    HOPWA Program  
    Immunization Program  
    Medicaid Division  
    Ryan White Title B & Title C Services  
    STD Program  
    TB Program  
    Reproductive Health Surveillance Program  
Nebraska Red Ribbon Community  
Panhandle Community Services  
People's Family Health Services  
Planned Parenthood of Nebraska & Council Bluffs  
Regional Advisory Groups  
    Central Nebraska Coalition on HIV/AIDS  
    Midlands CPG for HIV Prevention, Care and Treatment  
    Northeast Nebraska AIDS Prevention Partnership  
    Panhandle Prevention, Advocacy CARE Team (PPACT)  
    Southeast Nebraska AIDS Coalition (SNAC)  
Rural AIDS Prevention Project  
Santee Health Center  
University of Nebraska – Kearney  
University of Nebraska - Lincoln  
University of Nebraska Medical Center (UNMC)  
    HIV Clinic  
    Preventive and Societal Medicine  
Urban League of Nebraska





## **SECTION 2**

### **EXECUTIVE SUMMARY**



## **SECTION 2**

### **EXECUTIVE SUMMARY**

In 1993, the Centers for Disease Control and Prevention (CDC) directed states and localities that receive funding for HIV prevention to conduct a community planning process. The Nebraska Department of Health and Human Services (DHHS) HIV Prevention Program initiated a comprehensive community based participatory planning process in February 1994. The results of this process was the development of a statewide planning group called the Nebraska HIV Care and Prevention Consortium (NHPCPC). The first meeting of the NHPCPC was held in March 2000.

The overall mission of the Nebraska HIV Care and Prevention Consortium is to develop a Comprehensive HIV Care and Prevention Plan for the State of Nebraska. The purpose of the NHPCPC is to act in an advisory capacity to the Nebraska Department of Health and Human Services HIV Prevention and Ryan White Programs.

In 2003, the NHPCPC and the DHHS HIV Prevention Program completed the first five year HIV Comprehensive Plan for Nebraska, *NE HIV Comprehensive Plan, 2004-2008*. This process, with minor changes, was once again conducted in 2007, and resulted in a plan for the next five years, *NE HIV Comprehensive Plan, 2009-2013*. This comprehensive plan includes:

- 1) a description of the current NE Community planning process
- 2) an overview of the NHPCPC
- 3) the *2007 NE HIV/AIDS/STD Epidemiological Profile*
- 4) supplemental HIV-related data
- 5) the community services assessment
- 6) target populations
- 7) selected interventions, and
- 8) an evaluation plan for evaluating the community planning process.

Over the past eight years, the NHPCPC has collaborated with the Ryan White and HOPWA Programs to incorporate the Ryan White SCSN and both program's goals and objectives into the five year HIV Comprehensive Plan for Nebraska.

New to this comprehensive plan is information on the DHHS Hepatitis, STD and TB Programs and how these programs are collaborating with the HIV Prevention Program on program activities and interventions.

This document will be updated on a yearly basis, reviewed by the NHPCPC Executive Committee and a letter of concurrence, partial concurrence, or non-concurrence from the NHPCPC will be submitted with the HIV Prevention Program's CDC grant application each year.



## **SECTION 3**

### **INTRODUCTION TO COMMUNITY PLANNING PROCESS**



## **SECTION 3**

### **INTRODUCTION TO COMMUNITY PLANNING PROCESS**

#### **ORIGINS AND PURPOSE OF HIV PREVENTION COMMUNITY PLANNING**

In 1993, the Centers for Disease Control and Prevention (CDC) directed states and localities that receive funding for HIV prevention to conduct a community planning process. HIV Prevention Community Planning was built around the following principles:

- HIV Prevention Community Planning reflects an open, candid, and participatory process, in which differences in cultural and ethnic background, perspective, and experience are essential and valued.
- HIV Prevention Community Planning is characterized by shared priority setting between health departments administering and awarding HIV prevention funds and the communities for whom the prevention services are intended.
- Priority setting accomplished through a community planning process produces programs that are responsive to high priority, community-validated needs within defined populations. Persons at risk for HIV infection and persons with HIV infection play a key role in identifying prevention needs not adequately met by existing programs and in planning for needed services that are culturally appropriate. HIV prevention programs developed with input from affected communities are likely to be successful in garnering the necessary public support for effective implementation and in preventing the transmission of HIV infection.

In 2003, the CDC set three major goals for HIV Prevention Community Planning. These goals are:

1. Community planning supports broad-based community participation in HIV prevention planning.
2. Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.
3. Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

#### ***Comprehensive Planning Process: Prevention***

To ensure that the HIV Prevention Community Planning process is carried out in a participatory manner, the CDC expects community planning groups (CPGs) to address the following *Guiding Principles of HIV Prevention Community Planning*:

1. The health department and community planning group must work collaboratively to develop a comprehensive HIV prevention plan for the jurisdiction.
2. The community planning process must reflect an open, candid, and participatory process, in which differences in cultural and ethnic background, perspective, and experience are essential and valued.

3. The community planning process must involve representatives of populations at greatest risk for HIV infection and persons living with HIV or AIDS (PLWHA).
4. The fundamental tenets of community planning are parity, inclusion, and representation (often referred to as PIR).
  - *Parity* is defined as the ability of members to equally participate and carry out planning tasks and duties.
  - *Inclusion* is defined as meaningful involvement of members in the process with an active voice in decision making.
  - *Representation* is defined as the act of serving as an official member reflecting the perspective of a specific community.
5. An inclusive community planning process includes representatives of varying races and ethnicities, genders, sexual orientation, ages, and other characteristics such as varying educational backgrounds, professions, and expertise.
6. The community planning process must actively encourage and seek out community participation.
7. Nominations for membership should be solicited through an open process and candidate selection should be based on criteria established by the health department and the community planning group.
8. An evidence-based process for setting priorities among target populations should be based on the epidemiological profile and the community services assessment.
9. Priority setting for target populations must address populations for which HIV prevention will have the greatest impact.
10. The set of prevention interventions and activities for prioritized target populations should have the potential to prevent the greatest number of new infections.



## ORIGINS AND PURPOSE OF HIV CARE PLANNING

Part B of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 requires states to develop a comprehensive plan for their Ryan White Program and to fund the delivery of HIV care and support services. This plan is integrated into the annual Nebraska Part B application. This Act also requires states to coordinate the development of a Statewide Coordinated Statement of Need (SCSN). States are expected to provide the following planning-related information in describing the use of Part B funding:

- The purpose for which the state intends to use Part B funding to include services and activities to be provided and an explanation of how the state would maximize the quality of health and support services available to all PLWHA.
- How funded services will be coordinated with related services (to include other Ryan White funded entities) for individuals with HIV disease.
- How the allocation and use of resources are consistent or not with the SCSN.

### *Comprehensive Planning Process: CARE*

Utilizing epidemiological data and needs assessment information, the comprehensive planning process examines the HIV care needs for the state and assesses the resources available to meet those needs and to overcome barriers to service provision. The comprehensive plan sets annual goals, while addressing the vision and values that guide the development of a comprehensive system of care and support services.

## WHAT IS A COMPREHENSIVE HIV PREVENTION PLAN?

In 1993, the Centers for Disease Control and Prevention (CDC) mandated that all programs receiving HIV prevention funds implement a comprehensive community planning process. The plan is developed using a process in which state health departments, community representatives, and members of the identified risk populations all participate. That community planning process is now a key component of national prevention efforts. The role of those involved is twofold. The community planning group, regardless of structure, is charged with:

- 1) identifying and prioritizing target populations for HIV prevention which reflect the epidemiological makeup of the respective area; and
- 2) identifying prevention interventions based on sound behavioral theory, which are anticipated to be programmatically cost effective in working with the priority populations.

Through the community planning process, the plan identifies persons at increased risk and interventions used in reaching those populations. The community planning group is expected to regularly review, revise, and refine community plans indicated by new or enhanced surveillance data, intervention research, needs assessment, resource inventory, program policy, or technological transferring of information.

The essential elements of a Comprehensive HIV Prevention Plan include:

- Epidemiological Profile: describes the impact of the HIV epidemic in the jurisdiction and provides the foundation for prioritizing target populations;

- Community Services Assessment: describes the prevention needs of populations at risk for HIV infection, the prevention activities/interventions implemented to address these needs, and service gaps;
- Prioritized Target Populations: focuses on the set of target populations (identified through the epidemiologic profile and community services assessment) that require prevention efforts due to high rates of HIV infection and high incidence of risky behavior;
- Appropriate Science-Based Prevention Activities/Interventions: a set of prevention activities/interventions (based on intervention effectiveness and cultural/ethnic appropriateness) necessary to reduce transmission in prioritized target populations; and
- Letter of Concurrence/Concurrence with Reservations/Non-Concurrence: describes, via a written response from the CPG, whether the health department application does or does not, and to what degree, agree with the priorities set forth in the Comprehensive HIV Prevention Plan.

Additional components of the Nebraska Comprehensive HIV Prevention Plan include information related to the Ryan White Part B, HOPWA, Hepatitis Prevention, STD and TB Programs.

### [Ryan White Part B Program](#)

The purpose of the Ryan White Part B Program is to provide funding for the following program areas:

- AIDS Drug Assistance Program (ADAP) – providing therapeutic medications for the treatment of HIV infection;
- Direct Emergency Assistance – providing support services such as housing, utilities, transportation, food, and insurance premium payment assistance; and
- Comprehensive Case Management Services – providing access to Ryan White funded services and assistance in accessing other eligible services for qualified clients.

The Nebraska Department of Health and Human Services administers the Ryan White Part B Program. The program provides the above services to individuals who reside in the state, meet financial eligibility requirements, and have no other access to the above services.

The Ryan White Part B Program is funded through the federal Ryan White HIV/AIDS Treatment Modernization Act of 2006 legislation. The Health Resources and Services Administration (HRSA) is the federal entity responsible for the administration of Ryan White funding. Ryan White Part B funding is allocated to all fifty states and U.S. territories through formula funding.

### [Housing Opportunities for Persons With AIDS \(HOPWA\) Program](#)

HOPWA is a federally funded program which provides housing and supportive service assistance to persons living with HIV/AIDS with a strong focus on improving household self-sufficiency. The HOPWA Program is administered by the U.S. Department of Housing and Urban Development (HUD).

In Nebraska, funded services include:

- Case management
- Housing placement and counseling
- Move-in assistance (rental application fee, first/last month's rent, security deposit)
- Emergency short-term rent/mortgage assistance
- Tenant-based rental assistance
- Mental health treatment
- Substance abuse treatment
- Transportation assistance
- Self-sufficiency courses

### [Hepatitis Prevention Program](#)

The purpose of the Hepatitis Prevention Program is to reduce the transmission of Viral Hepatitis by integrating the Centers for Disease Control and Prevention (CDC) guidelines into existing disease prevention programs that share the same risk factors and transmission modes as Viral Hepatitis. Federal funding from the CDC enables the program to work with community based organizations, health departments, and educational institutions; thus providing continuing education of health care professionals, counseling and testing of high-risk populations, and harm reduction concepts. The majority of program funds are used to provide technical educational updates for health care professionals and prevention messages to high-risk populations.

The CDC has estimated that one out of every three people infected with HIV is also infected with the Hepatitis C virus (HCV). The presence of the Hepatitis C virus and HIV in a client can impact the treatment and management of both HCV and AIDS. Co-infection with the HIV virus and the Hepatitis C virus has been associated with higher titers of the Hepatitis C virus, a more rapid progression to liver disease, and an increase risk for cirrhosis of the liver. Since highly active antiretroviral therapy and prophylaxis treatment for opportunistic infections have increased the life span of AIDS patients, Hepatitis C related liver disease has become a major cause of hospital admissions and is the leading cause of death among AIDS patients.

### [Sexually Transmitted Disease Program](#)

The goal of the Nebraska Sexually Transmitted Disease (STD) Program is to control and prevent sexually transmitted diseases and reduce the burden and cost of these infections. The program assists state, local, and community efforts to help prevent the spread of chlamydia, gonorrhea, syphilis, hepatitis, and other STDs.

STD reports are strictly confidential. In Nebraska, as in most states, syphilis, gonorrhea, HIV/AIDS, and chlamydia are reported to the appropriate health department. Laboratories and health care providers provide the health department with information for controlling and preventing sexually transmitted diseases. Prompt reporting and accurate information is important for clients that may need treatment, for identifying sex partners who may be infected, and for monitoring disease trends.

Health professionals interview infected people to identify, locate, and treat sex partners, to ensure proper treatment, and to provide information to help prevent re-infection. Testing people who have no signs or symptoms of illness is important in the control of STDs. To that end, the Nebraska Infertility Prevention Program works with cooperating family planning and health care facilities throughout the state, testing 30,000 persons per year for chlamydia and gonorrhea.

The program makes available the latest guidelines regarding sexually transmitted diseases and their diagnosis and treatment to the STD health care providers in Nebraska. Information, educational materials, and posters are distributed to screening sites and community agencies.

### [Tuberculosis \(TB\) Program](#)

The Nebraska TB Control Program provides ongoing surveillance and prevention activities for tuberculosis disease for the state. Surveillance activities include: maintaining the state registry of active tuberculosis cases, collection and interpretation of data, and monitoring mycobacteriology laboratory reports from the Nebraska Public Health Lab (NPHL) and other private labs. Prevention activities include: providing medications, case management activities, professional education, consultation and technical assistance. The NPHL provides services statewide for mycobacterial identification, susceptibility testing and mailing for the CDC Genotyping Program.

In 2006 Nebraska had a total of 25 cases of Tuberculosis, resulting in a rate of 1.5 cases per 100,000 people. This is the lowest number of cases and attack rate in Nebraska in the last five years. The largest was 40 cases with a 2.3 attack rate in 2001. Nebraska ranked 38th nationally for the number of Tuberculosis cases in 2005 with 35 cases and continues to remain among the states with low Tuberculosis morbidity.

### [HIV/AIDS Surveillance Program](#)

The Nebraska HIV/AIDS Surveillance Program was implemented in 1983 when the first AIDS case was reported. Confidential name-based reporting of HIV infection was then mandated in July 1995.

Nebraska's communicable disease regulations (Title 173) require physicians and hospitals to report persons diagnosed with HIV infection and laboratories to report all cases with laboratory-confirmation of HIV. Demographics, exposure to the disease and clinical data are collected on each case and entered into the Nebraska HIV/AIDS Reporting System (HARS) database developed by the U.S. Centers for Disease Control and Prevention (CDC).

In 2007, the HIV/AIDS Surveillance Program completed the [2007 Nebraska HIV/AIDS/STD Epidemiological Profile](#) which includes data and information on HIV disease in Nebraska as well as information on STD's, Hepatitis and the Ryan White and HOPWA Programs. The entire profile is included in Section 5.

## **SECTION 4**

### **INTRODUCTION TO THE NEBRASKA HIV CARE AND PREVENTION CONSORTIUM (NHCPC)**



**SECTION 4**  
**INTRODUCTION TO**  
**THE NEBRASKA HIV CARE AND PREVENTION CONSORTIUM**  
**(NHCPC)**

**HISTORY OF THE NHCPC**

The Nebraska Department of Health and Human Services (DHHS) HIV Prevention Program initiated a comprehensive community based participatory planning process in February 1994 by conducting a forum which brought together 50 key stakeholders from across Nebraska. The forum resulted in the creation of six regional planning groups, corresponding geographically with the six state health planning regions, and one statewide planning body. Initial meetings of the six regional planning groups were held in June 1994. The first fourteen months of the community planning process in Nebraska proved challenging to both community participants and the Nebraska Department of Health and Human Services staff. Four DHHS staff members acted as liaisons to the six regional groups, with technical assistance from three regionally based community health nurses as needed.

In late 1995, the statewide planning group met to discuss the purpose of the statewide planning body and how the role of the statewide group differed from that of the regional groups. A part of the discussion involved an estimated cost-benefit analysis. The result of the meeting was to disband the statewide planning body and leave primary planning efforts at the regional level. A formal standing subcommittee composed of regional co-chairs, regional community health nurses, and the State Community Planning representative was developed to coordinate statewide efforts. In January of 1996, the HIV Prevention Program created the Community Planning Coordinator position whose primary job responsibility was to coordinate the entire community planning process. These changes supported a consolidated, yet specialized, communication network statewide and provided for more frequent and timely exchanges between regions and the DHHS HIV Prevention Program.

From 1996 through 1999, the six regional planning groups met on a regular basis. The regional co-chairs met approximately six times per year as a group to coordinate their efforts.

The regional planning groups were highly committed to the principles of community planning and did their best to achieve and maintain parity, inclusion, and representation; to participate in setting priority populations and interventions and to facilitate needs assessments; etc. However, the level of expertise and time needed to reach the outcomes desired by DHHS and CDC became increasingly difficult for the regional groups. The fluidity of the regional groups significantly slowed the process, even though the new ideas, opinions, and information were of great value. The regional groups were also having difficulty staying motivated about planning in a low incidence state and few providers had the capacity to actually implement the interventions that were recommended.

During this time, the Ryan White Part B Consortium groups were experiencing many of the same challenges as the regional groups. The two meetings were being held “back to

back.” During 1998, the Ryan White Part B Consortia and the regional planning groups formally merged at the community level. Even though there was not a push on the national level to begin merging CARE (Comprehensive AIDS Resources Emergency) and prevention initiatives, Nebraska felt the need to do so. At the HIV Community Planning Leadership Summit in 1998, discussion began to reevaluate the community planning process in Nebraska. That meeting was the springboard for the restructuring of the CARE Consortia and regional planning groups for Nebraska, which occurred over the next two years. Detailed analysis of multiple plans for consolidation and structure occurred over this time before the final structure was selected. Approximately nine months of development and transition time occurred before the first meeting of the Nebraska HIV CARE and Prevention Consortium (NHPC) was held in March 2000.

The first meeting of the Nebraska HIV CARE and Prevention Consortium (NHPC), in March 2000, consisted of reviewing the NHPC mission and purpose, objectives, committee structures, and administrative issues (such as expense reimbursement and meeting logistics).

To ensure continuity and accountability in the community planning process, members ratified the NHPC Bylaws (Appendix #1) and Operational Guidelines (Appendix #2).

### **NHPC MISSION AND PURPOSE**

The overall mission of the NHPC is to develop a Comprehensive HIV Care and Prevention Plan for the State of Nebraska. The plan will identify specific strategies and interventions that are responsive to validated needs within defined target populations. This mission will be accomplished in collaboration with the Nebraska Department of Health and Human Services HIV Prevention and Ryan White Title B Programs, the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA).

The purpose of the NHPC is to act in an advisory capacity to the Nebraska Department of Health and Human Services HIV Prevention and Ryan White Programs. Through this advisory relationship, the HIV Prevention and Ryan White Programs will respond to the care and prevention issues affecting those at risk for becoming HIV infected, as well as those who are currently living with HIV/AIDS. A Hepatitis Prevention Program was added in 2002. Integration of Hepatitis prevention education with HIV prevention has become an integral part of the overall program.

### **STRUCTURE OF NHPC**

The NHPC currently allows up to 38 positions. The members are classified as either “standing” positions or “elected” positions.

Standing positions are filled by persons required by federal funding and administrative recommendation to ensure specific expertise, which is critical to HIV prevention and care through public health forums. Persons identified to serve in these positions are appointed by the HIV Program Administrator upon recommendation by members or HIV Prevention Program staff. These positions comprise no more than 1/3 of the total membership.



Elected positions represent related functional areas, persons directly impacted by the epidemic, and geographic representatives. Persons identified to serve in these positions are determined by the Membership Committee of the NHCPC based on the current HIV epidemiological profile of the state and on the principles of parity, inclusion, and representation. Elected members comprise the remaining 2/3 of the membership. Of that 2/3, six regional representatives are elected by their respective regional community planning group. The membership positions of the NHCPC (Appendix #3) are:

Populations at Risk

(represent at-risk populations)

*Injecting Drug User*

*MSM – Rural (+ or -)*

*MSM – Urban (+ or -)*

*MSM of Color*

*Native American/American Indian*

*Person Living with HIV or AIDS (2)*

*Red Ribbon Community (HIV+ persons advisory group)*

*Woman at Risk – Affected or Infected*

Community Stakeholders

(represent community organizations)

*Business*

*City / County Health Department*

*Counseling and Testing*

*HIV Case Management*

*Mental Health / Substance Abuse*

*Minority Community Based Organization (CBO)*

*Minority Faith-Based*

*Minority HIV- Impacted*

*Prevention Subgrantee*

Standing Positions

(represent key functions for the process)

*Adolescent and School Health (NDE)*

*Ryan White AIDS Drug Assistance Program (ADAP)*

*Behavioral Health (2)*

*Direct Provision for STDs*

*Epidemiologist*

*Medicaid Issues*

*State Co-Chair*

*State Corrections*

*Ryan White State Title B Program Manager*

*Ryan White Title C Coordinator (2)*

*State HIV Program Administrator (Ex-Officio)*

### Regional Representatives

(represent the six health planning regions)

*Central Region*

*Eastern Region*

*Northern Region*

*Southeast Region*

*Southwest Region*

*Western Region*

Members serve for a period of three years, except for standing members, whose serve at the discretion of the HIV Program Administrator. Members are elected at any NHCP meeting. Terms expire on December 31. Members of the NHCP may not serve more than two consecutive terms.

The NHCP is directed by two co-chairs. The State Co-Chair is appointed by the HIV Program Administrator. The second, Community Co-Chair, is elected by the NHCP membership. The Community Co-Chair serves for a period of two years. He/she shall not serve more than two consecutive terms. The Community Co-Chair must be a member of the NHCP for six months prior to election.

The NHCP meets quarterly and also conducts a one day workshop in conjunction with the April or July meeting. The work of the NHCP is primarily accomplished in the committee meetings which are held for two hours prior to each general meeting. All meetings are held in compliance with the Nebraska Open Meeting Laws.

### **NHCP STANDING COMMITTEES**

The NHCP has six standing committees. Each standing committee has a State Liaison appointed by the HIV Program Administrator. The role of the liaison is to facilitate the work of the committee and serve as a resource for materials, information, direction, and provide technical assistance as needed.

All members of the NHCP are expected to serve on a committee during their term of membership. Supporting the NHCP philosophy of broadening community involvement to ensure parity, inclusion, and representation in all aspects of the process, persons outside the NHCP membership may be solicited to participate on committees and ad hoc groups or task forces. Each committee elects a chair to direct the activities of the committee. The committee chair must be a current member of the NHCP and ensures the committee operates under the Bylaws and Operational Guidelines.

The NHCP standing committees and purposes of each are as follows:

#### Assessment and Evaluation Committee

- Review and identify strengths and weaknesses and provide recommendations regarding prevention and care evaluation and assessment processes and results.

### Co-Infections Committee

- Review and report on mortality/morbidity issues related to co-infection.
- Establish a co-infection response that is incorporated in the Nebraska HIV Comprehensive Plan.
- Provide data analysis for priority populations related to co-infection impact and potential risk factors in Nebraska.
- Focus on the following primary infections: Hepatitis B, Hepatitis C, Syphilis and Tuberculosis.

### CARE Services Committee

- Review the continuum of services provided by the Ryan White Part B Program and provide feedback to the Ryan White Program regarding adequacy of services.
- Provide recommendations to the Part B Program regarding the addition/deletion of provided services.
- Research and provide information, as necessary, to identify additional services and assist in their procurement as necessary.
- Assist in the development of additional resources for service provision.

### Interventions Committee

- Utilize statewide needs assessment information for the purpose of identifying, prioritizing, and recommending behavioral interventions for funding with HIV prevention funds. Effectiveness and support for these interventions should be based in behavioral change theory, be cost effective, and be compatible with the norms, values, and relevance for the communities where they will be introduced.

### Membership Committee

- Recruit elected members and orient all participants. The committee will solicit new members under the guiding principles of achieving parity, inclusion, and representation of the epidemic for the NHCP. Personal knowledge and expertise will be sought for positions, which contribute critical information to the development of a comprehensive HIV Care and prevention plan.

### Public Information Committee

- Review proposed educational materials, discuss media and education that is made available to communities, make recommendations for educational materials, and participate in the development of a public information plan.

## **EXECUTIVE COMMITTEE**

The Executive Committee consists of eight members; the current chair of each standing committee and the two NHCP co-chairs (the Community Co-Chair and the State Co-Chair). The purpose of the Executive Committee is to provide decision making capability on behalf of the NHCP between meetings for specific and emerging functions.



## **SECTION 5**

### **2007 NEBRASKA HIV/AIDS/STD EPIDEMIOLOGICAL PROFILE**



**2007  
Nebraska  
HIV/AIDS/STD  
Epidemiological Profile**



**Nebraska HIV, Hepatitis, Ryan White and HOPWA Programs  
Nebraska Department of Health and Human Services**







## NEBRASKA 2007 HIV EPIDEMIOLOGIC PROFILE

Prepared by: Tina Brubaker, M.P.H., HIV Surveillance Program Manager

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## Executive Summary:

This profile describes the epidemic of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) in Nebraska. The primary source of data is the Nebraska Department of Health and Human Services HIV Surveillance Program, which is responsible for collecting data on all cases of HIV/AIDS in the state. Both HIV and AIDS are conditions reported by name; AIDS since 1983 and HIV since July 1995.

**HIV/AIDS Incidence:** As of the end of 2006, a total of 2,241 persons had been reported with Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) in Nebraska; of these 35% are known to have died. During 2006, 117 new cases of HIV and AIDS were diagnosed, reflecting an incidence rate of 6.7 cases per 100,000 population.

The number of HIV/AIDS cases increased from 3 cases in 1983 to a high of 136 cases in 2001, decreased to 75 cases in 2003, before increasing again to 117 cases in 2006. A substantial number of persons reported with HIV disease in Nebraska are being diagnosed at an advanced stage of the disease; 42% of those diagnosed between 1997 and 2006 either had AIDS at the time of their HIV diagnosis or progressed to AIDS within 12 months of their HIV diagnosis.

The largest number of deaths for persons with HIV/AIDS was 43 in 2001 and has since dropped to 24 deaths in 2006.

**Trends among Recently Diagnosed Cases:** Between 2004 and 2006, the number of males newly diagnosed with HIV/AIDS increased, from 68 cases in 2004 to 91 cases in 2006. HIV/AIDS cases among females remained stable at approximately 29 cases. Rates were higher among men (9.2 per 100,000 persons) than women (3.4 per 100,000 persons) and highest among persons aged 25 to 44 years (15.9 per 100,000). There have been an increasing number of cases among blacks, rising from 26 cases in 1997 to 45 cases in 2006, nearly matching the number of white cases (56). Rates among males were highest for blacks (59.3 per 100,000) compared to whites (5.3 per 100,000). The rate for Hispanic males was also high at 21.0 per 100,000. Rates among females were highest for blacks (42.4 per 100,000). Among men, the most commonly reported risk behaviors were men who have sex with other men (MSM; 50%), heterosexual contact with a person known to be at risk for HIV infection (10%), injection drug use (IDU; 7%), and MSM with IDU (4%). Among women, heterosexual contact was reported for 63% of the cases, and 8% reported injecting drug use as their risk behaviors.

**Prevalence:** At the end of 2006, 1,397 Nebraska residents were known to be living with HIV/AIDS (PLWHA). However, since not all persons infected with HIV are aware of their status, it is estimated that there were between 2,182 and 2,489 persons currently living in Nebraska with HIV disease.

The majority of PLWHA live in Douglas County (61%) and Lancaster County (17%). Most are male (73%), white (77%), 25 to 44 years of age (59.7%) with the predominate risk behaviors being MSM (43.8%).

**Service Utilization:** The federally funded Ryan White HIV/AIDS Treatment Modernization Act continues to serve low-income persons with HIV/AIDS in Nebraska. The AIDS Drug Assistance Program (ADAP) provided needed pharmaceuticals to 315 unduplicated clients for the period April 2005 through March 2006. There was an average of 179 clients served per month, with an average two new clients admitted to the program per month. The program did have a waiting list during this period due to the lack of adequate funding.

As of December 31, 2006, the Nebraska CARE Program (Ryan White Part B and Part C) had 904 clients. Most of the visits were medical-related services, but the largest average number of visits per client occurred for those seeking substance abuse treatment.

Case management is provided across the state by Nebraska AIDS Project. There were a total of 517 unduplicated HIV positive clients who were provided a total of 5,244 case management service units; an average of 10.14 service units per client. Of these 517 clients, 217 received direct emergency assistance which consists of housing (rent), utility, transportation, insurance and food assistance.

Information from the CARE Act Data Report indicated that transportation was by far the most utilized assistance category, followed by utilities, food and housing.

The Housing Opportunities for Persons with AIDS (HOPWA) served 133 unduplicated clients and 76 family members in 2006. The most utilized housing type was rental housing (72%) followed by private residence (18%).

**Unmet Need:** An important aspect of HIV/AIDS planning and service delivery is to estimate the size of the HIV/AIDS infected population that is aware of their infection, but not receiving medical care. For this reason, the Health Resources Services Administration (HRSA) requires that grantees under Ryan White Part B and Part C estimate this population annually. In Nebraska, persons with HIV infection who did not receive a viral load or CD4 lymphocyte test in 2005 are considered to have unmet primary medical need. Forty percent of the PLWHA were estimated to fall in to this category. Persons with unmet need were primarily male (80%), white (56%) or black (24%) and 30 to 39 years old (72%). The majority of those with unmet need reported MSM as their risk behaviors (44%), followed by heterosexual contact (11%), injecting drug use (11%), and MSM/IDU (9%).



## INTRODUCTION

This statewide profile describes the epidemiology of HIV/AIDS in Nebraska through December, 2006, with data received through March 2007. The report characterizes the distribution of HIV infection in terms of geography, race, gender, age, and associated causal factors. By examining changes over time, it also identifies trends of increasing risk in certain groups. This epidemiological profile has been prepared to assist in developing a comprehensive HIV/AIDS prevention and planning effort, and to quantify unmet need for prevention and care programs.

The Epidemiologic Profile (Epi Profile) plays a key role in the development of the HIV Comprehensive Plan for Nebraska. By June 2008 the second Five Year HIV Comprehensive Plan for Nebraska (2009-2013) will be completed. The Comprehensive plan consists of four key products: the Epidemiologic Profile, the Community Services Assessment, prioritized populations and a set of interventions for each population.

The statewide community planning group, the Nebraska HIV CARE and Prevention Consortia (NHCCPC), will begin the initial phase of developing the comprehensive plan in June 2007 by bringing together members of the Assessment and Evaluation Committee to preview the Epi Profile and identify data gaps prior to the NHCCPC quarterly meeting in July 2007. At this all day meeting we will be completing the Community Services Assessment (Needs Assessment, Resource Inventory and Gap Analysis) along with selecting our priority populations.

The completeness of the Epi Profile is key to determining priority target populations. Populations are prioritized by comparing infection rates, risk behaviors, and other factors. This process helps the HIV Prevention Program to direct prevention funds to those populations most at risk of transmitting HIV or becoming infected. As a result, targeted prevention efforts can be supported to reduce HIV transmission in populations with the highest rates of HIV infection, thereby achieving the greatest possible impact.

## ORGANIZATION OF THE PROFILE

This epidemiological profile is organized into five main sections; the outline is as follows:

### **Section 1: Description of Nebraska's population**

This question examines the overall demographic and socioeconomic characteristics of the general population in Nebraska. The information used to answer this section may be used to establish a baseline for comparison to other states and other populations.

### **Section 2: HIV/AIDS in Nebraska**

Examines the population of persons with HIV/AIDS in Nebraska. Additionally, through analysis of the information one will be able to target prevention groups as well as care services for those people who are most affected.

### **Section 3: Indicators of risk for HIV/AIDS infection in Nebraska**

The information relating to this question will provide a more in depth analysis of high risk populations associated with HIV transmission as well as identify measures that serve as indicators of high-risk behavior.

### **Section 4: Care and Services Utilized by Persons with HIV in Nebraska**

This information describes the patterns of HIV primary medical care and support services used by persons with HIV. It examines the characteristics of persons accessing Ryan White Part B and Part C care services and the types of services they received.

### **Section 5: The number and characteristics of persons who know they are HIV positive, but who are not receiving HIV primary medical care**

This section describes efforts that are underway to use a framework developed by CDC and HRSA to estimate unmet need for HIV primary medical care in Nebraska.

## PROFILE PREPARATIONS

This profile was prepared by the Nebraska Office of Public Health HIV/AIDS Surveillance Program in close collaboration with the Nebraska HIV Prevention and Ryan White CARE Act Programs and the Centers for Disease Control and Prevention (CDC). It was developed to provide key stakeholders and the Nebraska HIV Care and Prevention Consortium (NHCPC) with data to guide their planning and prevention efforts.

## PROFILES DATA SOURCES

Data were compiled from a variety of sources to provide the most complete picture possible. Few behavioral or supplemental surveillance projects are available in Nebraska; therefore, core surveillance data is heavily utilized. Each data source has strengths and limitations, which should be considered when interpreting the data. Below is a list of the data sources used in this profile. For a complete description of each data source and its strengths and limitations, please see Appendix A: Epi Profile Data Sources.

### Core HIV/AIDS Surveillance:

HIV/AIDS Case Surveillance	
Nebraska Youth Risk Behavior Survey (YRBS)	
Nebraska Behavioral Risk Factor Surveillance Program (BRFSS)	
STD Surveillance	
Substance Abuse Data:	Treatment Episode Data Set (TEDS)
	National Household Survey of Drug Abuse (NHSDA)
Vital Statistics Data	Death Data
Population Data	U.S. Census Bureau
HIV Care Data	Ryan White Care Act

## SURVEILLANCE RISK BEHAVIOR CATEGORIES

For surveillance purposes HIV and AIDS cases are counted only once in a hierarchy of risk behaviors categories, according to the CDC standards. The hierarchy is the list of behaviors that can lead to HIV infection, in the order of the behavior that can put one at a greatest risk for infection down toward those behaviors that are still risky, but not as risky as the behavior before it. Persons with more than one reported mode of exposure to HIV are classified in the exposure category listed first in the hierarchy, except for men with both a history of sexual contact with other men and a history of injection drug use. They make up a separate category. The modes of exposure are categorized in this report according to the following hierarchy:

### Men who have sex with men (MSM)

Include men who report sexual contact with other men, and men who report sexual contact with both men and women.

### Men who have sex with men and inject drugs (MSM/IDU)

Includes men who inject nonprescription drugs and report sexual contact with other men or who report sexual contact with both men and women.

### **Injection drug use (IDU)**

Includes persons who inject nonprescription drugs.

### **Heterosexual contact**

Includes persons who report specific heterosexual contact with an HIV positive person, or heterosexual contact with a person at increased risk for HIV infection, such as an injecting drug user, person with hemophilia, transfusion recipient or bisexual male.

Includes new category, Presumed Heterosexual, which includes females that are currently classified as an NIR, and reports a positive history of sex with a male prior to HIV diagnosis, has a negative history of injection drug use, and there is no other information that would suggest a likely alternative source of HIV infection (for example, occupational exposure)

### **No identified Risk Factor (NIR)**

A person who reports no or unknown information on sexual or injecting drug use behavior, or a person who reports heterosexual contact with partner(s) whose specific HIV risks and HIV status are unknown is considered to have no risk identified (NIR) as their risk behaviors

## **GUIDELINES TO PREVENT MISINTERPRETATION OF THE DATA**

### Recommendations

The following guidelines are intended to facilitate proper interpretation of the text, tables and figures presented in this profile. Decisions about how to allocate limited resources for prevention and care services depend, in part, on appropriate interpretation of epidemiological data. The following guidelines are intended to facilitate proper interpretation of the tables and figures presented in this profile.

- Carefully examine the entire table or graph. Read the title of the table or figure and look closely at the type of information presented on the vertical and horizontal axes. Are the data showing the number of cases or a percentage of the total cases? Pie graphs and stacked bar graphs can show total numbers or percentages. Examine how the graphs are scaled. Does the number of cases increase by 5, 10, 100, or some other factor? What is the time period covered? Have any data been excluded from total counts?
- These data have certain limitations. This report will present both AIDS-case report data and HIV infection case-report data. AIDS case report data span 18 years and are relatively complete. HIV case report data only span less than 10 years, making the HIV data relatively incomplete.
- Be careful not to over-interpret small changes or differences from year to year. Comparing one year with another year may be misleading, particularly given the low numbers of cases reported in Nebraska annually. Major trends over time will be highlighted in the narrative of this document.
- Look for consistencies with other information sources. Different findings should be examined carefully. All data sources are not equivalent; thus, lacking the ability to

generalize to the population of Nebraska. In particular, scientific studies should be examined for their purposes and for the population studied. Where scientific studies are presented, their limitations will be included in the discussion.

- Case rates have been calculated for 12-month periods per 100,000 population. The denominator for calculating rates is based on Census 2000 data from the U.S. Bureau of Census. The numerator is the number of cases reported during the 12-month period. This number is divided by the population estimate and multiplied by 100,000. Race-specific rates are the number of cases reported for a particular racial/ethnic group during the preceding 12-month period divided by the projected population for that race/ethnicity, multiplied by 100,000.

## Section 1: Description of Nebraska’s Population

Nebraska is largely a rural state, covering 77,358 square miles, making it the 16th largest of the 50 states in terms of land area. Nebraska measures 459 miles (740 kilometers) across at its widest point, following a diagonal from southeast to northwest.

Approximately two thirds of Nebraska’s 1.7 million people reside in three of Nebraska’s 93 counties (Douglas, Lancaster and Sarpy) which are considered urban counties and are located in the eastern portion of the state. These counties contain Nebraska’s major population centers, Omaha, Lincoln, and several smaller cities scattered along the Platte River and Interstate I-80. Counties located on the west-central side of Nebraska are less populated. The remaining one third of the population is located in the other 90 counties which are considered rural. According to the U.S. Census Bureau, Nebraska is the 38<sup>th</sup> most populated of the 50 states. Rural counties are losing population while urban centers are growing.

Table 1 lists the top 10 counties in Nebraska based on population size, according to the 2004 U.S. Census Estimates.

**Table 1: 10 Largest Counties in Nebraska**

County	Population
Douglas	482,112
Lancaster	261,545
Sarpy	135,973
Hall	54,862
Buffalo	43,406
Scotts Bluff	36,631
Dodge	36,066
Madison	35,752
Lincoln	34,979
Platte	31,245
Nebraska	1,747,214
<i>Source: US Bureau of the Census, 2004 Population estimates</i>	

The largest city in Nebraska is Omaha followed by Lincoln. All other cities in Nebraska are under 50,000 population, as listed in Table 2.

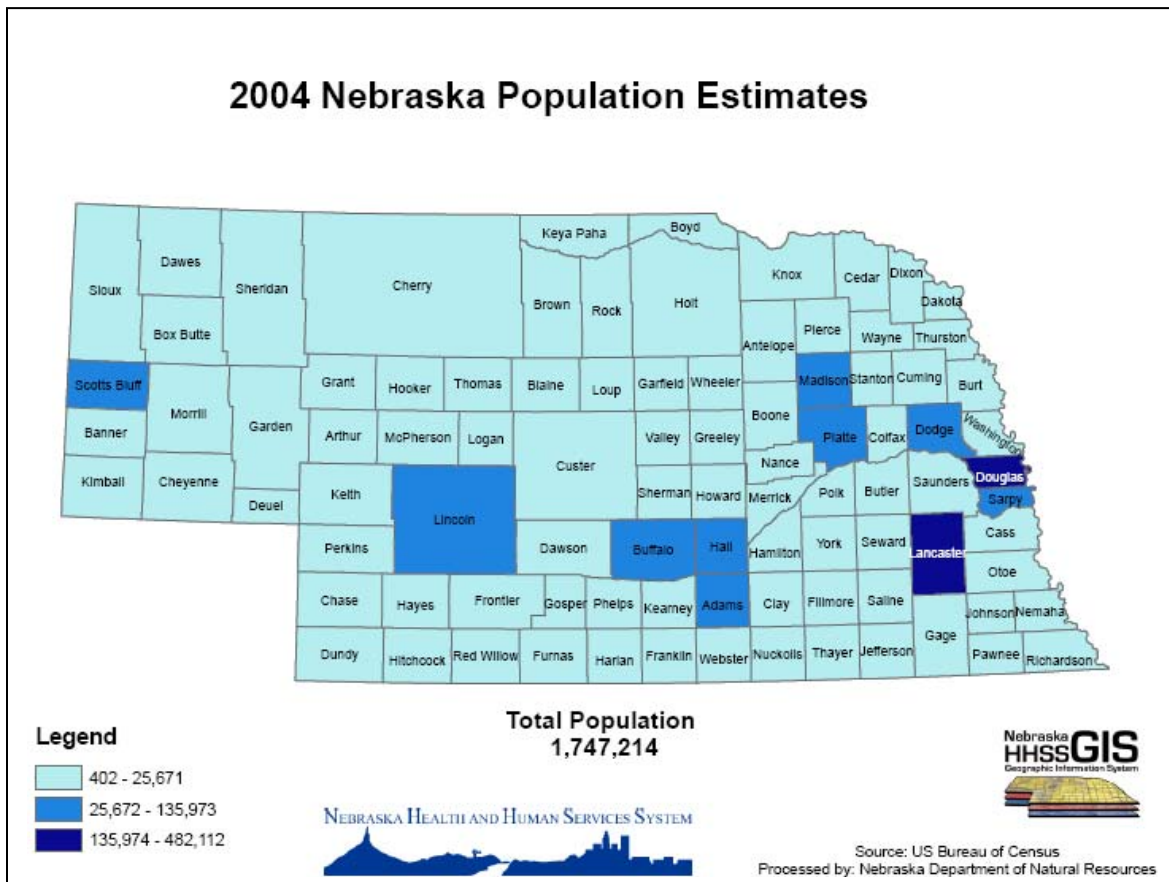
**Table 2: List of Top 10 Cities in Nebraska by Population Size**

City	Population
Omaha	409,416
Lincoln	236,146
Bellevue	47,347
Grand Island	44,287
Kearney	28,640
Fremont	25,272
Norfolk	24,072
Hastings	23,404
North Platte	23,944
Columbus	20,881

*Source: US Bureau of the Census, 2004 Population Estimates*

The map, immediately following, identifies the population in each of Nebraska’s 93 counties. The shading corresponds to the population range given in the key at the bottom of the map.

**Map 1:**



## DEMOGRAPHICS OF NEBRASKA

### Age and Gender

In 2004, the population of Nebraska was estimated at 1,747,214 persons (Table 1). According to the U.S Census, Nebraska's population increased 2.1% in five years (from 1,711,263 in 2000 to 1,747,214 in 2004). The largest proportion of the population was between the ages of 30-49 (27.8 % overall), and about 49.7 % of the population was between 13-49 years of age. The age distribution among males and females was similar; however, a slightly higher proportion (4.2%) of women were elderly (65 years and older) than men (Table3).

**Table 3: Percentage distribution of the general population, by age group and gender, Nebraska**

	Males, %	Females, %	Total Population, %	US Population
Age, years	(N = 863,793)	(N = 883,911)	(N = 1,747,214)	(N = 293,656,842)
< 13	21.3%	19.9%	20.6%	20.7%
13-19	7.7%	7.1%	7.4%	7.1%
20-24	8.1%	7.5%	7.8%	7.1%
25-29	7.0%	6.5%	6.7%	6.7%
30-49	28.4%	27.2%	27.8%	29.5%
50-64	16.3%	16.7%	16.3%	16.5%
65 or older	11.2%	15.4%	13.3%	12.4%
<i>Source. US Bureau of the Census, 2004 Population estimates,</i>				



## Race/Ethnicity

The racial and ethnic minority population in 2000 comprised 12.6% of the total population, and by 2004 it is estimated to have increased to 16.3%. The following Table 4 shows the increase in Nebraska's population groups from 2000 to 2004. The state's growth rate of 2% was fueled by the growth of ethnic and racial minority populations in the state, especially Hispanic which grew 27.1% from 2000 to 2004.

**Table 4: Increase in population, Nebraska, 2000 to 2004**

	<b>2000</b>	<b>2004 Estimate</b>	<b>% Increase</b>
Total Population	1,713,239	1,747,214	2.00%
White	1,587,082	1,609,056	1.30%
Black	70,212	74,815	6.80%
American Indian	15,664	16,562	5.90%
Asian	23,761	27,922	18.70%
Hispanic	95,308	119,975	27.10%
Non-Hispanic	1,617,931	1,627,239	
Minority	215,529	250,577	16.30%
<i>Source: US Bureau of the Census, 2004 Population Estimates</i>			

In the 2000 U.S. Census, the collection of race and ethnicity information was expanded to allow persons the opportunity to report more than one race group, as well as to report Hispanic ethnicity. For the purposes of this profile, to compare to HIV data, the numbers used are for those of one race. More than 92% of the men and women in Nebraska reported themselves as non-Hispanic White (Table 5). Non-Hispanic blacks comprised 4.3% of the population. Hispanics comprised 6.9% of the total population, and Asians/Pacific Islanders and American Indians/Alaska Natives totaled 1.6% and less than 0.9% respectively. The race/ethnicity distribution among males and females was similar.

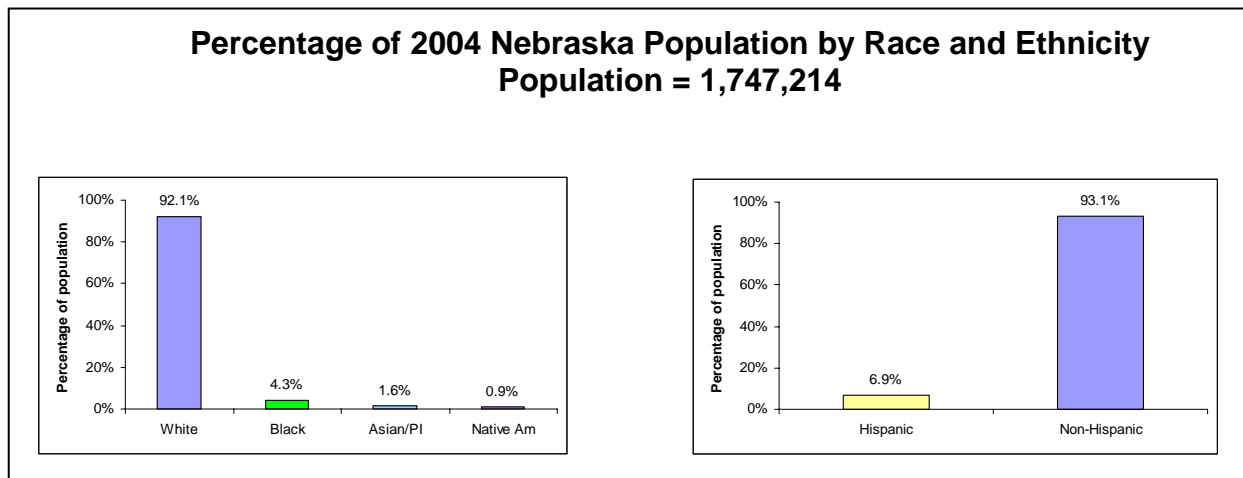
**Table 5: Percentage distribution of the general population, by race/ethnicity and gender**

	Males, % (N = 863,628)	Females, % (N = 883,586)	Total Population, % (N = 1,747,214)
Race/ethnicity			
Hispanic or Latino	7.5%	6.2%	6.9%
Not Hispanic or Latino			
White alone	92.1%	92.1%	92.1%
Black/African American alone	4.3%	4.3%	4.3%
American Indian/Alaska Native alone	0.9%	1.0%	0.9%
Asian/Native Hawaiian/Pacific Islander alone	1.6%	1.6%	1.6%

*Source. US Bureau of the Census, 2004 Population Estimates*

The racial and ethnic composition in Nebraska, according to the 2004 U.S. Census Estimates, is illustrated in Figure 1.

**Figure 1**



As Table 6 indicates, according to the 2004 Census, the distribution of race/ethnicity varied across Nebraska counties that had a population of more than 100,000.

**Table 6: Percentage distribution of the general population, by race/ethnicity for counties of >100,000 population compared with the population of Nebraska**

	Population, %			
	Douglas	Lancaster	Sarpy	Total Population, %
Race/ethnicity	(N = 482,112)	(N = 261,545)	(N = 135,973)	(N = 1,747,214)
Hispanic or Latino	8.5	4.1	5.1	6.9
Not Hispanic or Latino				
White alone	83.9	91.5	91.3	92.1
Black/African American alone	11.7	3.0	4.1	4.3
American Indian/Alaska Native alone	0.7	0.7	0.4	0.9
Asian/Native Hawaiian/Pacific Islander alone	2.2	3.3	2.2	1.6
<i>Source. Census 2004, US Bureau of the Census</i>				

In Douglas County, the most populous county, 11.7% of the population indicated their race as black, compared with 4.1% in Sarpy and 3.0% in Lancaster. Douglas County also reported the highest proportion of Hispanics (8.5%), while Lancaster had the lowest proportion of Hispanics (4.1%) compared with the other counties. Less than 1% of the population in each of these counties reported themselves as American Indian/Alaska Native. The percentages of persons in the three counties that identified themselves as Asian/Pacific Islander ranged from 2.2 - 3.3%.

## Socioeconomic Status

### Poverty Level

In 2004 census, the median household income in Nebraska was \$42,166. More than 172,162 residents (10.0% of the population) for whom poverty status was determined, had incomes that fell below the federally defined poverty level as compared with 12.7% nationally (Table 7).

The unemployment rate (among those in the labor force age 16 and older) in 2000 was 2.5% statewide. Nearly 13.8% of adults (19-64 years) in Nebraska were uninsured. In the 2000 census, 86% of male and 87% of female Nebraska residents aged 25 years and older reported educational attainment of high school diploma or higher.

**Table 7: Percentage distribution of persons living below the poverty level during 1999 for selected counties, compared with the population of Nebraska and the United States**

<b>County</b>	<b>Population</b>	<b>Below poverty level, %</b>
Douglas	463,585	9.8
Lancaster	250,291	9.5
Sarpy	122,595	4.2
Hall	53,534	12.0
Lincoln	34,632	9.7
Scotts Bluff	36,951	14.5
Thurston	7,171	25.6
Madison	35,226	11.2
Platte	31,662	7.7
Buffalo	42,259	11.2
Dawson	24,365	10.8
Statewide	1,711,263	9.7
U.S.	281,421,906	12.4
<i>Source. Census 2000, US Bureau of the Census</i>		

### **Education by Gender in Selected Counties**

In 2000, more than 85% of Nebraskans aged 25 and older had earned at least a high school diploma or its equivalent (Table 8). Additionally, a majority had at least some college, within each of the three largest counties and statewide.

**Table 8: Percentage distribution of the population 25 years or older, by educational attainment and gender, for counties of > 100,000 population, Nebraska, 2000**

Percentage	Douglas		Lancaster		Sarpy		Total Population, %	
	Males (N= 140,367)	Females (N= 152,709)	Males (N= 75,093)	Females (N= 77,654)	Males (N= 35,821)	Females (N= 37,983)	Males (N= 523,919)	Females (N= 563,322)
< 9 <sup>th</sup> grade	4.7	3.9	2.9	2.8	1.9	1.9	5.9	4.9
High school	8.5	8.4	7.3	6.0	4.2	5.4	8.4	7.8
High school diploma <sup>1</sup>	24.2	28.0	24.9	25.6	22.1	27.1	31.0	31.5
Some college	23.9	25.0	22.5	25.5	28.9	29.8	22.8	25.6
Associate or bachelor's degree	27.9	26.7	30.1	30.6	31.0	28.1	23.8	23.8
Graduate or professional degree	10.8	8.0	12.3	9.5	11.8	7.7	8.3	6.3

*Source. Census 2000, US Bureau of the Census*  
1. Includes equivalency

The most common level of education attainment among persons 25 years and older varied by location and sex. Statewide 31.0% of men and 31.5% of women had earned no more than a high school diploma or its equivalent. Douglas, Lancaster, and Sarpy Counties had higher percentages of men and women who earned at least one college or professional degree, compared to the statewide percentages. All three counties reported a lower percentage of both males and females with an education level of less than 9th grade as compared to the statewide percentage for both groups.

## Health Insurance

From 1999-2000, nearly 13% of Nebraskans ages 19-64 reported that they did not have health insurance coverage (Table 9). When only low income (less than 200% of poverty level) are considered this percentage increases to 28.6%. However, both of these values are less than their corresponding percentages nationwide. Approximately two-thirds (65.9%) of Nebraskans ages 19-64 reported receiving health insurance coverage from their employer (this value drops to 30.4% for low income Nebraskans). Five percent of all Nebraska adults received health coverage from Nebraska's Medicaid Program.

**Table 9: Percentage distribution of adults (19-64 years), by health insurance coverage and income level in Nebraska compared with the United States, 1999-2000**

	All Income Levels		Low Income <sup>1</sup>	
	Nebraska, % (N <sup>2</sup> = 1,119)	U.S., % (N <sup>2</sup> = 165,257)	Nebraska, % (N <sup>2</sup> =261)	U.S., % (N <sup>2</sup> = 48,783)
Employer	65.9	68.1	30.4	32.8
Medicaid <sup>3</sup>	5.0	6.3	15.5	17.6
Other <sup>4</sup>	16.3	7.9	25.4	12.1
Uninsured	12.7	17.7	28.6	37.6

Source. Kaiser Family Foundation  
**Note.** Percentages may not add to 100% because of rounding  
 1. Less than 200% of poverty level  
 2. In thousands  
 3. Medicaid includes CHIP  
 4. Includes private non-group and other public insurance (mostly Medicare and military-related)

## Section 2: HIV/AIDS in Nebraska

HIV disease has impacted persons in all sex, age, and racial/ethnic groups in Nebraska. This impact, however, has not been the same for all population groups. In the beginning of the national epidemic, HIV cases rose most sharply in white men who reported having sex with men. Although white men who have sex with men (MSM) are still disproportionately impacted by the epidemic, recent national trends suggest a shift in the epidemic towards women, blacks, and high-risk heterosexuals. As the national epidemic continues to change and the number of persons living with HIV continues to grow, it is extremely important to identify those populations most impacted and most at-risk for HIV infection in order to effectively plan for HIV prevention and care and to allocate limited resources.

Early in the epidemic, AIDS case data were the only available method to describe persons diagnosed with HIV infection. During the 1980s, AIDS cases alone provided an adequate picture of HIV trends because the time between infection with HIV and progression to AIDS was predictable (9-12 years). This predictability, however, has diminished since 1996, when highly active antiretroviral therapies (HAART) became available. Access, adherence, and response to HAART affect whether or when HIV progresses to AIDS. Thus, trends in AIDS cases alone no longer accurately reflect trends in HIV infection. Today, trends in the epidemic are better reflected by new HIV infections, regardless of whether they have progressed to AIDS.

Compared with the rest of the nation, Nebraska is considered a low HIV/AIDS incidence state. In 2005, the most current data available from CDC, state-specific AIDS rates ranged from 1.0 per 100,000 in Vermont to 32.7 per 100,000 in New York. Nebraska had the 11<sup>th</sup> lowest AIDS rate (3.0 per 100,000 persons). Compared with the surrounding states (IA, KS, CO, WY, and SD), Nebraska rates are very similar to Iowa and Kansas, at 3.2 and 3.9 per 100,000, respectively. Colorado has the highest rate at 7.7 per 100,000, while Wyoming has the lowest, 1.2 per 100,000, followed by South Dakota at 2.4 per 100,000.

Data will be presented by the year the case was diagnosed with HIV, regardless of a subsequent AIDS diagnosis. The data reflect reported cases that were residents of Nebraska at the time of diagnosis. Cases that were diagnosed in another state, but are receiving care and treatment in Nebraska are not included in this analysis. Cumulative HIV/AIDS cases include all reported cases, living or deceased.

**Notes:** Data are also provisional. The data contained in this epi profile reflects cases diagnosed through 2006, based on the information that was received through March 2007.

Two common terms used throughout the epi profile are incidence and prevalence. Incidence or incident cases, refers to new HIV and/or AIDS cases diagnosed during a particular time period; for example, from January 1, 2006, to December 31, 2006. Prevalence, or prevalent cases, refers to the number of people living with HIV and/or AIDS at any given time, for example, through the end of 2006.

### Cumulative AIDS Cases

Reporting of AIDS cases began in Nebraska when the first case was reported in 1983. Implementation of HIV reporting by name began in 1995. As of the end of 2006, a total of 2,241 persons had been reported with Human Immunodeficiency Virus (HIV) or Acquired

Immunodeficiency Syndrome (AIDS) in Nebraska; of these, 35% are known to have died. During 2006, 117 new cases of HIV and AIDS were diagnosed, reflecting an incidence rate of 6.7 per 100,000 population.

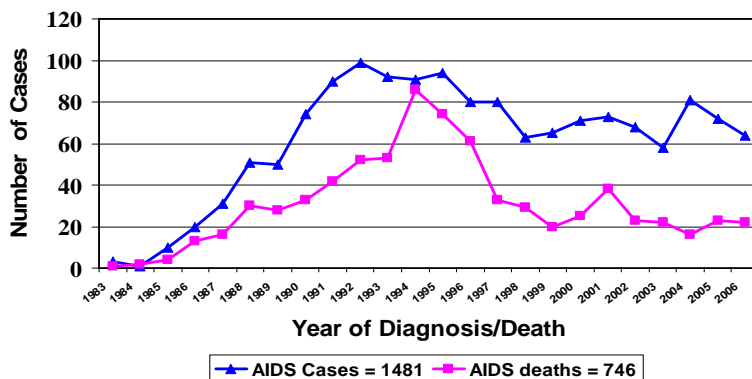
## Overall AIDS Trends

From 1983 to 2006, a total of 1,487 incident AIDS cases have been diagnosed among Nebraska residents. (see Figure 2). Since reporting of AIDS cases first started in 1983, the number of cases per year increased rapidly, reaching a peak of 99 cases in 1992. The number of AIDS cases remained stable from 1992 through 1995. Beginning in 1996, both the number of newly diagnosed AIDS cases and the number of deaths among AIDS cases declined sharply. This is primarily due to the success of new antiretroviral therapies including protease inhibitors. These treatments do not cure, but can delay progression to AIDS among persons with HIV (non-AIDS) infection and improve survival among those with AIDS. Since 1998, the number of reported AIDS cases in Nebraska has varied from 60 to 80 cases per year.

The total number of deaths in persons with AIDS between 1983 to 2006 was 746. The number of deaths has also leveled off to 21 deaths in 2006 from a high of 86 deaths in 1994. Information on deaths is received from yearly reviews of deaths certificates listing HIV or AIDS as one of the causes of death. Death certificates are obtained primarily from the HHSS Office of Vital Records. Other sources include local and state health departments, and active surveillance efforts.

**Figure 2:**

**Number of Newly Diagnosed AIDS Cases and Deaths, Nebraska, 1983 – 2006**



Source: Nebraska HIV/AIDS Reporting System

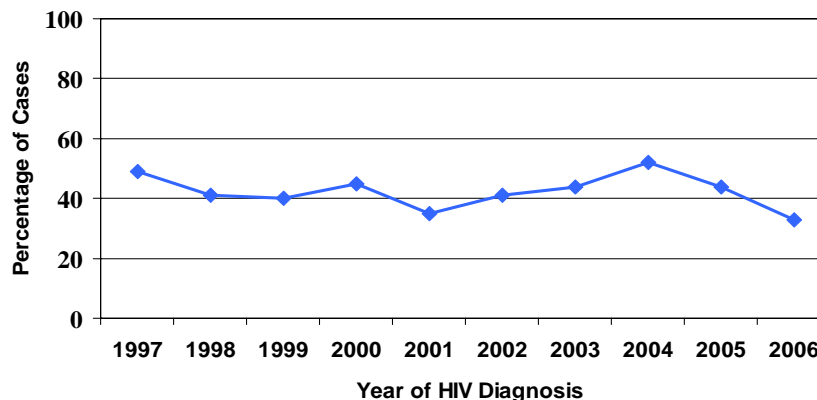


### AIDS at First Diagnosis

Figure 3 below shows the percentage of people who were diagnosed with AIDS within one year of their HIV diagnosis. In the time period from 1997 to 2006, there were 460 persons who were diagnosed with AIDS in the time period of less than 13 months from the time that they were diagnosed with HIV. These represented an average of 42% of all persons who were newly diagnosed with HIV infection in this time period. This compares with the national average of 40% for persons reported with AIDS in the United States in 2002. The percentage of those testing in the later stages of HIV disease varied from 49% in 1997 to 33% in 2006. This decline in the proportion of patients diagnosed at an advanced stage of disease is consistent with declines in mortality. However, reporting accuracy and insistence of surveillance staff on accurate dates of earliest diagnosis have likely improved the quality of dates of earliest diagnosis, and may explain some of the apparent improvement. These data suggest either that the average clinical latency from HIV to AIDS diagnosis has been prolonged, or that at-risk persons are testing earlier in the course of their infection. It is likely that both have occurred: clinical latency has been extended by antiretroviral therapy and early testing has increased as a result of public awareness of HIV, attributed to HIV prevention programs.

**Figure 3:**

**Percentage of Cases Diagnosed with AIDS  
within 1 Year of HIV Diagnosis,  
1997 to 2006  
N = 460**



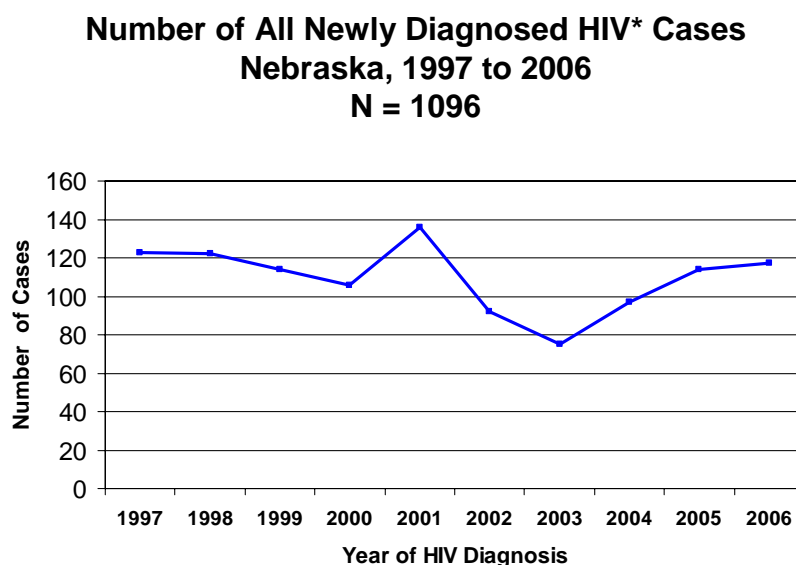
Includes persons who were diagnosed with HIV that received an AIDS diagnosis within the next 12 months. Cases were selected if there was an HIV diagnosis between 1997 and 2006, regardless of the current diagnosis (HIV or AIDS).

Source: Nebraska HIV/AIDS Reporting System

## HIV/AIDS Trends between 1997 and 2006

There were 1,096 incident cases of HIV and AIDS between 1997 and 2006 as shown in Figure 4. The combined number of HIV and AIDS diagnoses remained relatively steady from 1997 to 2000, between 105 and 123 cases per year, until there was a notable increase in the number of cases in 2001, when 136 cases were diagnosed. The number of cases then declined sharply to 75 cases in 2003, before increasing again to 114 cases in 2005 and appears to have leveled off again to 117 cases in 2006. The increase in incident cases in 2001 can be explained by the increase in the number of reported cases among white males, aged 25 to 44 years old.

**Figure 4:**



\* HIV cases include those diagnosed with HIV infection as well as AIDS

Source: Nebraska HIV/AIDS Reporting System

The remainder of this section will compare and contrast the trends in HIV disease, looking at trends over time and also by using a 3-year snapshot in time. The following data for new HIV and AIDS cases represent those diagnosed between 1997 through 2006. The three-year snapshot includes those cases diagnosed between 2004 and 2006. This was done because of the small numbers of cases diagnosed each year in Nebraska. Combining three years worth of data provides a better description of the most recent trends.

### **GENDER:**

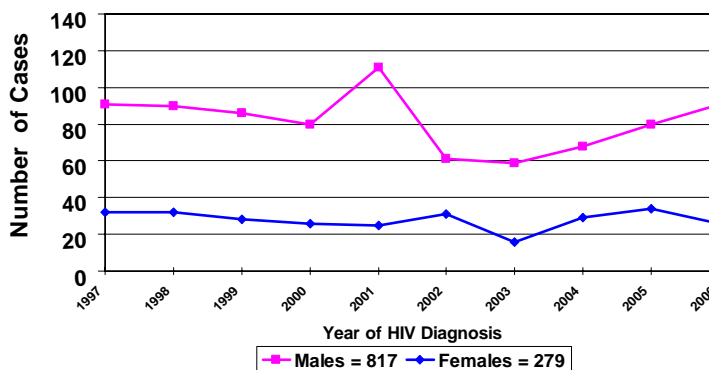
Figure 5 illustrates the incidence of HIV/AIDS by gender from 1997 to 2006. There were a total of 817 males and 279 females diagnosed with HIV/AIDS during this time period. Males have historically been the majority of new cases, and they continue to be so. Overall, males represented 75% of all the cases diagnosed in this ten-year time period, while females represented 25%.

The trend for males newly diagnosed with HIV/AIDS declined slightly from 91 cases in 1997 to 80 cases in 2000, then increased to 111 cases in 2001. After declining to 61 cases in

2002, there has been an increasing trend in the number of males diagnosed with HIV/AIDS. The trend for new female HIV/AIDS cases is very different. Female cases have remained relatively stable, since 1997, with the numbers of females with HIV/AIDS fluctuating between 16 to 34 cases per year.

**Figure 5:**

**Number of All Newly Diagnosed HIV\* Cases  
by Gender & Year of Diagnosis,  
Nebraska, 1997 - 2006  
N = 1096**



\* HIV cases include those diagnosed with HIV infection as well as AIDS

Source: Nebraska HIV/AIDS Reporting System

Table 10 below compares the incidence of males with HIV/AIDS to females. Between 2004 to 2006, the rate of new HIV/AIDS diagnoses was 9.2 for males and 3.4 for females.

**Table 10: HIV/AIDS diagnoses among persons in Nebraska, by age group and gender, 2004-2006**

Age (yrs)	Males			Females			Total		
	No.	%	Avg. Rates*	No.	%	Avg. Rates*	No.	%	Avg. Rates
0-4	2	1%	1.1	3	3%	1.7	5	2%	1.4
5-12	2	1%	0.5	0	0%	0.0	2	1%	0.3
13-24	31	13%	7.6	12	13%	3.1	43	13%	5.4
25-44	162	68%	22.5	63	71%	9.0	225	69%	15.9
45-64	40	17%	6.5	11	12%	1.7	51	16%	4.1
>64	2	1%	0.7	0	0%	0.0	2	1%	0.3
<b>Total</b>	<b>239</b>	<b>100%</b>	<b>9.2</b>	<b>89</b>	<b>100%</b>	<b>3.4</b>	<b>328</b>	<b>100%</b>	<b>6.3</b>

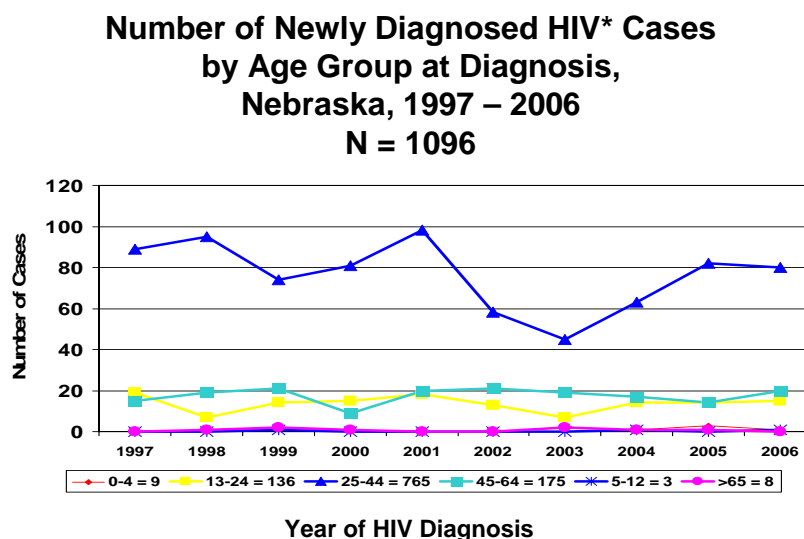
Source: Nebraska HIV Surveillance Program

\*Average yearly rate per 100,000 based on 2004 population – caution must be used in interpretation because of small numbers

## Age Groups

To look at changes in age at diagnosis, newly diagnosed HIV/AIDS cases are presented by the time of their HIV diagnosis in Figure 6. The 25 to 44 year old age group represents the largest age group and had the widest fluctuation in the number of cases per year. The number of cases varied in this age group from 89 cases in 1997 to a high of 98 cases in 2001 and declined to 80 cases in 2006. Trends for this age group mirror the overall HIV/AIDS trend, since they represent the largest age group. There was no obvious trend in all the other age groups.

**Figure 6:**



\* HIV cases include those diagnosed with HIV infection as well as AIDS

Source: Nebraska HIV/AIDS Reporting System

## Age and Gender

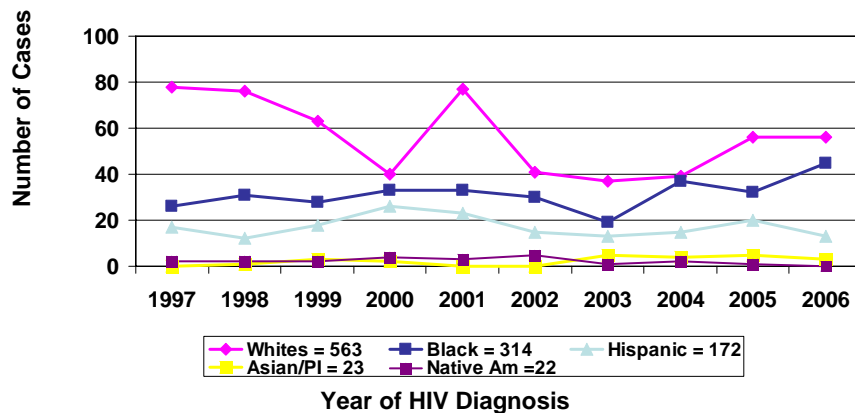
Table 10 shows the distribution of age group with gender. The majority of all the newly diagnosed HIV/AIDS cases, for both males and females, were in the age group 25-44. This age group represented 69% of all newly diagnosed HIV/AIDS cases, and also had the highest overall rate at 15.9 cases per 100,000.

## Race/Ethnicity

All persons of color have been disproportionately affected by HIV disease compared to whites, especially Blacks, in Nebraska. Figure 7 provides information on the trends for the number of HIV/AIDS cases by race/ethnicity by year of HIV diagnosis. The overall trend for White, non-Hispanic HIV/AIDS cases was a decline in cases from 78 cases in 1997 to 56 cases in 2006. The exception to this was in 2001 when the number of cases increased to 77 cases. HIV/AIDS cases among Blacks have increased from 26 in 1997 to 45 cases in 2006, nearly matching the number of White cases. The trend for HIV/AIDS cases among Hispanics has been stable, fluctuating between 12 to 26 cases per year. Trends for Asian/Pacific Islanders and Native Americans are not discernable because the number of cases per year was 5 or less.

Figure 7:

**Number of Newly Diagnosed HIV\* Cases  
by Race/Ethnicity, and Year of Diagnosis,  
Nebraska, 1997 – 2006  
N = 1096**



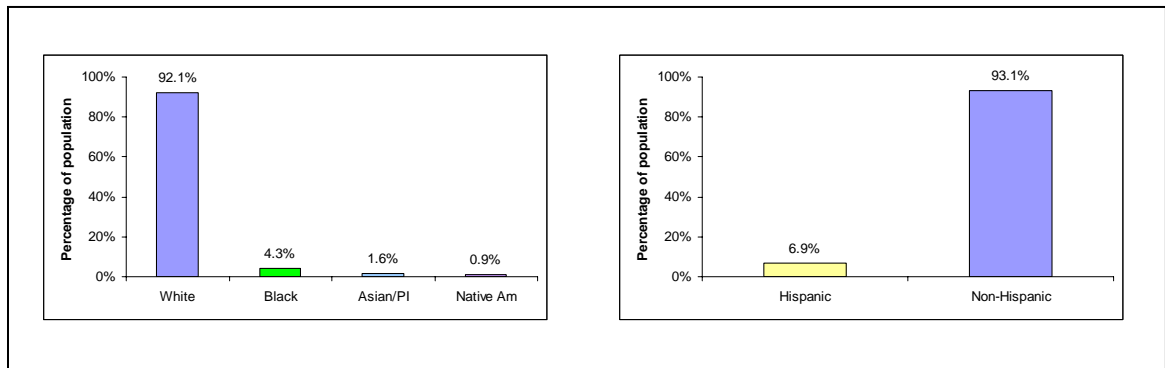
In addition, there were 2 of multi-race/ethnicity

Source: Nebraska HIV/AIDS Reporting System

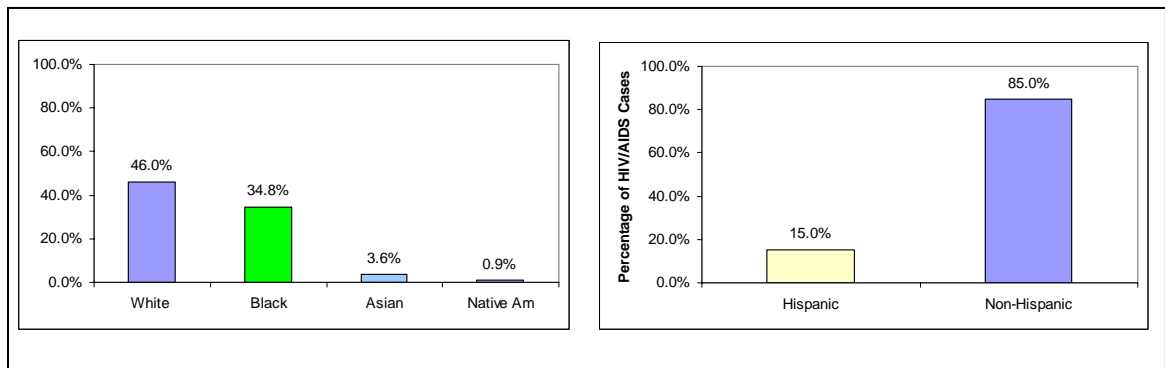
## Race/ethnicity compared to Nebraska population

Figures 8 and 9 below compares the proportion of HIV/AIDS cases by race/ethnicity to the distribution of race/ethnicities in the Nebraska population. While the majority of Nebraskans are white (86%), they only represent 46% of the HIV/AIDS cases. Blacks comprise 4% of Nebraska's population, but are 35% of all the HIV/AIDS cases. Hispanics are 15% of the cases while only 7% of the population. Native American and Asian/Pacific Islanders are represented only slightly higher among the HIV/AIDS cases than in the Nebraska population.

**Figure 8: Percentage of 2004 Nebraska Population by Race and Ethnicity**  
Population = 1,747,214



**Figure 9: Percentage of HIV/AIDS Cases Diagnosed 2004 to 2006, Nebraska**  
N = 328



## Race/ethnicity and Gender

As demonstrated in Table 11, even though male HIV/AIDS cases are primarily white, non-Hispanic (53%), and blacks account for 28% of these cases, the rates for these two groups is vastly different. The highest rate for HIV/AIDS is 59.3 per 100,000 for black males, while the rate for white males is very low at 5.3 per 100,000. The second highest rate for males is 21.0 per 100,000 for Hispanic males. When the number of cases varies as widely as these numbers, rates allow a better comparison between these race/ethnicities.

The majority of female HIV/AIDS cases are black (54%), while whites represent 27%, a very different distribution compared to males. The rates are highest for black female HIV/AIDS cases (42.4 per 100,000), followed by 16.9 per 100,000 for Asian females, 11.8 per 100,000 for Native American females, 4.2 per 100,000 for Hispanic females, and lowest for white females (1.0 per 100,000).

**Table 11: HIV/AIDS diagnoses and rates per 100,000 population in Nebraska, by race/ethnicity and gender, 2004-2006**

Race/Ethnicity	Males			Females			Total		
	No.	%	Rate*	No.	%	Rate*	No.	%	Rate <sup>a</sup>
Hispanic or Latino	41	17	21.0	7	8	4.2	48	15	13.3
Not Hispanic or Latino									
White alone	127	53	5.3	24	27	1.0	151	46	3.1
Black alone	66	28	59.3	48	54	42.4	114	35	50.8
American Indian/Alaska Native alone	0	0	0.0	3	3	11.8	3	1	6.0
Asian/Native Hawaiian/Pacific Islander alone	5	2	12.2	7	8	16.4	12	4	14.3
Total	239	100	9.2	89	100	3.4	328	100	6.3
<i>Source. Nebraska HIV Surveillance Program</i> Average yearly rate per 100,000 based on 2004 population - caution must be used in interpretation because of small numbers									

## Race/ethnicity by age groups

Table 12 compares the distribution of HIV/AIDS cases diagnosed between 2004 and 2006 by age groups and race/ethnicity. Reported HIV/AIDS cases tended to be 25 years and older, across all race/ethnicity groups. In addition, only Black and Asian/Pacific Islanders had HIV/AIDS cases less than 13 years of age.

**Table 12: HIV/AIDS diagnoses, Nebraska, by race/ethnicity and age group, 2004-2006**

Age (yrs)	White		Black		Hispanic		Asian/PI		Native Am		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
0-4	0	0%	3	3%	0	0%	2	17%	0	0%	5	2%
5-12	0	0%	2	2%	0	0%	0	0%	0	0%	2	1%
13-24	20	13%	15	13%	7	15%	1	8%	0	0%	43	13%
25-44	94	62%	87	76%	34	71%	8	67%	2	67%	225	69%
45-64	35	23%	7	6%	7	15%	1	8%	1	33%	51	16%
>64	2	1%	0	0%	0	0%	0	0%	0	0%	2	1%
<b>Total</b>	151	100%	114	100%	48	100%	12	100%	3	100%	328	100%

Source. Nebraska HIV Surveillance Program

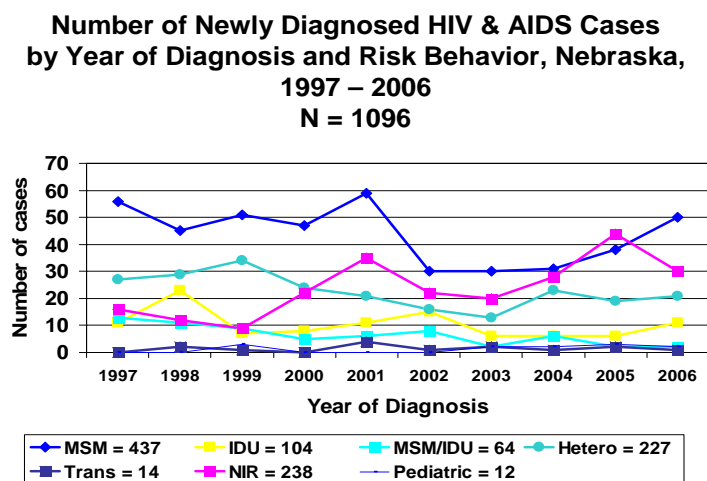


## Risk behaviors

Since the start of HIV/AIDS surveillance in Nebraska, the majority of HIV/AIDS cases have been among men who have sex with men (MSM), representing 40% of all risk behaviors. Figure 10 shows the trends in risk behaviors over time for new HIV/AIDS cases. Between 2004 and 2005, the number of cases that are classified as no identified risk (NIR) approximated the number reported as MSM. Cases reporting heterosexual contact have remained fairly stable, between a high of 34 cases in 1999 to 21 cases in 2006. Trends for all other risk behaviors cannot be determined since the number of cases for each has been less than 20 cases per year. Please refer to the Data Sources in the Introduction where the definitions for risk behaviors are described.

Cases reported as an NIR occur for a variety of reasons. One is that information on how a person believes they may have acquired HIV infection may not be shared with their health care provider, because of fears about disclosure of participation in culturally stigmatized behaviors. These behaviors include both injecting drug use and men who have sex with men. Often a person with HIV infection does not know at first how they may have acquired HIV, but after sufficient time, they realize what their risk behaviors was. Then, they must feel comfortable enough with their provider to share this information. Another reason is that a person who reports only heterosexual contact will be listed as an NIR unless they know their partner was HIV-infected or at increased risk for HIV. Often this level of knowledge about sexual partners (anonymous, casual, or exclusive) may be unknown. According to a study conducted by CDC, it is likely that 80% of women with no identified risk acquired HIV infection through heterosexual contact. Also recently diagnosed cases are more likely to not have a specific risk behaviors reported, compared to cases that have been reported for a longer period of time. Cases reported without a specific risk will likely be reclassified as epidemiologic follow-up is completed.

**Figure 10:**



Source: Nebraska HIV/AIDS Reporting System

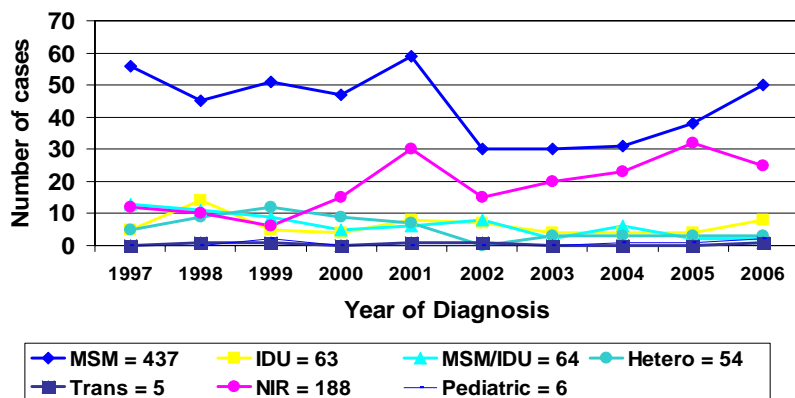
## Risk behaviors and Gender

Figures 11 and 12 show the trends in risk behaviors over time for new HIV/AIDS cases by gender. Men who have sex with men (MSM) represent the majority (53%) of new male HIV/AIDS cases, and the number of MSM has fluctuated from 56 cases in 1997 to a high of 59 cases in 2001. Cases of MSM then declined to 30 cases in 2002 and have shown a steady increase to 50 cases in 2006. During this same time period, cases of NIRs began increasing in 2001 and have fluctuated between 20 and 30 cases per year. NIRs among males in this 10 year time period were 23% of the total number of males with HIV/AIDS. All other reported risk behaviors have been below 15 cases per year.

The main risk behaviors for females is heterosexual contact. As shown in Figure 12, cases reporting heterosexual contact decreased from 22 cases in 1997 to 10 cases in 2003, and then increased to 18 cases in 2006. Heterosexual contact represented 62% in this 10-year time period. All other reported risk behaviors have been below 10 cases per year, making any interpretation difficult. From 1997 to 2006, NIRs accounted for 18% of all female cases, increasing from 4 cases in 1997 to a high of 12 cases in 2005 and then decreasing to 5 cases in 2006.

Figure 11:

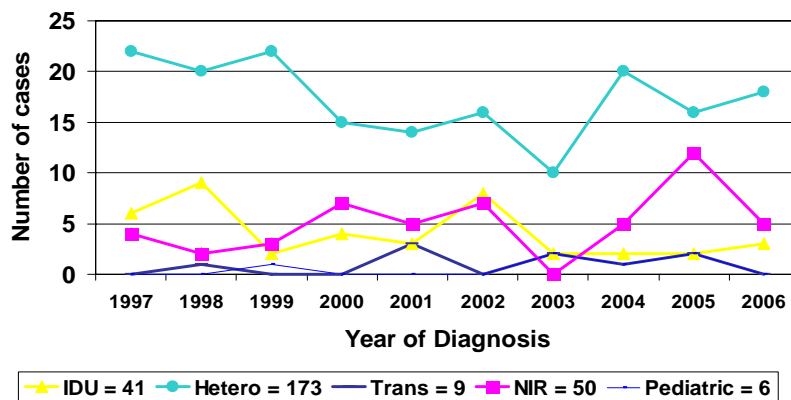
**Number of Newly Diagnosed HIV & AIDS Cases for Males by Year of Diagnosis and Risk Behavior, Nebraska, 1997 – 2006**  
N = 817



Source: Nebraska HIV/AIDS Reporting System

**Figure 12:**

**Number of Newly Diagnosed HIV & AIDS Cases for Females by Year of Diagnosis and Risk Behavior, Nebraska, 1997 – 2006**  
**N = 279**



Source: Nebraska HIV/AIDS Reporting System

Table 13 provides the breakdown of risk behaviors by gender. The majority (50%) of all male HIV/AIDS cases diagnosed between 2004 and 2006, are men who have sex with men (MSM). The next highest risk group is injecting drug use, which represented 7% of all male cases. All other specific risk behaviors account for less than 5% each, except for NIRs, which represent 33% of all male cases. Among females, the majority (61%) HIV/AIDS cases are related to heterosexual contact, and 8% are related to injecting drug use. One quarter of all female cases have no specific risk identified at the time of report.

**Table 13: HIV/AIDS diagnoses among persons in Nebraska, by risk behavior and gender, 2004-2006**

Risk Behavior	Males		Females		Total	
	No.	%	No.	%	No.	%
Male-to-male sex	119	50	NA		119	36
Injection drug use	16	7	7	8	23	7
Male-to-male sex and injection drug use	10	4	NA		10	3
Heterosexual contact	9	4	54	61	63	19
Other	5	2	6	7	11	3
No Identified Risk (NIR)	80	33	22	25	102	31
Total	239	100	89	100	328	100

Source. Nebraska HIV Surveillance Program  
 Other includes: Transfusion and pediatric cases (children under 13 years of age)

## Race and risk by gender

The proportion of cases attributable to a specific mode of exposure differs not only by gender, but also by race, as shown in Table 14. Of the new HIV/AIDS cases among male adult and adolescents 13 years of age and older diagnosed between 2004 and 2006, MSM accounted for 65% of white males, 34% of black males, 34% of Hispanic males, and 40% of Asian males. Injecting drug use represented 7% of all the male cases, and 6% of white and 10% of black. Men who have sex with men and use injecting drugs (MSM/IDU), represented 4% of all the male cases, with the percentage of MSM/IDU among whites at 5% and 6% for blacks. Caution must be used when interpreting these numbers since the number of cases is so small. The NIR percentage was high in all race/ethnicity groups, making interpretation of risk behaviors difficult.

**Table 14: Male adult/adolescent HIV/AIDS diagnoses, Nebraska, by risk exposure and race/ethnicity, 2004-2006**

Risk Behavior	Hispanic or Latino		Not Hispanic or Latino								Total	
	No.	%	White alone		Black Alone		American Indian/ Alaska Native alone		Asian/ Native Hawaiian/ Pacific Islander Alone		No.	%
Male to male sex	14	34	82	65	21	34	0	0	2	40	119	51
Injection drug use	2	5	8	6	6	10	0	0	0	0	16	7
Male-to-male sex and injection drug use	0	0	6	5	4	6	0	0	0	0	10	4
Heterosexual contact	2	5	2	2	5	8	0	0	0	0	9	4
Transfusion	1	2	0	0	0	0	0	0	0	0	1	0
No identified risk	22	54	29	23	26	42	0	0	3	60	80	34
Total	41	100	127	100	62	100	0	0	5	100	235	100

Source. Nebraska HIV Surveillance Program

Table 15 describes female adult/adolescent (13 years of age and older) HIV/AIDS cases by risk behaviors and race/ethnicity. The primary mode of exposure for females was heterosexual contact across all race/ethnic groups, representing 54% of whites, 70% of blacks, 43% of Hispanics, 100% of Native Americans, and 40% of Asian/Pacific Islanders. Injecting drug use occurred mainly in white and Hispanic females, 21% and 14% respectively. Caution must be used when interpreting these numbers since the number of cases is so small. It is also difficult because of the high numbers of NIRs in each race/ethnic group, ranging from 60% of Asian/Pacific Islanders to 21% of Blacks.

**Table 15: Female adult/adolescent HIV/AIDS diagnoses, Nebraska, by risk behavior and race/ethnicity, 2004-2006**

Risk Behavior	Hispanic or Latino		White alone		Black alone		American Indian/Alaska Native alone		Asian/Native Hawaiian/Pacific Islander alone		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Injection drug use	1	14	5	21	1	2	0	0	0	0	7	8
Heterosexual contact	3	43	13	54	33	70	3	100	2	40	54	63
Transfusion	0	0	0	0	3	6	0	0	0	0	3	3
No identified risk	3	43	6	25	10	21	0	0	3	60	22	26
Total	7	100	24	100	47	100	3	100	5	100	86	100

*Source. Nebraska HIV Surveillance Program*

## Country of Birth

Although the vast majority of HIV/AIDS cases in Nebraska are among individuals born in the U.S., a consistent number of cases have been reported annually among individuals born outside of the U.S. Foreign-born persons with HIV/AIDS are included in U.S. case counts once they come to this country. A summary of the number of cases by origin diagnosed between 2004 and 2006 is provided below in Table 16. For these purposes, those with an unknown country of birth, or when no country was noted on the case report, are assumed to be a U.S. born case. This box is more likely to be marked on the case report if the person is known to have arrived in this country fairly recently.

Foreign-born cases represented 28% of all the HIV/AIDS cases diagnosed between 2004 and 2006. Of the foreign-born, over half (54%) come from an African country, while those from Mexico/Central and South American countries represent 34%.

By gender, 60% of the foreign-born cases were male and 40% were female. Of the males, 41% were from Africa, and 51% were from Mexico/Central and South American countries. Females on the other hand, were primarily from Africa (76%) while only 11% were from Central and South American countries.

**Table 16: HIV/AIDS Diagnoses in Nebraska by Country of Birth, 2004-2006**

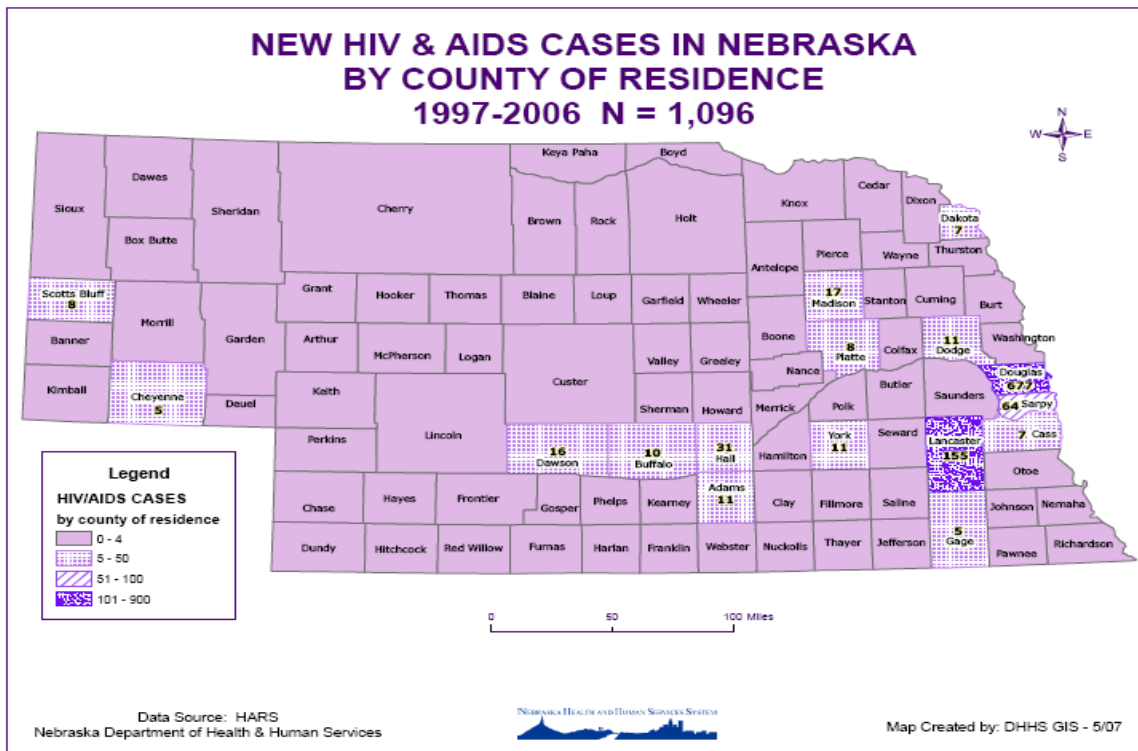
	#	%
US born/US dependency	238	72%
Foreign born total	90	28%
<b>Total</b>	<b>328</b>	<b>100%</b>
- Africa	49	54%
- Mexico/Central/South America	31	34%
- Asia/Other	5	6%
- Not specified	5	6%
<b>Total</b>	<b>90</b>	<b>100%</b>
<b>Source: Nebraska HIV Surveillance Program</b>		

## HIV/AIDS BY RESIDENCE AT HIV DIAGNOSIS IN NEBRASKA

The map shown below in Map 2 demonstrates the variation in total number of HIV and AIDS cases reported in each county. Numbers are given in ranges to highlight the difference as well as to protect confidentiality of the persons reported

Most of the 1096 HIV/AIDS cases newly diagnosed between 1997 and 2006, resided in the eastern part of the state, more specifically in Douglas, Lancaster and Sarpy counties, where most of the population is concentrated.

**Map 2:**



Douglas County had the highest number of newly diagnosed HIV and AIDS cases in the state at 677. Lancaster County was next highest with 155 cases reported. Sarpy County had 64 cases reported; Hall County had 31 cases; thirteen counties had between 5 and 50 cases reported, while seventy-one counties in Nebraska had less than 5 cases reported.

- Douglas and Lancaster counties, the two most populous counties in Nebraska with 41.7% of the total population of the state, reported 76% of all HIV/AIDS cases.
- Douglas and Sarpy counties (the Omaha metro area) represent 34% of Nebraska's population and 68% of newly diagnosed HIV/AIDS cases.
- Douglas County by itself represents 62% of all the cases, while making up 27% of the state's population.

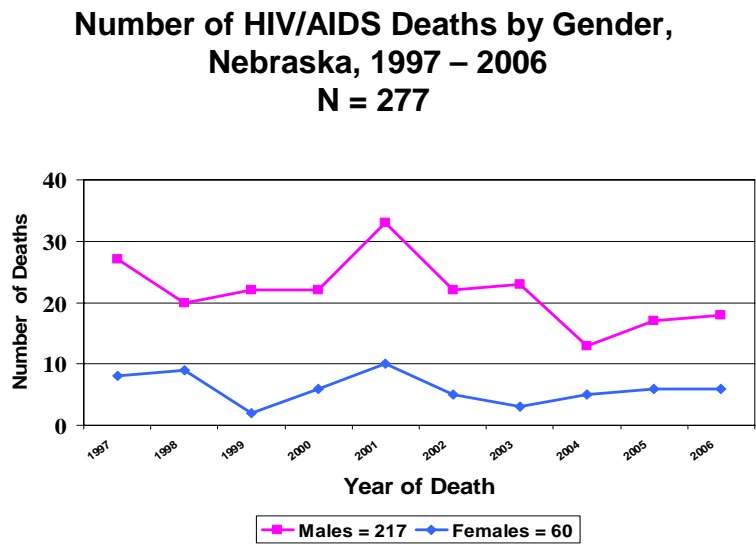
- Lancaster County comprises 14.6% of the state’s population, and accounts for 14% of the newly diagnosed HIV/AIDS cases.

**Note:** The number of cases by county may not accurately reflect the geographical distribution of where persons with HIV and AIDS are currently residing, because the only information received from case reports is the address at the time of the HIV or AIDS diagnosis. Persons can relocate in-state as well as move out of state, and this would not be reflected in these numbers. These numbers also do not include persons who were diagnosed elsewhere and moved into the state and are receiving care and treatment here in Nebraska.

### HIV/AIDS-Related Mortality

Deaths due to HIV/AIDS are obtained from health care providers, the HHSS Office of Vital Records, and other states HIV/AIDS surveillance programs. From 1983 to 2006, there have been 780 deaths among persons diagnosed with HIV/AIDS in Nebraska. There were more deaths among males with HIV/AIDS than there were among females, but this is to be expected since the number of incident cases is much greater among males than females. Figure 13 below describes the trends in the number of deaths per year by gender for HIV/AIDS cases that died between 1997 and 2006. HIV/AIDS deaths among males have declined from 27 cases in 1997 to 18 cases in 2006, except for an increase in 2001, when 32 deaths occurred. Deaths among females with HIV/AIDS have varied between 2 and 10 cases per year, and have remained stable at 6 deaths per year for the last 3 years.

**Figure 13:**



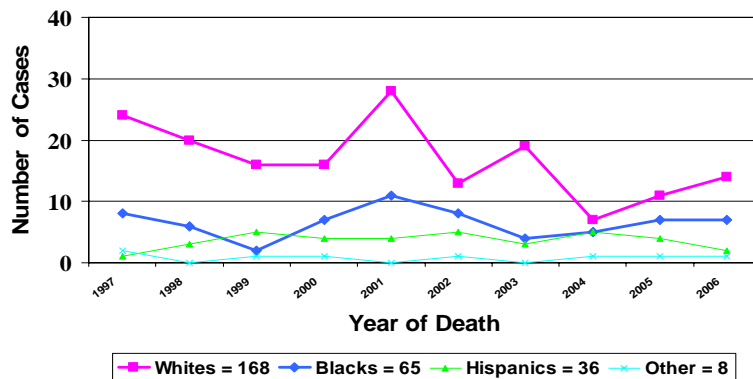
Source: Nebraska HIV/AIDS Reporting System



Figure 14 demonstrates the trends in HIV/AIDS-related deaths by race/ethnicity. Most deaths were among whites, while blacks made up a smaller proportion. Whites experienced a significant decline in deaths between 1997 and 2006, falling from 24 deaths in 1997 to 14 deaths in 2006, except for a spike in deaths in 2001. The number of HIV-related deaths for blacks has varied from 2 cases in 1999 to 11 cases in 2001, when blacks experienced the same increase in deaths as whites, though to a smaller degree. HIV-related deaths for Hispanics and Others (representing Native American and Asian/Pacific islanders) have remained low, ranging from 5 cases to 1 case between 1997 and 2006.

**Figure 14:**

**Number of HIV/AIDS Deaths by Race/Ethnicity ,  
Nebraska, 1997 – 2006  
N = 277**



Source: Nebraska HIV/AIDS Reporting System

Deaths related to HIV infection are not listed in the top 10 leading causes of death in Nebraska in 2004, according to the Department of Vital Records. HIV-related deaths are also not reported as one of the top 10 leading causes of death for males or females in Nebraska.

## **HIV Prevalence - Persons Living with AIDS**

Prevalence is defined as the number of cases living at a certain point in time. The decrease in the number of deaths among persons with AIDS, combined with an increase in the number of new cases of HIV/AIDS, has contributed to an increase in the prevalence of HIV disease in Nebraska (i.e., the number of persons living with HIV disease). The total number of persons known to be living with HIV/AIDS (PLWHA) was 1,397 as of December 31, 2006. Table 19 below compares persons who were newly diagnosed with HIV/AIDS between 2004 and 2006 to those who are living with HIV/AIDS in Nebraska, as of December 31, 2006.

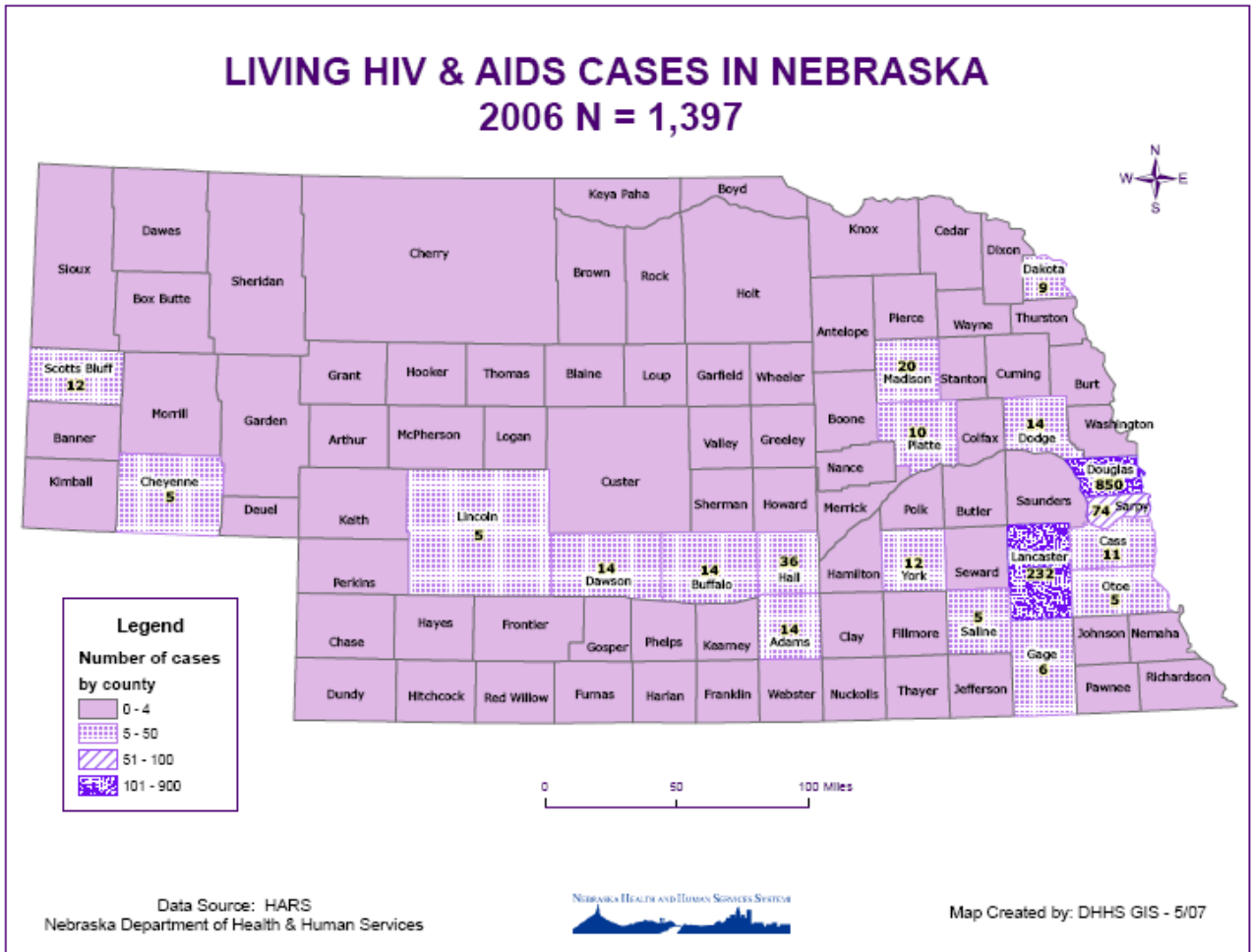
Males constitute the majority of newly diagnosed cases (73%), as well as those living with HIV/AIDS (77%). Whites constitute the largest racial group for both newly diagnosed cases and those living with HIV/AIDS (46% and 56% respectively). Blacks continue to be disproportionately impacted by the epidemic. Although the percentage of Blacks in the total population is 4%, they represent 35% of newly diagnosed cases as well as 27% of prevalent cases. The majority (59.7%) of the PLWHA are currently 25 to 44 years of age, which is similar to newly diagnosed cases of HIV/AIDS. Prevalent cases, however, are more likely to be older, over 44 years of age, than newly diagnosed cases. MSM is the predominate risk behaviors (44%) of PLWHA, as well as those newly diagnosed with HIV/AIDS. Injecting drug use is higher when combined with MSM/IDU among PLWHA, 16%, compared to 10% of the newly diagnosed cases. NIRs are much less among prevalent cases than among newly diagnosed cases, 17.7% and 30.5%, respectively.

**Table 17: Characteristics of persons with HIV/AIDS, Nebraska, Data through 2006**

Characteristic	Persons with new HIV/AIDS diagnosis, 2004 to 2006		Persons Presumed to be Living with HIV/AIDS as of 12/06	
	#	%	#	%
<b>GENDER</b>				
Male	239	72.9	1075	77.0
Female	89	21.0	322	21.0
<b>Total</b>	<b>328</b>	<b>100.0</b>	<b>1397</b>	<b>100.0</b>
<b>RACE/ETHNICITY</b>				
White	151	46.0	783	56.0
Black	114	34.8	380	27.2
Hispanic	48	14.6	180	12.9
Asian/ Pacific Islander	12	3.7	25	1.8
American Indian/AK Native	3	0.9	27	1.9
Multi-race	0	0.0	2	0.1
<b>Total</b>	<b>328</b>	<b>100.0</b>	<b>1397</b>	<b>100.0</b>
<b>AGE*</b>				
0-4	5	1.5	5	0.4
5--12	2	0.0	7	0.5
13-24	43	9.7	42	3
25-44	225	72.1	834	59.7
45-64	51	16.8	480	34.4
65(+)	2	1.1	29	2
<b>Total</b>	<b>328</b>	<b>100.0</b>	<b>1397</b>	<b>100</b>
* Age at diagnosis is used for new HIV/AIDS cases. For living HIV/AIDS cases, the age group used is the current age.				
<b>Risk behaviors</b>				
MSM	119	36.3	612	43.8
IDU	23	7.0	137	9.8
MSM/IDU	10	3.0	89	6.4
Heterosexual contact	65	19.8	271	19.4
Adult Hemophilia	0	0.0	9	0.6
Transfusion	4	1.2	19	1.4
Pediatric	7	2.1	22	1.6
No Risk Reported (NIR)	100	30.5	238	17.0
<b>Total</b>	<b>328</b>	<b>100.0</b>	<b>1397</b>	<b>100.0</b>

The majority of persons diagnosed with HIV/AIDS (77%) live in Douglas and Lancaster Counties; Douglas County had 61%; and Lancaster County had 17%. However, 54% of Nebraska's 93 counties have been affected by HIV/AIDS. See Map 3..

**Map 3:**



## Estimated Numbers of Persons Living with HIV/AIDS in Nebraska

The combination of living HIV and AIDS cases that have been reported provides a minimum estimate of HIV prevalence in Nebraska. These numbers do not include persons with HIV infection who have not been tested and are unaware of their status, and it does not include those persons with HIV who have tested anonymously, nor those who have died. It also does not include those who were diagnosed in another state and who are now living in Nebraska and receiving treatment for HIV.

The prevalence estimation method used here allows only a gross estimate of the number of infected persons living in Nebraska. The method utilized here is based on cases already reported and extrapolated from the national data. The Centers for Disease Control and Prevention (CDC) estimates that nationwide the total number of persons living with HIV/AIDS is between 1,039,000 to 1,185,000. The actual numbers of persons living with HIV/AIDS, based on cases reported nationwide to CDC, is 640,643. Since only 38 states have HIV reporting by name, and some of these states only recently began HIV reporting, national HIV estimates are likely to be low. Using the estimation procedure provided by CDC, and adjusting the data for those unreported and undiagnosed persons, the HIV/AIDS prevalence in Nebraska is **2,182 to 2,489**. (See Table 20 below.) Therefore, based upon the prevalence estimate and the known number of HIV/AIDS cases as of December 31, 2005, one can infer that between 36% to 44% of persons with HIV/AIDS and residing in Nebraska are unaware of their HIV infection. Nationally, the CDC estimates that between 24% and 27% of persons who are infected with HIV/AIDS are unaware of their infection.

Although the estimation of HIV prevalence in Nebraska yields an imprecise estimate, it is done to emphasize that the number of persons currently infected is much larger than the number of persons reported with HIV or AIDS, because not all persons currently infected with HIV have been tested. Some HIV infected persons seek testing only when they are known to be exposed or have become sick. The prevalence estimate can be useful to provide health care planners and educators information on the burden of HIV disease in Nebraska.

**Table 18: Calculation of Prevalence Estimate of HIV/AIDS in Nebraska, 2006**

# of known living HIV/AIDS cases in Nebraska	1,397
# of known living HIV/AIDS cases in U.S.	640,643
Proportion of persons living in NE compared to U.S.	0.0021
Lower estimate of U.S. HIV prevalence	1,039,000
Upper estimate of U.S. HIV prevalence	1,185,000
HIV Prevalence in Nebraska, lower estimate	2,182
HIV Prevalence in Nebraska, upper estimate	2,489

## Section 3: Indicators of risk for HIV infection in Nebraska

Persons most likely to become infected with HIV are those who engage in high-risk behaviors with persons that live in communities with high HIV prevalence. Although Nebraska is considered to be a low prevalence state in terms of HIV, the following section examines the trends and characteristics of populations practicing high-risk behaviors in Nebraska, to help community planning groups understand the varying risks for HIV infection in Nebraska. The primary focus of this section is on two high-risk populations: injection drug users and heterosexuals, even though Men Who have Sex with Men (MSM) is the majority risk group in Nebraska. There are no external data sources for MSM in Nebraska who are at risk for HIV infection, but have not yet been diagnosed with HIV.

This section examines several measures of risk behavior in groups most at risk for acquiring HIV infection. The following measures of risk behavior are available in Nebraska to provide important information on factors that may indirectly affect risk for acquiring or transmitting HIV infection:

- Substance abuse
- Treatment Episode Data Set
- Binge drinking
- Hepatitis C
- Sexually transmitted disease (STD) rates
- Unintended pregnancy
- Attitudes towards HIV/AIDS
- HIV testing

To examine these behaviors, the following data sources were used:

### **National Household Survey on Drug Use & Health (NHSDUH)/National Household Survey on Drug Abuse (NHSDA)**

The 2003-2004 National Household Survey on Drug Use and Health, formerly called the National Household Survey on Drug Abuse, was conducted by the Department of Health and Human Services: Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies. This data is from an ongoing survey of the civilian, noninstitutionalized population of the United States aged 12 years or older. Approximately 136,100 persons were interviewed in 2004-2005.

### **Behavioral Risk Factor Surveillance System (BRFSS)**

The Nebraska Behavioral Risk Factor Surveillance System Report 2001-2005 was conducted by the Nebraska Risk Factor Surveillance Program, Nebraska Department of Health and Human Services. BRFSS has been conducting surveys annually since 1986 in order to collect data on the prevalence of major health risk factors among adults residing in the state. The Nebraska BRFSS uses guidelines and reports survey results to CDC to be compared with those of all the other states and the nation. The 2001-2005 report results are based on telephone surveys with 30,225 randomly selected Nebraska residents aged 18 and older.

## **Youth Risk Behavior Survey (YRBS)**

To monitor priority health-risk behaviors among youth and young adults, CDC developed the Youth Risk Behavioral Surveillance System (YRBSS). The YRBS is a statewide survey of a sample of youth in grades 9-12 enrolled in public schools across Nebraska. Since 1991 Nebraska has conducted the survey biannually in the spring of odd years. Survey procedures were designed to protect the privacy of students by allowing for anonymity and voluntary participation. Local parental permission procedures were followed before survey administration.

Sixty high schools with students in grades 9-12 were randomly selected in the spring of 2005 from all Nebraska public schools with students in these grades. Seventy-two percent of these schools agreed to participate in the YRBS, with 93% (3,755) of the students participating, resulting in an overall response rate of 67%. Statistically, the results are weighted to be representative of all Nebraska public school students in grades 9-12. These survey results provide an important description of priority health risk behaviors.

## **Nebraska Pregnancy Risk Assessment Monitoring System (NE PRAMS)**

PRAMS is an ongoing, population-based surveillance system designed to identify, monitor and provide high quality, timely data on selected maternal health behaviors and experiences before, during, and after pregnancy among women who have had a live birth. Nebraska is one of 32 states and one city who formally participate in the CDC PRAMS initiative.

The 2004 data is based on findings from a random sample of 2,432 Nebraska resident women who had a live birth in the year 2004; 80% of women selected to participate responded. Nebraska data is not available for African American or Native American populations because the response rate for each of the two racial groups was below the established guideline set by the Centers for Disease Control (CDC) of 70% for calculation of weighted numbers representative of each population. The NE PRAMS survey has 82 questions covering a range of topics.

## **NHHS Sexually Transmitted Disease (STD) Program**

STDs are among the most frequently reported infectious diseases in Nebraska. The goal of the NDHHS Sexually Transmitted Disease Program is to control and prevent sexually transmitted diseases and reduce the burden and cost of these infections. The program assists state, local, and community efforts to help prevent the spread of Chlamydia, gonorrhea, syphilis, hepatitis, and other STDs.

## **Treatment Episode Data Set (TEDS)**

The Treatment Episode Data Set (TEDS) provides information on the demographic and substance abuse characteristics from the 1.9 million annual admissions to treatment for abuse of alcohol and drugs in facilities that report to individual State administrative data systems. TEDS is an admission-based system. TEDS admissions do not represent individuals, i.e., an individual admitted to treatment twice within a calendar year would be counted as two admissions.

## 1. Injecting Drug and Other Substance Use

### National Survey on Drug Use and Health (NHSDA)

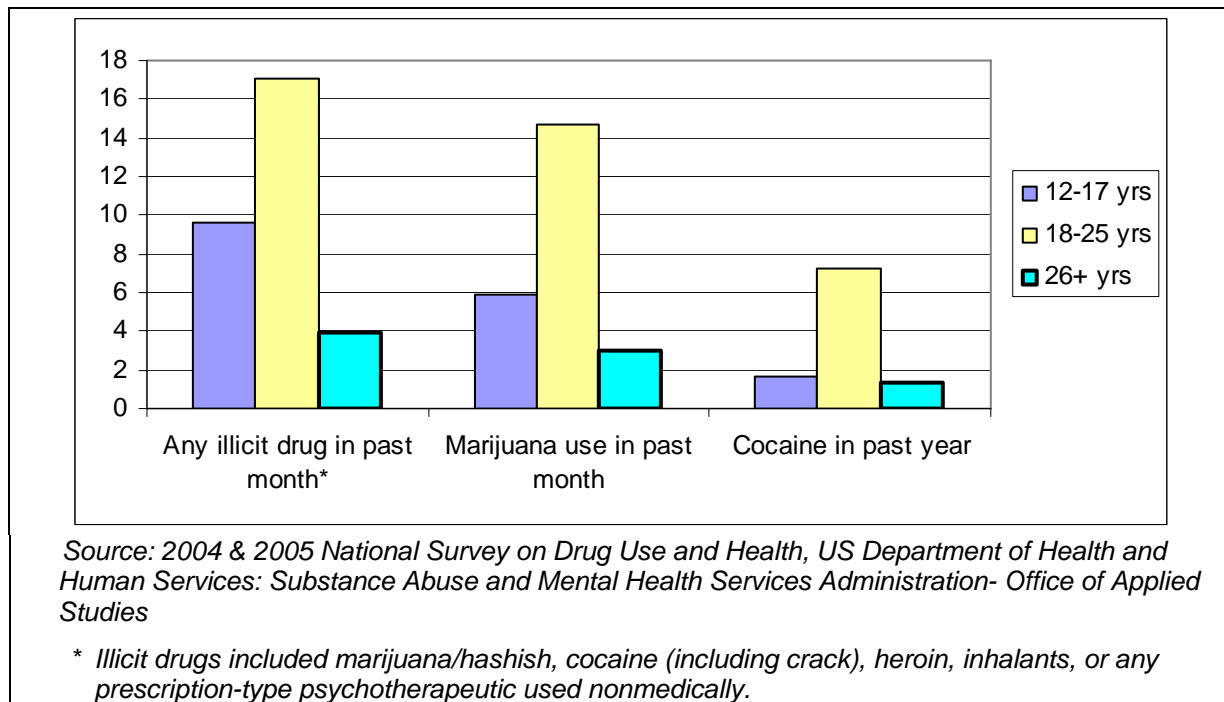
Table 21 provides data for the general population in Nebraska interviewed for the 2004-2005 NHSDAS. Seven percent of persons 12 year of age and older reported using an illicit drug at least once during the past month. Illicit drugs included marijuana/hashish, cocaine (including crack), heroin, inhalants, or any prescription-type psychotherapeutic used nonmedically. Regardless of type of illicit drug, drug use was highest among person 18-25 years of age with 17% reporting that they had used illicit drugs in the past month, followed by 9.6% of the younger age group (12-17 years of age), and 4% the older age group (26+ years). Figure 15 compares this data by age group.

**Table 19 : Selected measures of substance abuse for persons aged 12 years and older, by age, Nebraska, 2004-2005**

Measure	Age Group			
	12-17	18-25	26+	12 or older
Percentages reporting past month use of any illicit drug*	9.58	17.03	3.98	6.47
Percentages reporting past moth use of marijuana	5.88	14.73	3.02	5.02
Percentages reporting past year use of cocaine	1.62	7.22	1.31	2.21
Percentages reporting past month use of alcohol	18.63	71.30	57.61	55.60
Percentages reporting past month binge alcohol use	13.05	51.31	24.41	27.17
Percentages reporting perceptions of great risk of having five or more drinks of an alcoholic beverage once or twice a week	35.03	23.50	38.11	35.65
Percentages reporting past year dependence on or abuse of any illicit drug or alcohol	9.38	26.12	7.55	10.45
Percentages reporting needing but not receiving treatment for illicit drug use in the past year	4.07	6.58	1.17	2.26
<i>Source: 2004-2005 National Survey on Drug use and Health, US Department of Health and Human Services: Substance Abuse and Mental Health Services Administration Office of Applied Studies</i> <i>*Illicit drugs included marijuana/hashish, cocaine (including crack), heroin, inhalants, or any prescription-type psychotherapeutic used nonmedically.</i>				



**Figure 15: Percentage reporting drug use in last month for selected measures of substance abuse by age group, Nebraska, 2004-2005**



### Treatment Episode Data Set (TEDS)

TEDS is a compilation of data on the demographic characteristics and substance abuse problems of those admitted for substance abuse treatment. TEDS data comes primarily from facilities that receive some public funding. The goal of TEDS is to collect information on complete treatment episodes; therefore SAMHSA has expanded the TEDS system to include discharge data that can be linked to admissions data. Currently about 20 States, including Nebraska, submit discharge data.

From 2001 through 2005, the number of drug-related treatment admissions to publicly funded facilities in Nebraska varied from drug to drug with increases reported for methamphetamine and marijuana and decreases reported for cocaine and heroin. The TEDS data in Table 22 indicates that methamphetamine-related treatment admissions almost doubled during the five year time period, reflecting the increasing problem methamphetamines poses to Nebraska.

**Table 20: Drug Related Treatment Admissions to Publicly Funded Facilities in Nebraska, 2001-2005**

Year	Methamphetamine	Cocaine	Marijuana	Heroin
2001	1,294	757	862	11
2002	1,485	713	774	13
2003	1,722	680	861	8
2004	2,064	735	1,057	NR
2005	2,060	666	1,052	NR

Source: Nebraska Treatment Episode Data Set

## Youth Risk Behavior Survey (YRBS)

Juvenile drug abuse is a concern in Nebraska. The 2005 Youth Risk Behavior Survey reported that, of 3,755 high school students who responded in Nebraska, 23.9% of males and 20% of females reported that they were offered, sold, or given an illegal drug on school property during the past 12 months.

According to the 2005 CDC “Youth Risk Behavior Survey 9-12<sup>th</sup> Grade” Nebraska has had a 1.1% increase in the use of illegal intravenous drug use since 2003 and is now 1% above the national average. With 68% of all new Hepatitis C cases and 31% of all new HIV cases being related to the use of illegal injectable drugs this is an alarming trend for the youth of Nebraska.

**Table 21: Comparison of Selected Behavior Risk in Nebraska to U.S.**

Behavior Risk	U.S.		Nebraska	
	2003	2005	2003	2005
Ever Injected Illegal Drugs	3.20%	2.10%	2.00%	3.10%
Ever Used Heroin	3.30%	2.40%	2.70%	3.10%
<i>Source: Nebraska Youth Risk Behavior Survey 2003-2005</i>				

## Hepatitis C and HIV Co-Infection

The CDC has estimated that one out of every 3 people infected with the Human Immunodeficiency Virus (HIV) is also infected with the Hepatitis C virus (HCV). The presence of both the Hepatitis C virus and HIV in a client can impact both the treatment and management of both HCV and AIDS. Co-infection with the AIDS virus and the Hepatitis C virus has been associated with a more rapid progression to liver disease and an increase risk for cirrhosis of the liver. Liver disease is currently the 7<sup>th</sup> leading cause of death for Americans age 24-65 yr. Since highly active antiretroviral therapy and prophylaxis treatment for opportunistic infections have increased the life span of AIDS patients, Hepatitis C related liver disease has become a major cause of hospital admissions and death among AIDS patients. Currently Hepatitis C is the leading cause of death for those Americans co-infected with both the HCV and HIV virus.

### 2004 Nebraska Co-Infection HCV Project

As the HIV and Hepatitis C surveillance programs use different software programs and are unable to talk to each other, in 2004 a demonstration project using both rapid HCV testing and rapid HIV testing was conducted at 3 HIV testing sites in Nebraska. The overall objective of this project was to establish a co-infection rate within Nebraska. As Nebraska has a low incidence rate of HIV, no new cases of HIV were discovered but there was an overall HCV positive rate of 21%. The analysis of the client demographics clearly shows a need for more minority studies with Hepatitis C prevalence.

Analysis of client demographics from this study revealed the following:

- While only 17.7% of those tested were Hispanic 28.5% of all positives were Hispanic
- While only 2.3% of those tested were Native American, 3.5% of all positives were Native American
- While only 1.6% of those tested were African American, 3.5% of all positives were African American

- Women made up 38.3% of those tested and 13.8% of those testing positive
- Men made up 61.7% of those tested and 86.2% of those testing positive

Nebraska Hepatitis C Trends

Based on the CDC estimates and Nebraska's 2001 census statistically there are an estimated 31,307 Nebraskan's currently infected with the Hepatitis C virus. As of December 31, 2003 the Nebraska carries only 10,375 on the state epidemiology Hepatitis C roster. The Nebraska Hepatitis C roster does not track client demographics, but a statistical analysis can be done by applying national statistics to Nebraska's population. Table 24 provides information on Hepatitis C, using the 2005 estimated census for Nebraska and the national trends for high risk populations.

**Table 22:**

<b>Hepatitis C in Nebraska, 2005</b>			
	#	National Average % HCV positive	Statistical # NE Positive
<b>NE 2005 Population Estimate</b>	1,706,976	1.8 %	30,725
NE HCV State Registry Total as of December 31, 2005			13,984
Estimated un-diagnosed Nebraska HCV cases			16,741
<b>HCV Known High Risk Populations Statistics:</b>			
2005 Substance Abuse Treatment Admissions	14,470	50 %	7,235
2005 Nebraska Veteran Population 12.2%	208,251	7.5 %	15,619
2005 Nebraska Inmate Population	4,928	20 %	986
2005 Nebraska Living with HIV/AIDS	1,285	33 %	424
Statistical Positives for Nebraska High Risk Populations			24,264
<i>Source: Nebraska Hepatitis Program</i>			

**Behavioral Risk Factor Surveillance System Survey (BRFSS)**

Binge drinking is defined as having five or more drinks of alcohol (beer, wine, wine coolers, cocktails, or liquor) on an occasion, one or more times during the past 30 days.

As shown in Table 25, among respondents aged 18 and older in 2005, a higher percentage of men than women reported binge drinking. Young men were more likely than young women to report binge drinking. More than one-third of the male respondents aged 18 through 24 (38%) had participated in binge drinking in the past month, compared to 26% of women in this aged group.

The proportion of respondents who reported binge drinking increased by educational attainment. Eleven percent of those with less than a high school education reported drinking five or more drinks in the past month, compared to 21% of those with some college education. The proportion of binge drinking was similar across all income levels.

**Table 23: Prevalence of binge drinking by gender, age group, education and income, aged 18 years and older in Nebraska, 2005**

<i>Overall Rate</i> .....	17%
<i>Male</i> .....	26%
<i>Female</i> .....	10%
<i>Gender and Age Group</i>	
Male	
18-24.....	38%
25-34.....	38%
35-44.....	30%
45-54.....	21%
55-64.....	15%
65-74.....	6%
Female	
18-24.....	26%
25-34.....	13%
35-44.....	11%
45-54.....	7%
55-64.....	3%
65-74.....	1%
<i>Education</i>	
Less than HS.....	11%
HS Graduate/GED.....	18%
Some College/Tech.....	21%
College Grad.....	15%
<i>Income</i>	
<\$20,000.....	16%
\$20,000 = \$34,999.....	17%
\$35,000 - \$49,999.....	18%
\$50,000 +.....	20%
<i>Source: Nebraska Health &amp; Human Services System: BRFSS</i>	
<b>Note:</b> Five or more drinks of alcohol on at least one occasion during the last month for men and four or more drinks for women.	

## 2. Heterosexual contact

### Behavioral Risk Factor Survey (BRFSS)

According to results of the 2004 BRFSS, women aged 18-44 were asked whether or not they or their partner were using any kind of birth control at the time of the survey. Birth control was defined for them as “having your tubes tied, vasectomy, and the pill, condoms, diaphragm, foam, rhythm, Norplant, shots (Depo-Provera) or any other way to keep from getting pregnant.”

Seven out of every ten respondents in this age group (70%) said they were currently using a form of birth control (Table 26). Sixteen percent (16%) reported that they were not currently using any form of birth control to prevent pregnancy. Fourteen percent (14%) reported they did not have a regular partner or had a same sex partner. One (1%) percent of respondents didn't know if they were using birth control or refused to answer the question.

Of the women who reported that they or their partner were currently using birth control, 14% percent of respondents reported using condoms to prevent pregnancy.

**Table 24: Use of birth control for women age 18-44, Nebraska, 2004**

Using birth control	70%
Not sexually active	14%
Not using birth control and at risk for unintended pregnancy	16%
Don't know if using birth control or did not answer	1%
<i>Source: Nebraska Health &amp; Human Services System: BRFSS</i>	

### Youth Risk Behavior Survey

Results of the 2005 YRBS are shown in Table 27. In Nebraska the percentage of high school students who ever had sexual intercourse during their lifetime was 41%, compared to 47% nationwide. The percentage of Nebraska students who had sexual intercourse for the first time before the age of 13 years was 4%, compared to 6% of students nationwide. Approximately one third (33%) of students nationwide reported having had sexual intercourse during the three months preceding the survey (i.e., currently sexually active), as compared to 30% of Nebraska students.

Of the currently sexually active students in Nebraska, 24% reported they had drunk alcohol or used drugs before their last sexual intercourse, compared to 23% of students nationwide. Finally, 88% of students nationwide had been taught in school about AIDS or HIV infection, as compared to 85% of Nebraska students.

**Table 25: Comparison of Selected Risk Behaviors, Nebraska to U.S.**

	<b>Nebraska</b>	<b>United States</b>
Ever had sexual intercourse	40.8%	46.8%
First sexual intercourse <13 years old	4.4%	6.2%
>4 sex partners in lifetime	11.9%	14.3%
Currently sexually active	29.9%	33.9%
Condom use during last sexual intercourse	61.6%	62.8%
Birth control use during last sexual intercourse	21.6%	17.6%
Alcohol or drug use before last sexual intercourse	24.0%	23.3%
Had been pregnant or impregnated someone	3.4%	4.2%
Taught about AIDS and/or HIV infection in school	85.4%	87.9%
<i>Source: 2005 Youth Risk Behavior Survey</i>		

### **Condom Use during the Last Sexual Intercourse**

Among the currently sexually active students nationwide, 63% reported that either they or their partner had used a condom during the last sexual intercourse. Overall, the prevalence of having used a condom during the last sexual intercourse was higher among male (70%) than female (56%) students. In Nebraska, among students who reported ever having sexual intercourse, 62% reported using a condom the last time they had sexual intercourse, which is almost equal to students nationwide. Among Nebraska students, 38% did not use a condom during the last sexual intercourse and 78% did not use birth control pills before their last sexual intercourse.

### **Four or More Partners**

Nationwide, 14% of high school students had sexual intercourse during their lifetime with four or more sex partners. In Nebraska, the percentage of high school students who have had sexual intercourse with four or more people during their lifetime was 12%. Overall, the prevalence of having had more than four sex partners was higher among male (17%) than female (12%) students.

### **Taught in School about AIDS or HIV Infection**

Nationwide, 88% of students reported having been taught in school about AIDS or HIV infection as compared to 85% of Nebraska students.

## Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS)

Pregnancy is considered to be unintended when the woman did not want to be pregnant (unwanted) or desired a later pregnancy (mistimed). In 2004, 43% of the women surveyed, who had given birth in 2004, reported that they wanted to be pregnant later (34%) or did not want to become pregnant then or at any time in the future (9%) (Table 28).

**Table 26: Pregnancy Intention**

Wanted to become pregnant sooner	17%
Wanted to become pregnant then	39%
Wanted to become pregnant later	34%
Did not want to become pregnant then or at any time in the future	9%
No response	1%
<b>Total</b>	<b>100%</b>
<i>Source: PRAMS 2004, Nebraska</i>	

Overall, 73% of women surveyed, who gave birth in 2004, reported that they had been talked to about HIV testing during their pregnancy. Eighty two percent of Hispanic mothers, 76% Asian American and 70% of White mothers reported being talked to during their pregnancy about HIV testing (Table 29). (Note: PRAMS data is not available for African American or Native American populations.)

**Table 27: Talked to About HIV Testing, 2004 PRAMS, Nebraska**

	<b>Overall</b>	<b>Caucasian</b>	<b>Asian American</b>	<b>Hispanic</b>
<b>Yes</b>	73	70	76	82
<b>No</b>	27	30	24	18
<b>Total</b>	100	100	100	100
<i>Source: 2004 PRAMS, Nebraska</i>				

Overall, 60% of women surveyed, who gave birth in 2004, reported that they had been tested for HIV during their pregnancy. Seventy nine percent of Hispanic mothers, 70% of Asian American and 55% of Caucasian mothers report that they were tested for HIV during their pregnancy (Table 30).

**Table 28: Tested for HIV,**

	<b>Overall</b>	<b>Caucasian</b>	<b>Asian American</b>	<b>Hispanic</b>
<b>Yes</b>	60	55	70	79
<b>No</b>	40	45	30	21
<b>Total</b>	100	100	100	100
<i>Source: 2004 PRAMS, Nebraska</i>				

## Sexually Transmitted Diseases (STD)

STD Surveillance data provides information that may help identify the potential occurrence of high-risk heterosexual behavior. While STD rates may reflect unsafe sexual behavior, they do not necessarily correlate with HIV infection. National data suggest that syphilis rates, especially when related to crack cocaine use or the exchange of sex for drugs, may be more closely associated with HIV risk than either gonorrhea or Chlamydia. However, the presence of non-ulcerative STDs, such as Chlamydia and gonorrhea, can facilitate the transmission of HIV. If you have gonorrhea or Chlamydia, you have a five times greater chance of contracting HIV, and if you have syphilis, you have a 100 times greater chance of contracting HIV.

In Nebraska the STDs Chlamydia, gonorrhea, primary/secondary syphilis, early latent syphilis and genital herpes are reportable diseases. From 2001 to 2005 the total number of STDs reported increased from 5,177 to 7,477 cases. The incidence rate for STDs also increased from 302.5 per 100,000 population in 2001 to 427.9 per 100,000 population in 2005.

Table 31 shown below summarizes STD information from 2001 to 2005. The most frequently reported STD is Chlamydia, with 5,080 cases reported in 2005, followed by gonorrhea with 1,158 cases. Nebraska's rate for Chlamydia was 290.7 per 100,000 in 2005, compared to 332.5 per 100,000 nationally. The gonorrhea rate in Nebraska in 2005 was 66.3 per 100,000, compared to 115.6 per 100,000.

**Table 29: Number of Cases and Incidence Rates of STDs, 2001-2005**

STD	2001		2002		2003		2004		2005	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Chlamydia	3196	186.8	4595	268.2	4825	279	5241	301.3	5080	290.7
Gonorrhea	1187	69.4	1423	83.1	1664	96.2	1144	65.8	1158	66.3
Primary /Secondary Syphilis	6	0.4	4	0.2	10	0.6	5	0.3	3	0.2
Early Latent Syphilis	0.0	0.0	0.0	0.0	1	0.1	0.0	0.0	2	0.1
Genital Herpes	673	39.3	779	45.5	648	37.5	730	42	986	56.4
All STDs	5177	302.5	6934	404.7	7301	422.2	7381	424.4	7477	427.9

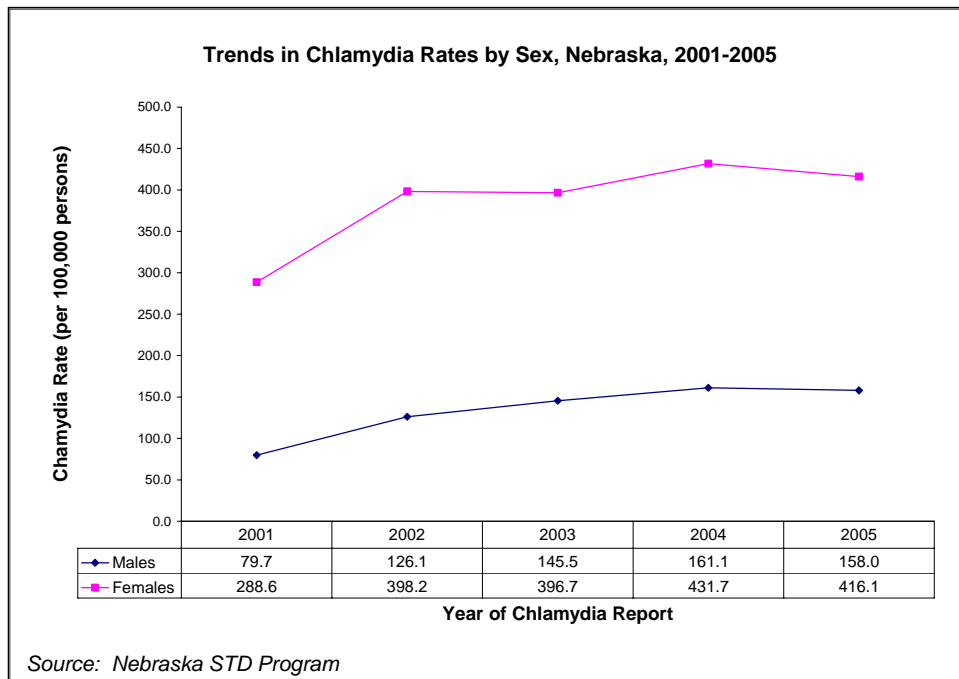
*Source: Nebraska STD Program*



## Chlamydia

Figure 16 compares the trends in Chlamydia rates by gender. Between 2001 and 2005, Chlamydia rates were consistently and substantially (2.8 to 3.9 times) higher in females as compared to males. Between 2003 and 2005, yearly Chlamydia rates for both males and females varied only slightly.

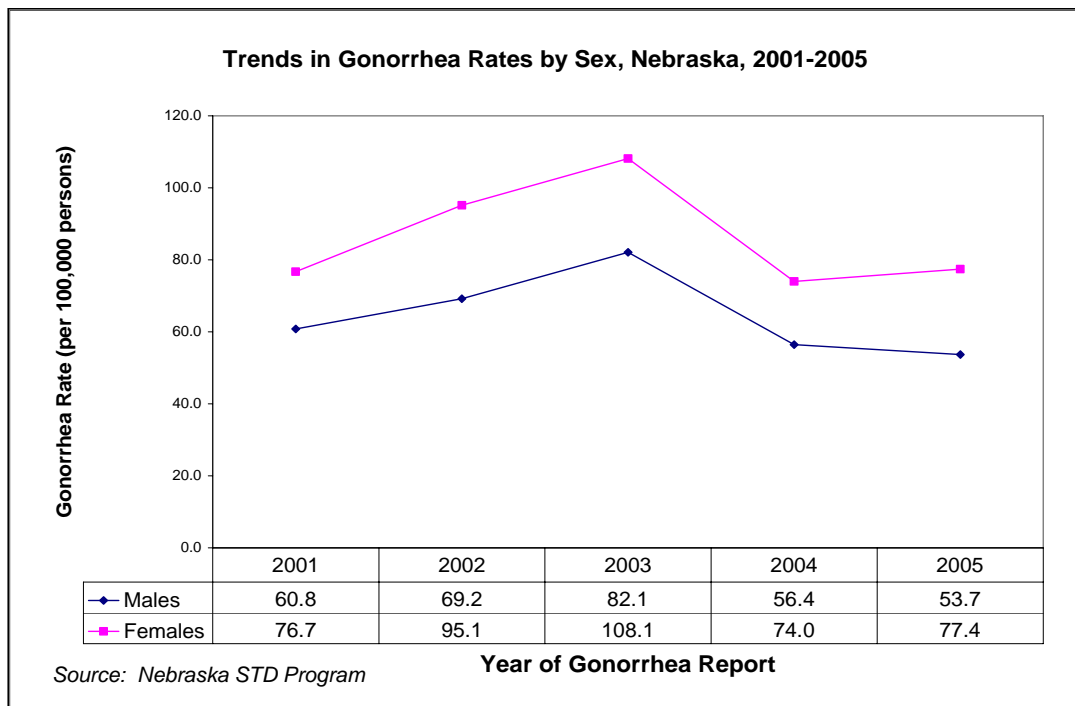
**Figure 16:**



## Gonorrhea

In Figure 17, the trends in gonorrhea rates by gender are shown. Between 2001 and 2005, gonorrhea rates were consistently higher in females as compared to males. In comparison, the yearly gonorrhea rate for both males and females remained consistent for 2004 and 2005, but remained lower than the highest rate for the past five years that was recorded in 2003.

**Figure 17:**



## ATTITUDES TOWARDS HIV/AIDS

### *Behavior Risk Factor Surveillance System (BRFSS)*

According to 2004 BRFSS results, approximately one-third of respondents aged 18-64 years (34%) said their blood had been tested for HIV infection (excluding tests they may have had as part of blood donations). Men and women were equally likely to have had their blood tested for this infection (29% and 33%, respectively). One-half (46%) of young adult respondents aged 25-34 had been tested for HIV. (Table 32)

**Table 30: Percentages who have ever had their blood tested for HIV by age and gender, aged 18-64**

<i>Age</i>	
18-24.....	31%
25-34.....	46%
35-44.....	38%
45-54.....	22%
55-64.....	14%
<i>Gender</i>	
Male .....	29%
Female .....	33%
<i>Source: Nebraska BRFSS 2004</i>	

Reasons for having blood tested for HIV infection varied, but two-thirds (68%) of those tested stated that the HIV test was done as a requirement of some kind (e.g. pregnancy exam, routine checkup, life insurance checkup, etc.). One fifth (17%) of respondents who had been tested cited reasons that may indicate that the respondent felt he or she was at increased risk for contracting HIV (e.g. for own information, possible exposure, illness, etc.). (Table 33)

**Table 31: Main reason for most recent HIV blood test, aged 18-64**

<i>Routine Reasons</i>	
It was required.....	25%
Routine medical checkup .....	23%
Pregnancy .....	20%
Subtotal .....	68%
<i>Perceived Risk Reasons</i>	
Just wanted to find out .....	13%
Someone suggested it .....	2%
May have been exposed .....	2%
Worried about passing it on .....	< 1%
Subtotal .....	17%
<i>Other reasons</i>	
Other .....	14%
Don't know .....	< 1 %
Refused.....	< 1 %
Subtotal .....	15%
<i>Source: Nebraska BRFSS, 2004</i>	

### HIV Treatment

According to 2004 BRFSS results, of all individuals surveyed in 2004, 98% agreed that treatment exists to live longer with HIV but only 77% agreed that treatment exists to reduce HIV in babies.

## HIV Testing

### Counseling, Testing, and Referral (CTR) Data

The CTR program has federally funded HIV test sites that are located across Nebraska. These sites do not include physician offices, hospitals, or medical clinics. At these test sites, the client has the option of testing anonymously (by number) or confidentially (by name). (See Appendix A for more details.) The test sites gather risk behavior and demographic information on all individuals seeking HIV testing during pre-test counseling. Test results, when reported, are linked to demographic and risk information. CTR testing data include both HIV positive and negative test results. This permits the measurement of demographics and high risk behaviors, by those testing positive as well as those testing negative.

As shown in Table 34, in 2005, 8,234 tests were done. The percent of positive tests was 0.7%. Two-thirds of the HIV tests performed at counseling and testing sites in Nebraska in 2005 were confidential.

**Table 32: Counseling, Testing, & Referral: Summary Statistics, Nebraska, 2005:**

	#	%
<b>ALL TESTS</b>	<b>8234</b>	<b>100%</b>
<b>TYPE OF TEST</b>		
Anonymous	2748	33.0%
Confidential	5445	66.0%
<b>TEST RESULT</b>		
Positive Tests	56	0.7%
Negative Tests	8140	99.0%
<i>Source: Nebraska Counseling, Testing and Referral, 2005</i>		

**Note: Numbers do not add up due to incomplete information**

Table 35 provides a comprehensive list of results from persons being tested at the counseling and testing sites in 2005. Most of the tests (53.2%) were male, and they were also the majority of the positive tests (71.4%). By race/ethnicity, 45.6% of the positive tests were for whites, and 33.3% were for blacks. The most common age of the positives was 20 to 29 years old (42.9%), followed closely by the 30 to 39 years old at 37.5%. The most common risk behaviors of the positive tests was MSM (41.1%), while heterosexual contact came in a very close second at 39.3%. Interpretation from data collected at counseling and testing sites must be used with caution. The data is not deduplicated, and persons may have been tested and entered into the database more than one.

**Table 33: Characteristics of Clients Utilizing Counseling, and Testing Clinics**

	TESTS		POSITIVE TESTS	
	#	%	#	%
<b>GENDER</b>				
Male	4,378	53.2%	40	71.4%
Female	3,855	46.8%	16	28.6%
Not Specified	1	0.0%	0	0.0%
<b>Total</b>	8,234	100%	56	100%
<b>RACE/ETHNICITY</b>				
White	4931	59.9%	26	45.6%
Black	1911	23.2%	19	33.3%
Hispanic	893	10.8%	7	12.3%
Asian/ Pacific Islander	150	1.8%	2	3.5%
American Indian/AK Native	190	2.3%	2	3.5%
Other	115	1.4%	1	1.8%
Undetermined	42	0.5%	0	0.0%
Not Specified	2	0.0%	0	0.0%
<b>Total</b>	8234	100.0%	57	100.0%
<b>AGE</b>				
<5	1	0.0%	0	0.0%
5-12	5	0.1%	0	0.0%
13-19	1272	15.4%	1	1.8%
20-29	3884	47.2%	24	42.9%
30-39	1612	19.6%	21	37.5%
40-49	1004	12.2%	8	14.3%
50+	447	5.4%	2	3.6%
Unknown	0	0.0%	0	0.0%
Not Specified	9	0.1%	0	0.0%
<b>Total</b>	8234	100.0%	56	100.0%
<b>RISK BEHAVIORS</b>				
MSM IDU	67	0.8%	2	3.6%
MSM	841	10.2%	23	41.1%
Heterosexual IDU	642	7.8%	1	1.8%
Sex Partner at Risk	4092	49.7%	22	39.3%
Children of HIV+ Women	0	0.0%	0	0.0%
Diagnosed w/STD	519	6.3%	2	3.6%
Sex for drugs/money	26	0.3%	0	0.0%
Sex while using drugs	632	7.7%	3	5.4%
Hem/Blood Recipient	18	0.2%	0	0.0%
Victim Sexual Assault	<b>52</b>	0.6%	<b>0</b>	0.0%
Health care exposure	30	0.4%	0	0.0%
No acknowledged risk	467	5.7%	0	0.0%
Heterosexual/No other risk	799	9.7%	3	5.4%
Other	29	0.4%	0	0.0%
Not Specified	20	0.2%	0	0.0%
<b>Total</b>	8234	100.0%	56	100.0%
<i>Source: Nebraska Counseling, Testing, and Referral, 2005</i>				

## Section 4: Care and Services Utilized by Persons with HIV in Nebraska

Congress authorized the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990 to provide medical care and medication to people living with HIV/AIDS (PLWHA) who would not otherwise be able to afford them. These funds were reauthorized in 2006 and are now known as the HIV/AIDS Treatment Modernization Act. The [HIV/AIDS Bureau of the Health Resources and Services Administration \(HRSA\)](#), is the largest single source, next to the [Medicaid](#) and [Medicare](#) programs, of federal funding for HIV/AIDS care for low-income, un-insured, and underinsured individuals. In order to participate in the Nebraska CARE Program during Calendar Year 2006, an individual had to be a resident of Nebraska, have proof of HIV diagnosis or perinatal exposure, and an income less than 200% of the federal poverty level.

### *Ryan White HIV/AIDS Treatment Modernization Act in Nebraska*

There are three programs that provide financial resources specifically for persons with HIV/AIDS. They are categorized as Parts A, B, and C. Nebraska receives federal funding from Part B of the *HIV/AIDS Treatment Modernization Act in Nebraska* from the Health Resources and Services Administration (HRSA). Part B of this grant funds both the Direct Emergency Assistance Program, which provides assistance for rent, utilities, transportation, food, health insurance, nutritional supplements and limited home health care to individuals with HIV disease, as well as case management services and the AIDS Drug Assistance Program (ADAP). In the 2007 federal grant, Nebraska received \$2,381,505 for the Part B portion of the 2007 Ryan White Care grant.

*ADAP:* The AIDS Drug Assistance Program provides access to needed pharmaceuticals for treatment of HIV disease. Nebraska's ADAP formulary currently includes 120 medications, all medications approved by the FDA for the treatment of HIV disease. In addition to Federal funding, ADAP receives an additional \$900,000 annually in State funding for HIV medications. The University of Nebraska Medical Center (UNMC) acts as the ADAP provider for the State. Qualified individuals statewide receive medications either through walk-in pharmacy services at the hospital or through a mail order system.

*Part C:* Ryan White Part C funding provides for ongoing medical care, oral health care, psychosocial services, nutritional, and other care services or persons with HIV infection. Part C services include:

- Risk-reduction counseling, antibody testing, medical evaluation, and clinical care;
- Antiretroviral therapies; protection against opportunistic infections; and ongoing medical, oral, nutritional, psychosocial, and other care services for HIV-infected clients;
- Case management to ensure access to services and continuity of care for HIV-infected clients; and
- Attention to other health problems that occur frequently with HIV infection, including tuberculosis, and substance abuse.

Funding goes directly to providers of medical care, and patients are charged fees according to a sliding scale. Part C healthcare and healthcare related services are offered through the University of Nebraska Medical Center in Omaha which provides services to the eastern two-

thirds of the State, and Western Community Health Resources, located in Chadron, which provides services in the Panhandle region. For the fiscal year (April 1, 2007 to March 30, 2008), UNMC received \$557,640 for Part C funds and the Panhandle received \$129,233. Together these services allow individuals who do not qualify for Medicaid, Medicare, or private insurance to access needed services. Ryan White Part C data cannot be generalized to all HIV-infected persons living in the state because they are collected only for persons who (1) know their HIV status and (2) are currently seeking care and treatment services from Part C funded providers.

**AETCs:** AIDS Education and Training Centers (AETCs) support a network of regional centers that conduct targeted, multi-disciplinary education and training programs for health care providers of clinical care for persons with HIV/AIDS. There are also several national, cross-cutting components of the AETC program which support and complement the regional training centers. The award for Nebraska's AETC was \$146,377 for the funding year July 2006 to June 2007.

**AETC Name:** Nebraska AETC

**Training Models:** Direct training; mini-sabbaticals; case conferences; clinical consultations; interactive educational offerings for larger groups

**Target Audience:** Targeted health care providers are physicians, physician assistants, nurse practitioners, nurses, dentists, dental hygienists and assistants, and pharmacists; we attempt to reach providers who care for rural patients as well as providers in our community health centers who treat the urban poor as well as minority patients, specifically African American, Hispanic, and Sudanese.

**Program Description:** The Nebraska AETC provides education to targeted providers over the entire state of Nebraska using many different training models as appropriate for the audience. NAETC also provides Level III preceptorships at the HIV Clinic at the University of Nebraska. Clinical consultations are provided by HIV care specialists from the University of Nebraska Medical Center. Because Nebraska is a low incidence state, much education is directed at basic HIV recognition and testing issue

**Training Components:** On-going needs assessment process, direct training events; case conferences; Level III clinical preceptorships, clinical consultations, program evaluation using standard MPAETC tools.

### **CARE Services:**

As of December 31, 2006, the Nebraska CARE Program (Part B and Part C) had 904 clients. There were 1,397 persons living with HIV/AIDS reported to the HIV Surveillance Program. Individuals enrolled in the Nebraska CARE program, are a subset of individuals living with HIV/AIDS in Nebraska. In Table 36 below, a summary of services utilized by Ryan White clients is provided. Most of the visits were medical-related services, but the largest average number of visits per client occurred for those seeking substance abuse treatment. (Note: The Part C data in this section includes only UNMC Part C clients. The Panhandle Part C clients are not included in this section.)



**Table 34: Utilization of health care services by Ryan White Part B & Part C clients, Nebraska, 2006**

Service	# of clients	# of visits	Avg # visits/client
Ambulatory	886	3101	3.5
Mental Health	84	226	2.7
Oral Health	85	140	1.7
Substance Abuse	11	88	8.0
Case Management services	417	417	1.0
<i>Source: Nebraska Ryan White Program</i>			

Comparing demographic and other characteristics of CARE clients and PLWHA reported to the Nebraska HIV Surveillance program allows for a comparison between CARE clients and the total reported Nebraska HIV/AIDS cases. However, it is important to note that some CARE clients may not be accounted for in HARS if they lived in another state when they were diagnosed with HIV. On the other hand, some PLWHA reported to HIV surveillance may no longer live in Nebraska, and therefore, are not eligible to participate in CARE. Also, the demographics for CARE clients represent both Nebraska and non-Nebraska cases, whereas, the demographics for persons living with HIV/AIDS at the end of 2006, represent only cases residing in Nebraska at the time of diagnosis. The comparison of the two data sets, although limited, is the best comparison available.

Table 37 illustrates the demographic characteristics of CARE Act Part B and Part C Clients Compared with Characteristics of Person Living with HIV Disease in Nebraska. The proportional demographic distribution of persons enrolled in CARE does not differ substantially from individuals living with HIV disease at the end of 2006, by gender, race/ethnicity, or age. There may be slight differences by age group since the age for the CARE Act and ADAP clients is the age they were at enrollment, and the age for PLWHA is their current age.

**Table 35: Comparison of Demographic Characteristics of CARE Act Part B & C Clients to Persons Living with HIV/AIDS, Nebraska, 2006**

Characteristic	CARE Act Clients (N=904)		Persons Living with HIV/AIDS (N=1397)	
<b>GENDER</b>				
Male	665	73.6%	1075	77.0%
Female	234	25.9%	322	23.0%
Transgender	5	0.6%	0	0.0%
<b>Total</b>	<b>904</b>	<b>100.0%</b>	<b>1397</b>	<b>100.0%</b>
<b>RACE/ETHNICITY</b>				
White	535	59.2%	783	56.0%
Black	238	26.3%	380	27.2%
Hispanic	106	11.7%	180	12.9%
Asian/Pacific Islander	3	0.3%	25	1.8%
American Indian/AK Native	14	1.5%	27	1.9%
Multi-race	8	0.9%	2	0.1%
<b>Total</b>	<b>904</b>	<b>100.0%</b>	<b>1397</b>	<b>100.0%</b>
<b>AGE</b>				
0-4	3	0.3%	5	0.4%
5-12	5	0.6%	7	0.5%
13-24	26	2.9%	42	3.0%
25-44	546	60.4%	834	59.7%
45-64	315	34.8%	480	34.4%
<65	9	1.0%	29	2.1%
<b>Total</b>	<b>904</b>	<b>100.0%</b>	<b>1397</b>	<b>100.0%</b>
<b>Note:</b> Age for ADAP clients represents the age at enrollment in CARE. Age for PLWHA is the current age as of December 31, 2006.				
<i>Source: Nebraska Ryan White Program</i>				

The AIDS Drug Assistance Program (ADAP) served 315 unduplicated clients for the period April 2005 through March 2006. There was an average of 179 clients served per month, with an average expenditure on drugs of \$120,348 per month and an average of \$671 per client. There were approximately two new clients admitted to the program per month. During this time, ADAP was closed to new admissions due to a shortage of funds and a waiting list resulted. When state funds were allocated to the program in July 2006, the additional funds enabled the program to eliminate the waiting lists. Figures 18, 19, and 20 represent ADAP services for this period by age group, sex and race/ethnicity, and by region. Proportionately, females were slightly more likely to utilize services than males, while use of services by race/ethnicity and age group were essentially the same as those living with HIV/AIDS.

Figure 18:

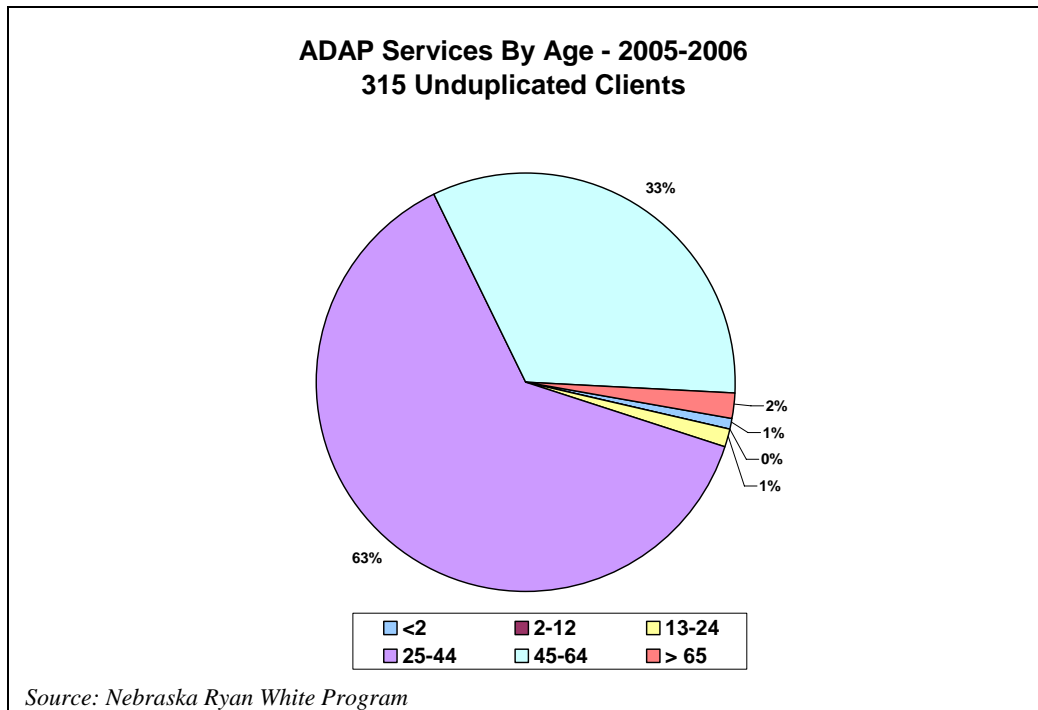
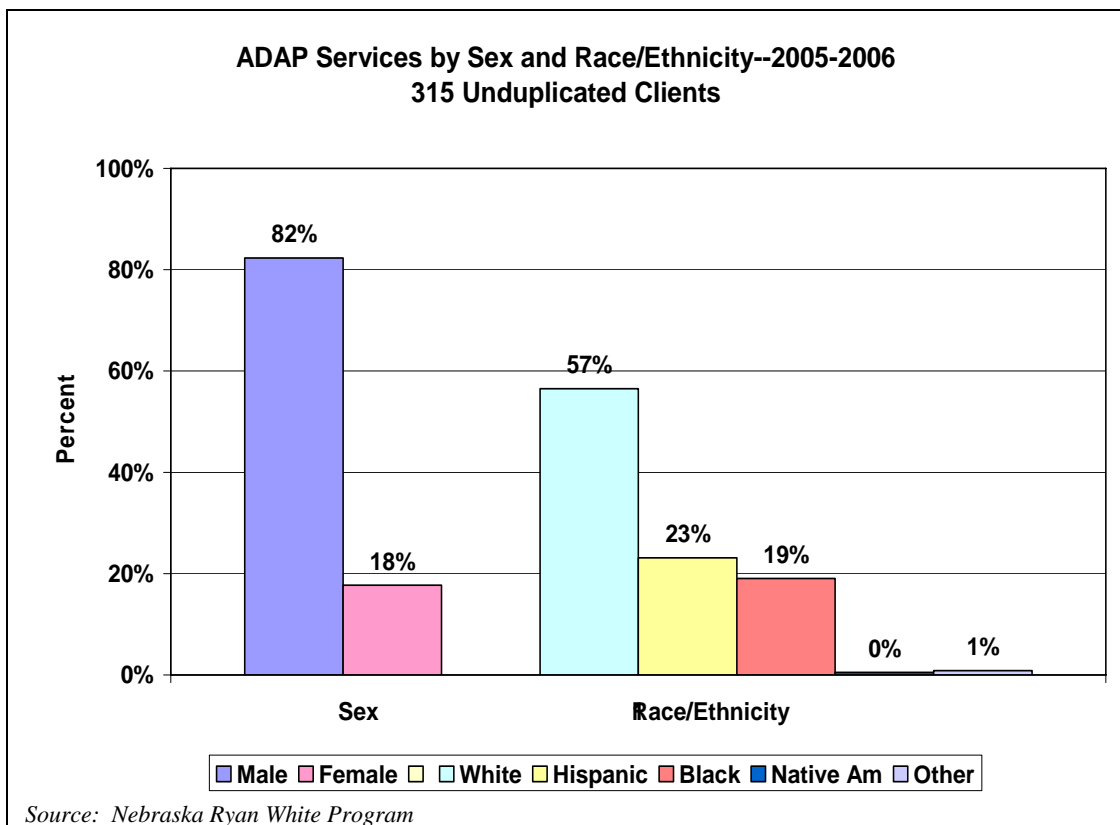
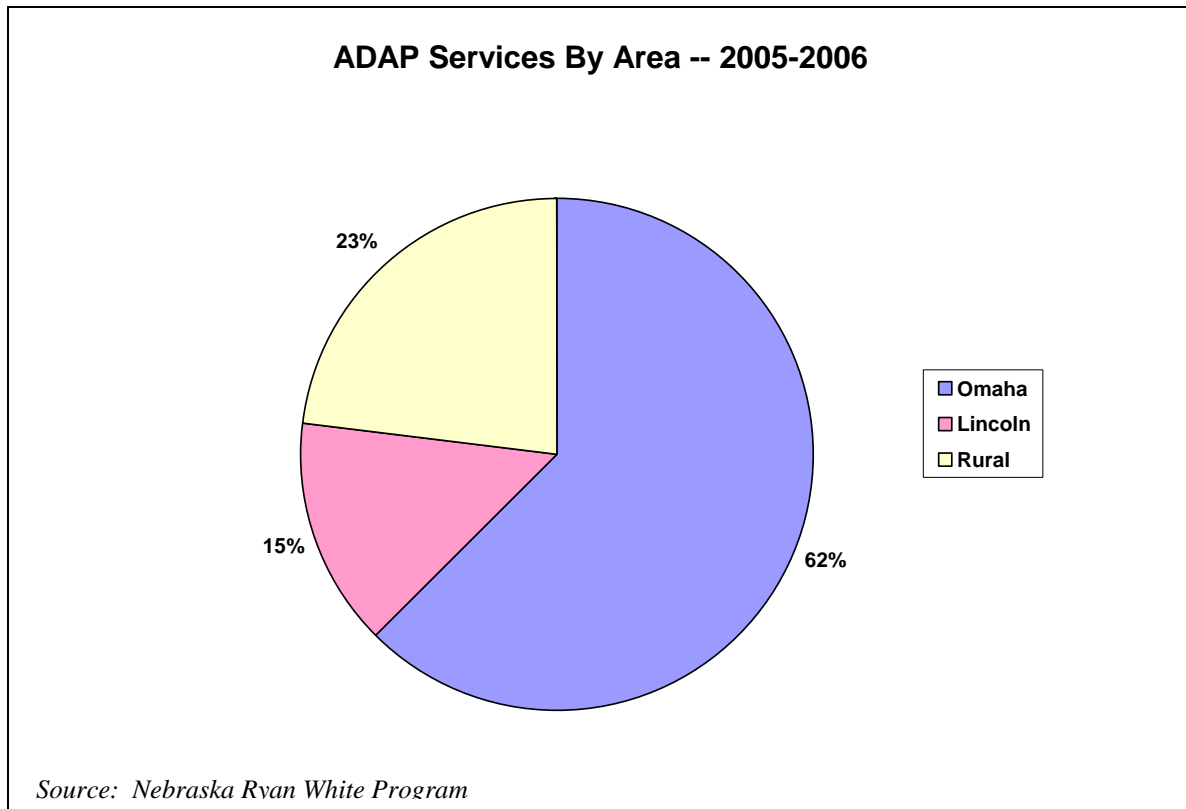


Figure 19:



**Figure 20:**

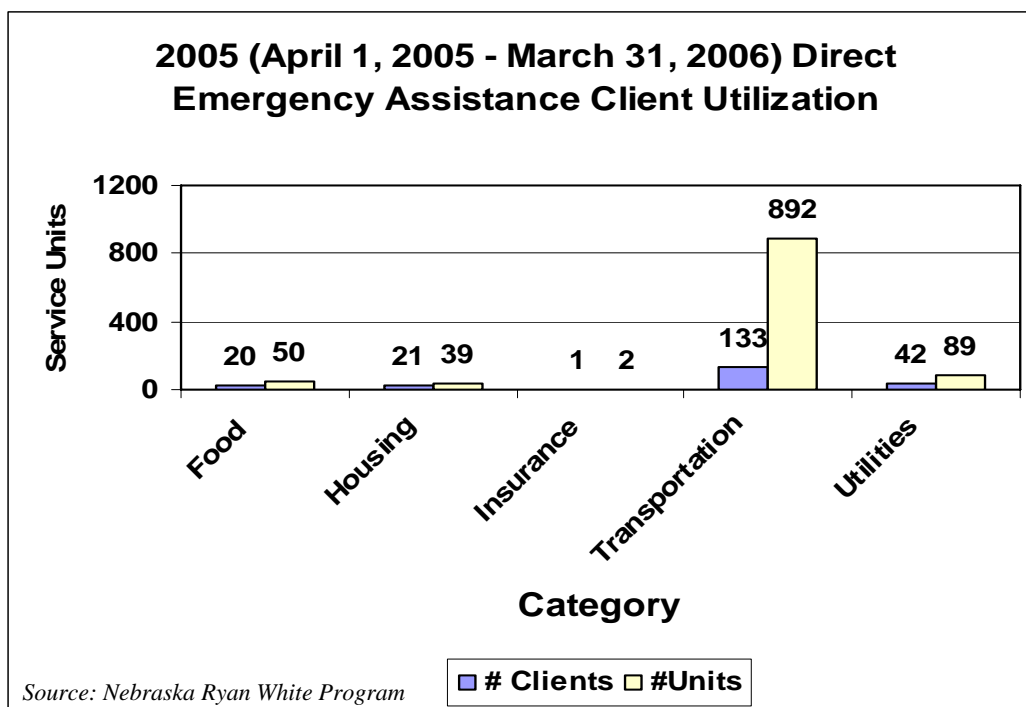


### **Case Management and Direct Emergency Assistance (DEA)**

Case management is provided across the state by Nebraska AIDS Project. There were a total of 524 unduplicated clients served. Of those, 517 were unduplicated HIV positive clients (seven were family members). There were a total of 5,244 case management service units provided to the 517 HIV positive clients; an average of 10.14 service units per client. Of these 517 clients, 217 received direct emergency assistance, consisting of housing (rent), utility, transportation, insurance and food assistance. A total of \$33,250 was spent providing DEA services.

The CARE Act Data Report provided information shown in Figure 21. Transportation was by far the most utilized assistance category, with 892 units of service and 133 clients served. Utilities followed, with 89 units of services and 42 clients served.

Figure 21:



**Housing Opportunities for Persons with AIDS (HOPWA):**

In March 2004, Nebraska Health and Human Services (NHHS) was awarded a 3-year HOPWA grant from the U.S. Department of Housing and Urban Development (HUD) in the amount of \$1,357,192 to provide services statewide to persons and their families living with HIV/AIDS. Activities funded through this grant include case management services, permanent housing placement, short-term rental and mortgage assistance, tenant-based rental assistance, move-in expenses (first/last month rent, security deposit, and application fee), transportation assistance, personal empowerment client education and mental health and substance abuse treatment. Targeted special populations include the chronically homeless, dual diagnosed and post-incarcerated. NHHS submitted a 3 year renewal grant application to HUD for ongoing HOPWA funding for the period 2007 through 2010. Table 38 gives information on how the federal funding for HOPWA was spent in the fiscal year 2006.

**Table 36: HOPWA Expenditures for FY 2006**

Service	% Utilization	Expenditures
Housing Information/Counseling	5.60%	23,397.00
Resource Identification/TA	10.30%	42,732.00
Rental/Mortgage and Tenant-Based Housing Assistance	51.70%	214,474.00
Supportive Services*	22.70%	94,032.00
Administrative Cost	9.70%	40,136.00
Total	100.00%	\$414,771.00

\*Case Management, Security Deposits, First Month's Rent, Transportation, Self-Sufficiency Course, Mental Health/Substance Abuse Services)

The Housing Opportunities for Persons with AIDS (HOPWA) served 133 unduplicated clients and 76 family members in 2006. The most utilized housing type was rental housing (72%) followed by private residence (18%). Other types of housing included living with a relative or friend, group facility, and transitional housing. The demographic characteristics of clients who participated in this program are given in Table 39.

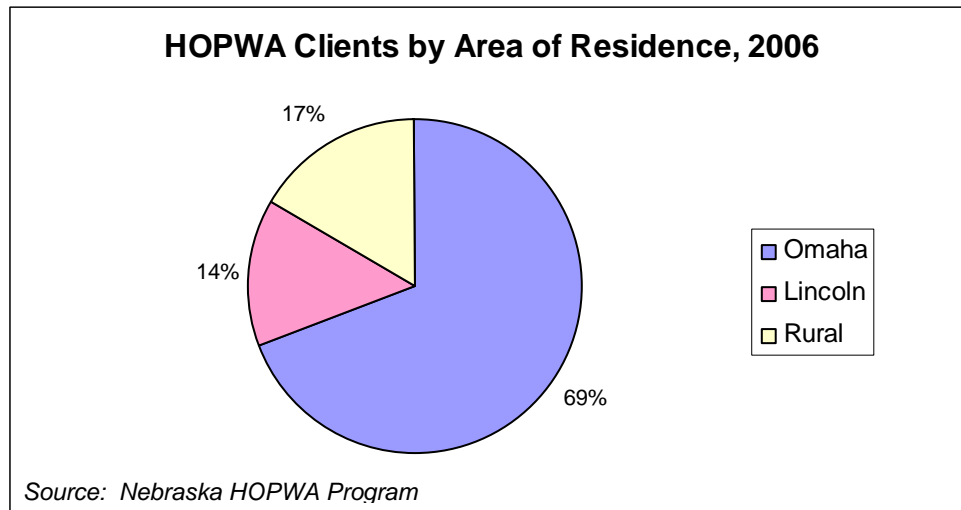
**Table 37: Demographic Characteristics of HOPWA Clients, Nebraska 2006**

Characteristic	HOPWA Clients (N=133)		Persons Living with HIV/AIDS (N=1397)	
<b>GENDER</b>				
Male	97	72.9%	1075	77.0%
Female	36	27.1%	322	23.0%
<b>Total</b>	<b>133</b>	<b>100.0%</b>	<b>1397</b>	<b>100.0%</b>
<b>RACE</b>				
White	82	61.7%	783	56.0%
Black	38	28.6%	380	27.2%
American Indian/AK native	5	3.8%	27	1.9%
Other/Multi-race	8	6.0%	207	14.8%
<b>Total</b>	<b>133</b>	<b>100.0%</b>	<b>1397</b>	<b>100.0%</b>
<b>ETHNICITY</b>				
Hispanic	20	15.0%	180	12.9%
Other and non-Hispanic	113	85.0%	1217	87.1%
<b>Total.</b>	<b>133</b>	<b>100.0%</b>	<b>1397</b>	<b>100.0%</b>
<b>AGE</b>				
0 - 12	0	0.0%	12	0.9%
13 - 24	2	1.5%	42	3.0%
25 - 44	82	61.7%	834	59.7%
45+	48	36.1%	509	36.4%
Unknown	1	0.8%	0	0.0%
<b>Total</b>	<b>133</b>	<b>100.0%</b>	<b>1397</b>	<b>100.0%</b>
<b>RISK BEHAVIORS</b>				
MSM	56	42.1%	612	43.8%
IDU	14	10.5%	137	9.8%
MSM/IDU	n/a	n/a	89	6.4%
Heterosexual contact	47	35.3%	262	18.8%
Adult Hemophilia	n/a	n/a	9	0.6%
Transfusion	2	1.5%	19	1.4%
Pediatric	n/a	n/a	22	1.6%
Undetermined, Unknown, and Not Available	14	10.5%	247	17.7%
<b>Total</b>	<b>133</b>	<b>100.0%</b>	<b>1397</b>	<b>100.0%</b>

Source: Nebraska HOPWA Program

Most of the HOPWA clients found housing in Omaha (69%), while 14% resided in Lincoln, and 17% were housed in the rural area of Nebraska, as shown in Figure 22. Females and whites were proportionately more likely to have received these services than their counterparts. It may be that the minority populations who have not utilized these services are not as aware of these services.

**Figure 22:**



## Section 5: The number and characteristics of persons who know they are HIV-positive but who are not receiving HIV primary medical care

The Health Resources and Services Administration (HRSA) require that Ryan White CARE Act grantees estimate unmet need among persons with HIV/AIDS. Unmet need is defined as the proportion of HIV infected persons without basic HIV medical care in a 12-month period. HIV primary medical care is defined as a viral load test or a CD4 lymphocyte count. In Nebraska, unmet need was estimated based on a framework provided by HRSA.

“Met need” was defined as the number of persons with HIV/AIDS with at least one viral load or CD4 lymphocyte test collected during a calendar year. Unmet need was simply the difference between the estimated total number of HIV/AIDS cases and the met need.

The most current analysis of unmet need is for 2005. By December 31, 2005, there were 1,256 persons living with HIV/AIDS in Nebraska. Of these 758 (60%) were determined to be in-care, based on the definitions listed above. This methodology utilized in the framework below indicated that 498 (40%) PLWHA people in Nebraska were out of care during calendar year 2005. See Table 40 below.

**Table 38: Measurement of Unmet Need, Nebraska, 2005**

Measure	Value	Data Source
<b>Population Sizes</b>		
Total number of individuals known to be living with HIV/AIDS in Nebraska, as of December 31, 2005.	1256	HARS
<b>Care Patterns</b>		
Total Number of PLWHA (aware of HIV+ status) who received specified HIV primary medical care in 2005	758	HARS
<b>Calculated Results</b>		
Total HIV+/aware not receiving specified HIV primary medical care	498	HARS
<b>Quantified estimate of unmet need of HIV+/aware not receiving HIV primary medical care</b>	40%	HARS

One limitation of this estimate is that the population estimate did not take into account the movement of cases out of state. This may have resulted in an artificially high population estimate, thereby resulting in an overestimate of unmet need. Another limitation is that only CD4 counts under 800 are reportable, which means that HIV surveillance is not receiving all CD4 tests. This may also overestimate the amount of unmet need. Table 41 describes the characteristics of those PLWHA who have unmet need in 2005. The majority of persons with unmet need were men. By race/ethnicity: 56% were white; 24% black; 14.5 % Hispanic; 3% Native American; 1.8% Asian. Three persons reported more than one race/ethnicity. Most of those not in care (73%) were 30 to 39 years old, while 16.8% were 40 to 49 years old, and



9.7% were 20 to 29 years old. By risk behaviors, 44% were MSM, 10.6 % IDU, 9% MSM/IDU, and 11.4% heterosexual contact. However, a substantial number were reported without a known risk (NIR) (22.5%) which makes interpretation of risk behaviors difficult.

**Table 39: Characteristics of persons with unmet need, Nebraska, 2005**

Characteristic	Persons with unmet need, 2005	
	#	%
<b>GENDER</b>		
Male	399	80.1
Female	99	21.0
<b>Total</b>	498	100.0
<b>RACE/ETHNICITY</b>		
White	278	55.8
Black	121	24.3
Hispanic	72	14.5
Asian/ Pacific Islander	9	1.8
American Indian/AK Native	15	3.0
Multi-race	3	0.6
<b>Total</b>	498	100.0
<b>AGE*</b>		
<13	3	0.6
13-19	2	0.0
20-29	47	9.7
30-39	170	72.1
40-49	180	16.8
50+	96	1.1
<b>Total</b>	498	100.0
<b>Risk behaviors</b>		
MSM	219	44.0
IDU	53	10.6
MSM/IDU	45	9.0
Heterosexual contact	57	11.4
Adult Hemophilia	3	0.6
Transfusion	5	1.0
Pediatric	4	0.8
No Risk Reported (NIR)	112	22.5
<b>Total</b>	498	100.0

Source: Nebraska HIV Surveillance Program

## Appendix A: Epi Profile Data Sources

### 1. Core HIV/AIDS Surveillance

Tracking of HIV infection in Nebraska began when the first AIDS case in the state was reported in 1983. In July 1995, HIV surveillance was further enhanced by legislation instituting confidential name-based reporting of HIV infection. Persons diagnosed with HIV before July 1995, may not have been reported to the Nebraska Department of Health and Human Services.

Nebraska's communicable disease regulations (Title 173) require physicians and hospitals to report persons diagnosed with HIV infection and laboratories to report all cases with laboratory-confirmation of HIV. Demographics, exposure to the disease and clinical data are collected on each case and entered into Nebraska's HIV/AIDS Reporting System (HARS) database developed by the U.S. Centers for Disease Control and Prevention (CDC).

**Population:** All persons who confidentially test positive for HIV and those who are diagnosed with AIDS.

**Strengths:** AIDS Surveillance data has been determined to be > 85% complete nationwide. The data include all demographic groups (age, race/ethnicity, and sex). HIV surveillance data represent persons more recently infected than AIDS surveillance data.

**Limitations:** Factors that impact the completeness and accuracy of HIV/AIDS surveillance data include; compliance with case reporting, timeliness of case reporting, test-seeking behaviors of HIV-infected individuals, and the availability and targeting of HIV testing services. While HIV case reports do represent persons more recently infected than AIDS case reports, there are still several limitations that affect the completeness and timeliness of the data..

First, CDC estimates that about 30% of HIV-infected individuals are unaware of their status. This is partly because early HIV infection does not produce severe nor distinct symptoms and so delays in testing are common. Additionally many people acknowledge avoiding testing for fear of a positive test result or believing that they are not at risk.

Second, cases of new HIV infection can also go undetected by HIV surveillance due to the availability of anonymous testing at any of the federally funded HIV testing sites. Once a person begins care, however, the HIV/AIDS surveillance system would more likely detect the case.

Thus, although HIV case reporting is our best estimate of new HIV infections, the system does not capture all new cases. There are varying amounts of delay between infection, testing, and reporting. HIV/AIDS data collectively provide a minimum estimate of the number of persons known to be HIV infected.

As of February 2007, forty-eight states, including Nebraska, conduct surveillance using a name-based system. The three remaining states use a code-based or name-to-code system to collect HIV data. This makes it difficult to ensure that duplicate reports are not entered into the national database. HIV reporting laws vary by state; therefore consultation with local

surveillance staff is advised on how to interpret HIV surveillance data. Furthermore, reporting of behavioral risk information may not be complete.

## **HIV Counseling and Testing Data**

**Overview:** The Nebraska Health and Human Services HIV Prevention/Ryan White/Hepatitis C Program receives federal funds to operate 56 designated HIV Counseling, Testing, and Referral Program (CTRP) sites throughout the state. The CTR program provides HIV antibody testing and risk reduction counseling. For HIV Prevention efforts, voluntary HIV antibody testing and post-test counseling is provided to any Nebraska resident at no charge. Nebraska law requires written informed consent prior to HIV testing at all provider sites throughout the state.

Efforts are made to target individuals practicing high-risk behaviors for testing. Target populations for outreach programs, counseling and testing services, partner counseling and referral services (PCRS), and referral for HIV treatment include: men who have sex with men (MSM); injection drug users (IDUs) and other substance abusers; individuals who trade sex for money or drugs; persons who share needles; sex partners of individuals either infected with HIV or diagnosed with AIDS; individuals with multiple sex partners; patients of STD Clinics; state and local correctional facilities and sexually active youth.

The CTR Program collects information on counseling and testing services delivered, as well as the characteristics of clients receiving the services. The characteristics include demographics, insurance, risk information, and testing information data (data testing history, test result). All sites offer both anonymous and confidential testing options. However, 66% of persons that were tested in 2005 were tested confidentially.

Pre-test counseling is the first step in the counseling and testing process. During this step, the client is informed about HIV, the syndrome it causes, ways to prevent transmission and the implications of a negative or a positive HIV antibody test. In Nebraska, both confidential and anonymous testing options are provided. Confidential testing includes the use of a Unique Identifier (UI) number on CTS report forms as well as the client's name, address, date of birth (DOB) and home phone number. Anonymous testing also utilizes the UI, but no personal information is collected. Consequently, anonymous testing data are analyzed in terms of tests, as opposed to individuals.

The second step of the process is test decision counseling. The option to test or not to test is based on the perceived risk of the client. With the assistance of the counselor, the client determines whether or not to be tested. If the client declines testing, the process ceases. If testing is to be performed, the client is informed of the testing technologies available at the testing site. (OraSure, OraQuick or serum tests are done in Nebraska, based on where the test site is located.) Once testing is completed, the client is reminded to return for the post-test counseling session to retrieve his/her results in person. The client must also retain and present the number (UI) that will be used to identify him/her in order to get the result.

During post-test counseling, the third step, the client is informed of their test result (negative, positive, or indeterminate) and one-on-one HIV/AIDS counseling is reinforced in all outcomes. Additional counseling is provided to those who tested positive for HIV, including information

regarding the reduction of further HIV transmission and the importance of partner notification. All health departments offer services to assist clients with partner notification. Furthermore, seropositive individuals receive referrals for medical and psychiatric follow-up, including early screening for and treatment of other STDs, TB and hepatitis.

If the client tests positive, it is the recommendation of the HIV Prevention Counseling and Testing Program that a trained Disease Intervention/Investigation Specialist (DIS) be available to give results and perform the partner/spousal notification and partner counseling and referral services (PCRS) process at that time. This is a voluntary process, and several options are offered to the client. The DIS are trained to get names and other contact information for sex and/or needle-sharing partners, locate those individuals, inform them that they may have come in contact with an HIV+ individual, and offer testing in the field or make referral to a publicly funded test site or a private physician. This is all done anonymously. No information about the source patient, or the initial HIV+ client, is divulged. That information is protected under both state and federal statutes.

**Population:** All clients who receive confidential or anonymous HIV testing services at a counseling and testing site funded through a CDC cooperative agreement.

**Strengths:** CTRP provides standardized data on clients who are tested for HIV, which is available at many sites across Nebraska. It may offer insights into HIV infection rates in an area's high-risk population. CTS testing data can help define the impact of prevention programs upon targeted populations.

**Limitations:** CTRP collects test-based, rather than person-based data. Since Nebraska offers both anonymous and confidential testing, there is no sure means of discerning if the tests were duplicates or not. Information is collected only from persons who seek counseling and testing services or agree to be tested after consultation with a counselor at a testing site. Therefore, estimation of HIV statewide seroprevalence is not possible with CTS data because the clients self-select for testing. Because a person can repeatedly seek testing, it is not possible to distinguish individuals who have been tested multiple times; however a "previous HIV test" variable is available on the client abstract form to quantify prior testing. Since the CTS system gathers data on HIV testing or program activities, changes in testing patterns may reflect changing program priorities rather than testing patterns of individuals.

## **STD Surveillance-STD Case Reporting**

**Overview:** The goal of Nebraska Department of Health and Human Services Sexually Transmitted Disease Program is to control and prevent sexually transmitted diseases and reduce the burden and cost of these infections. The STD Program conducts statewide surveillance to determine the number of reported cases of STDs, to monitor trends in the epidemics, and to offer voluntary partner counseling and notification services. The STDs given priority for surveillance and follow-up are Chlamydia, gonorrhea, and syphilis. These cases are reportable by hospitals, physicians and laboratories.

The STD program has developed partnerships with over 80 clinics throughout the state screening for Chlamydia, gonorrhea and other sexually transmitted diseases. These clinics include family planning clinics, community health centers, Indian health clinics, correctional

facilities, county and district health departments, hospitals, women health centers, children and adolescent university health clinics, primary care clinics, youth center clinics, and a large number of private health care providers.

Testing people who have no signs or symptoms of illness is important in the control of STDs. The Nebraska Infertility Prevention Program works with cooperating family planning and health care facilities throughout the state to test approximately 30,000 persons per year for Chlamydia and gonorrhea.

**Population:** All persons who are diagnosed with an infection that meets the CDC surveillance case definition for the infection and are reported to the health department.

**Strengths:** STD surveillance data can serve as surrogate markers for unsafe sexual practices and may demonstrate changes in behavior among specific populations that increase their risk for HIV infection. Because of a shorter time from exposure to infection to symptomatic disease, STD diagnoses may better indicate recent unsafe behavior and/or changes in community norms. In addition, certain STDs (i.e., ulcerative STDs) can facilitate transmission and/or acquisition of HIV infection. Finally, changes in trends of STDs may indicate changes in community sexual norms, such as unprotected sex. Nebraska's STD data are available on the web at: <http://www.hhs.state.ne.us/std/stindex.htm>.

**Limitations:** STDs are reportable, but requirements for reporting vary across states. The quality of the data is highly dependent on whether the provider is public or private and may be incomplete. Women may be routinely screened whereas men are more likely to be tested only if they are symptomatic. Other data limitations are discussed in the profile. Although STD risk behaviors result from unsafe sexual behavior, they do not necessarily correlate with HIV risk.

### **Behavioral Risk Factor Surveillance System (BRFSS)**

**Overview:** The BRFSS is a state-based random-digit-dialed land line telephone survey of adults that monitors state-level prevalence of the major behavioral risks associated with premature morbidity and mortality. Each month, a sample of households is contacted, and one person in the household who is 18 years or older is randomly selected for an interview. Multiple attempts are made to contact the sampled household. A Spanish translation of the interview is available. Respondents to the BRFSS questionnaire are asked a variety of questions about their personal health behaviors and health experiences. A sexual behavior module was added to this survey in 1994, 1995, 1996, 1998, and 2000. The questions in this module, for adults (aged 18-49), concerned number of sex partners, condom use, and treatment for STDs. The survey is not conducted on households with only cellular phones. This data is submitted to CDC and compiled with all other states to make a national database.

**Population:** All non-institutionalized adults, 18 years and older, who reside in a household with a telephone.

**Strengths:** Data from the BRFSS survey are population-based; thus, estimates about testing attitudes and practices can be generalized to the adult population of a state. Information collected from the BRFSS survey may be useful for planning community-wide education

programs. National comparisons are available.

**Limitations:** BRFSS data are self-reported; thus, the information may be subject to recall bias. Because BRFSS respondents are contacted by telephone, the data are not representative of households that do not have land-line telephones. In addition, BRFSS data are representative of the general non-institutionalized population in an area, not just persons at highest risk for HIV/AIDS. The extent of the HIV behavioral risk information collected by the BRFSS questionnaire is limited, and inferences can be made only at the state level.

## **Youth Risk Behavior System (YRBS)**

**Overview:** The YRBS was established to monitor six priority high-risk behaviors that contribute to the leading causes of mortality, morbidity, and social problems among youth and young adults in the United States. YRBS was developed to collect data that are comparable nationally, statewide, and locally. It is a self-administered questionnaire that is given to a random sample of 9<sup>th</sup> through 12<sup>th</sup> grade students in Nebraska. The YRBS is part of the Youth Risk Behavior Surveillance System, established by the CDC, and has been completed eight times in Nebraska: 1991, 1993, 1995, 1997, 1999, 2001, 2003, and 2005. The Nebraska YRBS collects information on six categories of behaviors, of which sexual behaviors that contribute to unintended pregnancy and STDs, including HIV, is one. Questions are also asked about exposure to HIV prevention education materials, sexual activity, contraceptive use, and pregnancy history.

**Population:** YRBS surveys a random sample of 9<sup>th</sup> through 12 grade students in Nebraska, but does not include the Omaha Public School System students.

**Strengths:** In Nebraska, the YRBS samples adolescents in grades 9-12 in public schools. The YRBS questionnaire is administered to students anonymously during school. Repeated attempts are made to contact students who are not in attendance. Inferences from the YRBS estimates can be drawn about behaviors and attitudes of adolescents in school, which makes the information useful for developing state-wide prevention programs aimed at younger persons. The YRBS uses a standardized questionnaire so that comparisons can be made across all states. Each state has the option to ask specific questions to meet their needs.

**Limitations:** The YRBS relies upon self-reported information; therefore, reporting of sensitive behavioral information may not be accurate (under- or over-reporting may occur). The Nebraska YRBS data are based on randomly selected public high schools sample in the state. It would not be valid to generalize the findings of the surveys to all youths who are not in public schools and the selected grades. These findings are only valid for public high school youths in Nebraska. In addition, the lack of participation by some of the randomly selected schools in the sample resulted in unweighted data in 1993, 1999 and 2001. Findings from these years do not give an accurate representation of the high school youths in the state.

## **Pregnancy Risk Assessment Data**

### **Nebraska Pregnancy Risk Assessment Monitoring System (NE PRAMS)**

**Overview:** NE PRAMS is an ongoing population-based surveillance system consisting of a monthly survey of new mothers from across Nebraska. PRAMS is designed to identify and monitor selected maternal behaviors and experiences before, during, and after pregnancy. Each month, a stratified sample of approximately 200 mothers is randomly selected from recent birth certificates. Between two to six months after the baby's birth an introductory letter and up to three PRAMS questionnaires are mailed to the mother. If no response is received after the third mailing PRAMS staff then telephones the non-responders and attempts to fill out the survey over the telephone. Responses are collected in a database and weighted to be representative of all women giving birth in Nebraska. Questions include attitudes and feelings about the pregnancy, i.e., was the pregnancy planned, how did the new mother feel about being pregnant, and use of alcohol before, during and after pregnancy.

**Populations:** Pregnant women in Nebraska

**Strengths:** The major strengths of PRAMS include: 1) it is flexible and relatively inexpensive for collecting public health data, 2) it is a population-based survey, allowing the data to be generalized to overall state-level populations, and 3) the PRAMS survey has been conducted in 32 states for many years. Thus, states can compare their data with each other, as well as analyze the data for trends over time.

**Limitations:** PRAMS limitations include: 1) the data collected consist of self-reported information that has not been verified, 2) the survey has a limited number of completed interviews, and the sample size may be too small for analysis on some sub-populations, and 3) the PRAMS survey uses complex sampling methods, and the data from the survey are subject to sampling errors.

## **Substance Abuse Data**

### **Treatment Episode Data Set (TEDS)**

**Overview:** TEDS is a national data set maintained by the Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA). Data are captured annually on more than 1.5 million records of treatment admissions for substance abuse. TEDS is comprised of data that are routinely collected by states to help monitor their individual substance abuse treatment programs. TEDS collects information on client demographics; information about the number of prior treatments; usual route of administration for each problem substance; frequency of use; age of first use; and services provided. Facilities that report TEDS data usually receive state funding for the provision of substance abuse treatment.

**Population:** Individuals admitted to substance abuse treatment facilities reporting to TEDS.

**Strengths:** While TEDS does not represent the total demand for substance abuse treatment, it does include a significant proportion of all admissions to substance abuse treatment. It includes admissions that constitute a burden on public funds.

**Limitations:** TEDS is based on records of admissions and does not represent individuals.

Because of this, an individual admitted to treatment twice within the same calendar year would be counted as two admissions. Also, because most states cannot identify individuals that have been assigned a unique ID at the state level to protect their confidentiality, TEDS is unable to follow individual clients through a sequence of treatment episodes. TEDS does not represent the total substance abuse treatment burden, or the prevalence of substance abuse in the general population.

## **National Household Survey of Drug Abuse (NHSDA)**

**Overview:** The NHSDA is an ongoing survey on the use of illicit drugs by the U.S. population aged 12 or older. The survey collects data by administering questionnaires to a representative sample of the population. Face-to-face computer-assisted interviews are conducted at the respondent's place of residence. Information captured by the NHSDA questionnaire includes use of cocaine, receipt of treatment for illicit drugs, and need of treatment for illicit drugs during the past year; use of alcohol, tobacco, or marijuana during the past month; and perceived risk of binge drinking, marijuana use, or smoking.

The NHSDA employed a 50-state sampling design; for the eight states with the largest populations, the sampling design provides a sample large enough to support direct state estimates. For the 42 remaining states and the District of Columbia, small area estimation techniques were used to calculate state estimates. Youth and young adults were over-sampled so that each state's sample was approximately equally distributed among three major age groups; 12–17 years, 18-25 years, and 26 years or older.

**Strengths:** NHSDA is national, standardized survey of drug use behaviors among the general population. To increase the level of honest reporting, since 1999, information has been collected using a combination of computer-assisted interviewing methods. This provides respondents with a more private and confidential means of responding to questions about substance use and other sensitive behaviors.

**Limitations:** Direct state-level estimates are available only for 8 states; Nebraska must rely on statistical estimates. NHSDA estimates represent behaviors in the general population, thus the survey may underestimate the level of substance use in the population at highest risk for HIV. Further, data from the NHSDA are self-reported and are subject to recall bias, which may result in under-reporting the level of a sensitive behavior.

## **Vital Statistics Data**

### **Death data**

**Overview:** The Nebraska Department of Health and Human Services Vital Statistics section receives information on births and deaths through a program of voluntary cooperation with state government agencies (i.e., state departments of health, state offices of vital statistics) called the Vital Statistics Cooperative Program. A standard certificate of death is used to record death information on each decedent. Death certificates capture decedent demographics, underlying cause of death (using an ICD-10 code), and contributions of selected factors to the death (i.e., smoking, accident, or injury).

**Population:** All deaths occurring in Nebraska and all deaths of Nebraska residents in other states.



**Strengths:** Reporting of deaths in Nebraska is approximately 100% complete. The data are widely available and can be used to determine the impact of deaths related to HIV infection in a service area. Standardized procedures are used throughout the nation to collect death certificate data.

**Limitations:** Deaths resulting from, or whose underlying cause was, HIV infection may be under-reported on a death certificate. Clinical information related to HIV or AIDS may be missing.

## Ryan White Care Act Data

Since 1993, the HIV/AIDS Program of the Nebraska Department of Health and Human Services has collected data on persons served by the Nebraska Ryan White Part B Program. To be eligible for Part B services, a persons must have HIV, be a resident of Nebraska, and have an income that is equal to or less than 200% of the current year's federal poverty level. Part B services include core medical services such as the AIDS Drug Assistance Program (ADAP), limited home health care, medical health services, and medical case management. Each service provider maintains his/her own database. Information collected from the service providers includes basic demographic and risk information, eligibility verification data (current address, current income, HIV diagnosis date), the type of services received, the date and quantity of services received, the cost of these services, and other pertinent information (history of substance abuse or mental health treatment, veteran status, current pregnancy status). The data indicate which Ryan White resources are being used, how often, and by whom.

**Population:** All HIV-infected persons receiving services funded by Ryan White Part B. In order to be eligible for Ryan White Part B services a person must be living with HIV/AIDS, be a resident of Nebraska, and have an income that is equal to or less than 200% of current year's federal poverty level.

**Strengths:** The program database is a comprehensive database that includes key fields of information on all persons receiving Ryan White Part B services. The database is an important tool for monitoring which Ryan White resources are being utilized, how often and by whom. The program is able to "unduplicate" clients within a particular service area and can also "unduplicate" clients across all services. This provides a more accurate picture of how many people are truly seeking care through services provided by Ryan White Part B. Data are collected on an on-going basis as services are utilized.

**Limitations:** The data cannot be generalized to all HIV-infected persons living in Nebraska. These data only reflect persons who (1) know their HIV serostatus, (2) are currently seeking care and treatment services from Ryan White Part B-funded providers, and (3) are financially eligible to receive services. Only aggregate data from the annual summary CARE Act Data Report (CADR) are most readily available.

The AIDS Drug Assistance program provides antiretroviral drugs and a limited number of other medications to persons who qualify for Ryan White Part B services and who are not fully covered for medications through Medicaid or other insurance plans. Although part of Ryan

White Part B funding, a separate database is kept at NHHSS for the ADAP Program. These data are, therefore, unduplicated, client-level data. Information collected in the database is limited to basic demographic information on each client, eligibility verification data, and laboratory information at the time of application.

### **Nebraska State Data Center**

**Overview:** The NSDC is a cooperative program between Nebraska and the U.S. Bureau of the Census and was created in 1978 to make data available locally to the public through a network of state agencies, universities, libraries, and regional and local governments. The NSDC lead organizations are appointed by the Governor of Nebraska. The NSDC is an official source of demographic, economic, and social statistics produced by the Census Bureau. The web site for the center <http://www.census.gov/sdc/www/nesdc.html> includes current population estimates and projections; economic, income and poverty status information; demographic profiles and rankings; and census geography. Information is available for the state, counties, cities and metropolitan areas.

**Population:** Nebraska population

**Strengths:** A wide range of online statistical data on the Nebraska population is available in different formats (e.g., tables, and maps). Links to other census information Web sites are provided.

**Limitations:** Some files may take longer to download. Although most data is available at no charge, customized products may have a fee.

### **U.S. Bureau of the Census (Census Bureau)**

**Overview:** The Census Bureau collects and provides information about the people and economy of the U.S. The Census Bureau's Web site (<http://www.census.gov>) includes data on demographic characteristics (e.g., age, race, Hispanic ethnicity, and sex) of the population, family structure, educational attainment, income level, housing status, and the percentage of persons living at or below the poverty level. Tables and maps of census data are available for all geographic areas to the block level. Summaries of the most requested information for states and counties are provided, as well as analytical reports on population change, race, age, family structure, and apportionment.

**Population:** U.S. population.

**Strengths:** A wide range of online statistical data on the U.S. population is available in different formats (e.g., tables, and maps). State and county-specific data are easily accessible. Links to other census information Web sites are provided.

**Limitations:** Some files may take longer to download





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## **SECTION 6**

### **CARE PRIORITIES**



## **SECTION 6 CARE PRIORITIES**

### **SCSN/CARE Comprehensive Plan**

Nebraska's 2006 Statewide Coordinated Statement of Need (SCSN) and Care Comprehensive Plan is a combined document outlining the strengths, gaps, and barriers to care and support services for individuals living with HIV/AIDS in Nebraska.

The CARE Comprehensive Plan combines the work plans, goals, and objectives of the four federally funded entities in the state providing services. Those four entities are: The University of Nebraska Medical Center (Part C), Chadron Community Hospital (Part C), and the State of Nebraska (Part B and HOPWA programs). Together these four programs provide the bulk of care and support services to HIV+ individuals in the state who lack needed resources to maintain their health and well being.

The SCSN/Care Comprehensive Plan was developed by the Nebraska Department of Health and Human Services Ryan White Program utilizing information from the following sources:

- Ryan White Part B client satisfaction survey completed in 2004
- Ryan White Part B client surveys completed from 2000-2001
- Annual Administrative Reports (AAR)
- Client focus group conducted in November 2005
- Ryan White Part B Priorities survey conducted in January, 2005
- DHHS HOPWA Housing Plan
- Grantee work plans from Chadron Community Hospital (Part C)
- University of Nebraska Medical Center (Part C)
- Nebraska Department of Health and Human Services (Part B and HOPWA).

### **Limitations**

While the Nebraska 2006 SCSN/Care Comprehensive Plan attempts to address the needs of HIV+ individuals living in Nebraska through the coordination of activities/services between programs, it must be noted that this document is limited in scope and cannot fully address the needs of all HIV+ individuals living in the state. It must be noted that issues such as limited federal/state funding, the general lack of healthcare infrastructure and lack of service providers (especially in rural areas of the state) make the provision of care and services in the state extremely difficult, and in some areas not possible.

### **PLWHA Not Receiving HIV Primary Medical Care**

The Health Resources and Services Administration (HRSA) requires that Ryan White CARE Act grantees estimate unmet need among persons with HIV/AIDS. Unmet need is defined as the proportion of HIV infected persons without basic HIV medical care in a 12-month period. HIV primary medical care is defined by a viral load test or a CD4 lymphocyte count. In Nebraska, unmet need was estimated based on a framework provided by HRSA.

“Met need” was defined as the number of persons with HIV/AIDS with at least one viral load or CD4 lymphocyte test collected during a calendar year. Unmet need was simply the difference between the estimated total number of HIV/AIDS cases and the met need.

The most current analysis of unmet need is for 2006. By December 31, 2006, there were 1,341 persons living with HIV/AIDS in Nebraska. Of these, 887 (66%) were determined to be in-care, based on the definitions listed above. The methodology, utilized in the framework below, indicated that 454 (34%) PLWHA in Nebraska were out of care during calendar year 2006. See Table 6.1 below.

**Table 6.1: Measurement of Unmet Need, Nebraska, 2006**

Measure	Value	Data Source
<b>Population Sizes</b>		
Total number of individuals known to be living with HIV/AIDS in Nebraska, as of December 31, 2006.	1341	HARS
<b>Care Patterns</b>		
Total Number of PLWHA (aware of HIV+ status) who received specified HIV primary medical care in 2006	887	HARS
<b>Calculated Results</b>		
Total HIV+/aware not receiving specified HIV primary medical care	454	HARS
<b>Quantified estimate of unmet need of HIV+/aware not receiving HIV primary medical care</b>	34%	HARS

One limitation of this estimate is that the population estimate did not take into account the movement of cases out of state. This may have resulted in an artificially high population estimate, thereby resulting in an overestimate of unmet need. Another limitation is that only CD4 counts under 800 are reportable, which means that HIV surveillance is not receiving all CD4 tests. This may also overestimate the amount of unmet need.

Table 6.2 describes the characteristics of those PLWHA who have unmet need in 2006. The majority of persons with unmet need were men. By race/ethnicity: 51.1% were white; 28.4% black; 15.4 % Hispanic; 2.6% Native American and 2% Asian. Two persons reported more than one race/ethnicity. The highest percentage of those not in care (37%) were 40 to 49 years old age group, closely followed by 31.5% in the 30 to 39 years old age group, and 17.4% were over 50 years of age. Only 11.9% of the 20-29 year olds were not in care. By risk behaviors, 42.1% were MSM, 10.6 % IDU, 7.5% MSM/IDU, and 11.2% heterosexual contact. However, a substantial number were reported without a known risk (NIR) (24.9%) which makes interpretation of risk behaviors difficult.



**Table 6.2: Characteristics of persons with unmet need, Nebraska, 2006**

<b>Persons with unmet need, 2006</b>		
<b>Characteristic</b>	<b>#</b>	<b>%</b>
<b>GENDER</b>		
Male	353	77.8
Female	101	22.2
<b>Total</b>	454	100.0
<b>RACE/ETHNICITY</b>		
White	232	51.1
Black	129	28.4
Hispanic	70	15.4
Asian/ Pacific Islander	9	2.0
American Indian/AK Native	12	2.6
Multi-race	2	0.4
<b>Total</b>	454	100.0
<b>AGE*</b>		
<13	7	1.5
13-19	3	0.7
20-29	54	11.9
30-39	143	31.5
40-49	168	37.0
50+	79	17.4
<b>Total</b>	454	100.0
<b>Risk behaviors</b>		
MSM	191	42.1
IDU	48	10.6
MSM/IDU	34	7.5
Heterosexual contact	51	11.2
Adult Hemophilia	2	0.4
Transfusion	6	1.3
Pediatric	9	2.0
No Risk Reported (NIR)	113	24.9
<b>Total</b>	454	100.0

*Source: Nebraska HIV Surveillance Program*

### **Statewide Coordinated Statement of Need (SCSN)**

The Ryan White CARE Act Amendment of 2000 (PL 101-38) Sec. 2617(2)(C) requires that state Part B applications include “a description of how the allocation and utilization of resources are consistent with the Statewide Coordinated Statement of Need developed in partnership with other grantees in the state that receive funding under this title” and in Sec. 2617(b)(3) “an assurance that the public health agency administering the grant for the State will periodically convene a meeting of individuals with HIV, representatives of grantees under each part of this title, providers, and public agency representatives for the purpose of developing a Statewide Coordinated Statement of Need.”

The purpose for the development of a Statewide Coordinated Statement of Need in Nebraska is twofold:

1. To increase the effectiveness in serving persons with HIV disease in Nebraska through the three Ryan White funded entities in the state by identifying common unmet needs and barriers to receiving services.
2. To increase and improve coordination of services provided to persons and their families living with HIV disease. The process for accomplishing this purpose is based on current HIV and AIDS epidemiological information, information collected from consumers, and data compiled from services provided by the Ryan White Funded entities in the State.

### **Development of the 2006 SCSN/Comprehensive Plan**

The 2006 SCSN/Comprehensive Plan was developed by the Nebraska Department of Health and Human Services Ryan White Part B Program utilizing information from the Part B client satisfaction survey completed in 2004, Part B client surveys completed from 2000-2001, Annual Administrative Reports (AAR), a client focus group conducted in November 2005, and the Ryan White Part B Priorities survey conducted in January, 2005, the Nebraska HOPWA Housing Plan, grantee work plans from Chadron Community Hospital (Part C), University of Nebraska Medical Center (Part C), and the Nebraska Department of Health and Human Services (Part B and HOPWA). The document was then distributed among the contributing agencies for review and concurrence and was presented in April 2006 to the Nebraska HIV CARE and Prevention Consortium (NHCPC) for final concurrence. The 2009 SCSN/Comprehensive Plan will be developed in the fall of 2008.

### **Comprehensive Plan**

Section 2617(b)(2) of the Ryan White CARE Act requires a comprehensive plan for the organization and delivery of HIV healthcare and support services which will then be funded with the assistance received.

The purpose of the comprehensive plan is to demonstrate strategies, goals, and timelines for statewide entities receiving Ryan White Titled funding to ensure the availability and adequacy of HIV-related core services statewide.

### **Gaps and Barriers to Service Delivery**

The following gaps and barriers, whether real or perceived, are included and prioritized as:

- Geographic distance to providers: For individuals living in rural areas in particular, access to healthcare and support services (including case management) may involve several hours of travel. Individuals utilizing HIV specialists as primary care givers are further limited due to the number of specialists and their location, which is predominantly in the eastern part of the state.
- Affordable healthcare: Individuals who are chronically ill often lack sufficient employment to maintain health insurance. For those who are unemployed, options

are limited to Medicaid/Medicare, COBRA, or Ryan White funded services. Even if an individual is able to access Medicaid or Medicare, the restrictive nature and eligibility of these programs in the state may require high “spend down” requirements as well as make it difficult for an individual to transition from public assistance. COBRA insurance, as well as the “High Risk” pool of the state, are financially prohibitive to individuals who are unable to work. Finally, Ryan White funding is limited to outpatient primary medical care and diagnostic services and does not cover inpatient care when needed.

- Lack of healthcare providers: Especially in rural parts of the state there is a general lack of primary care providers, dentists, and mental health professionals willing to treat HIV+ individuals.
- Lack of mental health/substance abuse services: Especially in rural areas, there are insufficient services available for mental health/substance abuse. This is especially evident when clients need inpatient treatment, which is frequently unavailable.
- Lack of affordable housing: While there may be a general availability of housing in urban areas, there is a lack of housing, especially low-income housing, in rural areas. Smaller municipalities lack the resources and programs for qualified individuals to access housing services. Other concerns revolve around stigma of HIV and the fear of disclosure of status to landlords or neighbors.
- Confidentiality: Both clients and case management providers acknowledge that confidentiality of a client’s HIV status is a barrier to the provision of services where the nature of a client’s request involves disclosure of status. This is especially evident in small towns where communities are close knit and residents know each other. Confidentiality concerns are also expressed in a client’s decision to access healthcare outside of his/her community for fear of disclosure of status.
- Lack of transportation: Public transportation services are limited to the state’s two largest cities. Clients living in rural areas must travel sometimes several hours to access needed healthcare and support services. Clients residing in the Lincoln or Omaha areas also experience difficulty in utilizing the public transportation system, which is limited in routes and availability.
- Access to medications: Clients taking medications are limited to formulary restrictions when accessing ADAP, which may not be adequate for a client’s particular medical condition. Clients who are covered by Medicaid or private insurance are faced with co-pays, which can be expensive considering multiple prescriptions.
- Lack of income/back to work issues: Clients who are chronically ill lack financial resources to maintain self-sufficiency and often have to depend on family, friends, human services, and government programs for assistance. There is also a lack of educational and job-training opportunities for individuals who want to re-enter the work force.
- Lack of accessible case management services: Clients often must travel, especially in rural parts of the state, to access case management. Case management services

that are accessible are overwhelmed (especially in urban areas) with caseloads resulting in inadequate services.

- Lack of knowledge regarding the availability of Ryan White Services: Clients are not aware of all the services provided through case management, which is looked upon as a separate entity, and the Ryan White Titles. There is a lack of information available to clients regarding exactly what Ryan White pays for and what entity is the payer.

### **Nebraska's Current System of Care**

There are currently three Ryan White Part B and/or Part C entities operating in Nebraska along with the DHHS HOPWA program. Services are divided between the three entities and HOPWA to allow for assistance to clients with little duplication of effort. Part C entities provide assistance statewide for healthcare, dental care, outpatient mental health and substance abuse treatment, translation services, eye care, and nutritional consultations. The Ryan White Part B program provides support services such as transportation, housing assistance, utility assistance, insurance premium payment, food/non-food items, case management and ADAP.

The HOPWA program coordinates with the Part B program for the provision of housing, housing support services, mental health and substance abuse treatment. All three entities jointly fund case management services statewide. The following is a description of each program, its services, and client demographics.

### **DHHS Ryan White Part B Program**

The DHHS Ryan White Part B Program is located within the Nebraska Department of Health and Human Services, Division of Public Health, Infectious Disease Prevention and Care Unit. The administrative offices are located in Lincoln, Nebraska. The Program Administrator is responsible for overall program oversight of the 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 Client Services Coordinator is responsible for the oversight of Part B statewide case management and direct emergency assistance program components.

The Ryan White Part B Program is funded through federal Ryan White HIV/AIDS Treatment Modernization Act of 2006 legislation. The Health Resources and Services Administration (HRSA) is the federal entity responsible for the administration of Ryan White funding. Ryan White Part B funding is allocated to all fifty states and U.S. territories through formula funding.

The purpose of the Ryan White Part B program is to provide funding for the following program areas:

- 1) AIDS Drug Assistance Program (ADAP)- providing therapeutic medications for the treatment of HIV infection;
- 2) Direct Emergency Assistance – providing support services such as housing, utilities, transportation, food, and insurance premium payment assistance;

- 3) Comprehensive Case Management Services – providing access to Ryan White funded services and assistance in accessing other eligible services for qualified clients.

These services are provided to individuals who reside in the state, meet financial eligibility requirements, and have no other access to the above services.

ADAP is operated through a subgrant with the University of Nebraska Medical Center. Dr. Susan Swindells M.B.B.S. is the ADAP Director. Physicians statewide are able to access ADAP through a mail order system with the UNMC Pharmacy. Clients who live locally can access the UNMC outpatient pharmacy directly. Clients living in other areas of the state receive medications via mail order through the pharmacy. Currently there are 117 medications in the formulary. These medications include:

- All FDA approved medications for the treatment of HIV
- Treatments for Opportunistic Infections
- Medications for treatment of mental health issues

The Direct Emergency Assistance component provides emergency financial assistance to clients experiencing financial difficulties due to HIV/AIDS. Services include financial assistance for housing, utilities, food, transportation assistance, and insurance premium payment assistance. Services are requested by case management through the PROVIDE Case Management software system, linking the Part B Program (Part C Program in some cases), case management, the HOPWA program, and clients. Requests for assistance are reviewed at the state level by the state Client Services Coordinator. If approved, payment is authorized and a check is mailed within 1-2 business days.

The PROVIDE Case Management software system allows for in depth data collection, documentation of client activities, and case planning to enable case managers to effectively document client information. The system also allows for the Client Services Coordinator (and HOPWA Coordinator) to ensure information is clear and accurate in the review of client information in processing requests for assistance. Finally, the Provide system provides for in depth data collection for required reporting both at the agency and state level, as well as for quality assurance and evaluation activities.

Case management is currently offered to clients statewide through a subgrant with Nebraska AIDS Project (NAP). NAP provides case management services in five offices located in Omaha, Lincoln, Norfolk, Kearney, and Scottsbluff. NAP also receives Part C funding for case management, bilingual services, HIV outreach/education, and counseling and testing. With funding from both Part B and Part C in the state, NAP is able to coordinate services offered by each program for clients in need.

In FY 2006 the State Ryan White Part B Program provided direct emergency assistance to 257 clients. In the same period, case management services were provided to 524 unduplicated clients, and ADAP formulary medications were provided to 904 unduplicated clients.

## **University of Nebraska Medical Center Ryan White Part C Program**

The UNMC Ryan White Part C Program, directed by Dr. Susan Swindells, M.B.B.S., an Infectious Disease Specialist, provides early intervention services (EIS) as previously mentioned, to clients residing in the eastern three-fourths of Nebraska as well as portions of Southwest Iowa. The program's mission is to provide comprehensive services to those at risk for or infected with HIV disease. EIS services are provided primarily through the UNMC HIV clinic and associated services at UNMC in Omaha: primary HIV Health Care (outpatient visits and lab), ophthalmology, mental health care, oral health care, nutritional consultation, pap smear and annual TB skin testing. The program also provides services through contracted physicians, dentists, and mental health/substance abuse providers located throughout the eastern two-thirds of the state. Currently, the program contracts with 423 providers (348 urban and 75 rural) in the region.

Eligible clients include persons who are at risk for or infected with HIV disease who have an income below 200% of the Federal poverty level, and are ineligible for Medicaid, private insurance or coverage by a third-party payer. In 2006, UNMC provided services to 151 new clients and a total of 904 clients in all.

UNMC's Part C program provides rural clients access to EIS through the availability of an outreach clinic held every eight weeks in Grand Island, Nebraska. The program also expands access to healthcare by offering evening hours at the HIV clinic in Omaha, thereby providing services to those who are unable to attend clinics held during the day.

## **Chadron Community Hospital, Ryan White Part C Program**

Chadron Community Hospital, located in Chadron, Nebraska, is the Part C grantee for western Nebraska and the surrounding areas which includes parts of eastern Wyoming and southern South Dakota. Like UNMC, Chadron Community Hospital provides healthcare, dental care, outpatient mental health and substance abuse treatment, translation services, eye care, and nutritional consultations. Jeff Tracy, Program Coordinator, is responsible for overall program operations. Dr. Bill Burman, Medical Director for Denver Public Health's Infectious Disease Clinic, is the program's Medical Director. Quarterly HIV clinics are conducted by Dr. Burman at Panhandle Community Services (PCS) Health Center in Gering, Nebraska. The program contracts with 22 providers in the region, including PCS, for care related services.

Eligible clients must reside in the region and be HIV positive. There are no income-eligibility limitations at this time. Case management services are provided by the Nebraska AIDS Project's western office, located in Scottsbluff, Nebraska. Case Management services are jointly funded by Part B and Part C. In 2007, Chadron Community Hospital's Ryan White Part C program provided services to 41 clients in the region.

## **Nebraska's HIV Care and Service Continuum Goals**

### **NDHHS Ryan White Part B Program Goals**

- Goal 1:** Provide funding/planning support to the Nebraska HIV Care and Prevention Consortium (NHCCPC), the statewide advisory body for the Ryan White Title Program.
- Goal 2:** Provide funding for the continued operation of the AIDS Drug Assistance Program (ADAP) through a subgrant agreement with the University of Nebraska Medical Center (UNMC).
- Goal 3:** Provide supportive services through the provision of direct emergency assistance for qualified clients to ensure a stable living situation and access to care and support services.

### **UNMC Ryan White Part C Program Goals**

- Goal 1:** Continue to provide HIV counseling, testing, referral, and partner counseling services in central and northeast Nebraska, with access to bilingual services.
- Goal 2:** Continue to provide medical evaluation, clinical care, and patient education.
- Goal 3:** Continue to ensure that UNMC Part C clients are receiving coordinated, high quality HIV care.

### **Chadron Community Hospital Ryan White Part C Program Goals**

- Goal 1:** Provide local, high quality comprehensive primary care/EIS for HIV infected persons living in western Nebraska and surrounding areas.
- Goal 2:** Increase access to care for HIV positive individuals living in western Nebraska and the surrounding area.
- Goal 3:** Ensure high quality EIS/primary care is delivered by the Ryan White Part C program.
- Goal 4:** Ensure meaningful consumer involvement in the planning, implementation, and evaluation of the Chadron Community Hospital and Health Services Ryan White Part C Program.
- Goal 5:** Ensure collaboration of HIV Care and Prevention activities in the Panhandle and surrounding areas.

## Quality Assurance

The Ryan White Program is responsible for program monitoring and quality management initiatives as required by their funding entities, HRSA and HUD. Yearly progress reports are submitted to HRSA and HUD which address specific program components, goals, and objectives. The following objectives are addressed in the progress report for each of the Ryan White components:

### ADAP

- Monitor adherence to PHS Guidelines
- Demonstrate positive outcomes of medications
- Managed Medicare Part D clients

### Case Management

- Monitoring visits
- File reviews
- Provide data analysis

### Direct Emergency Assistance

- Request reviews/accuracy in requests and billing
- Policy updates/revisions
- Case management standards review/revisions
- Coordination with HOPWA

## Ryan White Part B Priorities Survey

The Ryan White Part B Priorities Survey is conducted yearly at the April NHCP meeting and is a way to provide periodic input regarding program priorities for the Part B Program. Additional input is solicited through the Nebraska Red Ribbon Community (NRRC), focus groups and surveys.

### 2007 Ryan White Part B Priorities Survey Results

Top ten priorities:

ADAP  
Case Management  
Housing  
Utilities  
Transportation  
Food  
Health Insurance Premium Payment  
Benefits Coordination  
Additional Mental Health Benefits  
Additional Dental Benefits



## **Case Management Standards**

The goals of HIV case management are to maintain or improve the client's ability to remain independent in his or her home environment, and to maintain or improve quality of life for the client during the course of his or her illness. The case management standards (Appendix 4) outline the components necessary to assist clients in meeting those goals.

Evaluation of case management services must include measures of the successful accomplishment of these components. Each agency providing case management services will develop and maintain an ongoing quality assurance and evaluation program to determine the appropriateness, adequacy and effectiveness of the case management system. The quality assurance and evaluation program will help to ensure that case management standards are being followed, and that case management services are meeting the needs of the client. The agency quality assurance and evaluation program will include data collection and reporting methodology. Documentation of this program will be available to the Nebraska Department of Health and Human Services.

## **Housing Opportunities for Persons With AIDS (HOPWA) Program**

The HOPWA Program is a program created by the Federal Government in 1992 and is administered through the U.S. Department of Housing and Urban Development (HUD). In March 2004, the Nebraska Department of Health and Human Services was awarded a 3-year HOPWA grant from HUD in the amount of \$1,357,192. Targeted special populations include the chronically homeless, dual diagnosed and post-incarcerated. In 2007, DHHS received a 3 year renewal grant in the amount of \$1,414,728 for ongoing HOPWA funding for 2007 – 2010. The HOPWA program in Nebraska is a cooperative effort between DHHS, Nebraska AIDS Project (NAP) and Assistive Technology Partnership (ATP).

### **HOPWA Goals**

- Allow people living with HIV and AIDS to avoid homelessness
- Create stable, permanent living situations for people living with HIV and AIDS
- Increase access to health care by creating stable living situations
- Work with other programs to enhance the support systems available for people living with HIV and AIDS

### **Cooperative Approach**

The HOPWA program is designed to complement and enhance assistance which is currently funded through the Ryan White Part B and Part C, ADAP, Section 8 and other funding resources. HOPWA is designed to fill in the current gaps in housing assistance for people with HIV and AIDS. The assistance available in Ryan White Part B will remain a “last resort” for funding the housing needs of clients.

The HOPWA program is designed to provide assistance in four key areas:

- Emergency Rent and Mortgage Assistance (ERMA) for clients in situations where people are facing a housing crisis possibly resulting in homelessness. This assistance is limited to 21 weeks out of a 52 week period.
- Tenant Based Rental Assistance (TBRA) for clients who require long-term, monthly assistance with housing needs. This assistance is similar to Section 8. Clients receiving TBRA will also be required to apply for Section 8 assistance, which will replace the TBRA assistance if they are awarded Section 8.
- Supportive Services assistance is designed to increase access to a variety of resources. Assistance may include case management, mental health and substance abuse counseling, self-sufficiency courses and transportation.
- Permanent Housing Placement is designed to help persons obtain permanent housing through assistance with first/last month's rent, security deposit and rental application fee.

## Requirements for Assistance

There are three main requirements for assistance through HOPWA:

- 1) The household assisted must be low income. Low income is defined as a household income at or below 80% of the area median income.
- 2) The person must be diagnosed as HIV positive or have AIDS. This 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 money awarded by HUD to the Nebraska HOPWA program.

## Application Process

Clients enter the program through Nebraska AIDS Project Case Managers. Upon verification of eligibility and need, Case Managers make assistance requests to DHHS. DHHS approves the requests in accordance with established federal and local guidelines. ATP assists NAP Case Managers in locating housing and supportive services resources throughout the state. NAP Case Managers work together with clients to create housing plans and alternative options for housing to ensure client needs are met with long-term, permanent strategies.

## Nebraska HIV/AIDS Housing Plan

In 2003, AIDS Housing of Washington completed a Nebraska HIV/AIDS Housing Plan for the Nebraska Department of Health and Human Services. The Nebraska HIV/AIDS Housing Plan was the culmination of a nine-month planning process that brought together a wide range of community stakeholders to consider and plan for the housing needs of Nebraskans living with HIV/AIDS and their families. Housing and services providers, people living with HIV/AIDS, and others statewide participated in the needs assessment process and provided input and feedback on the Nebraska HIV/AIDS Housing Plan. The URL address for the current Nebraska HIV/AIDS Housing Plan released in October 2003 is: [www.hhs.state.ne.us/dpc/HOPWA.htm](http://www.hhs.state.ne.us/dpc/HOPWA.htm).

## HOPWA Expenditures for FY 2007

Expenditures for HOPWA in fiscal year 2007 totaled \$432,132. Table 6.3 gives information on how this federal funding for HOPWA was spent.

**Table 6.3: HOPWA Expenditures for FY 2007**

Service	% Utilization	Expenditures
Housing Information/Counseling	3.49%	15,061
Resource Identification/TA	12.23%	52,850
Rental/Mortgage and Tenant-Based Housing Assistance	41.06%	177,438
Supportive Services*	33.94%	146,651
Project Outcomes/Data Evaluation	2.55%	11,030
Administrative Cost	6.73%	29,102
<b>Total</b>	<b>100.00%</b>	<b>\$432,132</b>

\*Case Management, Security Deposits, First Month's Rent, Transportation, Self-Sufficiency Course, Mental Health/Substance Abuse Services

The Housing Opportunities for Persons with AIDS (HOPWA) served 138 unduplicated clients and 97 family members in 2007. The most utilized housing type for persons served was rental housing (67%) followed by private residence (19%). Other types of housing included living with a relative or friend, group facility, and transitional housing. The demographic characteristics of clients who participated in this program are given in Table 6.4.

**Table 6.4: Demographic Characteristics of HOPWA Clients, Nebraska 2007**

Characteristic	HOPWA Clients (N=138)		Persons Living with HIV/AIDS* (N=1397)	
<b>GENDER</b>				
Male	101	73.2%	1075	77.0%
Female	37	26.8%	322	23.0%
<b>Total</b>	<b>138</b>	<b>100.0%</b>	<b>1397</b>	<b>100.0%</b>
<b>RACE</b>				
White	89	64.5%	783	56.0%
Black	39	28.3%	380	27.2%
American Indian/AK native	5	3.6%	27	1.9%
Other/Multi-race	5	3.6%	207	14.8%
<b>Total</b>	<b>138</b>	<b>100.0%</b>	<b>1397</b>	<b>100.0%</b>
<b>ETHNICITY</b>				
Hispanic	23	16.7%	180	12.9%
Other and non-Hispanic	115	83.3%	1217	87.1%
<b>Total.</b>	<b>138</b>	<b>100.0%</b>	<b>1397</b>	<b>100.0%</b>
<b>AGE</b>				
0 - 12	0	0.0%	12	0.9%
13 - 24	3	2.2%	42	3.0%
25 - 44	84	60.9%	834	59.7%
45+	51	36.9%	509	36.4%
Unknown	0	0.0%	0	0.0%
<b>Total</b>	<b>138</b>	<b>100.0%</b>	<b>1397</b>	<b>100.0%</b>
<b>RISK BEHAVIORS</b>				
MSM	55	39.9%	612	43.8%
IDU	14	10.1%	137	9.8%
MSM/IDU	n/a	n/a	89	6.4%
Heterosexual contact	53	38.5%	262	18.8%
Adult Hemophilia	n/a	n/a	9	0.6%
Transfusion	2	1.4%	19	1.4%
Pediatric	n/a	n/a	22	1.6%
Undetermined, Unknown, and Not Available	14	10.1%	247	17.7%
<b>Total</b>	<b>138</b>	<b>100.0%</b>	<b>1397</b>	<b>100.0%</b>
*Persons Living with HIV/AIDS data is for 2006				
Source: Nebraska HOPWA Program				

## State of Nebraska HOPWA Program

### Goals

**Goal 1:** The State of Nebraska will improve accessibility for the purpose of creating suitable living environments through investments in public facilities and/or infrastructure activities.

**Goal 2:** The State of Nebraska will improve sustainability for the purpose of creating suitable living environments and providing decent affordable housing through investments in comprehensive revitalization for targeted neighborhoods.

**Goal 3:** The State of Nebraska will improve affordability for the purpose of providing decent affordable housing through investments in constructing affordable new rental units.

**Goal 4:** The State of Nebraska will improve affordability for the purpose of providing decent affordable housing through investments in rental rehabilitation activities.

**Goal 5:** The State of Nebraska will improve affordability for the purpose of providing decent affordable housing through investments in construction, acquisition and/or acquisition with rehabilitation of new units for homeownership.

**Goal 6:** The State of Nebraska will improve affordability for the purpose of providing decent affordable housing through investments in owner occupied rehabilitation activities.

**Goal 7:** The State of Nebraska will improve affordability for the purpose of providing decent affordable housing through investments in direct financial assistance to homebuyers.

**Goal 8:** The State of Nebraska will improve sustainability for the purpose of providing and creating economic opportunity through investments in economic development projects for job creation and retention activities.

**Goal 9:** The State of Nebraska will improve sustainability for the purpose of providing and creating economic opportunity through investments in economic development projects by assisting businesses for the purpose of job creation/retention.

**Goal 10:** The State of Nebraska will improve accessibility for the purpose of creating suitable living environments to insure appropriate emergency shelter and/or transitional housing and services for people who are homeless or at imminent risk of becoming homeless.

**Goal 11:** The State of Nebraska will improve affordability for the purpose of providing decent affordable housing through investments in tenant based rental assistance activities for persons with HIV/AIDS and their families.

**Goal 12:** The State of Nebraska will improve affordability for the purpose of providing decent affordable housing through investments in short-term rent, mortgage and utilities activities for persons with HIV/AIDS and their families.

**Goal 13:** The State of Nebraska will improve affordability for the purpose of providing decent affordable housing through investments in housing information services for persons with HIV/AIDS and their families.

**Goal 14:** The State of Nebraska will improve affordability for the purpose of providing decent affordable housing through investments in supportive services activities for persons with HIV/AIDS and their families.

**Goal 15:** The State of Nebraska will improve affordability for the purpose of providing decent affordable housing through investments in permanent housing placement activities for persons with HIV/AIDS and their families.

## **SECTION 7**

### **DHHS PROGRAM COLLABORATION**





## **SECTION 7**

### **DHHS PROGRAM COLLABORATION**

The HIV Prevention, HOPWA, Ryan White and Hepatitis Programs reside within the Infectious Disease Prevention and Care Section of DHHS. In 2007 DHHS realigned many programs and the STD, TB and HIV Surveillance Programs merged with this section (Chart 7.1) Prior to this merger, collaboration between these programs was minimal, i.e., each program had a representative who was a member of a NHCPC sub-committee and/or was present at the quarterly NHCPC meetings. The physical location of individual programs did not allow for frequent communication and information sharing which would contribute to program collaboration. Since the merger, the seven programs attend a weekly staff meeting where information is shared about current and future program activities. Future plans are for a physical relocation of these programs into the same general area thereby increasing the daily contact with programs.

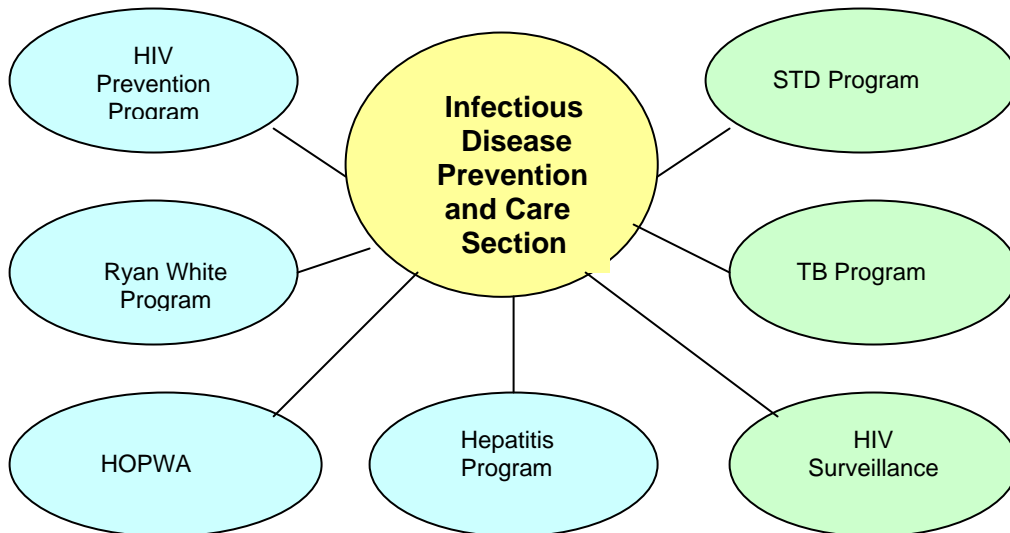


Chart 7.1: Infectious Disease Prevention and Care Section Programs-2008.

This chapter will provide information on three programs in the Infectious Disease Prevention and Care Section (Hepatitis, STD, and TB), their current activities and their goals/objectives for 2008 and beyond. The HIV Surveillance Program has routinely provided information and guidance to all of these programs since 1983.

## HEPATITIS PROGRAM

In March 2004, the Nebraska Hepatitis C Virus (HCV) Prevention Plan was created by constituents from across Nebraska, representing the professional disciplines involved in the prevention of Hepatitis C within Nebraska. The purpose of the plan is to outline a comprehensive and systemic approach that will aid in the prevention of the spread of the Hepatitis C virus in Nebraska and to limit the progression and complications of Hepatitis C related chronic liver diseases within Nebraska.

### Background

The Hepatitis C virus (HCV) is the most common chronic blood borne infection in the United States. The Center for Disease Control and Prevention (CDC) estimates one out of every fifty Americans have been infected with the Hepatitis C virus, 75% of whom have no idea they are infected and capable of transmitting it to others. These figures are a conservative low as the CDC estimates do not take into account the homeless population or those incarcerated; both of these population groups have a higher percent infection rate than the general public. Any person infected with the Hepatitis C virus can transmit the virus to others at any time during the disease process. There is no vaccine for the prevention of the Hepatitis C virus. The Center for Disease Control and Prevention (CDC) has predicated a fourfold increase in chronic Hepatitis C infections by the year 2015.

### Hepatitis C and HIV Co-Infection

The CDC has estimated that one out of every three people infected with the Human Immunodeficiency Virus (HIV) is also infected with the Hepatitis C virus. The presence of the Hepatitis C virus and HIV in a client can impact the treatment and management of both HCV and HIV/AIDS. Co-infection with HIV and the Hepatitis C virus has been associated with higher titers of the Hepatitis C virus, a more rapid progression to liver disease and an increased risk for cirrhosis of the liver. Since highly reactive antiretroviral therapy and prophylaxis treatment for opportunistic infections have increased the life span of AIDS patients, Hepatitis C related liver disease has become a major cause of hospital admissions and death among AIDS patients.

### Nebraska Hepatitis C Trends

Based on the CDC estimates and 2006 Nebraska census data, statistically there are an estimated 28,293 Nebraskans currently infected with the Hepatitis C virus. It is estimated that approximately 11,000 Nebraskans are currently unaware that they are infected with the Hepatitis C virus; 85% (9,350) of these will be chronic and capable of transmitting the disease to others.

**Table 7.1: Statistical table estimating HVC disease in Nebraska, 2006.**

Nebraska HCV Statistical Table			
		National Average % HCV positive	NE # Potential Positives
NE 2006 Census	1,768,331	1.6 %	28,293
HCV Known High Risk Populations			
2006 Substance Abuse Treatment Admissions	14,968	50.0 %	7,484
2006 Nebraska Veteran Population	159,982	7.5 %	11,999
2006 Nebraska Inmate Population	5,129	20.0 %	1026
2006 Nebraska Living with HIV/AIDS	1,379	33.0 %	455
<b>Statistical Positives for Nebraska High Risk Populations</b>			<b>20,964</b>

## Hepatitis C Prevention

As there is no vaccine to prevent the Hepatitis C viral infection, prevention of the spread of this virus is crucial. Because the Hepatitis C virus, the Hepatitis B virus, and HIV all have similar risk factors and modes of transmission, the CDC has recommended that prevention strategies and efforts for these three viruses be combined. Trial projects by the CDC have shown that by decreasing the spread of the Hepatitis C virus, the spread of HIV and Hepatitis B virus are also reduced.

- A. *Primary prevention* methods are aimed at decreasing the rate of new cases of HCV and therefore reducing the transmission rate of the virus to others. Primary prevention methods consist of any of the following:
- Strategies that decrease sharing of syringes, needles, or works among substance abusers.
  - Strategies that promote liver wellness.
  - Strategies that decrease needle sticks & blood exposures among health care workers.
  - Education of medical professionals and substance abuse counselors on HCV updates and trends.
- B. *Secondary prevention* methods are focused at high-risk populations for HCV, aimed at identifying current persons infected with HCV and preventing further spread of the virus. Secondary prevention methods include any of the following:
- HCV education for substance abuse counselors.
  - HCV education for sexually transmitted disease (STD) counselors.
  - HCV education for Human Immunodeficiency Virus (HIV) counselors.
  - Testing of all donated blood products for the presence of HCV.
  - Virus inactivation of plasma/blood products at blood centers.

## Screening Factors for Hepatitis C

*A person with any of the following risk factors should be tested for HCV:*

1. Any history of IV drug use, even just one time.
2. Any history of intranasal use of cocaine, even just one time.
3. Any client that tests positive for HIV.
4. Clients with a history of STDs.
5. Occupational exposure to blood.
6. Clients receiving blood products or tissue donations prior to 1992.
7. Hemophiliacs receiving clotting factors prior to 1987.
8. Clients with high-risk sexual behaviors.
9. Clients showing clinical manifestations indicating impaired liver function.
10. Children born to Hepatitis C positive mothers.
11. Clients with an exposure to a known Hepatitis C source.

## Hepatitis C Surveillance

In accordance with "Title 173", the Hepatitis C virus, in both acute or chronic form, is considered a communicable disease that providers and laboratories are required to report to the Nebraska Department of Health and Human Services epidemiology department. The Viral Hepatitis surveillance officer for Nebraska Department of Health and Human Service Systems is responsible for monitoring the spread of HCV in

Nebraska and will work closely with the Hepatitis Prevention Coordinator to identify target populations or areas in Nebraska that demonstrate a need for investigation or intervention.

Surveillance for newly acquired symptomatic HCV is needed as an ongoing monitor of HCV activity and can indicate outbreaks of the disease. Investigation of these cases to determine their characteristics and risk factors provide the best information for monitoring trends in transmission patterns. Since HCV is a progressive disease, often taking years to identify in a patient, limitations exist for the use of positive HCV antibody laboratory reports to conduct surveillance for HCV infections. However, these reports can be an important source from which state and local health departments can identify HCV infected persons who need counseling and medical follow-up. Surveillance of chronic HCV cases will play a crucial role in identifying priority populations or areas of Nebraska needing interventions.

Nebraska currently has three Hepatitis C support groups located in Omaha, Grand Island, and Scottsbluff. For contact information for these groups or for more information on the Hepatitis Program go to the website:

[www.hhs.state.ne.us/hew/dpc/Hep\\_C.htm](http://www.hhs.state.ne.us/hew/dpc/Hep_C.htm)

To review the Hepatitis C Prevention Plan for Nebraska go to:

[www.cdc.gov/ncidod/diseases/hepatitis/partners/pdf/nebraska\\_plan.pdf](http://www.cdc.gov/ncidod/diseases/hepatitis/partners/pdf/nebraska_plan.pdf)

# Adult Viral Hepatitis Prevention

## Goals & Objectives 2007 - 2008

### *Program Management Activities*

**Goal 1:** Ensure continuity of public health efforts regarding viral hepatitis.

- Objective 1:** The former Nebraska ELC Hepatitis C coordinator will take over as Nebraska's Adult Viral Hepatitis Prevention Coordinator (AVHPC) on November 1, 2007.
- Objective 2:** The Nebraska AVHPC will participate in the CDC 2008 AVHPC conference.
- Objective 3:** The Nebraska AVHPC will participate in the 2008 Mid-West AVHPC regional conference.
- Objective 4:** By August 31, 2008, HAV and HBV prevention strategies for high-risk adults will be incorporated into Nebraska's existing HCV plan.
- Objective 5:** By December 31, 2007, an integrated workgroup with representation from the following State of Nebraska health programs: Behavioral Health, Corrections, Family Planning, Hepatitis, HIV, Immunization, and STD will be developed. This group will meet at least quarterly, exchanging updates on opportunities for program networking with common targeted populations/risk factors.
- Objective 6:** Working with a legislative appointed task force, the Adult Viral Hepatitis Prevention Coordinator will assist with the development of an HCV strategic plan for the State of Nebraska by December 2007.

### *Primary Prevention Activities*

**Goal 2:** Decrease the number of newly infected viral hepatitis cases within Nebraska.

- Objective 7:** Using carryover funding from the HIV Prevention Program, Title 317 vaccine funding, and the infrastructure of Title X Family Planning clinics, in the 2007-2008 fiscal year, HBV immunity testing will be performed on 1,000 adults at high-risk for HBV infection. The 3 shot HBV vaccine series will be provided to 600 adults at high-risk for HBV infection that demonstrate a non-immune status to HBV.
- Objective 8:** Using carryover funding from the Nebraska HIV Prevention Program and the infrastructure of Nebraska's 3 largest HIV test sites, in the 2007-2008 fiscal year, HAV immunity testing will be performed on 400 of Nebraska's MSM adult population and the 2 shot HAV vaccine series will be provided for up to 200 individuals that demonstrate a non-immune status to HAV.

- Objective 9:** Using carryover funding from the HIV Prevention Program and the infrastructure of community health centers that provide care to minorities within Nebraska, in the 2007-2008 fiscal year, 600 HCV tests will be performed on minorities that that are disproportionately impacted by HCV.
- Objective 10:** During the 2007-2008 grant cycle, Nebraska AVHPC will provide 900 HCV Home Access test kits to the 2 Nebraska state STD clinics, which are also the state's 2 largest HIV counseling and testing sites.
- Objective 11:** An educational booth at the 2008 State Fair is expected to reach approximately 25% of the state's population providing educational material on viral hepatitis to the general public.
- Objective 12:** During the 2007-2008 fiscal year, educational material will be distributed at targeted community health fairs, Native American health fairs, and a health night event with Nebraska's minor league baseball team.
- Objective 13:** During the 2007-2008 fiscal year, provide an educational exhibit booth with updates and guidelines at 5 annual healthcare professional conferences in Nebraska: Nurse Practitioner, Physician Assistant, Nursing Leadership, Public Health, Nebraska Nursing Association.

### ***Secondary Prevention Activities***

**Goal 3:** Prevent and reduce complications associated with chronic viral hepatitis infections and end stage liver disease.

- Objective 14:** During the February-March 2008 time frame, a phone survey of private HIV treatment clinics was conducted by the AVHPC to identify any missed opportunities of vaccinating HIV positive clients for HAV and HBV.
- Objective 15:** By June 2008, HAV and HBV public information and healthcare professional material will be incorporated into the state HCV web page.
- Objective 16:** Two educational DVDs will be purchased and provided to each of Nebraska's 10 state correctional facilities and 1 federal detention facility by December 2007. One of the DVDs is translated in Spanish and will be purchased in Spanish as well.
- Objective 17:** During the 2007-2008 grant cycle, 7 regional "Viral Hepatitis" training sessions will occur throughout the state for nurses and substance abuse counselors.

## 2008-2012 Long Range Objectives

The 2007-2008 specific goals and objectives provide the framework for the five-year term of the AVHPC project. Ongoing activities in years two through five will depend upon the results of the first year activities and will be based on both the outcomes of the first year as well as available funding for years two through five. For example, the results of the Nebraska legislative efforts to develop a statewide strategic plan can have an outcome of future legislation that could result in state funding, which will provide more specific activities for 2008-2009, 2009-2010, etc. The following are the long range objective activities for 2008 – 2012:

- Objective 1:** Maintain AVHPC Position
- Objective 2:** Participate in National & Regional Updates
- Objective 3:** Update State Plan
- Objective 4:** Update State Web Page
- Objective 5:** Provide Professional Updates
- Objective 6:** Provide Professional Trainings
- Objective 7:** Increase Public Awareness
- Objective 8:** Increase Public Education
- Objective 9:** Increase Adult HAV/HBV Vaccine Access
- Objective 10:** Increase HCV Testing Access

## Sexually Transmitted Disease (STD) Program

The goal of Nebraska Department of Health and Human Services (DHHS) Sexually Transmitted Disease (STD) Program is to control and prevent sexually transmitted diseases and reduce the burden and cost of these infections. The program assists state, local and community efforts to help prevent the spread of chlamydia, gonorrhea, syphilis, hepatitis, and other STDs.

In Nebraska, STDs are mandated by legislation to be reported. Nebraska's reportable STD's include: primary, secondary and early latent syphilis, gonorrhea, HIV/AIDS, herpes (initial outbreak) and chlamydia. All STD reports are strictly confidential. Laboratories, health care providers, and STD test sites provide local/district health departments with positive test information. Prompt reporting and accurate identification is important so clients may receive treatment and identify any sex partners who may also be infected and require treatment. This information is also transmitted to the state STD Program for the purpose of monitoring disease trends.

In Nebraska the ELIRT (Electronic Lab Information Reporting Technology) system was developed and implemented in 2008 for the NPHL (Nebraska Public Health Lab). Once test samples are received at the NPHL and results are entered into the ELIRT system, the Nebraska DHHS STD Program, STD test sites and Nebraska Infertility Prevention Program (NIPP) testing sites have the ability to access test results from the NPHL database directly. Test results are then given to the client and treatment is initiated, if necessary. This system allows for a shorter turn around time from the time of testing until the results are given to the client.

Individuals may be tested for STDs, HIV and Hepatitis upon request at physician's offices, health clinics, some local/county/district health departments, reproductive health clinics and State of Nebraska Counseling and Testing sites in Nebraska. Currently, there are 3 STD clinics, 17 semi-STD clinics, 40 CTR sites, and approximately 25 local/county/district health departments across the state that either provide testing or can provide information on testing sites. Positive test results are given to each client at the testing site or clinic where tested.

Follow-up investigation is conducted upon request of the testing site or physician by a Disease Investigative Specialist (DIS). DIS are community health educators/nurses who have received specialized training in the follow-up of reportable diseases. In the instance of a case being reported that did not receive treatment following the diagnosis, the health department will notify the DIS who will then attempt to locate the individual, provide medical treatment, offer partner notification and STD education to prevent the further transmission of the disease. If the individual has received treatment at the time of diagnosis but requests assistance with partner notification, the health department/health care provider will contact the DIS to assist. In rural Nebraska, the DIS works directly with local health care providers.

In 2006, there were 8,111 individual cases of STD's reported to the STD Program. For the past five years, 2002 to 2006, both the number and rate of STDs in Nebraska has been steadily increasing. Chlamydia is the number one STD reported in Nebraska.



## Chlamydia

Chlamydia testing began in Nebraska in 1992, and at that time focused only on childbearing females ages 15-44 years. Symptoms of chlamydia can be mild or even absent but may cause damage to a woman's reproductive organs, such as infertility, before she even knows it.

Current screening guidelines for chlamydia screening are:

- \* Women 15-24 years of age
- \* Women 25-29 years of age with ONE of the following risk factors:
  - 1) new partner or multiple partners in last 90 days
  - 2) recent contact to male with urethritis, known chlamydia or other STD
  - 3) Clinical signs suggestive of chlamydia infection:  
cervicitis, mucopus, cervical friability, PID

In 2006, 18,392 tests were conducted for chlamydia with a positivity rate of 8.2%. Chlamydia cases are under-reported due to the fact that most people are not aware of their infection, do not get tested and so do not receive a diagnosis and treatment.

Overall, the rate of chlamydia in Nebraska has shown a slight increase for the past five years from 268.2/100,000 population in 2002 (4,595 cases) to 309.9/100,000 population in 2006 (5,451 cases). The health impact of chlamydia infection is particularly severe for women, especially those of child-bearing age. In 2006, 74% of the total number of chlamydia cases reported occurred in females versus 26% in males. The 15-24 age group accounted for 74% (3,979) of all chlamydia cases and 78% were female and 22% males. The two largest counties in Nebraska, Douglas and Lancaster, accounted for 71% of all reported chlamydia cases in 2006. Currently, 10% of all reported cases are reported from STD clinics; 90% are diagnosed by private health care providers.

The 2010 Healthy People Objective is to decrease infections in females, ages 15-24, in STD clinics to 3%. In 2006, Nebraska's rate was 7.8%.

## Gonorrhea

It is estimated by the CDC that only one-half of new gonorrheal infections are reported. Gonorrheal infections can be treated and cured with antibiotics. If gonorrhea is not treated, it also can cause very serious and permanent health problems in both men and women.

In Nebraska in 2006, 1,441 cases of gonorrhea were reported for a rate of 81.5 per 100,000 population. Over the past five years, the rate has fluctuated slightly from a high rate of 95.7 in 2003 to the lowest rate of 65.8 in 2004. Of all reported gonorrhea cases in 2006, two-thirds occurred in the 15-24 age group (31% in the 15-19 age group and 37% in the 20-24 age group). According to data obtained through DIS follow-up interviews, the increase in Gonorrhea morbidity in Nebraska is attributed primarily to increased methamphetamine usage, which often leads to sexual behaviors which place the individual at risk of contracting Gonorrhea. The metropolitan areas of Douglas, Sarpy and Lancaster counties accounted for 92% of reported Gonorrhea cases during 2006. Only 110 cases occurred outside of these three counties in 2006. Sixty-one percent of all positive cases of Gonorrhea occurred in females. The highest rate of

Gonorrhea in Nebraska occurs in Blacks (775/100,000) with Native Americans reporting 117 cases per 100,000 population.

Nebraska's objective is to reduce the incidence of Gonorrhea to no more than 75 cases per 100,000 by 2009. In 2006, the Nebraska rate was 81.5 per 100,000 population. The 2010 Healthy People Objective is to decrease gonorrhea cases to a rate of 19 per 100,000.

### Syphilis

Syphilis is an STD which often goes undiagnosed until much later in the disease process because the signs and symptoms mimic other diseases and go away in the early stages only to show up late in the disease process. Syphilis is easy to cure in the early stages. Generally, syphilis is transmitted through direct contact with a syphilitic lesion. In this manner Syphilis can easily facilitate the transmission of HIV from male to female or female to male through vaginal sex.

In 2006, Nebraska reported five (5) cases of primary/secondary syphilis cases and one (1) case of early latent syphilis. All five cases were reported in males living in either Douglas or Lancaster County. According to DIS follow-up contact investigation information, the highest risk factor for syphilis is attributed to the use of sex for drugs among MSM (Men who have Sex with Men).

### Intervention and Prevention Activities

The DHHS STD Program is funded by a federal grant from the Centers for Disease Control and Prevention(CDC). Funding covers staffing costs, contractual services with the two largest county health departments, travel and lab testing costs. This program partners with three clinics and 78 testing sites throughout the state to provide screening for chlamydia, gonorrhea, syphilis and other sexually transmitted diseases. These clinics include family planning clinics, community health centers, Indian Health Service clinics, correctional facilities, county and district health departments, hospitals, womens health centers, university health clinics, primary care clinics, youth center clinics, and a large number of private health care providers. STD services are coordinated with the Title X Program, HIV/AIDS Prevention, Hepatitis B and C, HIV/AIDS Surveillance, the Tuberculosis Program and the NDHHS Office of Minority Health. The key populations that STD efforts in Nebraska focus on are: persons who are incarcerated; persons with substance abuse issues; and migrant farm workers.

The two largest Nebraska counties, Douglas and Lancaster, have county health departments with outreach programs that focus on providing health education to hard-to-reach minority communities. The four targeted minority groups in Douglas and Lancaster Counties are: African American, Sudanese, Hispanic and Native Americans. The STD program focuses its efforts statewide with minority organizations such as: One World, the Nebraska Urban Indian Health Coalition, the Southern Sudanese Community Association, and the Women's Health Center.

One of the programs goals is to ensure that screening is provided for chlamydia, gonorrhea and syphilis in all of the counties that have large numbers of incarcerated populations and that local service providers target this population for screening and

testing. Nebraska has three state correctional facilities and six juvenile correctional facilities which are a primary focus for screening, testing and prevention activities.

Nebraska's migrant farm worker population is primarily in the western third of the state and is centered around the cities of Lexington and Scottsbluff. The STD Program collaborates with the Panhandle Community Health Center to provide routine screening and testing for this target population.

Statewide, the DHHS STD Program provides the latest guidelines regarding STDs, their diagnosis and treatment to health care providers. Information, educational materials and posters are distributed to screening sites and community agencies upon request. Many materials are available in different formats and languages. In recent years, there has been a noted increase in the need for interpreters and educational materials for refugees and immigrant populations. These language barriers make it very difficult to maintain confidentiality when a third party is required for interpretation. The transitory nature of refugee populations makes it difficult to locate patients for follow-up when investigating an STD.

The STD program continues to develop intervention and prevention activities across Nebraska as needs are identified. In FY 2007-2008, the following new activities were implemented:

- 1) *NE STD Rural Teleconference Committee Chalk Talks* : A quarterly teleconference was implemented for rural STD partners and providers. This activity is lead by the STD Community Health Nurse with the goal of providing the rural partners with current information and educational materials on a quarterly basis.
- 2) *NE STD Program Case Management Protocol*: This protocol was developed in conjunction with a CDC case management protocol and was implemented in five of Nebraska's rural health districts that have trained DIS.
- 3) *Semi-STD Clinics*: Seventeen testing sites across Nebraska implemented enhanced testing for women who would not be covered by the Infertility Prevention Project guidelines for testing.
- 4) *Increased female testing*: With the availability of one time state funding, the STD program was able to increase testing for women at testing sites and to provide funds for medications to treat chlamydia and Gonorrhea infections.
- 5) *Increased STD testing/medications for North Omaha*: The STD Program collaborated with high risk screening sites in North Omaha by providing increased testing and medications to Charles Drew Health Center, Healthy Start, Essential Health Pregnancy Services and Douglas County Youth Center. For the past few years Omaha has experienced a rate of STDs which is higher than the state and national STD rates.

Nebraska has one STD coalition in Douglas County called the North Omaha Coalition and consists of members from the Omaha/Douglas County area: Charles Drew Health Center, Douglas County Health Department, Alegent Health, 100 Black Men and the DHHS STD program staff. The goal of this coalition is to decrease the rate of Gonorrhea and chlamydia in North Omaha.

## STD Program Goals and Objectives

### A. Healthy People 2010 Target Objectives

**Healthy People 2010 Goal: Reduce Chlamydia infections in females age 15 to 24 attending STD clinics to 3.0% by 2010.**

- Objective 1:** Reduce Chlamydia infections in females age 15 to 24 attending STD clinics to 4.0% by 2009.
- Objective 2:** Reduce Gonorrhea to 19 new cases per 100,000 persons by 2010.
- Objective 3:** Reduce primary and secondary syphilis infection rate to 0.2 per 100,000 persons by 2010.
- Objective 4:** From January 1, 2007, through December 31, 2007, program staff will maintain current, as well as identify and develop, new community partnerships encompassing all areas of special emphasis for collaborating to influence community and individual behavior change in order to reduce STD morbidity toward year 2010 goals.
- Objective 5:** By December 31, 2007, the Nebraska STD Program will contact at least 5 community based organizations to provide STD education to high risk African American families.

### B. Partner Services

- Objective 1:** From January 1, 2007, through December 31, 2007, DIS will conduct an intensive disease intervention interview on at least 70 percent of all cases of Chlamydia within three days of initiation to the field.
- Objective 2:** From January 1, 2007, through December 31, 2007, DIS will conduct an intensive disease intervention interview on at least 75% of all cases of Gonorrhea within three days of initiation to the field.
- Objective 3:** From January 1, 2007, through December 31, 2007, DIS will conduct an intensive disease intervention interview on a minimum of 95% of all syphilis cases within seven days of initiation to the field.
- Objective 4:** From January 1, 2007, through December 31, 2007, DIS will perform 20 surveillance and educational visits to laboratories and providers in Nebraska.
- Objective 5:** From January 1, 2007, through December 31, 2007, DIS will conduct at least one intensive disease intervention re-interview on 90 percent of all early syphilis cases during the course of the investigation.
- Objective 6:** From January 1, 2007, through December 31, 2007, DIS will conduct an intensive disease intervention interview on at least 70% of all cases of Chlamydia through county health departments where they are assigned.
- Objective 7:** From January 1, 2007, through December 31, 2007, DIS will conduct an intensive disease intervention interview on at least 75% of all cases of Gonorrhea through county health departments where they are assigned.
- Objective 8:** From January 1, 2007, through December 31, 2007, DIS will initiate at least 1.0 sexual partners per case of Chlamydia interviewed.
- Objective 9:** From January 1, 2007, through December 31, 2007, DIS will initiate at least 1.0 sexual partner per case of Gonorrhea interviewed.

- Objective 10:** From January 1, 2007, through December 31, 2007, DIS will initiate at least 2.0 sexual partners per case of syphilis interviewed.
- Objective 11:** From January 1, 2007, through December 31, 2007, DIS will initiate at least 1.0 cluster suspects or associates per case of early syphilis interviewed.
- Objective 12:** From January 1, 2007, through December 31, 2007, DIS will examine at least 65 percent of all new, locatable, in jurisdiction sexual partners and treatment follow-up of Chlamydia cases within three days from the date of initiation.
- Objective 13:** From January 1, 2007, through December 31, 2007, DIS will examine at least 60 percent of all new, locatable, in jurisdiction sexual partners and treatment follow-up of Gonorrhea cases within three days from the date of initiation.
- Objective 14:** From January 1, 2007, through December 31, 2007, DIS will examine at least 70 percent of all new, locatable, in jurisdiction sexual partners and treatment follow-up of syphilis cases within seven days from the date of initiation.

### **C. Training and Professional Development**

- Objective 1:** From January 1, 2007, through December 31, 2007, the Nebraska STD Control program staff will attend the Electronic Lab Information Reporting Technology (ELIRT) Nebraska Public Laboratory training provided by the Nebraska Public Health Laboratory.
- Objective 2:** By December 31, 2007, 80% of the local health districts will have attended an STD 101 update provided by the St. Louis training center.
- Objective 3:** By December 31, 2007, 70% of STD program staff will receive training on Region VII HIV, STD, and Family Planning.
- Objective 4:** By December 31, 2007, the Nebraska STD/IPP will provide an in-service about Human Papilloma Virus and vaccine to at least 80% of partnering agencies.

### **D. Surveillance and Data Management**

- Objective 1:** By December 31, 2007, NE STD Program will provide new/reformatted lab requisitions to all program providers.
- Objective 2:** By December 31, 2007, at least 85% of Nebraska STD/IPP Providers will test within their allotment.
- Objective 3:** By December 31, 2007, 10 more Nebraska STD/IPP Providers will discontinue printed requisitions and utilize the ELIRT compliance program.

### **E. Nebraska Infertility Prevention Plan (NIPP) Core Components**

#### **1. Clinical Services**

- Objective 1:** During 2007, sites with greater than 3.5% of their total specimens submitted outside the screening criteria will receive an on-site assessment.
- Objective 2:** During 2007, the Nebraska IPP Coordinator will monitor and evaluate quality control in the management of screening and treatment of all patients and their partners participating in the Nebraska Chlamydia

Control Program and make on-site assessments to at least 15% of all NIPP sites.

## 2. Laboratory Support

- Objective 1:** During 2007, sites with greater than 2% unsatisfactory specimens will be evaluated by the NIPP Coordinator and may receive an on-site assessment.
- Objective 2:** Enhance cooperation among state laboratories in Region VII for lab testing, lab test pricing, and data standards.
- Objective 3:** By December 31, 2007, the Nebraska IPP Committee program will have met quarterly with Nebraska Public Health Lab.

## 3. Expanded Surveillance and Data Management

- Objective 1:** During 2007, the IPP Coordinator and the Quality Specialist in Omaha will provide an ongoing effort to maximize and support data collection activities to maintain a minimum of 90% data completeness.
- Objective 2:** During 2007, 90 percent of data submitted to the Region VII will not be missing any core data elements and the information asked for will be complete and accurate.
- Objective 3:** By December 31, 2007, NE STD Program will provide to the state web master 2 Infertility reports to place on the Nebraska STD Control Program Website.
- Objective 4:** By December 31, 2007, Nebraska STD/IPP Program, in collaboration with Hepatitis and HIV programs, will create a comic book addressing co-infection.

## 4. Program Management and Leadership

- Objective 1:** During 2007, the NIPP Coordinator will collaborate with family planning, laboratory, and county and district health departments to insure continued representation of these entities in the Region VII Advisory Committee meetings.
- Objective 2:** By December 31, 2007, of those females between 25-29, only 10% will be considered out-of-guidelines.
- Objective 3:** By December 31, 2007, the Nebraska STD/IPP Program will explore opportunities in finding infection in those women 15-24 by identifying one or two new sites serving this group.
- Objective 4:** By December 31, 2007, the Nebraska STD/IPP will create new criteria for IPP clinics.

## 5. Provider Training

- Objective 1:** During 2007, the NIPP, in collaboration with STD, will produce a semi-annual newsletter which incorporates chlamydia and Gonorrhea prevalence data by demographics, and geographic variables to be posted on the STD web site.
- Objective 2:** By December 31, 2007, 80 % of IPP providers will receive state sex partner management protocols.

## Nebraska Infertility Prevention Program (NIPP)

The Regional Advisory Committee (RAC) for Region VII (Nebraska, Iowa, Kansas and Missouri) has been in place since 1992. The RAC is comprised of state STD, family planning and laboratory program managers from these four states. This committee meets at least twice per year to discuss the enhancement and expansion of programs to reduce the prevalence of chlamydial and gonococcal infection, particularly in young women.

A project that the RAC collaborates on is the Region VII Infertility Prevention Project (IPP). This project is funded through the Centers for Disease Control and Prevention (CDC) and is administered collaboratively by the CDC and the Office of Population Affairs (OPA). The overall goal of the Region VII IPP is to lead a collaborative effort to prevent and reduce STD related infertility.

A sub-committee of the RAC, which focuses on the IPP, is the IPP Regional Advisory Committee. This sub-committee is composed of the five Family Planning Directors, the four state STD Directors and the four State Laboratory representatives from Iowa, Kansas, Missouri and Nebraska. The committee meets approximately three times per year to share information and make policy and program decisions.

## **Background Information**

Chlamydial infection is the most prevalent bacterial sexually transmitted disease in the United States, with gonococcal infection being the second most prevalent.

The wider availability of affordable, cost-effective laboratory diagnostic tests for the presence of *Chlamydia trachomatis* and *Neisseria gonorrhoea* has allowed further exploration of the broad spectrum of disease caused by these organisms.

Chlamydial infections are among the most common genital tract infections health care providers see in men. It is estimated that *Chlamydia trachomatis* causes approximately 50% of reported cases of non-gonococcal urethritis (NGU) among men. This STD has an estimated incidence of *at least 2.5* times that of gonococcal urethritis. *Chlamydia trachomatis* is also responsible for approximately 50% of the estimated 500,000 cases of acute epididymitis seen each year in the United States.

Even more important are chlamydial infections among women. *Chlamydia trachomatis* plays an important role in causing cervicitis, acute pelvic inflammatory disease (PID), and maternal and infant infections during pregnancy and following delivery. Chlamydia accounts for one-quarter to one-half of the one million recognized cases of PID in the United States each year. These infections, in addition to sub-clinical infections of the fallopian tubes not clinically recognized as PID, contribute significantly to the increasing number of women who experience ectopic pregnancy or involuntary infertility. Approximately 20% of women treated for PID will be infertile; another 18% will experience chronic pelvic pain resulting from the infection. Approximately ten percent (10%) of the women who do conceive after PID will have an ectopic pregnancy. Women infected with *Chlamydia trachomatis*, if exposed to HIV, have a three to five-fold increased risk of acquiring the disease.

In addition to its association with mucopurulent cervicitis and PID, *Chlamydia trachomatis* plays an important role in the urethral syndrome (dysuria-pyuria syndrome) and in perihepatitis (Fitz-Hugh Curtis syndrome). Maternal chlamydial infection during pregnancy has been associated with pre-term labor, premature rupture of membranes and postpartum endometritis.

Each year more than 155,000 infants are born to chlamydia-infected mothers. Almost two-thirds of the infants born vaginally to chlamydia-infected mothers become infected during delivery. These newborns are at high risk of developing inclusion conjunctivitis and chlamydial pneumonia and are at elevated risk of having otitis media and bronchiolitis. *Chlamydia trachomatis* is the most common cause of neonatal eye infections and of afebrile interstitial pneumonia in infants less than six months of age. Gonococcal infections among infants usually result from exposure to infected cervical exudate at birth. Usually an acute illness, gonococcal infection becomes manifest 2-5 days after birth. The most severe manifestations of gonococcal infections in newborns are ophthalmia neonatorum and sepsis, including arthritis and meningitis. Less severe manifestations include rhinitis, vaginitis, urethritis, and inflammation at sites of fetal monitoring.

Enormous costs are associated with chlamydial and gonococcal infections. Each year, almost \$4 billion is spent on these infections in the United States. Many of these costs result from the management (including hospitalization and surgery) of women with PID and its complications and from the management of infants hospitalized with chlamydial pneumonia. This estimated cost does not reflect the human suffering experienced by those with chlamydial and gonococcal diseases.

To reduce morbidity and subsequent complications associated with chlamydial and gonococcal infection in the United States, effective prevention and control strategies are being implemented.

### ***Nebraska Infertility Prevention Program (NIPP)***

Nebraska Infertility Prevention Project (NIPP) focuses on the prevention and early treatment of chlamydial and gonococcal infection through the collaborative effort of health care providers throughout Nebraska.

In Nebraska, there are currently 69 IPP clinics across the state. These clinics are:

- Adolescent care facility – 1
- Community Health Center – 4
- Corrections – 15
- Family Planning Clinic– 22
- Indian Health Services – 6
- Private physician office – 16
- STD Clinic – 3
- Substance Abuse Clinic – 2
- Of these, 19 also include a Semi-STD Clinic

Currently, NIPP provides medication to most clinic types. Sites must fill out a new Confidential Case Report form that lists the initial positive patient and their sex partners.



The form must be faxed to the state within 7 days of treatments. The medication is provided to the positive patient and up to three sex partners. Those partners can be presumptively treated or can come into the clinic and be tested free of charge.

In June 2004, the NIPP implemented the following guidelines to screen clients:

All clients attending Family Planning clinics

All females ages 15 – 24 years

All female's age 25-29 with one of the following risk factors:

New partner or multiple partners in the past 90 days

Recent contact to a STD

Symptoms suggesting a STD

These guidelines have been developed to guide health care providers in initiating, updating and maintaining screening and treatment policies and procedures appropriate to the provider's individual needs, services and resources. The guidelines have been designed to efficiently direct a limited resource, i.e., the availability of screening tests for those women who are at high risk of having a chlamydial or gonococcal infection.

Nebraska is currently moving to the Electronic Lab Information Reporting Technology (ELIRT) system which is a secure electronic system for ordering test supplies, submitting results, receiving results within 48 hours and the ability to transform data into an electronic spreadsheet at the touch of a button. All clinics will be trained and will use this environmentally friendly, paperless system by the close of 2009.

## **Region VII Infertility Prevention Plan**

### **Goals** **2006-2008**

- Goal/Priority 1:** Target/expand Chlamydia screening to young, sexually active women and men at risk (public and private settings).
- Goal/Priority 2:** Incorporate data analysis to maximize the Infertility Prevention Project.
- Goal/Priority 3:** Improve appropriate and timely treatment for persons with Chlamydia and their partners.
- Goal/Priority 4:** Regionally maintain the use of high quality diagnostic assays for the detection of Chlamydia and Gonorrhea.
- Goal/Priority 5:** Increase adoption of best practice prevention strategies to decrease Chlamydia transmission.

### **Future of STD's in Nebraska**

Over the past five years, Nebraska's numbers and rates for STDs has shown only a slight increase. In order for these numbers to show a decline, communities will have to show more involvement in strategies and interventions to prevent STDs. Communities need to become proactive and take responsibility for the high STD rates in their communities. For this to occur, it will require communication and collaboration between key stakeholders. For example, local/district health departments need to increase

awareness and intervention activities that target STDs in their districts. Health providers need to be aware of what is going on in their communities and be kept current with testing and treatment options. Organizations need to be aware of opportunities to collaborate on STD prevention efforts, especially schools and organizations that work with youth and young adults. It is no longer feasible for interventions to be lead only by the state STD Program. Communities need to step forward and become accountable for what is occurring within their own communities. Then, we will begin to see changes in the numbers and rates of STDs in Nebraska.

Nebraska has seen an influx of immigrant and migrant populations to the state over the past few years. This has created problems with communication when it comes to testing sites, health care providers and follow-up disease investigation. We need to develop language access services that are easily accessible, that are able to interpret medical terminology and that can guarantee confidentiality to their clients. Currently in Nebraska, we can locate interpreters but finding ones that fit these three qualifications is difficult. The STD Program is not alone with this problem. All provider service organizations in Nebraska have this problem. We need to develop a network of language access providers across Nebraska to assist all programs when necessary.

Electronic Lab Reporting of test results was implemented in Nebraska in 2006. The DHHS Office of Epidemiology and the Nebraska Public Health Lab (NPHL) collaborated on the development of the National Electronic Data Surveillance System (NEDSS). Due to the volume of lab reporting and the number of providers and test sites using laboratories for test results, we needed to have a system that was user friendly and could be quickly accessed for test results by health care providers and testing sites across Nebraska. Since implementation, many initial problems have been overcome but problems continue. Prior to first use, the system requires formal training. This requires face-to-face training at the provider's site, which is labor intensive and not cost effective. Future plans are for this system to also include case reporting

Over the next five years, the goal of the STD Program is to decrease the number of STDs in Nebraska. With increased awareness, community involvement, communication, and collaboration this will be achieved.

For further information on STD's in Nebraska go to the DHHS STD Program website at: [www.dhhs.ne.gov/std/stdindex.htm](http://www.dhhs.ne.gov/std/stdindex.htm)

## **NEBRASKA TUBERCULOSIS (TB) CONTROL PROGRAM**

Tuberculosis (TB) is an infectious disease caused by the bacterium mycobacterium tuberculosis, and is one of the leading causes of death in the world today. In the United States, TB was the leading cause of death in 1900. With the advent of effective treatment, the US experienced a steady decline in cases until the mid-1980s. A resurgence of TB occurred at that time, with national case rates peaking in the early 1990s. Through extensive public health interventions at the national, state, and local levels, tuberculosis is once again on the decline both nationally and in Nebraska. There were 13,767 cases reported in the US for 2006, which are the last reported incidence numbers available. Since 2002, the number of tuberculosis cases has declined in Nebraska, reaching 25 cases in both 2006 and 2007.

The Nebraska TB Control Program's primary purposes are to:

- 1) conduct TB surveillance and maintain disease surveillance records
- 2) provide services to support the treatment of individuals with TB disease or infection, and
- 3) conduct TB prevention activities

TB surveillance activities include maintaining the state registry of active tuberculosis cases, collection and interpretation of data, and monitoring mycobacteriology laboratory reports from the Nebraska Public Health Lab (NPHL) and other private labs.

The services provided to support the treatment of individuals with TB disease or infection are: laboratory services for AFB smears, cultures and susceptibilities; medications used for the treatment of TB or Latent TB Infection (LTBI); contracts with local health departments to provide Directly Observed Therapy (DOT) when ordered and to conduct contact investigations; and payment for x-rays and medical office visit fees for cases and contacts of infectious cases when there is no other source of payment available.

TB prevention activities include education and training as requested to local and district health departments, hospitals, nursing homes, Indian Health Services, meat packing plants, refugee resettlement agencies and health care providers, including physicians and nurses. LTBI medications also play a large part in TB prevention.

Staffing for the TB Control Program includes a 1.0 FTE program manager, 0.75 FTE staff assistant and a .25 FTE Community Health Nurse (CHN). The CHN position is shared with the STD and HIV Surveillance Programs and coordinates TB training and education for Nebraska.

## **TB SURVEILLANCE IN NEBRASKA**

### **Active TB cases**

Nebraska continues to use CDC's guidelines [www.cdc.gov/tb/pubs/MMWR/maj\\_guide.htm](http://www.cdc.gov/tb/pubs/MMWR/maj_guide.htm) for both clinical and laboratory-confirmed cases. This surveillance method started in 2003. Three of the 25 (12%) cases in 2007 were clinically diagnosed; the remaining twenty-two (88%) cases were laboratory-confirmed with positive cultures for M. Tuberculosis. It should be noted that even though the tuberculosis burden in the state is low, many more cases are investigated as tuberculosis suspects. In 2007, 48 suspects were evaluated and followed until either

proven to be active TB or until the decision was made to treat them for latent TB infection only.

### Latent TB Infection (LTBI)

TB also affects persons in the state who are infected with the disease but not yet sick with the disease. The state's TB Control Program provides preventative medication (isoniazid/INH) for these people if they choose to take it, without cost. In 2006, one thousand seventy-five (1,075) people were provided medication through the Latent TB Infection Program. In 2007, one thousand, three hundred and ninety nine (1,399) people were served with this program.

In 2005, 38% of LTBI clients completed a 6-month course of treatment and 16% completed a 9-month course of treatment. Current CDC guidelines recommend either a 6- or 9-month course of therapy for treatment of latent tuberculosis infection and Nebraska accepts either as completed therapy.

### Nebraska Public Health Laboratory (NPHL)

The Nebraska Public Health Laboratory (NPHL) provides diagnostic testing services to the State of Nebraska Tuberculosis Control Program under a fee for services contract. In 2006, a new blood test to assist in the evaluation of tuberculosis disease and latent tuberculosis infection became available through the Nebraska Public Health Laboratory. This test is FDA approved and is called QuantiFERON-TB Gold. Since prior vaccination with BCG does not cause the TB interferon test to become positive, it is very useful in testing people who have been vaccinated with BCG. The test is covered by Medicaid and insurance, and if third party payment is not available, through the TB Program on a case-by-case basis. It is necessary for any test to be paid for through the TB Program to have prior approval.

### TB Surveillance Data

In 2006, Nebraska had a total of 25 cases of Tuberculosis, resulting in a rate of 1.5 cases per 100,000 people (Table 7.2). This is the lowest number of cases and attack rate in Nebraska in the last five years. The largest was 40 cases with a 2.3 attack rate in 2001. Nebraska ranked 38th nationally for the number of Tuberculosis cases in 2005 with 35 cases and continues to remain among the states with low Tuberculosis morbidity.

**Table 7.2. Reported Cases of TB and Attack Rates for U.S. and Nebraska, 2002-2006**

Year	Number o f U.S. Cases	U.S. Attack Rate Per 100,000 Population	Number of Nebraska Cases	Nebraska Attack Rate Per 100,000 Population
2002	15,075	5.2	28	1.6
2003	14,871	5.1	28	1.6
2004	14,511	4.9	39	2.2
2005	14,985	4.8	35	2.0
2006	13,767	4.6	25	1.5

Attack Rates Calculated Using Year 2000 U. S. Census Figures

Source: NE DHHS TB Control Program

Table 7.3 shows the total number of cases and average annual attack rate of TB cases in Nebraska by race and ethnicity for 2002-2006.

**Table 7.3. TB Cases and Average Annual Attack Rate per 100,000 in Nebraska by Race and Ethnicity, 2002-2006**

Race and Ethnicity	2000 Nebraska Population	# Of Cases	% of Total Cases	NE Average Annual Attack Rate per 100,000 Population
<b>RACE</b>				
<i>White</i>	1,533,261	91	58%	1.3
<i>SE Asians</i>	22,767	20	13%	19.3
<i>Native Americans</i>	14,896	7	5%	13.4
<i>Blacks</i>	68,541	28	18%	9.3
<i>Other</i>	71,798	9*	6%	1.4
<b>Total by Race</b>	1,711,263	155	100%	2.0
<b>ETHNICITY</b>				
<i>Hispanics</i>	94,425	56	36%	12.0
<i>Non-Hispanics</i>	1,616,838	99	64%	1.4
<b>Total by Ethnicity</b>	1,711,263	155	100%	2.0

\*multiple races

Attack Rates Calculated Using Year 2000 U. S. Census Figures  
Source: NE DHHS TB Control Program

Foreign born persons have a higher risk for exposure to or infection with M.tuberculosis, especially those that come from areas that have a high TB prevalence, such as Asia, Africa, Latin America, Eastern Europe and Russia. Many persons from these groups now reside in Nebraska. During the years 2002-2006, the foreign-born accounted for 109 of 155 cases (70%) of tuberculosis cases reported. In 2006, they accounted for all 25 cases.

Douglas County (Omaha), Sarpy County (included in the Omaha metro area) and Lancaster County (Lincoln) in Nebraska are the state's three most populous counties and are located in the eastern third of Nebraska. Together, they reported 101 cases or 65% of the total cases reported during 2002-2006.

## NE TUBERCULOSIS CONTROL PROGRAM OBJECTIVES

### Grant Period Objectives/2008 Objective

**1. 1. Objective:** Ensure that 90% of TB patients for whom therapy is indicated for one year or less, complete treatment within 12 months of initiation of treatment. This is for Performance Goal #1 - Increase the percentage of TB patients who complete a course of curative TB treatment within 12 months of initiation of therapy (some patients require more than 12 months).

**2008 Objective:** Increase the percentage of TB patients who complete a course of curative TB treatment within 12 months of initiation of treatment to 87% in this reporting year (2008).

**2. 1. Objective:** Ensure that 100% of TB patients with initial positive cultures are tested for and receive drug susceptibility results. This is for National Performance Goal #2 which is to increase the percentage of TB patients with initial positive cultures who also are tested for and receive drug susceptibility results.

**2008 Objective:** Increase the percentage of TB patients with initial positive cultures who also are tested for and receive drug susceptibility results to 100% in this reporting year (2008).

**3. 1. Objective:**

- 3a) Contacts will be identified for at least 90% of newly reported pulmonary TB cases that are AFB smear positive.**
- 3b) At least 95% of contacts will be evaluated for TB infection and disease.**
- 3c) At least 85% of infected contacts who are started on treatment for latent TB infection will complete therapy.**

**2008 Objective:**

- 3a)** The State of Nebraska will meet the goal that contacts will be identified for 88% of newly reported pulmonary TB cases that are AFB smear positive.
- 3b)** The State of Nebraska will meet the goal that 90% of infected contacts will start treatment for latent TB infection.
- 3c)** The State of Nebraska will meet the goal that 85% of infected contacts who start treatment for latent TB infection will complete therapy in this reporting year (2008).

**4. 1. Objective:** Increase the percentage of other high risk infected persons who are placed on treatment for LTBI and complete a treatment regimen. This is for National Performance Goal #4 which is to increase the percentage of other high-risk infected persons who are placed on treatment for LTBI and complete a treatment regimen.

*Not applicable. Nebraska does not receive funds for targeted testing. Also, Nebraska has not met the goal of having close contacts complete therapy at established benchmarks.*

**5. 1. Objective: The State of Nebraska will increase the percentage of immigrants and refugees with a Class A, B1, or B2 designation that are appropriately evaluated and treated. This is for Performance Goal # 5 which is to increase the percentage of immigrant and refugee designated as class A, B1, or B2 who are appropriately evaluated and treated.**

**2008 Objective:** The State of Nebraska will maintain a 90% evaluation of immigrants and refugees with class A, B1, or B2 designation for TB within 45 days of notification. Of those designated to begin treatment, 85% will complete treatment in this reporting year (2008).

**6. 1. Objective: Develop partnerships with tribal health care centers to provide TB prevention and control for American Indian/Alaska Native (AI/AN) peoples. This is for National Performance Goal #6 which is to increase the collaboration among tribal agencies and communities in order to provide TB prevention and control for AI/AN peoples.**

**2008 Objective:** The State of Nebraska will increase collaboration with the Northern Ponca tribe using the tribal health center directors as the point of contact in this reporting year (2008).

**7. 1. Objective: HIV status will be reported for at least 75% of all newly reported TB cases for the 20-50 year old age group. This is for the National Performance Goal #7 which is to increase the proportion of adults with TB who have been tested for HIV.**

**2008 Objective:** The State of Nebraska will increase the proportion of adults with active TB who have been tested for HIV to 75% in this reporting year (2008).

The Report of Verified Case of Tuberculosis (RVCT) form, which is used for collecting information on all active TB cases, includes a section on HIV status. The HIV status may be listed as: negative, positive, indeterminate, refused, not offered, test done-results unknown, and unknown. This information is based upon medical documentation or patient history. Table 7.4 reports the outcome of HIV status for all active TB cases in 2005 and 2006.

**Table 7.4. Reported M. Tuberculosis Cases and HIV Status in Nebraska, 2005-2006**

Year	# of Reported Cases		HIV (+)	HIV (-)	# Tested	Test Done Results Unknown	Not Offered Testing
	All ages	20-50 Years					
2005	35	17	2	10	12	3	2
2006	25	14	1	11	12	1	1
<b>TOTAL</b>	60	31	3	21	24	4	3

## **THE FUTURE OF TB IN NEBRASKA**

The face of Tuberculosis in the State of Nebraska is changing. The TB Control Program has seen an unprecedented increase in the number of foreign born persons with tuberculosis in the last seven years. While Nebraska still remains low in overall TB morbidity, the challenges presented by this new phenomenon are great. The language and cultural barriers of this population require a tremendous amount of public health resources to ensure a successful TB treatment outcome. Nationally, there continues to be a great need for research in tuberculosis to develop new diagnostic tools and new drugs to fight the disease. Nebraska has not yet seen the increase in multi-drug and extensively drug-resistant disease, but these are showing up more frequently around the world and we realize that the global burden of TB is not far away from Nebraska's borders. For the past seven years, federal funding to the State has decreased with the recent years rescissions. Currently, this program runs on a total budget of approximately \$350,000.

For further information on TB in Nebraska go to the Nebraska DHHS TB Program website at: [www.hhss.ne.gov/puh/cod/Tuberculosis/tbindex.htm](http://www.hhss.ne.gov/puh/cod/Tuberculosis/tbindex.htm).



**SECTION 8**  
**SUPPLEMENTAL DATA**

1

## SECTION 8 SUPPLEMENTAL DATA

### CARE SERVICES DATA

*Ryan White Part B Program:* In FY 2007 (April 1, 2006-March 31, 2007), the Ryan White Part B Program provided case management and direct emergency assistance (housing, utilities, transportation, health insurance, and food assistance) to 545 unduplicated clients<sup>1</sup>. Males represented 72% and females represented 28% of clients served. 59% of clients served were white, 21% were black, and 20% identifying as Hispanic or other. The majority of clients served (60%) were between 25-44 years of age. Clients over 45 years of age represented 36%, with clients 20-24 representing 5% of clients served.

*Direct Emergency Assistance:* In FY 2007 (April 1, 2006 – March 31, 2007), \$169,113 in Part B funding provided Direct Emergency Assistance to 257 clients. The majority of funding (69%) provided housing assistance to clients. The remainder of funding was utilized for utility assistance (21%), transportation (5%), food (1%), and insurance premium payment assistance (1%)<sup>2</sup>.

*AIDS Drug Assistance Program (ADAP):* In FY 2007 (April 1, 2006-March 31, 2007), the Ryan White Part B Program also provided funding for ADAP. This program component provides formulary medications for the treatment of HIV disease and related opportunistic infections to qualified clients who have no other access to medications. In FY 2007, a formulary of 117 medications was available to 904 unduplicated clients.

According to the CARE Act Data Report covering calendar year 2007, 74% of clients were male and 26% female. The majority of clients (59%) were white, 26% black, and 2% identifying as Asian, Pacific Islander, or American Indian. 12% of clients served identified their ethnicity as Hispanic or Latino<sup>3</sup>.

The following table gives the funding history for ADAP for FY 2002 through FY 2007.

#### ADAP Funding History

<u>Fiscal Year</u>	<u>Funding Amount</u>	<u>+/-</u>
FY 2002	\$1,310,377	16.7%
FY 2003	\$1,435,873	9.6%
FY 2004	\$1,631,135	13.6%
FY 2005	\$1,563,355*	-4.2%
FY 2006	\$2,143,565**	37.1%
FY 2007	\$2,156,366**	6.0%

\*Allocated funding for FY 2005

\*\* Includes \$900,000 state funding

<sup>1</sup> Total includes all clients receiving at least one case management visit. Direct Emergency Assistance was provided to a portion of total clients reported.

<sup>2</sup> 3% of direct emergency assistance was utilized for administrative fees for check writing services and transportation assistance.

<sup>3</sup> Ethnicity is considered a subset of race for CARE Act Data Reporting; meaning clients identifying as Hispanic or Latino also identify a racial category.

Between FY 2005 and FY 2007, expenditures for ADAP increased 42% from \$1,563,355 in FY 2005 to \$2,156,366 in FY 2007. This can be attributed partly to the addition of state funds (\$900,000) the program received in FY 2006 and FY 2007. Without receiving this state funding, ADAP would have seen an overall decrease of 19.6% from FY 2005 to FY 2007.

From FY 2006 to FY 2007, the number of unduplicated ADAP clients increased 187% from 315 to 904.

## YOUTH RISK BEHAVIOR SURVEILLANCE (YRBS) DATA

### Overview

The Youth Risk Behavior Survey (YRBS) is part of the National Youth Risk Behavioral Surveillance System (YRBSS) that was established in 1991 by the Centers for Disease Control and Prevention (CDC). Since 1991, students in selected public schools, grades 9-12, have been surveyed biennially. The NDE conducts this survey with assistance from an outside contractor. First conducted in 1991, it is currently conducted in the spring of every odd calendar year. The YRBSS monitors six categories of priority health-risk behaviors among youth and young adults. These behaviors are:

- 1) unintentional injuries and violence
- 2) tobacco use
- 3) alcohol and other drug use
- 4) sexual behaviors
- 5) unhealthy dietary behaviors
- 6) physical inactivity

Sexual behaviors that are monitored are behaviors that may contribute to unintended pregnancy and sexually transmitted disease (STDs), including human immunodeficiency virus (HIV).

In order for data to be representative of the target population, it must be weighted. The CDC has determined that the data collected must meet a standard level for the response rate of schools before it can be weighted. If the percentage of schools who participated in the survey collection process falls below a set standard for that year, the data can not be weighted. YRBS reports from 1995 – 2001 were compiled using unweighted data due to an insufficient response rate. 2003 and 2005 YRBS data was weighted and is representative of the youth population; 2007 YRBS data was unweighted. .

**CDC 2005 Youth Risk Behavior: 9<sup>th</sup>-12<sup>th</sup> Grade  
Sexual Risk Behaviors**

<b>STATISTIC</b>	<b>UNITED STATES</b>	<b>NEBRASKA</b>
Ever Had Sexual Intercourse	47%	41%
First Sexual Intercourse < 13 Years	6%	4%
4 or More Sex Partners in Lifetime	14%	12%
Currently Sexually Active	34%	30%
Did Not Use a Condom During Last Sexual Intercourse*	27%	28%
Birth Control Use Before Last Sexual Intercourse*	18%	22%
Alcohol or Drug Use Before Last Sexual Intercourse*	23%	24%
Taught in School About AIDS or HIV Infection	88%	85%

\* among currently sexually active students

**CDC 2005 Youth Risk Behavior: 9<sup>th</sup>-12<sup>th</sup> Grade  
Alcohol and Other Drug Use Risk Behaviors**

<b>STATISTIC</b>	<b>UNITED STATES</b>	<b>NEBRASKA</b>
Lifetime Alcohol Use: Had at least 1 drink of alcohol 1 day or more during their life	74%	73%
Current Alcohol Use: Had at least 1 drink of alcohol per day or more of the 30 days preceding the survey	43%	43%
Episodic Heavy Drinking: Had 5 or more drinks of alcohol in a row on 1 or more of the 30 days preceding the survey	26%	30%
Lifetime Marijuana Use: Used marijuana 1 or more times in life	38%	32%
Current Marijuana Use: Used marijuana 1 or more times during the 30 days preceding survey	20%	18%
Lifetime Cocaine Use: Used any form of cocaine (powder, crack, freebase) 1 or more times in life	8%	8%
Current Cocaine Use: Used cocaine in any form (powder, crack, freebase) 1 or more times during the 30 days preceding survey	3%	3%
Lifetime Illegal IDU: Used a needle to inject any illegal drug into their body 1 or more times during their life	2%	3%
Lifetime Illegal Steroid: Took pills or shots without a doctors prescription 1 or more times during their life	4%	4%
Lifetime methamphetamine use: Used any form of methamphetamine (speed, crystal, crank, ice) 1 or more times during their life	6%	6%

## NEBRASKA RISK AND PROTECTIVE FACTOR STUDENT SURVEY (NRPFSS)

The NRPFSS is a substance abuse-related census survey of Nebraska public and non-public students in grades 6, 8, 10, and 12. First conducted in 2003, it is currently conducted during the fall of every odd calendar year. The NRPFSS is used primarily for generating local and regional estimates for substance abuse and risk and protective factors related to substance abuse. The survey covers alcohol, tobacco, and illicit drug use; gambling; anti-social behavior; and risk and protective factors that predict adolescent problem behaviors. The Nebraska Department of Education and the Nebraska Department of Health and Human Services partner to complete this survey with the assistance of an outside contractor. The NRPFSS differs from the YRBS in that it generates local and regional estimates for health planning and evaluation while the YRBS generates state level data.

### 2005 NRPFSS Data Results

#### Health and Safety

##### **How old were you when you first:**

- *had more than a sip or two of beer, wine or hard liquor?*

Of the 54% of students who had more than a sip or two of beer, wine, or hard liquor, the average age of first use was 12.9 years old.

- *began drinking alcoholic beverages regularly, that is, at least once or twice a month?*

Of the 23% of students who drank at least once or twice a month, the average age of first use was 14.7 years old.

- *used "meth" (also known as 'crank', 'crystal', or 'ice')?*

Of the 2.2% of students who have ever used meth, the average age of first use was 14.0 years old.

##### **On how many occasions (if any) have you:**

- *had alcoholic beverages (beer, wine or hard liquor) to drink in your lifetime-more than just a few sips?*

Occasions	Percent
0 Occasions	46.9
1-2 Occasions	15.3
3-5 Occasions	8.6
6-9 Occasions	6.3
10-19 Occasions	7.2
20-39 Occasions	5.6
40+ Occasions	10.0

- *Had beer, wine or hard liquor to drink during the past 30 days?*

Occasions	Percent
0 Occasions	75.0
1-2 Occasions	12.7
3-5 Occasions	5.4
6-9 Occasions	3.4
10-19 Occasions	2.1
20-39 Occasions	0.8
40+ Occasions	0.6

- *Think back over the last two weeks. How many times have you had five or more alcoholic drinks in a row?*

Occasions	Percent
0 Occasions	83.3
1 Occasion	6.2
2 Occasions	4.3
3-5 Occasions	3.9
6-9 Occasions	1.1
10 or more Occasions	1.2

- *Used marijuana (grass, pot) or hashish (hash, hash oil) in your lifetime?*

Occasions	Percent
0 Occasions	83.6
1-2 Occasions	4.6
3-5 Occasions	2.7
6-9 Occasions	1.6
10-19 Occasions	1.9
20-39 Occasions	1.3
40+ Occasions	4.2

- *Used marijuana (grass, pot) or hashish (hash, hash oil) in the past 30 days?*

Occasions	Percent
0 Occasions	93.0
1-2 Occasions	2.8
3-5 Occasions	1.1
6-9 Occasions	0.7
10-19 Occasions	0.8
20-39 Occasions	0.6
40+ Occasions	1.0



- *Used cocaine or crack in your lifetime?*

Occasions	Percent
0 Occasions	97.7
1-2 Occasions	1.2
3-5 Occasions	0.4
6-9 Occasions	0.3
10-19 Occasions	0.2
20-39 Occasions	0.1
40+ Occasions	0.2

- *Used cocaine or crack during the past 30 days?*

Occasions	Percent
0 Occasions	99.2
1-2 Occasions	0.5
3-5 Occasions	0.2
6-9 Occasions	0.1
10-19 Occasions	0.0
20-39 Occasions	0.0
40+ Occasions	0.0

- *Taken 'meth' (also known as 'crank', 'crystal', or 'ice') in your lifetime?*

Occasions	Percent
0 Occasions	98.2
1-2 Occasions	0.8
3-5 Occasions	0.3
6-9 Occasions	0.2
10-19 Occasions	0.2
20-39 Occasions	0.1
40+ Occasions	0.2

- *Taken 'meth' (also known as 'crank', crystal', or 'ice') in the past 30 days?*

Occasions	Percent
0 Occasions	99.3
1-2 Occasions	0.4
3-5 Occasions	0.1
6-9 Occasions	0.1
10-19 Occasions	0.0
20-39 Occasions	0.0
40+ Occasions	0.0

- *Used steroids without a doctor telling you to take them, in your lifetime?*

<b>Occasions</b>	<b>Percent</b>
0 Occasions	98.8
1-2 Occasions	0.6
3-5 Occasions	0.2
6-9 Occasions	0.1
10-19 Occasions	0.0
20-39 Occasions	0.0
40+ Occasions	0.1

- *Used steroids without a doctor telling you to take them, during the past 30 days?*

<b>Occasions</b>	<b>Percent</b>
0 Occasions	99.5
1-2 Occasions	0.3
3-5 Occasions	0.1
6-9 Occasions	0.0
10-19 Occasions	0.0
20-39 Occasions	0.0
40+ Occasions	0.1

## **School Health Profile (SHP)**

The School Health Profile (SHP) survey was developed in 1995 by the Centers for Disease Control and Prevention (CDC) Division of Adolescent and School Health (DASH) in collaboration with state and local education and health agencies. The survey provides a comprehensive assessment of school health policies and programs and helps state and local education and health agencies monitor and assess characteristics of and trends in:

- school health education
- physical education
- asthma management activities
- school health policies related to HIV and AIDS prevention
- tobacco-use prevention
- violence prevention
- physical activity
- competitive foods
- food service
- family and community involvement in school health programs

The survey has been conducted biennially since 1996. Surveys are sent to a random sampling of public middle/junior and senior high schools. The principal and lead health education teacher receive a self-administered questionnaire to complete. The results from these surveys are then weighted and national and state specific reports are developed. In Nebraska, the Nebraska Department of Education HIV prevention education program collaborates with DASH to conduct the survey.

### **2004 Nebraska School Health Profiles Results**

Among schools that required a health education course:

- 95.8% taught HIV prevention
- 90% taught how HIV is transmitted
- 71% taught how to find valid information or services related to HIV or HIV testing
- 88.1% taught STD prevention
- 79.7% taught pregnancy prevention
- 90.8% taught abstinence as the most effective method to avoid HIV infection
- 25.4% taught how to correctly use a condom

In 21.8% of schools, the lead health education teacher received staff development on HIV prevention during the past two years

58.6% of schools had a written policy that protects the rights of students or staff with HIV infection or AIDS

## BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS)

The Nebraska Behavioral Risk Factor Surveillance System (BFRSS) has been conducting surveys annually since 1986 for the purpose of collecting data on the prevalence of major health risk factors among adults residing in the state. Information gathered in these studies can be used to target health education and risk reduction activities in order to lower rates of premature death and disability.

This surveillance system is based on a research design developed by the Centers for Disease Control and Prevention (CDC) and used in all fifty states, the District of Columbia, and three U.S. territories.

Telephone surveys with 13,061 randomly selected Nebraska residents aged 18 and older were conducted by the Nebraska Department of Health and Human Services during 2001-2003.

The *Nebraska Behavioral Risk Factor Surveillance System Report, 2001-2003*, gives survey results for 24 key risk factors and measures of health for Nebraskans. The results for three of these risk factors, HIV/AIDS, Family Planning, and Alcohol Misuse, follow:

### HIV/AIDS

#### *Knowledge Of HIV/AIDS*

##### Definitions

BRFSS respondents aged 18 to 64 were asked two questions about their knowledge of "HIV, the virus that causes AIDS":

- 1) Correct response = "True" to statement, "A pregnant woman with HIV can get treatment to help reduce the chances that she will pass the virus on to her baby."
- 2) Correct response = "True" to statement, "There are medical treatments available that are intended to help a person who is infected with HIV to live longer."

#### *Prevalence of Correct Responses*

##### *Transmission of HIV from Pregnant Woman to Baby*

Little more than one-half of respondents aged 18 to 64 (53 percent) agreed that pregnant women with HIV can get treatment that will help reduce the chances that she will pass the virus on to her baby. Thirty percent of adults in this age group said they didn't know if this is true, while 15 percent said this statement is false. A significantly greater proportion of women (56 percent) were aware that such treatment is available, compared to men (49 percent). Younger adults were significantly more likely than older persons to correctly state that this treatment is available to prevent transmission of HIV to infants. Sixty percent of 18- to 29-year-olds were aware of this treatment, compared to 52 percent of 30- to 44-year-olds and 47 percent of those aged 45 to 64. The proportion of college graduates who agreed with this statement (59 percent) was significantly greater than the proportion reported for respondents with less education. Among respondents with some college or technical training, 54 percent were aware that

treatment is available for pregnant women that reduces the probability that they will pass HIV on to their babies. This group was also significantly more likely than high school graduates (48 percent) and respondents with less than a high school education (42 percent) to agree that this is true. Urban Nebraskans (58 percent) were significantly more likely than rural residents (48 percent) to correctly state that such treatment is available. Differences by household income of respondents and by race/ethnic origin of respondents were not significant.

#### *Medical Treatment for HIV to Prolong Life*

Nearly nine of every ten BRFSS respondents aged 18 to 64 (88 percent) were aware that medical treatments are available to help persons with HIV to live longer. Ten percent said they didn't know or refused to answer the question. Only two percent indicated that no treatments are available. The majority of respondents in each demographic and socioeconomic group correctly stated that this kind of medical treatment is available. However, persons with higher levels of education and persons with higher annual incomes were more likely than those at lower levels to agree with this statement. White respondents (89 percent) were also more likely than African Americans (80 percent) or Hispanic Americans (74 percent) to be aware that medical treatments for HIV that may help to prolong life are available.

## **HIV TESTING**

#### *Importance of HIV Testing*

##### *Current Prevalence*

The majority of respondents aged 18 to 64 (85 percent) said that it is "very important" that people learn their HIV status by getting tested. Six percent rated it "somewhat important", while four percent said it depends on your risk of contracting HIV. Less than one percent stated that learning your HIV status is not at all important. Four percent didn't know or refused to answer this question. Women (88 percent) were significantly more likely than men (82 percent) to say being tested for HIV is very important. The proportion of older adults aged 45 to 64 years who said that testing is very important (79 percent) was significantly lower, compared to the proportions for adults aged 30 to 44 (86 percent) and those aged 18 to 29 (89 percent). Hispanic Nebraskans (88 percent) and African Americans (89 percent) were significantly more likely to give this response than white (85 percent) or Asian American (78 percent) respondents.

##### *Ever Tested for HIV*

Despite high scores on the importance of HIV testing (i.e., 85 percent said it is "very important"), slightly more than one-third (35 percent) of all respondents aged 18 to 64 years said they had ever been tested for HIV.

##### *Trend over Time*

The proportion of respondents who stated that they ever had their blood tested for HIV infection changed little since the 1995-1996 BRFSS, ranging from 32 percent to the current rate of 35 percent.

##### *Who Has Been Tested?*

A significantly smaller proportion of men (33 percent) reported ever being tested, compared to women (36 percent). Only about one-fifth of respondents aged 45 to 64 (20 percent) stated they had ever been tested for HIV infection. This proportion was

significantly lower than that reported for 18- to 29-year-olds (39 percent) or 30- to 44-year-olds (40 percent). White (33 percent) and Hispanic (36 percent) Nebraskans were significantly less likely to say they ever had an HIV test, compared to African American (59 percent) and Native American (49 percent) respondents. Asian Americans (40 percent) were also less likely to report being tested for HIV than African Americans. Residents of rural Nebraska counties (29 percent) were significantly less likely than residents of urban counties (41 percent) to report ever being tested for this infection.

#### *Last HIV Test*

Sixteen percent of 2001-2003 BRFSS respondents who ever had an HIV test reported having their last HIV test within the past year. The greatest proportion (55 percent) said they last had this test between one and five years ago. Respondents aged 18 to 29 years (21 percent) were significantly more likely than respondents aged 30 to 44 (11 percent) to have an HIV test in the past year. Young adults (84 percent) were also much more likely to report having their last HIV test within the last five years, compared to adults aged 30 to 44 (64 percent) and adults aged 45 to 64 (63 percent). African Americans (22 percent) were significantly more likely than white respondents (16 percent) to report having their last HIV test within the past 12 months. African Americans (82 percent), Hispanic Americans (83 percent), and Asian Americans (87 percent) were more likely than whites (69 percent) to indicate they last had an HIV test within the last five years.

#### *Reasons for Testing*

Reasons for having their blood tested for HIV infection varied, but nearly two-thirds of the respondents (65 percent) stated that the HIV blood test was done as a routine requirement of some kind. They frequently said it “was required” (25 percent), was “part of a routine medical check-up” (23 percent), or was part of a pregnancy exam (17 percent). One-fourth of the respondents who had been tested (26 percent) cited reasons that may indicate that the respondent felt he or she was at increased risk for being infected with HIV. Most of them (22 percent of the total) said they “just wanted to find out whether [they] had HIV”. Two percent thought they “may have gotten HIV through sex or drug use”. An additional two percent had been tested because someone suggested it to them.

#### *Site of Most Recent HIV Test*

When asked where they had their last HIV test, nearly one-half (49 percent) said a private doctor or HMO did the testing. Nineteen percent reported being tested for HIV at a clinic, while 16 percent cited a hospital as the testing site. Six percent stated they were tested at home and four percent at a counseling and testing site.

#### *Respondents at High Risk for HIV*

##### Definition

At High Risk: “Yes” to any of the risk behaviors described in the following question. “I’m going to read you a list. When I’m done, please tell me if any of the situations apply to you. You don’t need to tell me which one.

- You have used intravenous drugs in the past year.
- You have been treated for a sexually transmitted or venereal disease in the past year.
- You have given or received money or drugs in exchange for sex in the past year.
- You had anal sex without a condom in the past year.

Do any of these situations apply to you?”

### *Current Prevalence*

Based on the above definition, only three percent of 2002-2003 BRFSS respondents in the 18-to-64 age group would be consider “at high risk”. The great majority (95 percent) said none of these situations apply to them and they would therefore not be classified as “high risk.” Two percent said they didn’t know or refused to answer this question.

### *Who’s at High Risk for HIV Infection?*

Younger respondents (aged 18 to 29, five percent; aged 30 to 44, three percent) were more likely than respondents aged 45 to 64 (one percent) to say that any of the four high-risk situations described in the above question applied to them. African American (six percent) and Hispanic American (six percent) respondents were more likely than White respondents (three percent) to be at high risk for HIV infection, based on their responses to this question.

### *Counseling about Sexually Transmitted Disease (STD) Prevention*

BRFSS respondents aged 18 to 64 were also asked a question about “sexually transmitted diseases other than HIV, such as syphilis, gonorrhea, chlamydia, or genital herpes.” The question stated, “In the past 12 months has a doctor, nurse, or other health professional talked to you about preventing sexually transmitted diseases through condom use?” Only 10 percent reported that a health professional had discussed this topic with them in the last year.

### *Who Has Received Counseling?*

Women (12 percent) were significantly more likely than men (7 percent) to say they had received counseling about condom use to prevent STDs in the past 12 months. Nearly one-fourth of young adults aged 18 to 29 (24 percent) stated that a doctor or other health professional discussed this subject with them. This rate is significantly greater than the rates reported by 30- to 44-year-olds (seven percent) and 45- to 64-year-olds (two percent). Persons with annual incomes under \$15,000 (23 percent) or \$15,000 to \$24,999 (16 percent) were significantly more likely than persons with incomes of \$25,000 or higher (4 to 8 percent) to receive counseling about STD prevention through condom use. Significantly greater proportions of Hispanic Americans (24 percent) and African Americans (20 percent) indicated they had discussed this method of preventing STDs with a health professional in the last year, compared to Whites (8 percent), Asian Americans (11 percent), and Native Americans (14 percent). Nebraskans living in urban counties (12 percent) were significantly more likely than those living in rural counties (8 percent) to have received this counseling from a health professional.

## **FAMILY PLANNING**

### **Birth Control Use and Methods**

#### *Use of Birth Control*

Nine percent were not using birth control and were at risk for unintended pregnancy.

**Condoms.** Overall, 15 percent of respondents to the question about birth control method used mentioned condoms as their method of choice. Young adults aged 18 to 29 (22 percent) were significantly more likely than respondents aged 30 to 44 (11 percent) or males aged 45 to 59 (7 percent) to use condoms as their primary method of preventing pregnancy. One-third of African American respondents (34 percent) reported that condoms were the birth control method they rely on. This proportion is significantly

higher than the proportion of white Nebraskans (14 percent) who say condoms are their first choice among birth control methods. Among Hispanic Americans, 23 percent mentioned condoms as their primary method.

## ALCOHOL MISUSE

### *Current Prevalence*

More than one-half (55 percent) of the respondents reported consuming at least one drink of an alcoholic beverage (such as beer, wine, wine coolers, liquor or cocktails) during the past month.

### *Binge Drinking*

17 percent of adults in Nebraska stated that they had five or more alcoholic drinks (binge drinking) on at least one occasion during the past month. The prevalence of binge drinking was nearly three times as high among men (25 percent) as among women (nine percent). White (17 percent) and Hispanic American (15 percent) adults were significantly more likely than Asian American (7 percent) or African American (11 percent) adults to binge drink.

### *Heavy Drinking*

Five percent of Nebraska adults surveyed in 2001-2003 said they consumed 60 or more alcoholic drinks during the past month, categorizing them as “heavy drinkers”. Men (six percent) were significantly more likely than women (four percent) to report behavior that placed them in the “heavy drinker” category.



## HEALTH STATUS OF RACIAL AND ETHNIC MINORITIES IN NEBRASKA

### Race/Ethnicity

The racial and ethnic minority population in 2000 comprised 12.6% of the total population, and by 2004 it is estimated to have increased to 16.3%. The following Table 8.1 shows the increase in Nebraska's population groups from 2000 to 2004. The state's growth rate of 2% was fueled by the growth of ethnic and racial minority populations in the state, especially Hispanic, which grew 27.1% from 2000 to 2004.

**Table 8.1: Increase in population, Nebraska, 2000 to 2004**

	2000	2004 Estimate	% Increase
<b>Total Population</b>	1,713,239	1,747,214	2.00%
<b>White</b>	1,587,082	1,609,056	1.30%
<b>Black</b>	70,212	74,815	6.80%
<b>American Indian</b>	15,664	16,562	5.90%
<b>Asian</b>	23,761	27,922	18.70%
<b>Hispanic</b>	95,308	119,975	27.10%
<b>Minority</b>	215,529	250,577	16.30%
<i>Source: US Bureau of the Census, 2004 Population Estimates</i>			

In the 2000 U.S. Census, the collection of race and ethnicity information was expanded to allow persons the opportunity to report more than one race group, as well as to report Hispanic ethnicity. For the purposes of this profile, to compare to HIV data, the numbers used are for those of one race. More than 92% of the men and women in Nebraska reported themselves as non-Hispanic White (Table 8.2). Non-Hispanic Blacks comprised 4.3% of the population. Hispanics comprised 6.9% of the total population, and Asians/Pacific Islanders and American Indians/Alaska Natives totaled 1.6% and less than 0.9% respectively. The race/ethnicity distribution among males and females was similar.

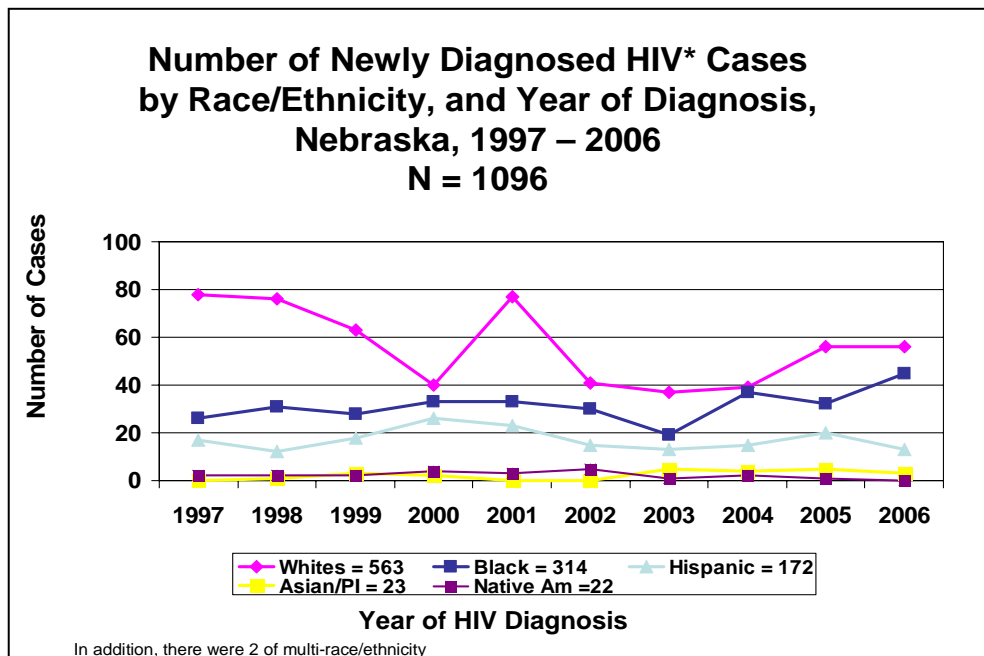
**Table 8.2: Percentage distribution of the general population, by race/ethnicity and gender**

	Males, %	Females, %	Total Population, %
<b>Race/Ethnicity</b>	(N = 863,628)	(N = 883,586)	(N = 1,747,214)
Hispanic or Latino	7.5%	6.2%	6.9%
<b>Not Hispanic or Latino</b>			
White alone	92.1%	92.1%	92.1%
Black/African American alone	4.3%	4.3%	4.3%
American Indian/Alaska Native alone	0.9%	1.0%	0.9%
Asian/Native Hawaiian/Pacific Islander alone	1.6%	1.6%	1.6%

*Source. US Bureau of the Census, 2004 Population Estimates*

All persons of color have been disproportionately affected by HIV disease compared to whites, especially Blacks, in Nebraska. Figure 8.1 provides information on the trends for the number of HIV/AIDS cases by race/ethnicity by year of HIV diagnosis. The overall trend for White, non-Hispanic HIV/AIDS cases was a decline in cases from 78 cases in 1997 to 56 cases in 2006. The exception to this was in 2001 when the number of cases increased to 77 cases. HIV/AIDS cases among Blacks have increased from 26 in 1997 to 45 cases in 2006, nearly matching the number of White cases. The trend for HIV/AIDS cases among Hispanics has been stable, fluctuating between 12 to 26 cases per year. Trends for Asian/Pacific Islanders and Native Americans are not discernable because the number of cases per year was 5 or less.

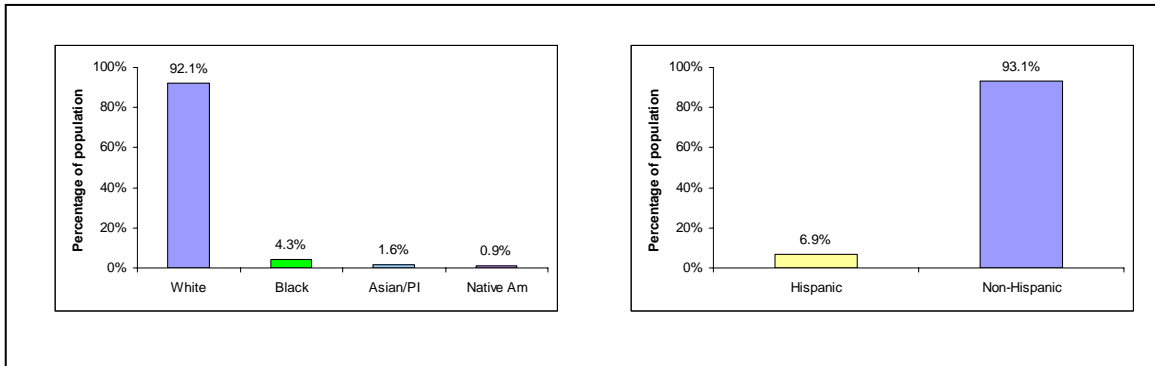
**Figure 8.1: Newly Diagnosed HIV Cases by Race/Ethnicity and Year of Diagnosis, NE, 1997-2006.**



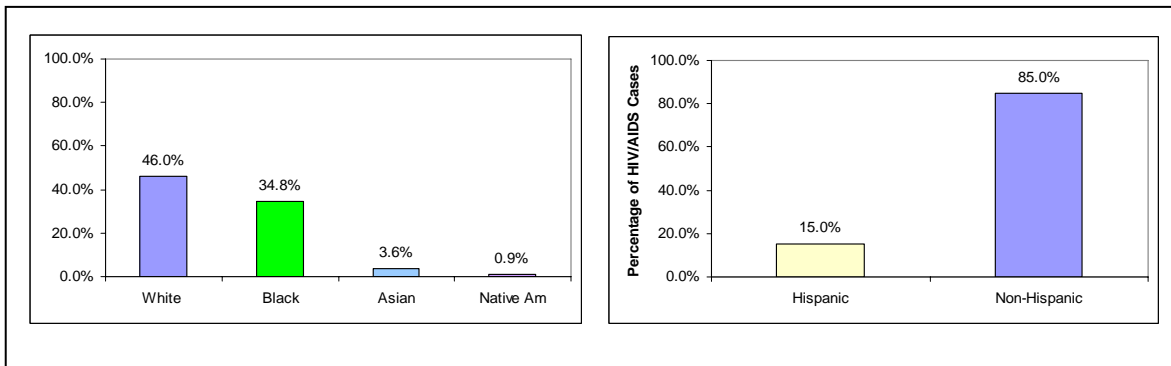
### Race/ethnicity compared to Nebraska population

Figures 8.2 and 8.3 below compare the proportion of HIV/AIDS cases by race/ethnicity to the distribution of race/ethnicities in the Nebraska population. While the majority of Nebraskans are white (86%), they only represent 46% of the HIV/AIDS cases. Blacks are over represented, comprising 35% of all the HIV/AIDS cases compared to 4% of the population. Hispanics are 15% of the cases while only 7% of the population. Native American and Asian/Pacific Islanders are represented only slightly higher among the HIV/AIDS cases than in the Nebraska population.

**Figure 8.2: Percentage of 2004 Nebraska Population by Race and Ethnicity**  
Population = 1,747,214



**Figure 8.3: Percentage of HIV/AIDS Cases Diagnosed 2004 to 2006, Nebraska**  
N = 328



### Race/Ethnicity and Gender

As demonstrated in Table 8.3, even though male HIV/AIDS cases are primarily white, non-Hispanic (53%), and blacks account for 28% of these cases, the rates for these two groups is vastly different. The highest rate for HIV/AIDS is 59.3 per 100,000 for black males, while the rate for white males is very low at 5.3 per 100,000. The second highest rate for males is 21.0 per 100,000 for Hispanic males. When the number of cases varies as widely as these numbers, rates allow a better comparison between these race/ethnicities.

The majority of female HIV/AIDS cases are black (54%), while whites represent 27%, a very different distribution compared to males. The rates are highest for black female HIV/AIDS cases (42.4 per 100,000), followed by 16.9 per 100,000 for Asian females, 11.8 per 100,000 for Native American females, 4.2 per 1000,000 for Hispanic females, and lowest for white females (1.0 per 100,000).

**Table 8.3: HIV/AIDS diagnoses and rates per 100,000 population, in Nebraska, by race/ethnicity and gender, 2004-2006**

Number and Rate* of HIV/AIDS Cases by race/ethnicity and gender, Nebraska, 2004 – 2006									
Race/Ethnicity	Males			Females			Total		
	No.	%	Rate*	No.	%	Rate*	No.	%	Rate <sup>a</sup>
Hispanic or Latino	41	17	21.0	7	8	4.2	48	15	13.3
<b>Not Hispanic or Latino</b>									
White alone	127	53	5.3	24	27	1.0	151	46	3.1
Black/African American alone	66	28	59.3	48	54	42.4	114	35	50.8
American Indian/Alaska Native alone	0	0	0.0	3	3	11.8	3	1	6.0
Asian/Native Hawaiian/Pacific Islander alone	5	2	12.2	7	8	16.4	12	4	14.3
<b>Total</b>	239	100	9.2	89	100	3.4	328	100	6.3

Source. HARS Reporting System

\*Average yearly rate per 100,000 based on 2004 population - caution must be used in interpretation because of small numbers

### *Race/ethnicity by age groups*

Table 8.4 compares the distribution of HIV/AIDS cases diagnosed between 2004 and 2006 by age groups and race/ethnicity. Reported HIV/AIDS cases tended to be 25 years and older, across all race/ethnicity groups. In addition, only Black and Asian/Pacific Islanders had HIV/AIDS cases less than 13 years of age.

**Table 8.4: HIV/AIDS diagnoses, Nebraska, by race/ethnicity and age group, 2004-2006**

Age (yrs)	White		Black		Hispanic		Asian/PI		Native American		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
0-4	0	0%	3	3%	0	0%	2	17%	0	0%	5	2%
5-12	0	0%	2	2%	0	0%	0	0%	0	0%	2	1%
13-24	20	13%	15	13%	7	15%	1	8%	0	0%	43	13%
25-44	94	62%	87	76%	34	71%	8	67%	2	67%	225	69%
45-64	35	23%	7	6%	7	15%	1	8%	1	33%	51	16%
>64	2	1%	0	0%	0	0%	0	0%	0	0%	2	1%
<b>Total</b>	151	100%	114	100%	48	100%	12	100%	3	100%	328	100%

Source. HARS Reporting System

*Race and risk by gender*

The proportion of cases attributable to a specific mode of exposure differs not only by gender, but also by race, as shown in Table 8.5. Of the new HIV/AIDS cases among male adult and adolescents 13 years of age and older diagnosed between 2004 and 2006, MSM accounted for 65% of white males, 34% of black males, 34% of Hispanic males, and 40% of Asian males. Injecting drug use represented 7% of all the male cases, and 6% of white and 10% of black. Men who have sex with men and use injecting drugs (MSM/IDU), represented 4% of all the male cases, with the percentage of MSM/IDU among whites at 5% and 6% for blacks. Caution must be used when interpreting these numbers since the number of cases is so small. The NIR percentage was high in all race/ethnicity groups, making interpretation of risk exposures difficult.

**Table 8.5: Male adult/adolescent HIV/AIDS diagnoses, Nebraska, by exposure category and race/ethnicity, 2004-2006**

Exposure category	Not Hispanic or Latino											
	Hispanic or Latino		White alone		Black/ African American Alone		American Indian/ Alaska Native alone		Asian/ Native Hawaiian/ Pacific Islander Alone		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Injection drug use	2	5	8	6	6	10	0	0	0	0	16	7
Male-to-male sex and injection drug use	0	0	6	5	4	6	0	0	0	0	10	4
Heterosexual contact	2	5	2	2	5	8	0	0	0	0	9	4
Other	1	2	0	0	0	0	0	0	0	0	1	0
Unknown	22	54	29	23	26	42	0	0	3	60	80	34
<b>Total</b>	41	100	127	100	62	100	0	0	5	100	235	100

Table 8.6 describes female adult/adolescent HIV/AIDS cases by risk exposure and race/ethnicity. The primary mode of exposure for females was heterosexual contact across all race/ethnic groups, representing 21% of whites, 19% of blacks, 29% of Hispanics and 67% of Native Americans. Injecting drug use occurred mainly in white and Hispanic females, 21% and 14% respectively. Caution must be used when interpreting these numbers since the number of cases is so small. It is also difficult because of the high numbers of NIRS in each race/ethnic group, ranging from 100% of Asian/Pacific Islanders to 33% of Native Americans.

**Table 8.6: Female adult/adolescent HIV/AIDS diagnoses, Nebraska, by exposure category and race/ethnicity, 2004-2006**

Exposure category	Not Hispanic or Latino											
	Hispanic or Latino		White alone		Black/African American alone		American Indian/Alaska Native alone		Asian/Native Hawaiian/Pacific Islander alone		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Injection drug use	1	14	5	21	1	2	0	0	0	0	7	8
Heterosexual contact	2	29	5	21	9	19	2	67	0	0	18	21
Other	0	0	0	0	3	6	0	0	0	0	3	3
Unknown	4	57	14	58	34	72	1	33	5	100	58	67
Total	7	100	24	100	47	100	3	100	5	100	86	100

### Country of Birth

Although the vast majority of HIV/AIDS cases in Nebraska are among individuals born in the U.S., a consistent number of cases have been reported annually among individuals born outside of the United States. Foreign-born persons with HIV/AIDS are included in U.S. case counts once they come to this country. A summary of the number of cases by origin diagnosed between 2004 and 2006 is provided below in Table 8.7. For these purposes, those with an unknown country of birth, or when no country was noted on the case report, it is assumed to be a U.S. born case. This box is more likely to be marked on the case report if the person is known to have arrived in this country fairly recently.

Foreign-born cases represented 28% of all the HIV/AIDS cases diagnosed between 2004 and 2006. Of the foreign-born, over half (54%) come from an African country, while those from Mexico/Central and South American countries represent 34%.

By gender, 53% of the foreign-born cases were male and 37% were female. Of the males, 41% were from Africa, and 51% were from Mexico/Central and South American countries. Females, on the other hand, were primarily from Africa (76%) while only 11% were from Central and South American countries.

**Table 8.7: HIV/AIDS Diagnoses in Nebraska by Country of Birth, 2004-2006**

	#	%
US born/US dependency	238	72%
Foreign born total	<b>90</b>	28%
Total	328	100%
- Africa	49	54%
- Mexico/Central/South America	31	34%
- Asia/Other	5	6%
- Not specified	5	6%
<b>Total</b>	<b>90</b>	100%

*No Reported Risk (NIR) and Country of Birth*

Taking a closer look at adult/adolescent NIRs by their country of birth may help in interpreting the large numbers of NIRs. Of the 138 NIRs among adult/adolescent HIV/AIDS cases diagnosed between 2004 and 2006, 55% were born in the U.S. and the remainder (45%) outside of the U.S. The rest of this section will refer to them as foreign-born cases.

Almost half (40%) of HIV/AIDS cases in males that were reported without a specific risk exposure were born outside of the U.S. Of these cases, 47% were born in Africa, and another 47% were from Mexico/Central and South American countries, and 3% were from Asia. The major modes of HIV transmission differs between countries in Africa and Mexico/Central/South America. Heterosexual contact is the primary mode of exposure in African countries, while the proportion of risk exposures in the Latin American countries and Asia more closely resembles that of the U.S.

The pattern for females is much different. The majority (77%) of the foreign-born females come from an African country, while only 7% come from a Latin American or Asian country. Again, heterosexual contact is the primary mode of exposure in African countries.

If the risk exposures are reclassified, adding in the information on country of birth, a better picture of HIV transmission in Nebraska can be presented.

Table 8.8 below demonstrates the reduction in NIRs when persons who were born in Africa are redistributed to heterosexual contact. For adult/adolescent males with HIV/AIDS the NIR percentage falls from 34% to 28%. The percentage of no identified risk for black males also is reduced from 42% to 18%. Heterosexual contact with the U.S. and African-born cases added together equal 10% for males with HIV/AIDS, and is even higher (32%) for black males alone.

**Table 8.8: Male adult/adolescent HIV/AIDS diagnoses, Nebraska, by adjusted exposure category and race/ethnicity, 2004-2006**

	Not Hispanic or Latino											
	Hispanic or Latino		White alone		Black/African American alone		American Indian/Alaska Native alone		Asian/Native Hawaiian/Pacific Islander alone		Total	
Exposure category	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Male-to-male sex	14	34	82	65	21	34	0	0	2	40	119	51
Injecting drug use	2	5	8	6	6	10	0	0	0	0	16	7
Male-to-male sex and injecting drug use	0	0	6	5	4	6	0	0	0	0	10	4
Heterosexual contact-US born	2	5	2	2	5	8	0	0	0	0	9	4
Heterosexual contact-African born					15	24					15	6
Other	1	2	0	0	0	0	0	0	0	0	1	0
Unknown	22	54	29	23	11	18	0	0	3	60	65	28
Total	41	100	127	100	62	100	0	0	5	100	235	100

For females, the overall NIR percentage falls from 67% to 41% when African-born females are added to the numbers for heterosexual contact, as presented in Table 8.9, the amount of NIRs is substantially reduced. The NIR percentage for blacks falls from 72% to 23%. Overall then, heterosexual contact represents 48% of all the female HIV/AIDS cases diagnosed between 2004 and 2006, and is even higher (68%) for black females.

**Table 8.9: Female adult/adolescent HIV/AIDS diagnoses, Nebraska, by adjusted exposure category and race/ethnicity, 2004-2006**

	Not Hispanic or Latino											
	Hispanic or Latino		White alone		Black/African American alone		American Indian/Alaska Native alone		Asian/Native Hawaiian/Pacific Islander alone		Total	
Exposure category	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Injecting drug use	1	14	5	21	1	2	0	0	0	0	7	8
Heterosexual contact-US born	2	29	5	21	9	19	2	67	0	0	18	21
Heterosexual contact-African born					23	49					23	27
Other	0	0	0	0	3	6	0	0	0	0	3	3
Unknown	4	57	14	58	11	23	1	33	5	100	35	41
Total	7	100	24	100	47	100	3	100	5	100	86	100



## INDIRECT INDICATORS OF RISK FOR HIV/AIDS INFECTION IN NEBRASKA

### SEXUALLY TRANSMITTED DISEASES (STD)

*STDs are among the most frequently reported infectious diseases in Nebraska. The goal of the NDHHS Sexually Transmitted Disease Program is to control and prevent sexually transmitted diseases and reduce the burden and cost of these infections. The program assists state, local, and community efforts to help prevent the spread of Chlamydia, gonorrhea, syphilis, hepatitis, and other STDs.*

STD Surveillance data provides information that may help identify the potential occurrence of high-risk heterosexual behavior. While STD rates may reflect unsafe sexual behavior, they do not necessarily correlate with HIV infection. National data suggest that syphilis rates, especially when related to crack cocaine use or the exchange of sex for drugs, may be more closely associated with HIV risk than either gonorrhea or Chlamydia. However, the presence of non-ulcerative STDs, such as Chlamydia and gonorrhea, can facilitate the transmission of HIV. If you have gonorrhea or Chlamydia, you have a five times greater chance of contracting HIV, and if you have syphilis, you have a 100 times greater chance of contracting HIV.

In Nebraska the STDs Chlamydia, gonorrhea, primary/secondary syphilis, early latent syphilis and genital herpes are reportable diseases. From 2002 to 2006 the total number of STDs reported increased from 6,934 to 8,111 cases. The incidence rate for STDs also increased from 404.7 per 100,000 population in 2002 to 461.2 per 100,000 population in 2006.

Table 8.10 shown below summarizes STD information from 2002 to 2006. The most frequently reported STD is Chlamydia, with 5,451 cases reported in 2006, followed by gonorrhea with 1,441 cases. Nebraska's rate for Chlamydia was 309.9 per 100,000 in 2006, compared to 347.8 per 100,000 nationally. The gonorrhea rate in Nebraska in 2006 was 81.9 per 100,000, compared to 120.9 per 100,000 nationally.

**Table 8.10: Number of Cases and Incidence Rates of STDs, 2002-2006**

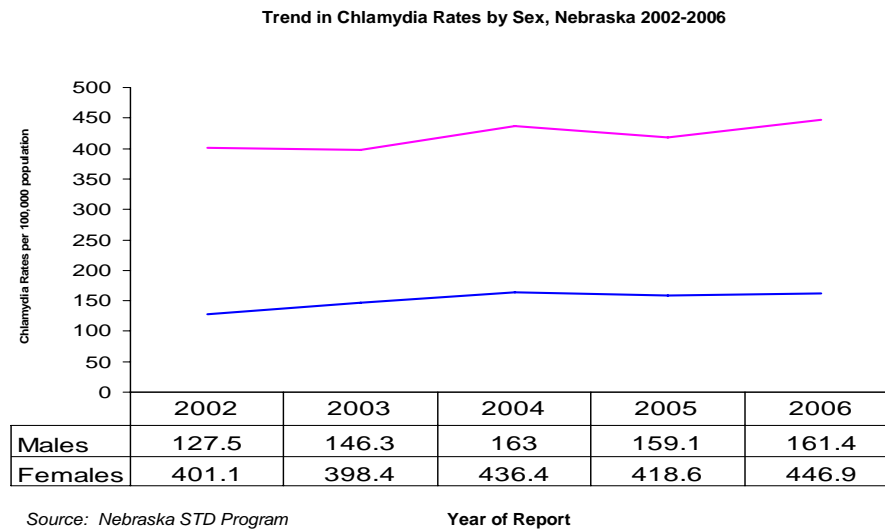
STD	2002		2003		2004		2005		2006	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Chlamydia	4595	268.2	4825	279.0	5241	301.3	5080	290.7	5451	309.9
Gonorrhea	1423	83.1	1664	96.2	1144	65.8	1158	66.3	1441	81.9
Primary /Secondary Syphilis	4	0.2	10	0.6	5	0.3	3	0.2	8	0.5
Early Latent Syphilis	0.0	0.0	1	0.1	0.0	0.0	2	0.1	1	0.1
Genital Herpes	779	45.5	648	37.5	730	42	986	56.4	1042	59.2
All STDs	6934	404.7	7301	422.2	7381	424.4	7477	427.9	8111	461.2

Source: Nebraska STD Program

## Chlamydia

Figure 8.4 compares the trends in Chlamydia rates by gender. Between 2002 and 2006, Chlamydia rates were consistently and substantially (2.6 to 3.1 times) higher in females as compared to males. Between 2004 and 2006, yearly Chlamydia rates for both males and females varied only slightly.

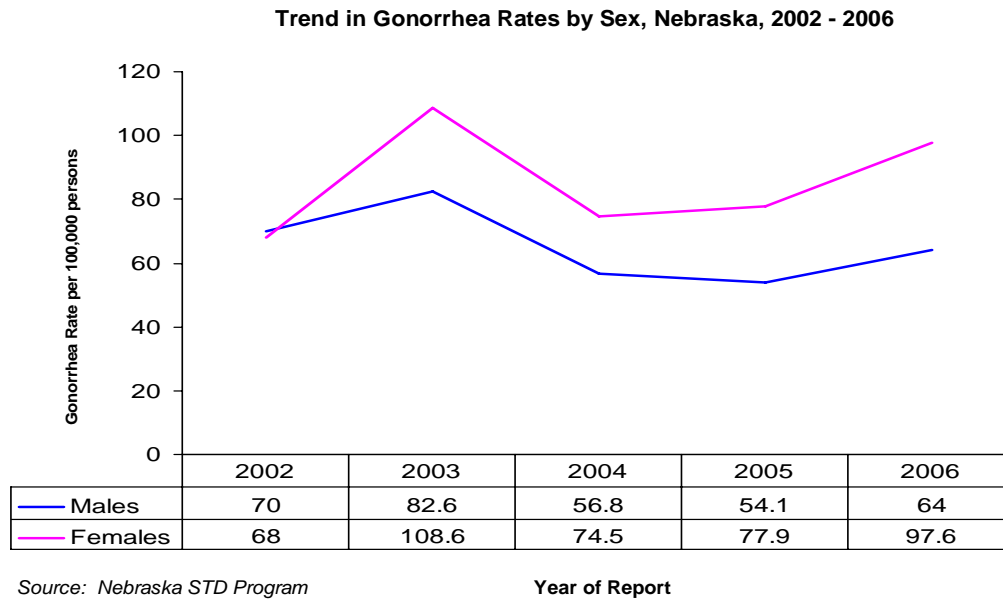
**Figure 8.4: Rates of Chlamydia by Sex, Nebraska, 2002-2006**



## Gonorrhea

In Figure 8.5 the trends in gonorrhea rates by gender are shown. Between 2002 and 2006, gonorrhea rates were consistently higher in females as compared to males. In comparison, the yearly gonorrhea rate for both males and females for 2005 and 2006 increased slightly, but remained lower than the highest rate for the past five years that was recorded in 2003 for both males and females.

**Figure 8.5: Rate of Gonorrhea by Sex, Nebraska, 2002-2006**



## Counseling, Testing, and Referral (CTR) Data

The CTR program has federally funded HIV test sites that are located across Nebraska. These sites do not include physician offices, hospitals, or medical clinics. At these test sites, the client has the option of testing anonymously (by number) or confidentially (by name). (See Appendix A for more details.) The test sites gather risk behavior and demographic information on all individuals seeking HIV testing during pre-test counseling. Test results, when reported, are linked to demographic and risk information. CTR testing data include both HIV positive and negative test results. This permits the measurement of demographics and high risk behaviors, by those testing positive as well as those testing negative.

As shown in Table 8.11, in 2005, 8,234 tests were done. The percent of positive tests was 0.7%. Two-thirds of the HIV tests performed at counseling and testing sites in Nebraska in 2005 were confidential.

**Table 8.11: Counseling, Testing, & Referral: Summary Statistics, Nebraska, 2005:**

ALL TESTS	#	%
	<b>8234</b>	<b>100%</b>
TYPE OF TEST		
Anonymous	2748	33.0%
Confidential	5445	66.0%
TEST RESULT		
Positive Tests	56	0.7%
Negative Tests	8140	99.0%
<i>Source: Nebraska Counseling, Testing and Referral, 2005</i>		

Note: Numbers do not add up due to incomplete information

Table 8.12 provides a comprehensive list of results from persons being tested at the counseling and testing sites in 2005. Most of the tests (53.2%) were male, and they were also the majority of the positive tests (71.4%). By race/ethnicity, 45.6% of the positive tests were for whites, and 33.3% were for blacks. The most common age of the positives was 20 to 29 years old (42.9%), followed closely by the 30 to 39 years old at 37.5%. The most common risk behaviors of the positive tests was MSM (41.1%), while heterosexual contact came in a very close second at 39.3%. Interpretation from data collected at counseling and testing sites must be used with caution. The data is not unduplicated, and persons may have been tested and entered into the database more than once.

**Table 8.12: Characteristics of Clients Utilizing Counseling, and Testing Clinics**

	TESTS		POSITIVE TESTS	
	#	%	#	%
<b>GENDER</b>				
Male	4,378	53.2%	40	71.4%
Female	3,855	46.8%	16	28.6%
Not Specified	1	0.0%	0	0.0%
<b>Total</b>	<b>8,234</b>	<b>100%</b>	<b>56</b>	<b>100%</b>
<b>RACE/ETHNICITY</b>				
White	4931	59.9%	26	45.6%
Black	1911	23.2%	19	33.3%
Hispanic	893	10.8%	7	12.3%
Asian/ Pacific Islander	150	1.8%	2	3.5%
American Indian/AK Native	190	2.3%	2	3.5%
Other	115	1.4%	1	1.8%
Undetermined	42	0.5%	0	0.0%
Not Specified	2	0.0%	0	0.0%
<b>Total</b>	<b>8234</b>	<b>100.0%</b>	<b>57</b>	<b>100.0%</b>
<b>AGE</b>				
<5	1	0.0%	0	0.0%
5-12	5	0.1%	0	0.0%
13-19	1272	15.4%	1	1.8%
20-29	3884	47.2%	24	42.9%
30-39	1612	19.6%	21	37.5%
40-49	1004	12.2%	8	14.3%
50+	447	5.4%	2	3.6%
Unknown	0	0.0%	0	0.0%
Not Specified	9	0.1%	0	0.0%
<b>Total</b>	<b>8234</b>	<b>100.0%</b>	<b>56</b>	<b>100.0%</b>
<b>RISK BEHAVIORS</b>				
MSM IDU	67	0.8%	2	3.6%
MSM	841	10.2%	23	41.1%
Heterosexual IDU	642	7.8%	1	1.8%
Sex Partner at Risk	4092	49.7%	22	39.3%
Children of HIV+ Women	0	0.0%	0	0.0%
Diagnosed w/STD	519	6.3%	2	3.6%
Sex for drugs/money	26	0.3%	0	0.0%
Sex while using drugs	632	7.7%	3	5.4%
Hem/Blood Recipient	18	0.2%	0	0.0%
Victim Sexual Assault	52	0.6%	0	0.0%
Health care exposure	30	0.4%	0	0.0%
No acknowledged risk	467	5.7%	0	0.0%
Heterosexual/No other risk	799	9.7%	3	5.4%
Other	29	0.4%	0	0.0%
Not Specified	20	0.2%	0	0.0%
<b>Total</b>	<b>8234</b>	<b>100.0%</b>	<b>56</b>	<b>100.0%</b>
<i>Source: Nebraska Counseling, Testing, and Referral, 2005</i>				

## Nebraska Pregnancy Risk Assessment Monitoring System (NE PRAMS)

PRAMS is an ongoing, population-based surveillance system designed to identify, monitor and provide high quality, timely data on selected maternal health behaviors and experiences before, during, and after pregnancy among women who have had a live birth. Nebraska is one of 32 states and one city who formally participates in the CDC PRAMS initiative.

The 2004 data is based on findings from a random sample of 2,432 Nebraska resident women who had a live birth in the year 2004; 80% of women selected to participate responded. Nebraska data is not available for African American or Native American populations because the response rate for each of the two racial groups was below the established guideline set by the Centers for Disease Control (CDC) of 70% for calculation of weighted numbers representative of each population. The NE PRAMS survey has 82 questions covering a range of topics.

Pregnancy is considered to be unintended when the woman did not want to be pregnant (unwanted) or desired a later pregnancy (mistimed). In 2004, 43% of the women surveyed, who had given birth in 2004, reported that they wanted to be pregnant later (34%) or did not want to become pregnant then or at any time in the future (9%) (Table 8.13).

**Table 8.13: Pregnancy Intention, 2004 PRAMS, Nebraska**

Pregnancy Intention	Percentage
Wanted to become pregnant sooner	17%
Wanted to become pregnant then	39%
Wanted to become pregnant later	34%
Did not want to become pregnant then or at any time in the future	9%
No response	1%
<b>Total</b>	<b>100%</b>
<i>Source: PRAMS 2004, Nebraska</i>	

Overall, 73% of women surveyed, who gave birth in 2004, reported that they had been talked to about HIV testing during their pregnancy. Eighty two percent of Hispanic mothers, 76% Asian American and 70% of White mothers reported being talked to during their pregnancy about HIV testing (Table 8.14). (Note: PRAMS data is not available for African American or Native American populations.)

**Table 8.14: Talked to About HIV Testing, 2004 PRAMS, Nebraska**

	Overall	Caucasian	Asian American	Hispanic
<b>Yes</b>	<b>73</b>	70	76	82
<b>No</b>	27	30	24	18
<b>Total</b>	100	100	100	100
<i>Source: 2004 PRAMS, Nebraska</i>				

Overall, 60% of women surveyed, who gave birth in 2004, reported that they had been tested for HIV during their pregnancy. Seventy nine percent of Hispanic mothers, 70% of Asian American and 55% of Caucasian mothers report that they were tested for HIV during their pregnancy (Table 8.15).

**Table 8.15: Tested for HIV During Pregnancy, 2004 PRAMS, Nebraska**

	<b>Overall</b>	<b>Caucasian</b>	<b>Asian American</b>	<b>Hispanic</b>
<b>Yes</b>	<b>60</b>	55	70	79
<b>No</b>	40	45	30	21
<b>Total</b>	100	100	100	100
<i>Source: 2004 PRAMS, Nebraska</i>				

## Treatment Episode Data Set (TEDS)

TEDS is a compilation of data on the demographic characteristics and substance abuse problems of those admitted for substance abuse treatment. TEDS data comes primarily from facilities that receive some public funding. The goal of TEDS is to collect information on complete treatment episodes; therefore SAMHSA has expanded the TEDS system to include discharge data that can be linked to admissions data. Currently about 20 States, including Nebraska, submit discharge data.

From 2001 through 2005, the number of drug-related treatment admissions to publicly funded facilities in Nebraska varied from drug to drug with increases reported for methamphetamine and marijuana and decreases reported for cocaine and heroin. The TEDS data in Table 8.16 indicates that methamphetamine-related treatment admissions almost doubled during the five year time period, reflecting the increasing problem methamphetamines poses to Nebraska.

**Table 8.16: Drug Related Treatment Admissions to Publicly Funded Facilities in Nebraska, 2001-2005**

Year	Methamphetamine	Cocaine	Marijuana	Heroin
2001	1,294	757	862	11
2002	1,485	713	774	13
2003	1,722	680	861	8
2004	2,064	735	1,057	NR
2005	2,060	666	1,052	NR

*Source: Nebraska Treatment Episode Data Set*



## National Household Survey on Drug Use & Health (NHSDUH)/ National Household Survey on Drug Abuse (NHSDA)

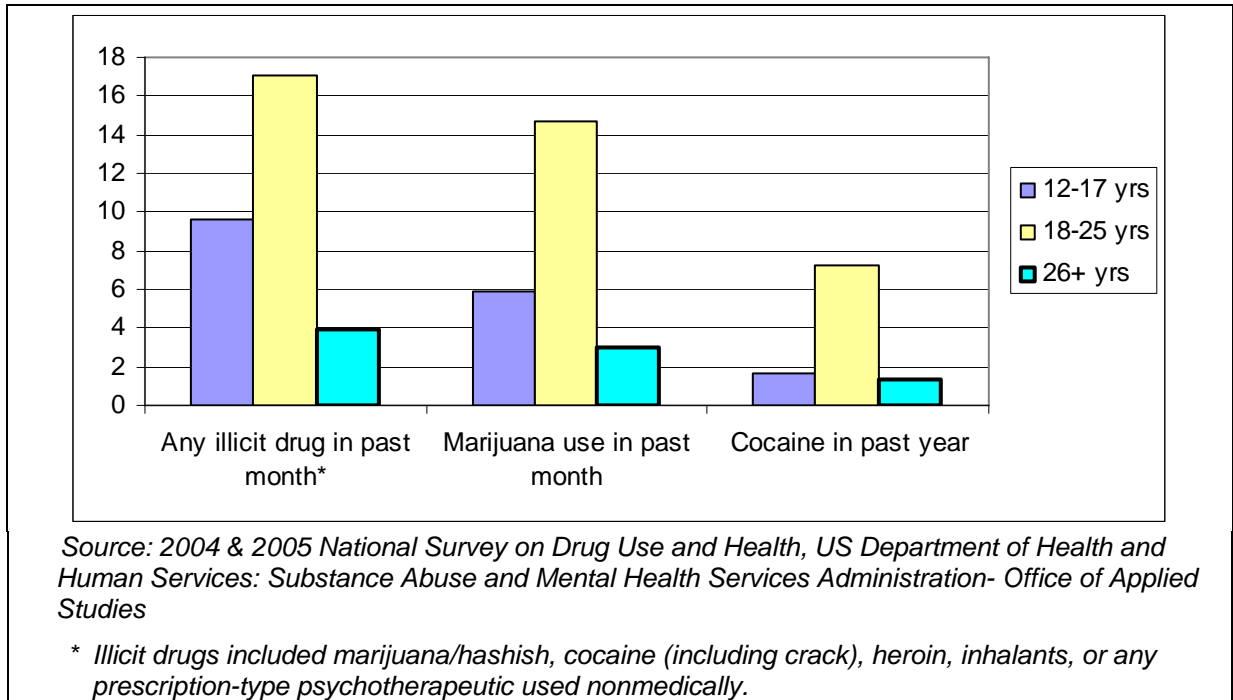
The 2003-2004 National Household Survey on Drug Use and Health, formerly called the National Household Survey on Drug Abuse, was conducted by the Department of Health and Human Services: Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies. This data is from an ongoing survey of the civilian, non-institutionalized population of the United States aged 12 years or older. Approximately 136,100 persons were interviewed in 2004-2005.

Table 8.17 provides data for the general population in Nebraska interviewed for the 2004-2005 NHSDAS. Seven percent of persons 12 years of age and older reported using an illicit drug at least once during the past month. Illicit drugs included marijuana/hashish, cocaine (including crack), heroin, inhalants, or any prescription-type psychotherapeutic used non-medically. Regardless of type of illicit drug, drug use was highest among persons 18-25 years of age with 17% reporting they had used illicit drugs in the past month, followed by 9.6% of the younger age group (12-17 years of age), and 4% the older age group (26+ years). Figure 8.6 compares this data by age group.

**Table 8.17: Selected measures of substance abuse for persons aged 12 years and older, by age, Nebraska, 2004-2005**

Measure	Age Group			
	12-17	18-25	26+	12 or older
Percentages reporting past month use of any illicit drug*	9.58	17.03	3.98	6.47
Percentages reporting past month use of marijuana	5.88	14.73	3.02	5.02
Percentages reporting past year use of cocaine	1.62	7.22	1.31	2.21
Percentages reporting past month use of alcohol	18.63	71.30	57.61	55.60
Percentages reporting past month binge alcohol use	13.05	51.31	24.41	27.17
Percentages reporting perceptions of great risk of having five or more drinks of an alcoholic beverage once or twice a week	35.03	23.50	38.11	35.65
Percentages reporting past year dependence on or abuse of any illicit drug or alcohol	9.38	26.12	7.55	10.45
Percentages reporting needing but not receiving treatment for illicit drug use in the past year	4.07	6.58	1.17	2.26
<i>Source: 2004-2005 National Survey on Drug use and Health, US Department of Health and Human Services: Substance Abuse and Mental Health Services Administration Office of Applied Studies</i> <i>*Illicit drugs included marijuana/hashish, cocaine (including crack), heroin, inhalants, or any prescription-type psychotherapeutic used non-medically.</i>				

**Figure 8.6: Percentage reporting drug use in last month for selected measures of substance abuse by age group, Nebraska, 2004-2005**



## Hepatitis C and HIV Co-Infection

The CDC has estimated that one out of every 3 people infected with the Human Immunodeficiency Virus (HIV) is also infected with the Hepatitis C virus (HCV). The presence of both the Hepatitis C virus and HIV in a client can impact both the treatment and management of both HCV and AIDS. Co-infection with the AIDS virus and the Hepatitis C virus has been associated with a more rapid progression to liver disease and an increase risk for cirrhosis of the liver. Liver disease is currently the 7<sup>th</sup> leading cause of death for Americans age 24-65 yr. Since highly active antiretroviral therapy and prophylaxis treatment for opportunistic infections have increased the life span of AIDS patients, Hepatitis C related liver disease has become a major cause of hospital admissions and death among AIDS patients. Currently Hepatitis C is the leading cause of death for those Americans co-infected with both the HCV and HIV virus.

### 2004 Nebraska Co-Infection HCV Project

As the HIV and Hepatitis C surveillance programs use different software programs and are incompatible, in 2004 a demonstration project using both rapid HCV testing and rapid HIV testing was conducted at 3 HIV testing sites in Nebraska. The overall objective of this project was to establish a co-infection rate within Nebraska. As Nebraska has a low incidence rate of HIV, no new cases of HIV were discovered but there was an overall HCV positive rate of 21%. The analysis of the client demographics clearly shows a need for more minority studies with Hepatitis C prevalence.

#### Analysis of client demographics from this study revealed the following:

- While only 17.7% of those tested were Hispanic 28.5% of all positives were Hispanic
- While only 2.3% of those tested were Native American, 3.5% of all positives were Native American
- While only 1.6% of those tested were African American, 3.5% of all positives were African American
- Women made up 38.3% of those tested with 13.8% testing positive
- Men made up 61.7% of those tested with 86.2% testing positive

#### Nebraska Hepatitis C Trends

Based on the CDC estimates and Nebraska's 2005 census statistically there are an estimated 30,725 Nebraskan's currently infected with the Hepatitis C virus. As of December 31, 2005 there are 13,984 cases of Hepatitis C reported to the Nebraska DHHS Office of Epidemiology. The Office of Epidemiology does not track client demographics, but a statistical analysis can be done by applying national statistics to Nebraska's population. Table 8.18 provides information on Hepatitis C, using the 2005 estimated census for Nebraska and the national trends for high risk populations.

**Table 8.18: Estimates of Number of Persons Hepatitis C Positive in Nebraska and in High Risk Populations in Nebraska, 2005**

<b>Hepatitis C in Nebraska, 2005</b>			
	<b>#</b>	<b>National Average % HCV positive</b>	<b>Statistical # NE Positive</b>
NE 2005 Population Estimate	1,706,976	1.8 %	30,725
NE HCV State Registry Total as of December 31, 2005			13,984
Estimated un-diagnosed Nebraska HCV cases			16,741
<b>HCV Known High Risk Populations Statistics:</b>			
2005 Substance Abuse Treatment Admissions	14,470	50 %	7,235
2005 Nebraska Veteran Population 12.2%	208,251	7.5 %	15,619
2005 Nebraska Inmate Population	4,928	20 %	986
2005 Nebraska Living with HIV/AIDS	1,285	33 %	424
<b>Statistical Positives for Nebraska High Risk Populations</b>			<b>24,264</b>
<i>Source: Nebraska Hepatitis Program</i>			

## ACHA-National College Health Assessment (NCHA)

The National College Health Assessment (NCHA) is a national research effort organized by the American College Health Association (ACHA) to assist college health service providers, health educators, counselors, and administrators in collecting data about their students' habits, behaviors, and perceptions on the most prevalent health topics:

- \* alcohol, tobacco, and other drug use
- \* sexual health
- \* weight, nutrition, and exercise
- \* mental health
- \* injury prevention, personal safety, and violence

Participating schools have the option of using paper-based or web-based surveys. With the web-based surveys, students are invited to participate via an e-mail message and then complete and submit the survey online which takes approximately 20-30 minutes.

Two versions of the survey are available: spring and fall. The fall survey asks students certain questions based on the time frame of "in the last 12 months..."; the spring survey asks students the same questions based on the time frame of "in the last school year...".

Nationwide, 16,832 college students completed the survey in the fall of 2005. Two colleges participated in the fall survey in Nebraska: the University of Nebraska-Lincoln (UNL) and the University of Nebraska-Kearney (UNK). UNL had 661 students participate while UNK had 800. Students at both schools completed the survey on the web.

Tables 8.19 – 8.24 show the percentage of students who experienced the following incidents for the two universities as compared to the national rates.

**Table 8.19: Comparison of Percentage of Students Affected by Campus by Type of Incident, 2005**

Type of Incident	National %	UNL %	UNK %
Physical Assault	0.7	1.1	0.8
Sexual Assault	1.0	0.8	1.0
HIV Infection	0.2	0.6	0.1
Pregnancy (self or partner)	1.4	1.1	1.4
Relationship Difficulty	14.7	9.7	17.5
STD	0.5	1.0	0.3

**Table 8.20: Comparison of Percentage of Students Affected by Type of Violence, by Campus, 2005**

Violence	National	UNL	UNK
Being physically assaulted (non-sexually)	4.3	3.2	3.0
Verbal threats for sex against their will	3.3	2.1	2.9
Unwanted sexual touching	8.0	6.7	8.6
Attempted sexual assault	2.8	2.6	3.4
Sexual assault	1.5	1.4	1.9
Physically abusive relationship	2.5	1.5	2.4
Sexually abusive relationship	1.8	1.4	1.9

**Table 8.21: Comparison of Percentage of Sexually Active Students Who Mostly or Always Used a Condom within last 30 days, by Campus, 2005**

Condom use within last 30 days mostly or always	National	UNL	UNK
Oral Sex	3.5	6.4	3.9
Vaginal Intercourse	46.9	57.9	52.9
Anal Intercourse	24.2	32.8	31.1

**Table 8.22: Comparison of Percentage of Sexually Active Students Who Used a Condom the Last Time They Had Sex, by Campus, 2005**

Condom use last time had sex	National	UNL	UNK
Oral Sex	3.6	5.9	3.6
Vaginal Intercourse	48.1	58.5	45.9
Anal Intercourse	23.4	29.8	28.4

**Table 8.23: Comparison of Percentage of Students Who are Sexually Active and Reported That They or Their Partner Used Emergency Contraception Within the Last School Year, by Campus, 2005**

Emergency Contraception Use	National	UNL	UNK
Male (partner)	8.9	13.5	7.9
Female	11.1	19	8.4
Overall	10.3	17.6	8.2

**Table 8.24: Comparison of Percentage of Students Who are Sexually Active and Reported That They Unintentionally Became Pregnant or Gotten Someone Else Pregnant Within the Last School Year, by Campus, 2005**

Unintentional Pregnancy	National	UNL	UNK
Male (partner)	2.5	1.2	1.3
Female	2.5	2.0	2.1
Overall	2.5	0.8	2.0

## **Section 9**

### **PRIORITY POPULATION SELECTION PROCESS 2007**





## **SECTION 9**

### **PRIORITY POPULATION SELECTION PROCESS (2007)**

The priority population selection process was completed at the April 19, 2007, NHCPD workshop. Prior to the workshop it was determined that the process developed and used in 2004 for the 2004-2008 HIV Comprehensive Plan would once again be utilized with only one change. Instead of pre-entering the HIV rates and AIDS rates separately for age groups by race, one rate, HIV disease rate, would be entered in the HIV column and the AIDS column would remain blank.

The priority population selection process consisted of five steps:

- Step 1: Completing a Weight/Rank Score Sheet for each high risk population (Appendix 5).
- Step 2: Completing the Race/Ethnicity, Age and Other Risk Factors Worksheet (Appendix 6)
- Step 3: Transferring scores to the Population Summary Sheet in descending order (Appendix 7).
- Step 4: Entering data into Final Score Summary Sheet (Appendix 8).
- Step 5: Reviewing each subpopulation to determine if these are appropriate targets for Nebraska.

Step 1: The purpose for Step 1 was to develop a numerical value for each high risk population that represents its total weight/rank score for five common factors according to HIV Surveillance and surrogate data. The surrogate data considered included:

- Sexually transmitted diseases of Chlamydia and gonorrhea as markers for sexual behavior.
- Drug and alcohol abuse data as the marker for related behaviors shown to directly relate to engaging in higher risk sexual behaviors.
- Limited data regarding multiple sex partners as a marker for increased transmission by virtue of repeated exposures with partners of potential positive or unknown status.
- Counseling and testing site use data as a marker for identifying who is concerned about sexual and/or needle sharing risk behaviors by virtue of their need and/or desire to test.

Step 2: This step factored in HIV and AIDS risk data along with other surrogate data for related risk markers.

Step 3: The top six scores were transferred to the Population Summary Sheet in descending order. They were listed according to race/ethnicity and age group.

Step 4: Step 4 transferred the data for all high risk populations onto one sheet. High risk populations were listed in order of priority and each group's subpopulations were listed.

Step 5: Step 5 allowed NHCPD members the ability to review each subpopulation to determine if these seemed appropriate for each target population. Changes such as combining groups or broadening groups were only made when they were merited and there was group consensus.

The NHPC membership reviewed the final list and voted to accept these priority populations for the comprehensive plan.

The following table lists the five priority populations selected for the 2009-2013 Nebraska HIV Comprehensive Plan:

POPULATION GROUP IN ORDER OF PRIORITY	POPULATION SUBGROUP
<b># 1 HIV Positive Persons</b>	Men Who Have Sex With Men (MSM) MSM/Injecting Drug User (MSM/IDU) Female High Risk Heterosexual (HRH) Female Injecting Drug User (IDU) Male Injecting Drug User (IDU) Male High Risk Heterosexual (HRH)
<b># 2 Men Who Have Sex With Men (MSM)</b>	African American ages 20-49 Native American ages 20-29 Hispanic ages 20-39 White ages 20-39
<b># 3 Male Injecting Drug Users (IDU)</b>	African American ages < 19 African American ages 30-39 White ages < 19 White ages 20-49
<b>#4 Female High Risk Heterosexual (HRH)</b>	African American ages 20-49 Native American ages 20-29 Hispanic ages 20-39 White ages 20-39
<b>#5 Men Who Sex With Men and Inject Drugs (MSM/IDU)</b>	African American ages 20-39 Native American ages 30-39 Hispanic ages 30-39 White ages 20-39

# **SECTION 10**

## **INTERVENTION SELECTION PROCESS 2007**



## **SECTION 10**

### **INTERVENTION SELECTION PROCESS (2007)**

Upon identification of the five priority populations, the Intervention Committee was assigned with the task of selecting interventions for each of the priority populations. This slate of interventions was presented to the NHCPC membership for confirmation. The intervention selection process consisted of the following steps:

#### *Seven Key Steps to Selecting Interventions for Target Populations*

- 1) Identify interventions
- 2) Determine factors
- 3) Weight factors
- 4) Rate interventions using factors
- 5) Score interventions using factors
- 6) Rank interventions
- 7) Review scores and select interventions

(Source: *Setting HIV Prevention Priorities: A Guide for Community Planning Groups*, AED Center on AIDS & Community Health, March 2005.)

**Step 1: Identify Interventions:** Each member of the Intervention Committee was assigned one of the five targeted populations. Data and information for each population was reviewed and a list of potential interventions for each population was developed.

**Step 2: Determine Factors:** Factors are simply pieces of information to consider in decision making. Some factors will be more important than others. The following factors were used to select each intervention:

- Targets a specific population
- Targets a specific behavior
- Effectiveness
- Sound theoretical basis
- Norms, values, consumer preferences
- Intervention feasibility
- Cost effectiveness
- Rural/Metro
- Is intervention current?

**Step 3: Weight Factors:** The committee assigned a level of importance (weight) to each factor.

**Step 4: Rate Interventions Using Factors:** Using the factors, each intervention was given a rating.

**Step 5: Score Interventions:** To determine each factor's score, the factor's rating was multiplied by its weight (rating X weight).

Step 6: Rank Interventions: The factors for each intervention were added together to get an overall score for each intervention. The interventions for each priority population were rank-ordered based on their overall scores.

Step 7: Review Rankings and Prioritize: The rankings of interventions for each population were reviewed and a final list of interventions in order of priority was developed for *each* target population.

At the January 2008 NHPC meeting, the Interventions Committee Chair gave a presentation to the NHPC membership to explain the process the Committee had used to arrive at the final slate of interventions being recommended. This included a short description of each intervention, the behavior theory it was based on, and the evaluation process utilized to document effectiveness.

The NHPC membership voted to approve the recommended slate of interventions. These interventions will be incorporated into the 2008 HE/RR Request for Applications (RFA) for implementation in 2009. The following is a complete list of these interventions:

Priority Populations	Population Subgroups	Interventions
#1 HIV Positive Persons	<ul style="list-style-type: none"> <li>◆ Men Who Have Sex with Men (MSM)</li> <li>◆ MSM/Injecting Drug User (MSM/IDU)</li> <li>◆ Female High-Risk Heterosexual (HRH)</li> <li>◆ Female Injecting Drug User (HRH)</li> <li>◆ Male Injecting Drug User (IDU)</li> <li>◆ Male High-Risk Heterosexual (HRH)</li> </ul>	<ul style="list-style-type: none"> <li>◆ Comprehensive Risk Counseling Services (CRCS)</li> <li>◆ Safety Counts</li> <li>◆ Holistic Harm Reduction Program</li> <li>◆ Choosing Life: Empowerment, Actions, Results (CLEAR)</li> <li>◆ *Counseling and Testing</li> </ul>
#2 MSM	<ul style="list-style-type: none"> <li>◆ Black Community ages 20-49</li> <li>◆ American Indians ages 20-29</li> <li>◆ Hispanics ages 20-39</li> <li>◆ Whites ages 20-39</li> </ul>	<ul style="list-style-type: none"> <li>◆ Popular Opinion Leader (POL)</li> <li>◆ Mpowerment</li> <li>◆ Many Men, Many Voices</li> <li>◆ Internet Outreach</li> <li>◆ *Counseling and Testing</li> </ul>
#3 Male IDU	<ul style="list-style-type: none"> <li>◆ Black Community &lt; 19</li> <li>◆ Black Community 30-39</li> <li>◆ White age &lt; 19</li> <li>◆ Whites 20-49</li> </ul>	<ul style="list-style-type: none"> <li>◆ Safety Counts</li> <li>◆ RESPECT</li> <li>◆ Voices/Voces</li> <li>◆ Holistic Health Recovery Program (HHRP)</li> <li>◆ Choosing Life: Empowerment, Actions, Results (CLEAR)</li> <li>◆ *Counseling and Testing</li> </ul>
#4 Female HRH	<ul style="list-style-type: none"> <li>◆ Black Community ages 20-49</li> <li>◆ American Indians ages 20-29</li> <li>◆ Hispanics ages 20-39</li> <li>◆ Whites ages 20-39</li> </ul>	<ul style="list-style-type: none"> <li>◆ Communal Effectance AIDS Prevention</li> <li>◆ Real AIDS Prevention Project (RAPP)</li> <li>◆ Sisters Informing Sisters on Topics and AIDS (Sista)</li> <li>◆ Voices/Voces</li> <li>◆ Women's Co-op</li> <li>◆ *Counseling and Testing</li> </ul>
#5 MSM/IDU	<ul style="list-style-type: none"> <li>◆ Black Community ages 20-39</li> <li>◆ American Indians ages 30-39</li> <li>◆ Hispanics ages 30-39</li> <li>◆ Whites ages 20-39</li> </ul>	<ul style="list-style-type: none"> <li>◆ Safety Counts</li> <li>◆ RESPECT</li> <li>◆ Voices/Voces</li> <li>◆ Holistic Health Recovery Program (HHRP)</li> <li>◆ Choosing Life: Empowerment, Actions, Results (CLEAR)</li> <li>◆ *Counseling and Testing</li> </ul>

\* Counseling and Testing has been identified as a priority intervention for ALL priority populations and appears at the “bottom” of each list of interventions. However, the Committee did NOT score this intervention as it should be included as a priority intervention for all populations.

A specific theoretical model, described below, supported each intervention.

## **HIV POSITIVE**

### **Interventions:**

- ◆ *Comprehensive Risk Counseling Services (CRCS) – individual-level intervention based on CDC recommended Guidelines.*
- ◆ *Safety Counts – group-level intervention based on Cognitive Behavior Model.*
- ◆ *Holistic Harm Reduction Program – group-level intervention based on Information, Motivation and Behavior (IBM) Model of Behavior Change.*
- ◆ *Choosing Life: Empowerment, Actions, Results (CLEAR) – individual-level intervention based on Cognitive Behavior Theory, Social Action Theory.*
- ◆ *Internet Outreach – individual-level intervention based on the Stages of Change Theory.*

## **MEN WHO HAVE SEX WITH MEN (MSM)**

### **Interventions:**

- ◆ *Popular Opinion Leader (POL) – community-level intervention based on Diffusion of Innovation Theory, Social Network Theory, Social Learning Theory.*
- ◆ *Mpowerment – formal and informal outreach, peer-led small groups, and social marketing intervention(s) based on the Diffusion of Innovations and Peer Influence theories.*
- ◆ *Many Men, Many Voices – group-level intervention based on Social Learning Theory.*
- ◆ *Internet Outreach – individual-level intervention based on the Stages of Change Theory.*

## **MALE IDU**

### **Interventions:**

- ◆ *Safety Counts – Individual and group-level intervention based on Health Belief Model, Theory of Protection Motivation and Transtheoretical Stages of Change Model.*
- ◆ *RESPECT – individual-level intervention based on Social Cognitive Theory, Theory of Reasoned Action.*
- ◆ *Voices/Voces – group-level intervention based on the Theory of Reasoned Action.*
- ◆ *Holistic Health Recovery Program (Previously Holistic Harm Reduction Program) – group-level intervention based on Information, Motivation and Behavioral (IMB) Model of Behavior Change.*
- ◆ *Choosing Life: Empowerment, Actions, Results (CLEAR) – individual-level intervention based on Cognitive Behavior Theory, Social Action Theory.*
- ◆ *Internet Outreach – individual-level intervention based on the Stages of Change Theory.*



## HIGH RISK HETEROSEXUAL FEMALE (HRH)

### Interventions:

- ◆ *Communal Effectance AIDS Prevention* – group-level intervention based on *Social Learning Theory, Conservation of Resources Theory, Theory of Gender and Power.*
- ◆ *Real AIDS Prevention Project* – Community-level intervention based on the *Transtheoretical Model of Behavior Change.*
- ◆ *Sisters Informing Sisters on Topics about AIDS Sista* – group-level intervention based on *Social Cognitive Theory and Theories of Gender and Power.*
- ◆ *Voices/Voces* – group-level intervention based on the *Theory of Reasoned Action.*
- ◆ *Women's Co-op* - individual/group-level intervention based on *African American feminism and Empowerment Theory.*
- ◆ *Internet Outreach* – individual-level intervention based on the *Stages of Change Theory.*

## MSM IDU

### Interventions:

- ◆ *Safety Counts* – Individual and group-level intervention based on *Health Belief Model, Theory of Protection Motivation and Transtheoretical Stages of Change Model.*
- ◆ RESPECT – individual-level intervention based on *Social Cognitive Theory, Theory of Reasoned Action.*
- ◆ *Voices/Voces* – group-level intervention based on the *Health Belief Model and the Theory of Reasoned Action.*
- ◆ *Holistic Health Recovery Program (Previously Holistic Harm Reduction Program)* – group-level intervention based on *Information, Motivation and Behavioral (IMB) Model of Behavior Change.*
- ◆ *Choosing Life: Empowerment, Actions, Results (CLEAR)* – individual-level intervention based on *Cognitive Behavior Theory, Social Action Theory.*
- ◆ *Internet Outreach* – individual-level intervention based on the *Stages of Change Theory.*

In addition to the interventions above, the following interventions are also being conducted in Nebraska:

HIV Counseling, Testing and Referral (CTR) activities are conducted at 42 state funded sites across Nebraska. CTR is designed to increase clients' knowledge of their HIV status; encourage and support risk reduction; and secure needed referrals for appropriate medical, prevention, and partner counseling and referral services. Both confidential (with name) and anonymous (without a name) testing are allowed at these sites.

Partner Counseling and Referral (PCRS) activities include counseling, testing and providing referrals to sex and needle sharing partners of HIV+ individuals. These activities are conducted by trained Disease Intervention Specialists (DIS) across the state.

Outreach Interventions are designed to change behavior by providing motivation, knowledge, risk reduction materials, and referrals to services that support behavior

change. Such programs access at-risk individuals on the street, in malls, parks, bars, public sex environments or other community settings. Outreach is directed towards a clearly defined target population.

Health Communication/Public Information: This intervention allows for the dissemination of HIV/AIDS Prevention messages through one or more media venues which target a specific audience. The audience may be the general public or a specific population. These programs can lead to increased knowledge of HIV/AIDS facts, offer support and referrals and lead to behavior change. Such programs may include print media, electronic media, 1-800 Hotline, resource library and presentations/lectures.

### **Barriers to Implementing Interventions**

Barriers that arise when implementing interventions may vary from region to region and city to city and population to population. Although many key barriers remain the same across the U.S. when implementing interventions, the implementor needs to have a thorough understanding of the population and region.

Barriers that are common across the U.S. are:

- 1) General complacency in both people living with HIV disease and the general public.
  - Media and the medical community now list HIV as a chronic disease and not a fatal disease. Public perception is that the disease is not as serious of a health issue as it was in the past. Media reports are fewer and rarely make the front page, now often placed further back into the newspaper. Most articles report on AIDS in Africa or other undeveloped countries and not what is happening in the U.S.
  - Medication and drug therapy regimens now allow people to live longer. Viral loads can be undetectable thereby giving people a false sense of security that the virus is so minute that they won't contract it or in the case of a person living with the disease that they can not transmit it to another person. This thought process can lead people to believe that they are not at risk, even when participating in high risk behaviors.
- 2) Money: Federal funding for HIV programs is showing a slight decline. As a result, less money is awarded to state HIV programs just at a time when they are needing more funding for interventions. Although, nationwide, we are seeing a decrease in the number of AIDS cases, HIV cases are increasing. With more individuals living with the disease, this places a greater number at risk of being infected if they are practicing high risk behaviors.
- 3) Social conditions: A variety of social conditions can contribute to intervention failure:
  - Education level
  - Income level
  - Violence
  - Stigma
  - Racism
  - Homophobia

- 4) Medical conditions: Medical conditions can contribute greatly to intervention failure:
- Mental Health conditions
  - Multiple diagnoses
  - Substance abuse – alcohol, drugs (meth)
  - Sexually transmitted diseases (STDs)

In Nebraska, with its large rural landscape, barriers seen at the national level may apply but for the successful implementation of interventions, local barriers must also be overcome. Local barriers may be:

- Anonymity – It is difficult to arrive at a test site or at a program that targets positive members when the community is small and everyone knows everyone.
- Location of intervention – Nebraska is 459 miles from east to west. Many individuals now drive 50-100 miles one way to receive care for their disease. It may be necessary to drive long distances to attend programs that target specific populations.
- Staff turnover – Individuals are trained to be facilitators for specific interventions. Staff turnover rates are generally high in the rural areas, leading to further training of newly hired individuals and a disruption to interventions that are currently underway.
- Adapting/Tailoring Interventions – Efforts to adapt and tailor existing interventions for a specific population are extremely difficult. When two groups are together as one (example: MSM person of color), it is difficult to find an intervention that will cover both race and risk.
- Resource allocation – It is not cost effective, from a programmatic point of view, to allocate funding to programs that target “small pockets” of individuals in rural areas even though need has been established. Program guidelines that are followed when allocating funding for specific activities need to be flexible to the needs of the specific community.

The national and local barriers listed above are not all inclusive. There are many more barriers that are not listed. One key to effective programs and the implementation of interventions is the identification of key barriers to the intervention prior to and during the implementation of the intervention. Addressing these barriers and tailoring the intervention to the target population and the community they are in will help make the intervention a success.



## **Section 11**

### **GAP ANALYSIS**



## **SECTION 11 GAP ANALYSIS**

From the time that the first HIV Comprehensive Plan for Nebraska was developed in 2003 until now, the HIV environment in Nebraska has shown little change. A review of the data in the 2007 HIV Epidemiological Profile along with the supplemental data shows that our target populations remain much the same, only expanding slightly to include a slightly older population who are either living with HIV or continue to exhibit high risk behaviors. Therefore, the identified needs of our target populations and the resources that are available in Nebraska have remained much the same as those identified in the HIV Comprehensive Plan, 2004-2008.

The following is a summary of the needs identified, the resources that Nebraska has to meet those identified needs, and the gaps identified to meet the needs. The breakdown of populations identified below reflects the major groups identified by the assessments and committee members responses as to the groups at risk. Many members identified youth within their broader population, i.e. Latino, African American, etc., hence youth were assigned a separate category.

### **PEOPLE LIVING WITH HIV/AIDS (PLWHA)**

#### Needs Identified

- treatment and care that is respectful
- culturally and linguistically appropriate
- understanding of HIV/AIDS by health care workers and providers
- negotiation skills
- safe and adequate housing
- transportation
- adequate nutrition
- adequate income and resources
- needle exchange program

#### Resources

- Nebraska AIDS Project
- University of Nebraska Medical Center
- Ryan White Part B and Part C Services
- AIDS Drug Assistance Program
- Western Community Health Resources
- Panhandle Community Services
- counseling and testing sites across Nebraska
- city/county/district health departments
- family planning facilities
- Charles Drew Health Center
- NAF Multicultural Human Development Corporation
- behavioral and mental health facilities
- private counseling services
- Central Nebraska Council on Alcoholism and Addiction (CNCAA)
- Nebraska HIV Care and Prevention Consortium (NHPCPC)

- statewide regional community planning groups
- DHHS Medicaid Program
- correctional facilities

#### Gaps Identified

- stigma of HIV/AIDS, prejudice, and homophobia, especially in rural areas
- perceived lack of assurance and confidentiality
- lack of medical and dental providers in rural areas
- HIV/AIDS education of health care workers and providers
- non-ADAP covered medications
- mental health/substance abuse services in rural areas
- access to case management services in rural areas
- information about Ryan White services unavailable
- safe, adequate, and affordable housing
- lack of transportation, especially in rural areas
- education and job training for PLWHA

### **MEN WHO HAVE SEX WITH MEN (MSM)**

#### Needs Identified

- HIV/AIDS/STD prevention education
- bilingual and culturally appropriate services
- negotiation skills
- recreation for young MSM
- drug and alcohol prevention
- faith community involvement
- safe and adequate housing
- transportation
- adequate nutrition
- adequate income and resources
- needle exchange program

#### Resources

- Nebraska AIDS Project
- Ryan White Part B and Part C Services
- UNL Health Center – Gay Men’s Support Group
- The Health Coalition
- Panhandle Prevention Advocacy CARE Team
- Panhandle Community Services
- Western Community Health Resources
- Calico Spirit Counseling Facilities
- NAF Multicultural Human Development Corporation
- counseling and testing sites across Nebraska
- Nebraska HIV Care and Prevention Consortium (NHPCPC)
- statewide regional community planning groups
- correctional facilities
- behavioral and mental health facilities
- private counseling services
- city/county/district health departments
- halfway houses/homeless shelters



### Gaps Identified

- bilingual and culturally appropriate prevention services
- HIV/AIDS/STD education
- interpreters for medical and educational services
- mental health services
- substance abuse prevention and treatment services
- safe and adequate housing

## **DRUG AND ALCOHOL USERS**

### Needs Identified

- HIV/AIDS prevention education
- counseling and testing
- needle exchange program
- HARM reduction
- negotiation skills
- transportation
- adequate nutrition
- adequate income and resources

### Resources

- CenterPointe
- Central Nebraska Council on Alcoholism and Addiction (CNCAA)
- private counseling services
- drug and alcohol treatment centers
- Ryan White Part B and Part C Services
- counseling and testing sites across Nebraska
- behavioral and mental health facilities
- city/county/district health departments
- Nebraska HIV Care and Prevention Consortium (NHPCPC)
- statewide regional community planning groups
- halfway houses/homeless shelters
- family planning facilities
- correctional facilities

### Gaps Identified

- mental health services
- drug and alcohol prevention and treatment services
- needle exchange program
- bilingual and culturally appropriate prevention services
- bilingual and culturally appropriate HIV/AIDS/STD education

## **HETEROSEXUAL FEMALES**

### Needs Identified

- HIV/AIDS/STD prevention and education
- bilingual and culturally appropriate education and services
- negotiation skills
- faith community involvement
- adequate income and resources
- safe and adequate housing

- transportation
- adequate nutrition
- needle exchange program

#### Resources

- counseling and testing sites across Nebraska
- Nebraska AIDS Project
- city/county/district health departments
- family planning facilities
- Lutheran Family Services
- Family Health Services, Inc
- St. Monica's substance abuse treatment program
- NAF Multicultural Human Development Corporation
- Panhandle Community Services
- Western Community Health Resources
- behavioral and mental health facilities
- private counseling services
- halfway houses/homeless shelters
- correctional facilities
- Nebraska HIV Care and Prevention Consortium (NHPCPC)
- statewide regional community planning groups

#### Gaps Identified

- bilingual and culturally appropriate prevention services
- HIV/AIDS/STD education
- interpreters for medical and educational services
- mental health and substance abuse treatment services
- adequate and safe housing

### **NATIVE AMERICANS**

#### Needs Identified

- HIV/AIDS/STD prevention and education
- drug and alcohol prevention
- counseling and testing
- bilingual and culturally appropriate services
- education for a transient population
- negotiation skills
- faith community involvement
- adequate income and resources
- safe and adequate housing
- transportation
- needle exchange program
- adequate nutrition

#### Resources

- Indian Health Services
- Western Community Health Resources
- Panhandle Community Services
- NAF Multicultural Human Development Corporation
- Nebraska AIDS Project

- counseling and testing sites across Nebraska
- family planning facilities
- city/county/district health departments
- Ryan White Part B and Part C Services
- private counseling services
- correctional facilities
- behavioral and mental health facilities
- halfway houses/homeless shelters
- Nebraska HIV Care and Prevention Consortium (NHPC)
- statewide regional community planning groups

#### Gaps Identified

- bilingual and culturally appropriate services and education
- HIV/AIDS/STD education that is comprehensive
- mental health and substance abuse prevention and treatment services
- adequate and safe housing

## YOUTH

#### Needs Identified

- HIV/AIDS/STD education that is comprehensive
- drug and alcohol prevention
- recreation
- faith community involvement
- negotiation skills
- transportation
- needle exchange program
- adequate nutrition
- adequate income and resources

#### Resources

- Lutheran Family Services
- Boys and Girls Homes of Nebraska, Inc
- Love Deliverance Temple Church
- Northeast Nebraska AIDS Prevention Partnership
- YWCA of Lincoln
- Lighthouse
- NAF Multicultural Human Development Corporation
- Family Health Services
- Panhandle Community Services
- Western Community Health Resources
- Nebraska AIDS Project
- Nebraska HIV Care and Prevention Consortium (NHPC)
- statewide regional community planning groups
- counseling and testing sites across Nebraska
- Ryan White Part B and Part C Services
- behavioral and mental health facilities
- private counseling services
- family planning facilities
- city/county/district health departments

- correctional facilities
- halfway houses/homeless shelters

#### Gaps Identified

- bilingual and culturally appropriate services and education
- HIV/AIDS/STD education that is comprehensive
- mental health and substance abuse prevention and treatment services
- community centers

One key gap that continues to be identified with all populations is the gap in the care offered and provided in many areas across Nebraska, especially in the rural areas. Therefore, the information below identifies health care workers and medical providers as part of the Gap Analysis.

### **HEALTH CARE WORKERS AND MEDICAL PROVIDERS**

#### Needs Identified

- HIV/AIDS/STD education
- cultural awareness
- bilingual health care providers
- interpreters
- negotiation skills
- conflict resolution skills

#### Resources

- University of Nebraska Medical Center
- infectious disease physicians
- Nebraska AIDS Project
- NAF Multicultural Human Development Corporation
- family planning facilities
- city/county/district health departments
- behavioral and mental health facilities
- Nebraska HIV Care and Prevention Consortium (NHPC)
- statewide regional community planning groups

#### Gaps Identified

- lack of knowledge of HIV/AIDS
- lack of bilingual health care workers and providers
- lack of medical/dental providers willing to provide care to HIV positive individuals
- lack of substance abuse/mental health providers
- culturally appropriate care

## **SECTION 12**

### **OTHER PARTNERS**



## **SECTION 12 OTHER COMMUNITY PARTNERS**

### **NEBRASKA RED RIBBON COMMUNITY**

The Nebraska Red Ribbon Community (NRRC) is a group of persons living with HIV and serves in an advisory capacity to the Nebraska HIV Care and Prevention Consortium (NHCP) and also provides information about HIV/AIDS care and prevention to the DHHS Ryan White Program.

***The mission of the Nebraska Red Ribbon Community (NRRC) is to enhance and enrich the lives of those infected with the Human Immunodeficiency Virus (HIV) through leadership and partnership with community, local, and state entities to empower ourselves, and to enhance and improve the quality of life for those infected with HIV and AIDS in Nebraska.***

This mission will be accomplished in an advisory capacity in collaboration with, but not limited to, the Nebraska HIV Care and Prevention Consortium (NHCP), Nebraska Department of Health and Human Services (DHHS), the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA).

The NRRC identifies their *statement of purpose* as follows:

1. To be a consumer-based advisory committee, not affiliated with any system of case management, dedicated to fulfilling our mission statement.
2. The NRRC has the continuing goals of: 1) producing and maintaining a good cross-section of the Nebraska-based HIV population on the membership of the NRRC itself; 2) operate and manage the NRRC website, [www.nebraskahivtesting.org](http://www.nebraskahivtesting.org), to encourage those at risk of HIV to be tested and to maintain an accurate listing of Nebraska testing sites and other pertinent information on the website.
3. Any other goals the NRRC decides to reach for should work toward early detection, education, compassion, awareness of HIV issues in the communities and medical communities of Nebraska, and for improving the lives of HIV positive Nebraskans.

It is the intent of the Nebraska Red Ribbon Community to be geographically balanced and reflect the diversity of the HIV epidemic in Nebraska. Any HIV+ individual living in Nebraska is eligible to apply for membership. Meetings are held quarterly at different sites across the state. The date and location of meetings is available by calling the DHHS Ryan White Program at (402) 471-9098.

## **NEBRASKA HIV RESOURCE DIRECTORY**

In April 2007, the DHHS HIV Prevention Community Planning Coordinator developed the Nebraska HIV Resource Directory. This directory is a tool to assist persons living with HIV in Nebraska with locating providers, organizations and services that would be useful in their daily lives and with managing their HIV disease. Information contained in the resource directory was obtained from public resources such as telephone books, organizational brochures, program resources and websites. The directory is in the public domain and is updated on an ongoing basis with the most current version available on the DHHS HIV Prevention web page: [www.dhhs.state.ne.us/dpc/hiv.htm](http://www.dhhs.state.ne.us/dpc/hiv.htm).



## **SECTION 13**

### **EVALUATION OF COMMUNITY PLANNING PROCESS**



## **SECTION 13**

### **EVALUATION OF COMMUNITY PLANNING PROCESS**

The evaluation of the Community Planning Process is a shared responsibility between DHHS HIV Prevention Program and the NHCPC. However, the HIV Prevention Program is responsible to report evaluation activities to the CDC in the annual progress report. The CDC has developed the *Evaluation Guidance* to assist community planning groups (CPG) with the evaluation process.

#### **PROGRAM PERFORMANCE INDICATORS**

Program performance indicators provide a gauge for HIV prevention community planning implementation specifically in processes, activities, and/or products that must be developed or implemented to achieve the goals and objectives of HIV prevention community planning (HIV Prevention Community Planning Guide, 2003).

**Indicator 1**  
**Proportion of populations most at risk, as documented in the epidemiologic profile, that have at least one NHCPC member that reflects the perspective of each population.**

Nebraska's epidemiological profile lists the following as populations most at risk:

- Men who have sex with men (MSM)                      36%
- Heterosexual contact    19%
- Injection drug users (IDU)    7%

The Comprehensive Plan lists the following as priority populations for 2009-2013:

- HIV+ individuals
- Men who have sex with men (MSM)
- Male injection drug users (IDU)
- Female high risk heterosexual (HRH)
- Men who have sex with men and inject drugs (MSM/IDU)

At the October 2007 NHCPC meeting, members completed the annual CDC Membership Survey. Members were asked to identify which high risk population was the primary and secondary population that they represented. Out of 25 members surveyed, all high-risk populations were represented.

- HIV+ individuals (7)
- MSM (13)
- IDU (4)
- HRH (12)
- MSM/IDU (2)

**Indicator 2****Proportion of key attributes of an HIV prevention community planning process that NHCPC membership agreed have occurred.**

At the October 2007 NHCPC meeting, members completed the Community Planning Membership Survey. Questions asked were directed at the key attributes for Objectives A – H. Allowed responses were “agree, “disagree,” or “don’t know”. There were a total of 1200 valid responses, with 1064 “agreed” responses and 136 “disagreed” responses. The percentage of responses that agreed key attributes occurred was **89 percent**.

**Indicator 3****Percent of prevention interventions/supporting activities in the health department CDC funding application specified as a priority in the comprehensive HIV prevention plan.**

All of the HIV Prevention interventions in the DHHS HIV Prevention CDC funding application are specified as a priority in the Nebraska Comprehensive HIV Plan 2004-2008 (**100 percent**).

**Indicator 4****Percent of health department-funded prevention interventions/supporting activities that correspond to priorities specified in the comprehensive HIV prevention plan.**

All HIV Prevention interventions correspond to the priorities that are specified in the Nebraska Comprehensive HIV Plan 2004-2008 (**100 percent**).

## **Section 9**

### **PRIORITY POPULATION SELECTION PROCESS 2007**



## **SECTION 9**

### **PRIORITY POPULATION SELECTION PROCESS (2007)**

The priority population selection process was completed at the April 19, 2007, NHCPD workshop. Prior to the workshop it was determined that the process developed and used in 2004 for the 2004-2008 HIV Comprehensive Plan would once again be utilized with only one change. Instead of pre-entering the HIV rates and AIDS rates separately for age groups by race, one rate, HIV disease rate, would be entered in the HIV column and the AIDS column would remain blank.

The priority population selection process consisted of five steps:

- Step 1: Completing a Weight/Rank Score Sheet for each high risk population (Appendix 5).
- Step 2: Completing the Race/Ethnicity, Age and Other Risk Factors Worksheet (Appendix 6)
- Step 3: Transferring scores to the Population Summary Sheet in descending order (Appendix 7).
- Step 4: Entering data into Final Score Summary Sheet (Appendix 8).
- Step 5: Reviewing each subpopulation to determine if these are appropriate targets for Nebraska.

Step 1: The purpose for Step 1 was to develop a numerical value for each high risk population that represents its total weight/rank score for five common factors according to HIV Surveillance and surrogate data. The surrogate data considered included:

- Sexually transmitted diseases of Chlamydia and gonorrhea as markers for sexual behavior.
- Drug and alcohol abuse data as the marker for related behaviors shown to directly relate to engaging in higher risk sexual behaviors.
- Limited data regarding multiple sex partners as a marker for increased transmission by virtue of repeated exposures with partners of potential positive or unknown status.
- Counseling and testing site use data as a marker for identifying who is concerned about sexual and/or needle sharing risk behaviors by virtue of their need and/or desire to test.

Step 2: This step factored in HIV and AIDS risk data along with other surrogate data for related risk markers.

Step 3: The top six scores were transferred to the Population Summary Sheet in descending order. They were listed according to race/ethnicity and age group.

Step 4: Step 4 transferred the data for all high risk populations onto one sheet. High risk populations were listed in order of priority and each group's subpopulations were listed.

Step 5: Step 5 allowed NHCPD members the ability to review each subpopulation to determine if these seemed appropriate for each target population. Changes such as combining groups or broadening groups were only made when they were merited and there was group consensus.

The NHPC membership reviewed the final list and voted to accept these priority populations for the comprehensive plan.

The following table lists the five priority populations selected for the 2009-2013 Nebraska HIV Comprehensive Plan:

POPULATION GROUP IN ORDER OF PRIORITY	POPULATION SUBGROUP
<b># 1 HIV Positive Persons</b>	Men Who Have Sex With Men (MSM) MSM/Injecting Drug User (MSM/IDU) Female High Risk Heterosexual (HRH) Female Injecting Drug User (IDU) Male Injecting Drug User (IDU) Male High Risk Heterosexual (HRH)
<b># 2 Men Who Have Sex With Men (MSM)</b>	African American ages 20-49 Native American ages 20-29 Hispanic ages 20-39 White ages 20-39
<b># 3 Male Injecting Drug Users (IDU)</b>	African American ages < 19 African American ages 30-39 White ages < 19 White ages 20-49
<b>#4 Female High Risk Heterosexual (HRH)</b>	African American ages 20-49 Native American ages 20-29 Hispanic ages 20-39 White ages 20-39
<b>#5 Men Who Sex With Men and Inject Drugs (MSM/IDU)</b>	African American ages 20-39 Native American ages 30-39 Hispanic ages 30-39 White ages 20-39



## **SECTION 10**

### **INTERVENTION SELECTION PROCESS 2007**



## **SECTION 10**

### **INTERVENTION SELECTION PROCESS (2007)**

Upon identification of the five priority populations, the Intervention Committee was assigned with the task of selecting interventions for each of the priority populations. This slate of interventions was presented to the NHCPC membership for confirmation. The intervention selection process consisted of the following steps:

#### *Seven Key Steps to Selecting Interventions for Target Populations*

- 1) Identify interventions
- 2) Determine factors
- 3) Weight factors
- 4) Rate interventions using factors
- 5) Score interventions using factors
- 6) Rank interventions
- 7) Review scores and select interventions

(Source: *Setting HIV Prevention Priorities: A Guide for Community Planning Groups*, AED Center on AIDS & Community Health, March 2005.)

**Step 1: Identify Interventions:** Each member of the Intervention Committee was assigned one of the five targeted populations. Data and information for each population was reviewed and a list of potential interventions for each population was developed.

**Step 2: Determine Factors:** Factors are simply pieces of information to consider in decision making. Some factors will be more important than others. The following factors were used to select each intervention:

- Targets a specific population
- Targets a specific behavior
- Effectiveness
- Sound theoretical basis
- Norms, values, consumer preferences
- Intervention feasibility
- Cost effectiveness
- Rural/Metro
- Is intervention current?

**Step 3: Weight Factors:** The committee assigned a level of importance (weight) to each factor.

**Step 4: Rate Interventions Using Factors:** Using the factors, each intervention was given a rating.

**Step 5: Score Interventions:** To determine each factor's score, the factor's rating was multiplied by its weight (rating X weight).

Step 6: Rank Interventions: The factors for each intervention were added together to get an overall score for each intervention. The interventions for each priority population were rank-ordered based on their overall scores.

Step 7: Review Rankings and Prioritize: The rankings of interventions for each population were reviewed and a final list of interventions in order of priority was developed for *each* target population.

At the January 2008 NHCPC meeting, the Interventions Committee Chair gave a presentation to the NHCPC membership to explain the process the Committee had used to arrive at the final slate of interventions being recommended. This included a short description of each intervention, the behavior theory it was based on, and the evaluation process utilized to document effectiveness.

The NHCPC membership voted to approve the recommended slate of interventions. These interventions will be incorporated into the 2008 HE/RR Request for Applications (RFA) for implementation in 2009. The following is a complete list of these interventions:

Priority Populations	Population Subgroups	Interventions
#1 HIV Positive Persons	<ul style="list-style-type: none"> <li>◆ Men Who Have Sex with Men (MSM)</li> <li>◆ MSM/Injecting Drug User (MSM/IDU)</li> <li>◆ Female High-Risk Heterosexual (HRH)</li> <li>◆ Female Injecting Drug User (HRH)</li> <li>◆ Male Injecting Drug User (IDU)</li> <li>◆ Male High-Risk Heterosexual (HRH)</li> </ul>	<ul style="list-style-type: none"> <li>◆ Comprehensive Risk Counseling Services (CRCS)</li> <li>◆ Safety Counts</li> <li>◆ Holistic Harm Reduction Program</li> <li>◆ Choosing Life: Empowerment, Actions, Results (CLEAR)</li> <li>◆ *Counseling and Testing</li> </ul>
#2 MSM	<ul style="list-style-type: none"> <li>◆ Black Community ages 20-49</li> <li>◆ American Indians ages 20-29</li> <li>◆ Hispanics ages 20-39</li> <li>◆ Whites ages 20-39</li> </ul>	<ul style="list-style-type: none"> <li>◆ Popular Opinion Leader (POL)</li> <li>◆ Mpowerment</li> <li>◆ Many Men, Many Voices</li> <li>◆ Internet Outreach</li> <li>◆ *Counseling and Testing</li> </ul>
#3 Male IDU	<ul style="list-style-type: none"> <li>◆ Black Community &lt; 19</li> <li>◆ Black Community 30-39</li> <li>◆ White age &lt; 19</li> <li>◆ Whites 20-49</li> </ul>	<ul style="list-style-type: none"> <li>◆ Safety Counts</li> <li>◆ RESPECT</li> <li>◆ Voices/Voces</li> <li>◆ Holistic Health Recovery Program (HHRP)</li> <li>◆ Choosing Life: Empowerment, Actions, Results (CLEAR)</li> <li>◆ *Counseling and Testing</li> </ul>
#4 Female HRH	<ul style="list-style-type: none"> <li>◆ Black Community ages 20-49</li> <li>◆ American Indians ages 20-29</li> <li>◆ Hispanics ages 20-39</li> <li>◆ Whites ages 20-39</li> </ul>	<ul style="list-style-type: none"> <li>◆ Communal Effectance AIDS Prevention</li> <li>◆ Real AIDS Prevention Project (RAPP)</li> <li>◆ Sisters Informing Sisters on Topics and AIDS (Sista)</li> <li>◆ Voices/Voces</li> <li>◆ Women's Co-op</li> <li>◆ *Counseling and Testing</li> </ul>
#5 MSM/IDU	<ul style="list-style-type: none"> <li>◆ Black Community ages 20-39</li> <li>◆ American Indians ages 30-39</li> <li>◆ Hispanics ages 30-39</li> <li>◆ Whites ages 20-39</li> </ul>	<ul style="list-style-type: none"> <li>◆ Safety Counts</li> <li>◆ RESPECT</li> <li>◆ Voices/Voces</li> <li>◆ Holistic Health Recovery Program (HHRP)</li> <li>◆ Choosing Life: Empowerment, Actions, Results (CLEAR)</li> <li>◆ *Counseling and Testing</li> </ul>

\* Counseling and Testing has been identified as a priority intervention for ALL priority populations and appears at the “bottom” of each list of interventions. However, the Committee did NOT score this intervention as it should be included as a priority intervention for all populations.

A specific theoretical model, described below, supported each intervention.

## **HIV POSITIVE**

### **Interventions:**

- ◆ *Comprehensive Risk Counseling Services (CRCS) – individual-level intervention based on CDC recommended Guidelines.*
- ◆ *Safety Counts – group-level intervention based on Cognitive Behavior Model.*
- ◆ *Holistic Harm Reduction Program – group-level intervention based on Information, Motivation and Behavior (IBM) Model of Behavior Change.*
- ◆ *Choosing Life: Empowerment, Actions, Results (CLEAR) – individual-level intervention based on Cognitive Behavior Theory, Social Action Theory.*
- ◆ *Internet Outreach – individual-level intervention based on the Stages of Change Theory.*

## **MEN WHO HAVE SEX WITH MEN (MSM)**

### **Interventions:**

- ◆ *Popular Opinion Leader (POL) – community-level intervention based on Diffusion of Innovation Theory, Social Network Theory, Social Learning Theory.*
- ◆ *Mpowerment – formal and informal outreach, peer-led small groups, and social marketing intervention(s) based on the Diffusion of Innovations and Peer Influence theories.*
- ◆ *Many Men, Many Voices – group-level intervention based on Social Learning Theory.*
- ◆ *Internet Outreach – individual-level intervention based on the Stages of Change Theory.*

## **MALE IDU**

### **Interventions:**

- ◆ *Safety Counts – Individual and group-level intervention based on Health Belief Model, Theory of Protection Motivation and Transtheoretical Stages of Change Model.*
- ◆ *RESPECT – individual-level intervention based on Social Cognitive Theory, Theory of Reasoned Action.*
- ◆ *Voices/Voces – group-level intervention based on the Theory of Reasoned Action.*
- ◆ *Holistic Health Recovery Program (Previously Holistic Harm Reduction Program) – group-level intervention based on Information, Motivation and Behavioral (IMB) Model of Behavior Change.*
- ◆ *Choosing Life: Empowerment, Actions, Results (CLEAR) – individual-level intervention based on Cognitive Behavior Theory, Social Action Theory.*
- ◆ *Internet Outreach – individual-level intervention based on the Stages of Change Theory.*

## HIGH RISK HETEROSEXUAL FEMALE (HRH)

### Interventions:

- ◆ *Communal Effectance AIDS Prevention* – group-level intervention based on *Social Learning Theory, Conservation of Resources Theory, Theory of Gender and Power.*
- ◆ *Real AIDS Prevention Project* – Community-level intervention based on the *Transtheoretical Model of Behavior Change.*
- ◆ *Sisters Informing Sisters on Topics about AIDS Sista* – group-level intervention based on *Social Cognitive Theory and Theories of Gender and Power.*
- ◆ *Voices/Voces* – group-level intervention based on the *Theory of Reasoned Action.*
- ◆ *Women’s Co-op* - individual/group-level intervention based on *African American feminism and Empowerment Theory.*
- ◆ *Internet Outreach* – individual-level intervention based on the *Stages of Change Theory.*

## MSM IDU

### Interventions:

- ◆ *Safety Counts* – Individual and group-level intervention based on *Health Belief Model, Theory of Protection Motivation and Transtheoretical Stages of Change Model.*
- ◆ RESPECT – individual-level intervention based on *Social Cognitive Theory, Theory of Reasoned Action.*
- ◆ *Voices/Voces* – group-level intervention based on the *Health Belief Model and the Theory of Reasoned Action.*
- ◆ *Holistic Health Recovery Program (Previously Holistic Harm Reduction Program)* – group-level intervention based on *Information, Motivation and Behavioral (IMB) Model of Behavior Change.*
- ◆ *Choosing Life: Empowerment, Actions, Results (CLEAR)* – individual-level intervention based on *Cognitive Behavior Theory, Social Action Theory.*
- ◆ *Internet Outreach* – individual-level intervention based on the *Stages of Change Theory.*

In addition to the interventions above, the following interventions are also being conducted in Nebraska:

HIV Counseling, Testing and Referral (CTR) activities are conducted at 42 state funded sites across Nebraska. CTR is designed to increase clients’ knowledge of their HIV status; encourage and support risk reduction; and secure needed referrals for appropriate medical, prevention, and partner counseling and referral services. Both confidential (with name) and anonymous (without a name) testing are allowed at these sites.

Partner Counseling and Referral (PCRS) activities include counseling, testing and providing referrals to sex and needle sharing partners of HIV+ individuals. These activities are conducted by trained Disease Intervention Specialists (DIS) across the state.

Outreach Interventions are designed to change behavior by providing motivation, knowledge, risk reduction materials, and referrals to services that support behavior

change. Such programs access at-risk individuals on the street, in malls, parks, bars, public sex environments or other community settings. Outreach is directed towards a clearly defined target population.

Health Communication/Public Information: This intervention allows for the dissemination of HIV/AIDS Prevention messages through one or more media venues which target a specific audience. The audience may be the general public or a specific population. These programs can lead to increased knowledge of HIV/AIDS facts, offer support and referrals and lead to behavior change. Such programs may include print media, electronic media, 1-800 Hotline, resource library and presentations/lectures.

### **Barriers to Implementing Interventions**

Barriers that arise when implementing interventions may vary from region to region and city to city and population to population. Although many key barriers remain the same across the U.S. when implementing interventions, the implementor needs to have a thorough understanding of the population and region.

Barriers that are common across the U.S. are:

- 1) General complacency in both people living with HIV disease and the general public.
  - Media and the medical community now list HIV as a chronic disease and not a fatal disease. Public perception is that the disease is not as serious of a health issue as it was in the past. Media reports are fewer and rarely make the front page, now often placed further back into the newspaper. Most articles report on AIDS in Africa or other undeveloped countries and not what is happening in the U.S.
  - Medication and drug therapy regimens now allow people to live longer. Viral loads can be undetectable thereby giving people a false sense of security that the virus is so minute that they won't contract it or in the case of a person living with the disease that they can not transmit it to another person. This thought process can lead people to believe that they are not at risk, even when participating in high risk behaviors.
- 2) Money: Federal funding for HIV programs is showing a slight decline. As a result, less money is awarded to state HIV programs just at a time when they are needing more funding for interventions. Although, nationwide, we are seeing a decrease in the number of AIDS cases, HIV cases are increasing. With more individuals living with the disease, this places a greater number at risk of being infected if they are practicing high risk behaviors.
- 3) Social conditions: A variety of social conditions can contribute to intervention failure:
  - Education level
  - Income level
  - Violence
  - Stigma
  - Racism
  - Homophobia



- 4) Medical conditions: Medical conditions can contribute greatly to intervention failure:
- Mental Health conditions
  - Multiple diagnoses
  - Substance abuse – alcohol, drugs (meth)
  - Sexually transmitted diseases (STDs)

In Nebraska, with its large rural landscape, barriers seen at the national level may apply but for the successful implementation of interventions, local barriers must also be overcome. Local barriers may be:

- Anonymity – It is difficult to arrive at a test site or at a program that targets positive members when the community is small and everyone knows everyone.
- Location of intervention – Nebraska is 459 miles from east to west. Many individuals now drive 50-100 miles one way to receive care for their disease. It may be necessary to drive long distances to attend programs that target specific populations.
- Staff turnover – Individuals are trained to be facilitators for specific interventions. Staff turnover rates are generally high in the rural areas, leading to further training of newly hired individuals and a disruption to interventions that are currently underway.
- Adapting/Tailoring Interventions – Efforts to adapt and tailor existing interventions for a specific population are extremely difficult. When two groups are together as one (example: MSM person of color), it is difficult to find an intervention that will cover both race and risk.
- Resource allocation – It is not cost effective, from a programmatic point of view, to allocate funding to programs that target “small pockets” of individuals in rural areas even though need has been established. Program guidelines that are followed when allocating funding for specific activities need to be flexible to the needs of the specific community.

The national and local barriers listed above are not all inclusive. There are many more barriers that are not listed. One key to effective programs and the implementation of interventions is the identification of key barriers to the intervention prior to and during the implementation of the intervention. Addressing these barriers and tailoring the intervention to the target population and the community they are in will help make the intervention a success.



## **Section 11**

### **GAP ANALYSIS**



## **SECTION 11 GAP ANALYSIS**

From the time that the first HIV Comprehensive Plan for Nebraska was developed in 2003 until now, the HIV environment in Nebraska has shown little change. A review of the data in the 2007 HIV Epidemiological Profile along with the supplemental data shows that our target populations remain much the same, only expanding slightly to include a slightly older population who are either living with HIV or continue to exhibit high risk behaviors. Therefore, the identified needs of our target populations and the resources that are available in Nebraska have remained much the same as those identified in the HIV Comprehensive Plan, 2004-2008.

The following is a summary of the needs identified, the resources that Nebraska has to meet those identified needs, and the gaps identified to meet the needs. The breakdown of populations identified below reflects the major groups identified by the assessments and committee members responses as to the groups at risk. Many members identified youth within their broader population, i.e. Latino, African American, etc., hence youth were assigned a separate category.

### **PEOPLE LIVING WITH HIV/AIDS (PLWHA)**

#### Needs Identified

- treatment and care that is respectful
- culturally and linguistically appropriate
- understanding of HIV/AIDS by health care workers and providers
- negotiation skills
- safe and adequate housing
- transportation
- adequate nutrition
- adequate income and resources
- needle exchange program

#### Resources

- Nebraska AIDS Project
- University of Nebraska Medical Center
- Ryan White Part B and Part C Services
- AIDS Drug Assistance Program
- Western Community Health Resources
- Panhandle Community Services
- counseling and testing sites across Nebraska
- city/county/district health departments
- family planning facilities
- Charles Drew Health Center
- NAF Multicultural Human Development Corporation
- behavioral and mental health facilities
- private counseling services
- Central Nebraska Council on Alcoholism and Addiction (CNCAA)
- Nebraska HIV Care and Prevention Consortium (NHPCPC)

- statewide regional community planning groups
- DHHS Medicaid Program
- correctional facilities

#### Gaps Identified

- stigma of HIV/AIDS, prejudice, and homophobia, especially in rural areas
- perceived lack of assurance and confidentiality
- lack of medical and dental providers in rural areas
- HIV/AIDS education of health care workers and providers
- non-ADAP covered medications
- mental health/substance abuse services in rural areas
- access to case management services in rural areas
- information about Ryan White services unavailable
- safe, adequate, and affordable housing
- lack of transportation, especially in rural areas
- education and job training for PLWHA

### **MEN WHO HAVE SEX WITH MEN (MSM)**

#### Needs Identified

- HIV/AIDS/STD prevention education
- bilingual and culturally appropriate services
- negotiation skills
- recreation for young MSM
- drug and alcohol prevention
- faith community involvement
- safe and adequate housing
- transportation
- adequate nutrition
- adequate income and resources
- needle exchange program

#### Resources

- Nebraska AIDS Project
- Ryan White Part B and Part C Services
- UNL Health Center – Gay Men’s Support Group
- The Health Coalition
- Panhandle Prevention Advocacy CARE Team
- Panhandle Community Services
- Western Community Health Resources
- Calico Spirit Counseling Facilities
- NAF Multicultural Human Development Corporation
- counseling and testing sites across Nebraska
- Nebraska HIV Care and Prevention Consortium (NHPCPC)
- statewide regional community planning groups
- correctional facilities
- behavioral and mental health facilities
- private counseling services
- city/county/district health departments
- halfway houses/homeless shelters

### Gaps Identified

- bilingual and culturally appropriate prevention services
- HIV/AIDS/STD education
- interpreters for medical and educational services
- mental health services
- substance abuse prevention and treatment services
- safe and adequate housing

## **DRUG AND ALCOHOL USERS**

### Needs Identified

- HIV/AIDS prevention education
- counseling and testing
- needle exchange program
- HARM reduction
- negotiation skills
- transportation
- adequate nutrition
- adequate income and resources

### Resources

- CenterPointe
- Central Nebraska Council on Alcoholism and Addiction (CNCAA)
- private counseling services
- drug and alcohol treatment centers
- Ryan White Part B and Part C Services
- counseling and testing sites across Nebraska
- behavioral and mental health facilities
- city/county/district health departments
- Nebraska HIV Care and Prevention Consortium (NHPCPC)
- statewide regional community planning groups
- halfway houses/homeless shelters
- family planning facilities
- correctional facilities

### Gaps Identified

- mental health services
- drug and alcohol prevention and treatment services
- needle exchange program
- bilingual and culturally appropriate prevention services
- bilingual and culturally appropriate HIV/AIDS/STD education

## **HETEROSEXUAL FEMALES**

### Needs Identified

- HIV/AIDS/STD prevention and education
- bilingual and culturally appropriate education and services
- negotiation skills
- faith community involvement
- adequate income and resources
- safe and adequate housing

- transportation
- adequate nutrition
- needle exchange program

#### Resources

- counseling and testing sites across Nebraska
- Nebraska AIDS Project
- city/county/district health departments
- family planning facilities
- Lutheran Family Services
- Family Health Services, Inc
- St. Monica's substance abuse treatment program
- NAF Multicultural Human Development Corporation
- Panhandle Community Services
- Western Community Health Resources
- behavioral and mental health facilities
- private counseling services
- halfway houses/homeless shelters
- correctional facilities
- Nebraska HIV Care and Prevention Consortium (NHPCPC)
- statewide regional community planning groups

#### Gaps Identified

- bilingual and culturally appropriate prevention services
- HIV/AIDS/STD education
- interpreters for medical and educational services
- mental health and substance abuse treatment services
- adequate and safe housing

### **NATIVE AMERICANS**

#### Needs Identified

- HIV/AIDS/STD prevention and education
- drug and alcohol prevention
- counseling and testing
- bilingual and culturally appropriate services
- education for a transient population
- negotiation skills
- faith community involvement
- adequate income and resources
- safe and adequate housing
- transportation
- needle exchange program
- adequate nutrition

#### Resources

- Indian Health Services
- Western Community Health Resources
- Panhandle Community Services
- NAF Multicultural Human Development Corporation
- Nebraska AIDS Project



- counseling and testing sites across Nebraska
- family planning facilities
- city/county/district health departments
- Ryan White Part B and Part C Services
- private counseling services
- correctional facilities
- behavioral and mental health facilities
- halfway houses/homeless shelters
- Nebraska HIV Care and Prevention Consortium (NHPC)
- statewide regional community planning groups

#### Gaps Identified

- bilingual and culturally appropriate services and education
- HIV/AIDS/STD education that is comprehensive
- mental health and substance abuse prevention and treatment services
- adequate and safe housing

## YOUTH

#### Needs Identified

- HIV/AIDS/STD education that is comprehensive
- drug and alcohol prevention
- recreation
- faith community involvement
- negotiation skills
- transportation
- needle exchange program
- adequate nutrition
- adequate income and resources

#### Resources

- Lutheran Family Services
- Boys and Girls Homes of Nebraska, Inc
- Love Deliverance Temple Church
- Northeast Nebraska AIDS Prevention Partnership
- YWCA of Lincoln
- Lighthouse
- NAF Multicultural Human Development Corporation
- Family Health Services
- Panhandle Community Services
- Western Community Health Resources
- Nebraska AIDS Project
- Nebraska HIV Care and Prevention Consortium (NHPC)
- statewide regional community planning groups
- counseling and testing sites across Nebraska
- Ryan White Part B and Part C Services
- behavioral and mental health facilities
- private counseling services
- family planning facilities
- city/county/district health departments

- correctional facilities
- halfway houses/homeless shelters

#### Gaps Identified

- bilingual and culturally appropriate services and education
- HIV/AIDS/STD education that is comprehensive
- mental health and substance abuse prevention and treatment services
- community centers

One key gap that continues to be identified with all populations is the gap in the care offered and provided in many areas across Nebraska, especially in the rural areas. Therefore, the information below identifies health care workers and medical providers as part of the Gap Analysis.

### **HEALTH CARE WORKERS AND MEDICAL PROVIDERS**

#### Needs Identified

- HIV/AIDS/STD education
- cultural awareness
- bilingual health care providers
- interpreters
- negotiation skills
- conflict resolution skills

#### Resources

- University of Nebraska Medical Center
- infectious disease physicians
- Nebraska AIDS Project
- NAF Multicultural Human Development Corporation
- family planning facilities
- city/county/district health departments
- behavioral and mental health facilities
- Nebraska HIV Care and Prevention Consortium (NHCPC)
- statewide regional community planning groups

#### Gaps Identified

- lack of knowledge of HIV/AIDS
- lack of bilingual health care workers and providers
- lack of medical/dental providers willing to provide care to HIV positive individuals
- lack of substance abuse/mental health providers
- culturally appropriate care

## **SECTION 12**

### **OTHER PARTNERS**



## **SECTION 12 OTHER COMMUNITY PARTNERS**

### **NEBRASKA RED RIBBON COMMUNITY**

The Nebraska Red Ribbon Community (NRRC) is a group of persons living with HIV and serves in an advisory capacity to the Nebraska HIV Care and Prevention Consortium (NHCP) and also provides information about HIV/AIDS care and prevention to the DHHS Ryan White Program.

***The mission of the Nebraska Red Ribbon Community (NRRC) is to enhance and enrich the lives of those infected with the Human Immunodeficiency Virus (HIV) through leadership and partnership with community, local, and state entities to empower ourselves, and to enhance and improve the quality of life for those infected with HIV and AIDS in Nebraska.***

This mission will be accomplished in an advisory capacity in collaboration with, but not limited to, the Nebraska HIV Care and Prevention Consortium (NHCP), Nebraska Department of Health and Human Services (DHHS), the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA).

The NRRC identifies their *statement of purpose* as follows:

1. To be a consumer-based advisory committee, not affiliated with any system of case management, dedicated to fulfilling our mission statement.
2. The NRRC has the continuing goals of: 1) producing and maintaining a good cross-section of the Nebraska-based HIV population on the membership of the NRRC itself; 2) operate and manage the NRRC website, [www.nebraskahivtesting.org](http://www.nebraskahivtesting.org), to encourage those at risk of HIV to be tested and to maintain an accurate listing of Nebraska testing sites and other pertinent information on the website.
3. Any other goals the NRRC decides to reach for should work toward early detection, education, compassion, awareness of HIV issues in the communities and medical communities of Nebraska, and for improving the lives of HIV positive Nebraskans.

It is the intent of the Nebraska Red Ribbon Community to be geographically balanced and reflect the diversity of the HIV epidemic in Nebraska. Any HIV+ individual living in Nebraska is eligible to apply for membership. Meetings are held quarterly at different sites across the state. The date and location of meetings is available by calling the DHHS Ryan White Program at (402) 471-9098.

## **NEBRASKA HIV RESOURCE DIRECTORY**

In April 2007, the DHHS HIV Prevention Community Planning Coordinator developed the Nebraska HIV Resource Directory. This directory is a tool to assist persons living with HIV in Nebraska with locating providers, organizations and services that would be useful in their daily lives and with managing their HIV disease. Information contained in the resource directory was obtained from public resources such as telephone books, organizational brochures, program resources and websites. The directory is in the public domain and is updated on an ongoing basis with the most current version available on the DHHS HIV Prevention web page: [www.dhhs.state.ne.us/dpc/hiv.htm](http://www.dhhs.state.ne.us/dpc/hiv.htm).

## **SECTION 13**

### **EVALUATION OF COMMUNITY PLANNING PROCESS**





## **SECTION 13**

### **EVALUATION OF COMMUNITY PLANNING PROCESS**

The evaluation of the Community Planning Process is a shared responsibility between DHHS HIV Prevention Program and the NHCPC. However, the HIV Prevention Program is responsible to report evaluation activities to the CDC in the annual progress report. The CDC has developed the *Evaluation Guidance* to assist community planning groups (CPG) with the evaluation process.

#### **PROGRAM PERFORMANCE INDICATORS**

Program performance indicators provide a gauge for HIV prevention community planning implementation specifically in processes, activities, and/or products that must be developed or implemented to achieve the goals and objectives of HIV prevention community planning (HIV Prevention Community Planning Guide, 2003).

**Indicator 1**  
**Proportion of populations most at risk, as documented in the epidemiologic profile, that have at least one NHCPC member that reflects the perspective of each population.**

Nebraska's epidemiological profile lists the following as populations most at risk:

- Men who have sex with men (MSM)                      36%
- Heterosexual contact    19%
- Injection drug users (IDU)    7%

The Comprehensive Plan lists the following as priority populations for 2009-2013:

- HIV+ individuals
- Men who have sex with men (MSM)
- Male injection drug users (IDU)
- Female high risk heterosexual (HRH)
- Men who have sex with men and inject drugs (MSM/IDU)

At the October 2007 NHCPC meeting, members completed the annual CDC Membership Survey. Members were asked to identify which high risk population was the primary and secondary population that they represented. Out of 25 members surveyed, all high-risk populations were represented.

- HIV+ individuals (7)
- MSM (13)
- IDU (4)
- HRH (12)
- MSM/IDU (2)

**Indicator 2****Proportion of key attributes of an HIV prevention community planning process that NHCPC membership agreed have occurred.**

At the October 2007 NHCPC meeting, members completed the Community Planning Membership Survey. Questions asked were directed at the key attributes for Objectives A – H. Allowed responses were “agree, “disagree,” or “don’t know”. There were a total of 1200 valid responses, with 1064 “agreed” responses and 136 “disagreed” responses. The percentage of responses that agreed key attributes occurred was **89 percent**.

**Indicator 3****Percent of prevention interventions/supporting activities in the health department CDC funding application specified as a priority in the comprehensive HIV prevention plan.**

All of the HIV Prevention interventions in the DHHS HIV Prevention CDC funding application are specified as a priority in the Nebraska Comprehensive HIV Plan 2004-2008 (**100 percent**).

**Indicator 4****Percent of health department-funded prevention interventions/supporting activities that correspond to priorities specified in the comprehensive HIV prevention plan.**

All HIV Prevention interventions correspond to the priorities that are specified in the Nebraska Comprehensive HIV Plan 2004-2008 (**100 percent**).

## CRITICAL COMMUNITY PLANNING ATTRIBUTES

Three goals and eight objectives were developed to provide a framework for monitoring and measuring progress in achieving a reduction of new HIV infections and reduced HIV-related morbidity.

### GOAL ONE: Community planning supports broad-based community participation in HIV prevention planning.

**Objective A:** Implement an open recruitment process (outreach, nominations, and selection) for CPG membership

**Indicator:**

**(Community Planning Membership Survey October 2007)**

- 100% agreed that NHCP has written procedures for nominations to the NHCP.
- 100% agreed that NHCP uses the written procedures for nominations to the NHCP.
- 96% agreed the NHCP has established a nominations/membership committee.
- 100% agreed that NHCP nominations target membership gaps identified by the members of the NHCP.
- 84% agreed that both NHCP members and DHHS staff participate in membership decisions.
- 92% agreed that NHCP has written procedures for how to select NHCP members.
- 92% agreed that NHCP uses written procedures in the selection of NHCP members.

**Objective B:** Ensure that the CPG(s) membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies.

**Indicator:**

**(NHCP Member Profile January 2008 – Appendix 10)**

The following tables show the characteristics of the NHCP membership as of January 2008:

GENDER	#
Male	12
Female	19
Transgender	0

<b>AGE</b>	<b>#</b>
13-18	0
19-24	0
25-34	2
35-44	6
45-64	23
65+	0

<b>RACE</b>	<b>#</b>
White	21
Black/African American	8
American Indian/Alaska Native	2
Asian	0

<b>ETHNICITY</b>	<b>#</b>
Hispanic/Latino	1
Non-Hispanic/Non-Latino	29
Unknown	1

<b>SEXUAL ORIENTATION</b>	<b>#</b>
Heterosexual	18
Gay	8
Bisexual	2
Lesbian	2
Unknown	1

<b>HIV STATUS</b>	<b>#</b>
HIV Positive	7
HIV Negative	24

<b>Geographic Location</b>	<b>#</b>
Rural pop < 2,500	5
Urban Non-Metro Pop 2,500 and 100,000	8
Urban Metro Pop > 100,000	18

## Population Represented by Voting and Non-Voting NHCPC Members

RISK	# VOTING MEMBERS	# NON-VOTING MEMBERS	TOTAL
MSM	8	1	9
MSM/IDU	0	0	0
IDU	1	0	1
HRH	5	1	6
Living with HIV	8	1	9

## Professional and Community Representation for Voting and Non-Voting NHCPC Members

PROFESSIONAL AND COMMUNITY REPRESENTATION	# of VOTING MEMBERS	# of NON-VOTING MEMBERS	TOTAL
Health department HIV/AIDS staff (state)	1	1	2
Health department STD/STI staff (local HD)	2	1	3
Health department hepatitis staff	0	1	1
Health department tuberculosis staff	0	1	1
Health department epidemiologist (local HD)	1	1	2
<b>Non-Health Department Staff:</b>			
Health or health services researchers	1	1	2
Program evaluators	0	0	0
Behavioral or social scientists	0	0	0
Representatives of the substance abuse community	1	0	1
Representatives of the mental health community	1	0	1
Representatives of the education community	1	0	1
Representatives of the corrections/criminal justice community	1	0	1
Medical doctors	0	0	0
Staff from community-based HIV prevention agencies	12	2	14
Staff from community-based social service agencies (includes services for homeless persons)	3	0	3
Faith leaders	1	0	1
Community members interested in or affected by HIV/AIDS	5	3	8
<b>TOTAL Number of Voting CPG Members</b>	<b>30</b>	<b>11</b>	<b>41</b>

**Objective C:** Foster a community planning process that encourages inclusion and parity among community planning members.

**Indicator:**

- Two co-chairs, Community and State, preside over the meeting and ensure that members are allowed to discuss matters fully and openly. All meetings abide by the State Open Meeting Laws. The agenda contains a Public Comments slot to allow non-voting standing committee members and visitors the ability to express comments and concerns.
- All voting members are assigned to one of six standing committees and are encouraged to participate in the community planning process.
- All new voting and non-voting standing committee members participate in a 45 minute orientation program presented by the NHCP Membership Committee. New members receive a DVD and orientation manual. New members are assigned a member to assist them for their first two meetings.
- Conflict of interest policies are reviewed annually at the January meeting. The policy is strictly adhered to for voting.
- An exit survey is conducted at the end of each meeting. Members are encouraged to express comments about the day's meeting as well as suggestions for topics/speakers for future meetings.
- Two voting members are selected each year to attend the HIV Prevention Leadership Summit along with the State Co-Chair.

**GOAL TWO: Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) for Nebraska.**

**Objective D:** Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in Nebraska

**Indicator:**

- The Community Planning Membership Survey conducted in October 2007 indicated that 96% of NHCP members agreed that the epidemiologic profile contains the most updated information.
- The *2007 Nebraska HIV/AIDS/STD Epidemiological Profile* was presented to the NHCP membership at the July 18, 2007 meeting to aid in the selection of priority populations for the future comprehensive plan.
- The Epidemiological Profile contains information about the defined populations most at risk for HIV infection, strengths and limitations of data sources, gaps in data and a narrative explanation of the data. (This profile is included in this plan.)
- A needs assessment was conducted in 2007 and was presented to the NHCP membership at the July 18, 2007 meeting as part of the priority population selection process.

- The *HIV Community Resource Directory* was developed in 2007 and is a compilation of HIV prevention and care services across Nebraska. The directory was presented to the NHPC at the July 2007 meeting and is available on the NHPC website.
- A gap analysis was developed for each identified priority populations using the epi profile and needs assessment data. This was presented to the NHPC at the July 2007 meeting.

**Objective E:** Ensure that prioritized target populations are based on an epidemiologic profile and a community services assessment.

**Indicators:**

- The Community Planning Membership Survey conducted in October 2007 indicated that 88% agreed that the NHPC considers available information on the estimated total of the most at risk populations.
- Eighty-four percent agreed that the NHPC considers the level of disease burden in and the priority needs of the most at risk populations.
- The Epi profile, needs assessments, resource inventory and gap analysis were utilized at the July 18, 2007, meeting when the NHPC choose priority populations.

**Objective F:** Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.

**Indicators:**

- The NHPC Intervention Committee based intervention selection upon seven factors including effectiveness, sound theoretical basis, norms and values, and cost effectiveness.
- The Community Planning Membership Survey conducted in October 2007 indicated that 84% agreed that the NHPC considers whether the prevention activities are culturally appropriate and acceptable for the most at risk populations.

**GOAL THREE: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.**

**Objective G:** Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.

**Indicators:**

- The Community Planning Membership Survey conducted in October 2007 indicated that 92% agreed that the NHPC was given evidence of correspondence between the

comprehensive plan and the DHHS CDC application for federal funding.

- The NHCPC Executive Committee held a conference call to review the 2008 DHHS HIV Prevention CDC application for funding and provided a letter of concurrence under both co-chair's signatures to be sent with the application to CDC.

**Objective H:** Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.

**Indicators:**

- The Community Planning Membership Survey conducted in October 2007 showed that 92% agreed that the NHCPC was given evidence of correspondence between the comprehensive plan and funded interventions/services delivered in the prior year.
- 100% of the Nebraska HIV Prevention Program's interventions correspond to the interventions for priority populations listed in the *Nebraska HIV Comprehensive Plan, 2004-2008*.

## EDUCATIONAL AND TECHNICAL ASSISTANCE NEEDS

At the July 2007 NHCPC meeting, NHCPC members completed two surveys: the Educational Needs Assessment and the Technical Assistance Needs Assessment. These Assessments will be completed every three years so as to address current educational and technical assistance needs.

The following table identifies the training needs, listed in order of importance, and the year the training will be conducted. Because of the time constraint with meetings, not all needs have a year listed by them. These needs will be worked into meeting agendas over the next three years as time permits.

### EDUCATIONAL NEEDS

<b>Intervention Design, Development, Implementation, and Evaluation</b>	▪ Developing cultural competence/linguistic appropriateness in intervention activity (2008)
	▪ Conducting population-based needs assessments (2009)
	▪ Developing curricula
	▪ Integrating services
	▪ Adapting or replicating effective interventions (2008)
<b>Community Capacity Building for HIV Prevention</b>	▪ Developing networks, partnerships and coalition building, and maintenance (2010)
	▪ Developing community leadership (2010)
	▪ Developing and implementing strategies for community needs assessments
	▪ Developing community mobilization strategies
<b>HIV Prevention Community Planning Effectiveness and Participation</b>	▪ Developing and maintaining cultural sensitivity (2008)
	▪ Using prioritization strategies for identifying target populations and interventions (2009)
	▪ Using data for decision-making
	▪ Skills in conflict management and negotiation



## TECHNICAL ASSISTANCE NEEDS

<b>CARE Services</b>	▪ ADAP (2008)
	▪ Developing resources (2008)
	▪ HOPWA (2008)
	▪ Case management standards
<b>Community Work</b>	▪ Understanding health beliefs of cultures other than your own (2009)
	▪ Identifying populations at risk in the community
	▪ Political advocacy
	▪ Advocacy issues/empowerment
<b>HIV Prevention and CARE</b>	▪ Counseling, testing, and referral update (2008)
	▪ Identifying and dealing with barriers to care (2009)
	▪ Gay, lesbian, bisexual, and transgender issues (2010)
	▪ Opportunistic infection update
<b>Organizational Infrastructure Development</b>	▪ Grant writing (2008)
	▪ Effective internal communication
	▪ Grant management (2010)
	▪ Program evaluation (2010)

Capacity building sessions are conducted at two of the four NHPC meetings held each year. The following table lists the topics for capacity building sessions by date of meeting for the next three years, 2008-2010.

<b>MEETING MONTH &amp; YEAR</b>	<b>CAPACITY BUILDING OFFERED</b>
<i>April 2008</i>	Adapting or replicating effective interventions that target Immigrant Populations in Nebraska Cultural Sensitivity in Health Education efforts targeting Immigrant Populations in Nebraska
<i>July 2008</i>	Care Services/HOPWA
<i>April 2009</i>	Developing and maintaining cultural sensitivity linked with developing cultural competence and linguistic appropriateness in intervention activity
<i>July 2009</i>	Wrap-around services for positives linked with community assessment
<i>April 2010</i>	Using prioritization strategies for identifying target populations and interventions
<i>July 2010</i>	Program evaluation linked with evaluation of community programs

## CONTINUAL MONITORING AND EVALUATION

DHHS and the NHPC support broad-based community participation in HIV prevention planning. Through this process, priority prevention needs are identified for established target populations. DHHS and the NHPC ensure prioritized populations are based on an epidemiologic profile and a community services assessment. In addition, DHHS and the NHPC ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended populations for cultural appropriateness, relevance, and acceptability.

## **POTENTIAL FUTURE OPPORTUNITIES**

There is a need for further education about HIV prevention and care in all areas of the state, but especially in rural Nebraska. Efforts are underway to provide educational opportunities in the communities of Nebraska and for professionals that serve persons impacted or affected by HIV. Continued integration by the DHHS HIV Prevention and Ryan White Programs, along with the Hepatitis Prevention Program, STD Program, TB Program, Department of Education, Office of Minority Health, Office of Rural Health, Office of Public Health, Office of Family Health, Office of Women's Health, and city/county/district health departments, is critical for ensuring the State of Nebraska combats health issues in a comprehensive manner. The utilization of existing infrastructures is also essential in fighting stigma associated with public health services.

Evaluation capacity continues to be built to enhance the ability of both providers and funders to determine the most effective approaches to prevention and care services. With dollars limited from all sources, targeted funding of truly effective interventions becomes more critical to ensure progress toward the goal of reducing transmission of HIV.

## **SECTION 14**

### **APPENDIX**



## **APPENDIX 1**

### **NEBRASKA HIV CARE and PREVENTION CONSORTIUM BYLAWS**

#### **ARTICLE I. NAME**

The name of the Advisory Group shall be Nebraska HIV CARE and Prevention Consortium (hereinafter referred to as the NHCPC).

#### **ARTICLE II. MISSION**

The mission of the NHCPC is to develop a comprehensive HIV CARE and Prevention Plan for the State of Nebraska. The plan will identify specific strategies and interventions that are responsive to validated needs within defined target populations.

This mission will be accomplished in an advisory capacity in collaboration with the Nebraska Department of Health & Human Services (DHHS), the National Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA).

#### **ARTICLE III. STATEMENT OF PURPOSE**

1. Assess the present and future extent, distribution, and impact of HIV prevention and care issues in defined populations in the state.
2. Identify and prioritize high-risk populations based on formal and informal epidemiological information.
3. Assess HIV care and prevention needs through the identification of existing care and prevention services, as well as gaps and barriers within defined populations.
4. Identify, prioritize, and recommend care and support services as well as adequacy for defined services.
5. Identify and recommend specific strategies and interventions to prevent new HIV infections in defined populations. These interventions should be based on sound behavioral change theory and cost effectiveness.
6. Ensure parity, inclusion, and representation reflective of the HIV epidemic within the community prevention planning as well as incorporated into CARE related decisions.
7. Develop a Comprehensive HIV Prevention Plan consistent with the high priority HIV care/support and prevention needs for defined target populations. Annually review and modify this plan as necessary.
8. Evaluate the effectiveness of the planning process.

***The DHHS HIV Prevention Program will develop applications for federal funds for HIV care and prevention based on the Comprehensive HIV CARE and Prevention Plan. The NHCPC will be asked to assess the responsiveness and effectiveness of funding applications in addressing the priorities identified in the Comprehensive HIV CARE and Prevention Plan.***

## **ARTICLE IV. MEMBERSHIP**

- Section 1. A member is an individual occupying a standing/appointed or elected position on the NHCPC. Only members have voting privileges. The membership of the NHCPC advisory group shall be geographically balanced and reflect the diversity of the HIV epidemic. Recruitment shall be guided by the principles of parity, inclusiveness, and representation, as established by CDC in Section 1.3.2.1, CDC Criteria, Handbook for HIV Prevention Community Planning (Addendum B) and Public Law 101-381.
- Section 2. There shall be two classifications of members:
- a. Standing/appointed members will be comprised of related state agencies and others recommended to serve in order to balance CDC requirements. Standing members will comprise no more than 1/3 of the total membership.
  - b. Elected members will represent related functional areas, persons directly impacted by the epidemic, and geographic representation. Elected representatives shall comprise the remaining 2/3 of the membership.
- Section 3. Any member may resign at any time from service on the NHCPC by submitting a written resignation to either the State or Community Co-Chair.
- Section 4. Any member or non-voting member serving on a standing committee determined to be in violation of the NHCPC Code of Conduct, contained in the Operational Guidelines, or in violation of a signed Disclosure of Conflict, may be removed by a majority vote at a meeting at which a quorum is present. Any member may report violations. Violations should be submitted in writing to either the Chair or State Liaison of the Membership Committee for presentation to members no less than 30 days prior to the next regularly scheduled meeting.

## **ARTICLE V. TERMS OF MEMBERSHIP**

- Section 1. Members will serve for a period of 3 years (36 months) with the following exceptions: 1) Standing Members and 2) circumstances identified in ARTICLE VIII Sections 4 and 5.
- Section 2. Members can be elected at any NHCPC meeting to fill a vacant elected position. Members whose first term on the NHCPC is ending may reapply for a second term. All terms expire on December 31.
- Section 3. Members of the NHCPC may not serve more than two consecutive terms (six years). A previous member of the NHCPC or an individual who, for whatever reason, resigned a previous position on the NHCPC prior to the end of their term may reapply for an open position after one year has passed.
- Section 4. Standing member positions are designated per requirements for the CDC and HRSA. Appointments to these positions will be at the discretion of the HIV Program Administrator.

## **ARTICLE VI. OFFICERS**

- Section 1. The NHCPC will be directed by two co-chairs. The State Co-Chair will be appointed by the HIV Program Administrator. The second, Community Co-Chair, will be elected by the NHCPC membership at the third official meeting of the calendar year and will take office on January 1 of the following year. Terms expire on December 31.
- Section 2. The Community Co-Chair term shall be for a period of two years. He/she shall not serve more than two consecutive terms. The Community Co-Chair shall be a member of the NHCPC. The Community Co-Chair must have attended three consecutive meetings prior to election.

## **ARTICLE VII. EXECUTIVE COMMITTEE**

The purpose of the Executive Committee is to provide decision making capability on behalf of the NHCPC between meetings for specific and emerging functions. The duties of the Executive Committee would be limited, but would include:

- Carry on the business of the NHCPC between meetings as needed.
- Assist in the revision of the NHCPC Comprehensive Plan.
- Review annual CDC grant applications and provide concurrence, non-concurrence, or concurrence with recommendations.
- Review and recommend revisions to the NHCPC Operational Guidelines and Bylaws on an as needed basis but no less than annually.
- Review the Statewide Coordinated Statement of Need.
- Act on behalf of the NHCPC in the event of unforeseen circumstances.

Members of the Executive Committee will be the State and Community Co-Chairs and the Standing Committee Chairs.

## **ARTICLE VIII. VACANCIES**

- Section 1. Should a regional representative to the NHCPC be unable to serve an entire term, the recognized area HIV prevention and/or care group shall select another representative. Should no area group exist, the NHCPC Membership Committee shall solicit/recruit an appropriate representative for the designated area. A recognized area HIV prevention and/or care group shall be defined as any formal body created or acting as a subcommittee to such a body, with the documented purpose of addressing HIV prevention and/or care issues through a mission statement, statement of purpose, and defined goals and objectives.
- Section 2. Should any other elected member to the NHCPC be unable to serve an entire term, another representative shall be recommended by the Membership Committee and voted on by the full NHCPC membership following established principles of parity, inclusion, and representation.
- Section 3. Should a standing member to the NHCPC resign from their position, another representative shall be appointed by the HIV Program Administrator.

- Section 4. If a vacancy occurs before half (less than 18 months) of the NHCPC member's term has been served, the person who fills that vacated position will have the same term expiration date as the member who vacated the position.
- Section 5. If a vacancy occurs after half of the NHCPC member's term has been served, the person who fills that vacated position will serve out the remainder of that term in addition to another 36 months.

#### **ARTICLE IX. ATTENDANCE**

- Section 1. To ensure consistent participation and input, members and non-voting members serving on standing committees who have three absences within the previous 12 months, whether excused or unexcused, will be considered non-participating and will be replaced. An excused absence is defined as notification to one of the two Co-chairs **prior** to the beginning of any regularly scheduled meeting.
- Section 2. Members and non-voting members serving on standing committees who have two unexcused absences within the previous 12 months will be considered non-participating and will be replaced.
- Section 3. An NHCPC member may not designate a proxy to attend a meeting should he/she be unable to attend. Should the member request a representative to attend the meeting, that representative will be considered a member of the public and have no voting privilege.

#### **ARTICLE X. MEETINGS**

- Section 1. The NHCPC shall hold no more than four formal meetings per calendar year.
- Section 2. The NHCPC co-chairs shall set agendas for meetings. Meeting agendas will be mailed to members at least 10 days prior to the next scheduled meeting.
- Section 3. All meetings are considered open meetings and as such will abide by Public Meeting Statutes, Neb. Rev. Stat. §§ 84-1414 (Reissue 1987 and Supp. 1989). Except for items of an emergency nature, the agenda shall not be altered later than 24 hours before the scheduled commencement of the meeting. The public body shall have the right to modify the agenda to include items of an emergency nature only at such public meeting.
- Section 4. Minutes shall be written and available for inspection within 10 working days or prior to the next convened meeting, whichever occurs earlier. Written minutes shall be provided to all NHCPC members prior to subsequent meetings.
- Section 5. It is the policy of the NHCPC to make decisions by consensus. Consensus is defined as all members willing to support and "sign-off" on decisions when a quorum is present. Should consensus not be achieved, voting procedures shall follow the guidelines set forth in Robert's Rules of Order. In accordance with the requirements of Nebraska's public meeting statutes, all formal decisions will be documented through roll call vote.
- Section 6. A quorum is defined as 60% of the current NHCPC membership and will be established at the time of the first roll call vote.



- Section 7. All NHCPC members will have voting privileges. The NHHS HIV Prevention Program, represented by the Ryan White title II Program Manager, will register one vote. In the event of a tie, the NHHS HIV Program Administrator will vote.
- Section 8. Each member present will have one vote at the meeting. No vote by proxy will be accepted.
- Section 9. Only NHCPC members will be allowed to speak at meetings unless the Co-Chairs have included a public presentation as a part of the regular meeting agenda.
- Section 10. At the end of each meeting, an open forum will be held in which members of the public may address the NHCPC with agenda-related items. Time limits for presentations may be set. All members of the public who speak must identify themselves.
- Section 11. Written notice of the time and place of all NHCPC meetings shall be posted in all regional HHS offices and at two other public sites in Lincoln and Omaha at least 24 hours prior to each meeting.
- Section 12. The Co-Chairs may call special meetings with at least 10 days notice by phone, fax, email, or letter. Public notice of such meetings shall follow procedures as established in Section 3.

#### **ARTICLE XI. CONFLICT OF INTEREST/CONFIDENTIALITY**

- Section 1. In making recommendations to the HHS, the NHCPC must operate in compliance with all applicable state and local conflict of interest laws. In order to safeguard NHCPC recommendations from potential conflict of interest, each member and non-voting member serving on a standing committee shall disclose any and all professional and/or personal affiliations with agencies that may pursue funding. An annual Disclosure of Conflict of Interest Statement will be completed by each member and non-voting member serving on a standing committee and will be kept on file. On issues where a participant's affiliate is the potential recipient of funds, that participant may not vote on that issue or formally review that affiliate's request for funds or other supports.
- Section 2. Per Article IV., Section 4, violations by members and non-voting members serving on standing committees of their signed Disclosure of Conflict of Interest/Confidentiality Statement may be grounds for removal.
- Section 3. Disclosures or discussions which place a member at possible risk of harm to person or reputation shall be kept confidential and restricted to the business of the NHCPC. Information discussed and provided, whether written or oral, is for the purpose of accomplishing the missions and objectives of the advisory group."

#### **ARTICLE XII. COMMITTEES AND TASK FORCES**

- Section 1. The NHCPC shall have the ability to create standing committees as deemed appropriate to ensure that the mission of the NHCPC is successfully met.
- Section 2. Each January, committees shall elect a Chair to direct the activities of the committee. The Chair shall be a voting or non-voting member of the NHCPC. The Chair must have

attended three consecutive meetings prior to election. Terms will run from April through January.

- Section 3. Committee Chair(s), with assistance from State Liaisons, shall set agendas for committee meetings and submit items for inclusion with the NHCPC agenda to either the State or Community Co-Chair no less than 20 days prior to the next convened meeting.
- Section 4. All members of the NHCPC are expected to serve on a committee during their term(s) of membership. Supporting the NHCPC policy of broadening community involvement to ensure parity, inclusion, and representation in all aspects of the process, persons outside the NHCPC membership may be solicited to participate on committees and ad hoc groups or task forces.
- Section 5. All committee meetings will be governed by the same set of rules as established in ARTICLE IX – ATTENDANCE and the Operational Guidelines.
- Section 6. The NHCPC Co-Chairs, to fulfill time-limited objectives may, as needed, designate ad hoc groups. Chairpersons for ad hoc groups will be appointed by NHCPC Co-Chairs and will report to the NHCPC Co-Chairs for the duration of the appointment.
- Section 7. The Chairperson(s) for ad hoc group(s) will be members of the NHCPC.

#### **ARTICLE XIII. BOOKS AND RECORDS**

The NHCPC shall keep minutes of all proceedings of the NHCPC and such other books and records as may be required for proper conduct of its business and affairs.

#### **ARTICLE XIV. ADOPTION AND AMENDMENTS**

- Section 1. The Executive Committee will meet prior to the first formal meeting of the year to review the Bylaws and Operational Guidelines of the Nebraska HIV CARE and Prevention Consortium for changes to be presented to the NHCPC membership for ratification at the first formal NHCPC meeting of the year.
- Section 2. These Bylaws may be amended at any regular or special meeting of the NHCPC. Written notice of the proposed Bylaws change shall be mailed or delivered to each member at least 10 calendar days prior to the date of the next regular meeting. Bylaws changes require a two-thirds majority vote of the NHCPC members present.
- Section 3. All NHCPC members shall be provided a current edition of NHCPC Bylaws and Operational Guidelines. A signed Statement of Receipt and Acceptance of Bylaws and Operational Guidelines shall be kept on file.

*Ratified on: 5/23/2000*

*Changes Approved: 1/23/2003*

*Changes Approved: 2/12/2004*

*Changes Approved: 4/22/2004*

*Changes Approved: 6/24/2004*

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*Changes Approved: 4/19/2007*

*Changes Approved: 1/24/2008*



## **APPENDIX 2**

### **NEBRASKA HIV CARE and PREVENTION CONSORTIUM OPERATIONAL GUIDELINES**

The Nebraska Department of Health and Human Services, HIV/AIDS Program, under the requirements of Cooperative Agreements with the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA), has established the Nebraska HIV CARE and Prevention Consortium (NHCPC). The Nebraska HIV CARE and Prevention Consortium, henceforth referred to as the NHCPC, shall function as an advisory body to the Department's HIV/AIDS and Ryan White or Title II Programs. The following information shall be known as the Operational Guidelines for the NHCPC and shall direct the operational aspects of the NHCPC.

All members of the NHCPC shall, upon reading and signing a Statement of Receipt and Acceptance, adhere to these guidelines as a part of their membership.

#### **I. Purpose**

The purpose of the NHCPC is to act in an advisory capacity to the Nebraska Health and Human Services HIV/AIDS and Ryan White Programs. Through this advisory relationship, the HIV/AIDS and Ryan White Programs will respond to the care and prevention issues affecting those at risk for becoming HIV infected as well as those who are currently living with HIV disease through facilitating health education, risk reduction programming, public information, HIV counseling, testing, referral and partner notification, support services, AIDS Drug assistance, and treatment.

#### **II. Organizational Structure**

The NHCPC will be made up of no more than 38 members. The members will be classified as "standing" positions or "elected" positions. Standing positions are filled by persons required by federal funding and administrative recommendation to ensure specific expertise, which is critical to HIV prevention and care through public health forums. These positions will comprise no more than 1/3 of the total membership. The elected positions will represent related functional areas, persons directly impacted by the epidemic, and geographic representatives. These members comprise the remaining 2/3 of the membership.

Parity - Inclusion - Representation (P.I.R.)

Per the Centers for Disease Control and Prevention, all grantees (HHS) are required to adhere to certain principles for HIV prevention community planning. Parity, inclusion, and representation (PIR) characterize this process.

Parity is the condition where *all* members of the NHCPC are provided opportunities for orientation and skills building to participate in the process and to have *equal voice* in voting and other decision-making activities.

Inclusion is defined as the assurance that the views, perspectives, and needs of *all affected communities* are included, to the extent possible, and involved in a meaningful manner in the community planning process.

Representation is the assurance that those who are representing a specific community truly reflect that community's values, norms, and behaviors. These representatives must also be able to participate as group members in objectively weighing the overall priority prevention needs of the jurisdiction.

## **A. Geographic Representation**

The large geographic area of Nebraska creates unique challenges for service providers. Successful public health initiatives in the areas of prevention and care/treatment issues require attention to service availability, gaps/barriers to services and participation by those residing in the community. The social norms, values, and resources may vary according to each area of the state and its proximity to other communities. These issues support the need for geographically diverse representation in the planning process. Issues must be prioritized based on a number of factors including economic feasibility, programmatic effectiveness, community acceptance, existing capacity for implementation, etc. These issues support the need for geographic representatives to ensure the process is inclusive of the needs of all affected Nebraskans.

For the purpose of the NHCPC, geographic representation will follow the geographic boundaries established by HHS for service delivery. These Service Areas will be designated as such:

**Southeast Region (I)**, Counties of Butler, Cass, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, and York

**Eastern (II)**, Counties of Dodge, Douglas, Sarpy, and Washington

**Northern (III)**, Counties of Antelope, Boone, Boyd, Brown, Burt, Cedar, Cherry, Colfax, Cuming, Dakota, Dixon, Holt, Keya Paha, Knox, Madison, Nance, Pierce, Platte, Rock, Stanton, Thurston, and Wayne

**Central (IV)**, Counties of Adams, Blaine, Buffalo, Clay, Custer, Franklin, Garfield, Greeley, Hall, Hamilton, Harlan, Howard, Kearney, Loup, Merrick, Nuckolls, Phelps, Sherman, Valley, Webster, and Wheeler

**Southwest (V)**, Counties of Arthur, Chase, Dawson, Dundy, Frontier, Furnas, Gosper, Grant, Hayes, Hitchcock, Hooker, Keith, Lincoln, Logan, McPherson, Perkins, Red Willow, and Thomas

**Western (VI)**, Counties of Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, and Sioux

These service areas may change or vary based on state or programmatic discretion.

## **B. Standing Members and Elected Members**

See *Section II-Organizational Structure* for definitions of members. The HHS HIV Program, per recommendation needed for the “standing” categories, will determine the positions required by the CDC and HRSA. Persons identified to serve in these positions will be chosen by the HIV Program Administrator upon recommendation. The positions designated as “elected” categories will be determined by the Membership Committee of the NHCPC based on the current HIV epidemiological profile of the state and based on the principles of Parity, Inclusion, and Representation. The Membership Committee will assess the need for specific classification positions for the NHCPC periodically and will make recommendations to the members to coincide with future elections.

## **III. Member Roles**

### **A. The Role of the NHCPC as a body will be as follows:**

#### Prevention Related:

9. Assess the present and future extent, distribution, and impact of HIV prevention and care issues in defined populations in the state.
10. Identify and prioritize high-risk populations based on formal and informal epidemiological and needs assessment information.
11. Identify and recommend specific strategies and interventions to prevent new HIV infections in defined populations. These interventions should be based on sound behavioral and social science, cost and cost effectiveness, needs assessment, and outcome evaluation.
12. Identify the technical assistance needs of the NHCPC and community-based providers in the areas of planning, implementing, and evaluating prevention interventions as well as the NHCPC’s needs to enable it to execute an effective planning process.
13. Review the HHS HIV Program application to the CDC for federal HIV prevention funds, including the proposed budget, and write a letter of concurrence or nonconcurrence.

#### CARE Related:

1. Assess HIV care and treatment needs for individuals and families living with HIV disease through the identification of existing care and prevention services, as well as gaps and barriers to those needs.

2. Encourage public/private partnerships in planning, developing, and providing care.
3. Encourage local decision making about what care is needed.
4. Ensure parity, inclusion, and representation reflective of the HIV epidemic in decision making and the planning process, including the involvement of affected populations.
5. Assure that care and services are provided to people regardless of their ability to pay, except where income guidelines must be applied due to funding limitations.
6. Assure that localities use CARE funds only for services as payer of last resort, assisting both rural and urban areas.
7. Establish service standards. NHCPC may assist in developing service or quality of care standards for providers.
8. Take a leadership role in assessment and evaluation of service quality, unit costs, effectiveness, and administrative efficiency of subgrantees/providers/contractors, in cooperation with providers, the lead agency, and the grantee.

Prevention and Care Related:

1. Develop a Comprehensive HIV Prevention Plan consistent with the high priority HIV care/support and prevention needs for defined target populations. Annually review and modify this plan as necessary.
2. Review and endorse Statewide Coordinated Statement of Need incorporating information required per HRSA.
3. Evaluate the effectiveness of the planning process.

**IV. Responsibilities between NHCPC and HHS**

**A. Shared Responsibility between the NHCPC and HHS will be as follows:**

1. Two co-chairs will direct the NHCPC. The State Co-Chair will be appointed by HHS. The second, the Community Co-Chair, will be elected by the NHCPC membership. The terms of co-chairs are outlined in Article VI of the Bylaws for the NHCPC.
2. Develop and implement policies and procedures that clearly address and outline systems for regularly re-examining:



- a. NHCPC composition, selection, appointment, and terms of office to ensure that it reflects, as much as possible, the population characteristics of the epidemic in State and local jurisdictions in terms of age, race/ethnicity, gender, sexual orientation, geographic distribution, and risk for HIV infection as well as persons living with HIV disease.
  - b. Methods for reaching decisions, attendance at meetings, resolution of disputes identified in planning and decision making as well as resolution of conflict of interest(s) for members of the NHCPC.
  - c. Roles and responsibilities of the NHCPC members and its various components (e.g. standing committees, ad hoc groups, or task forces).
3. Develop and apply criteria for selecting the individual members of the NHCPC with special emphasis being placed on procedures for identifying representatives of socioeconomically marginalized groups, persons at greatest risk for HIV transmission, and groups that are underserved by existing HIV prevention programs.
  4. Provide a thorough orientation for all new members as soon as possible after election/appointment. New members should understand:
    - a. The roles, responsibilities, and principles outlined in this document.
    - b. The procedures and ground rules used in all deliberations and decision making.
    - c. Specific policies and procedures for resolving disputes and avoiding conflict of interests that are consistent with the principles of the CDC Community Planning Guidance and Section VII of the Ryan White CARE Act Title II Manual.
  5. Assess the present and future extent, distribution, and impact of HIV in defined populations.
  6. Conduct a needs assessment process to identify unmet HIV prevention and care needs within defined populations.
  7. Identify specific high priority prevention strategies and interventions for defined target populations.
  8. Identify location, gaps, barriers, and effectiveness of services available to persons infected and living with HIV.
  9. Integrate multiple sources of information, i.e., behavioral, treatment, psychosocial, geographic, scientific, cost effectiveness, etc., into a statewide, comprehensive HIV prevention and care plan.
  10. Foster collaboration and coordination among agencies, individuals, and programming efforts relevant to HIV care and prevention including but not

limited to: STD, TB, Substance Abuse and Prevention and Treatment, Women's Health Services, Mental Health Services, and other public health needs.

11. Evaluate the community prevention and care planning process to assure that it is meeting the core objectives for CDC Community Planning and HRSA Consortia Responsibilities.

**B. Co-Chair responsibilities will be as follows:**

1. Develop an agenda for each meeting based on input from the NHCPC members and HHS HIV staff.
2. Co-facilitate the meetings. If a meeting facilitator is used, assist said facilitator.
3. Participate in briefing prior to each meeting.
4. Participate in debriefings after each meeting.
5. Manage and resolve NHCPC conflicts.
6. Coordinate standing committee work and reports.
7. Represent the NHCPC to the public.
8. Advocate the work of the NHCPC.
9. Together with the NHCPC membership, lead the group in attaining the purpose of the group and its mission through active participation in process, solicitation of community input, supporting the principles of P.I.R., providing and/or seeking technical assistance from experts, and collecting/analyzing and disseminating relevant data as appropriate.

In addition to the time requirements outlined for the NHCPC meetings (estimate of four meetings per year from 8:00 a.m. to 5:00 p.m. and standing committee work), co-chairs can expect to spend an estimated additional 24 hours per quarter on NHCPC business.

**C. NHCPC member responsibilities will be as follows:**

1. Make a commitment to the mission of the NHCPC, its process, and results.
2. Participate in all decisions and problem solving in achieving the group's purpose.
3. Undertake special tasks as requested by the NHCPC.
4. Gather data and information as needed.

5. Serve as a representative spokesperson for the position served on the NHCPC.
6. Serve as a liaison between the NHCPC and the community/area represented by your position as well as the community at large.
7. Participate on a minimum of one standing committee for the NHCPC per calendar year.
8. Facilitate and/or serve as liaison with focus or special interest groups in order to ensure that information and input is obtained from targeted populations and communities.
9. Follow the Bylaws.
10. Support the Code of Conduct defined in this document (Section X).
11. Evaluate the process and assess the responsiveness and effectiveness of the HHS applications for federal HIV Prevention and CARE funds as identified in the Comprehensive HIV CARE and Prevention Plan.
12. Define technical assistance needs for the successful implementation of a comprehensive HIV prevention and care plan for Nebraska.

It is expected that NHCPC members will have to spend 16-24 hours per quarter on NHCPC related activities. This should include the time spent for travel, standing committee work, and other duties that may arise.

**D. NHCPC non-voting member serving on a standing committee responsibilities will be as follows:**

1. Make a commitment to the mission of the NHCPC, its process, and results.
2. Participate in all decisions and problem solving in achieving the group's purpose.
3. Undertake special tasks as requested by the NHCPC.
4. Gather data and information as needed.
5. Participate on a minimum of one standing committee meeting for the NHCPC per calendar year.

6. Facilitate and/or serve as liaison with focus or special interest groups in order to ensure that information and input is obtained from targeted populations and committees.
7. Follow the Bylaws.
8. Support the Code of Conduct defined in this document (Section XI).

It is expected that NHCPC non-voting members serving on a standing committee will have to spend 3-10 hours per quarter on NHCPC related activities. This should include the time spent for travel, standing committee work, and other duties that may arise.

**E. NHCPC Consultant responsibilities will be as follows:**

1. Based on their expertise, provide consultation to NHCPC membership and committees as requested.
2. Support the mission of the NHCPC, its process, and results.
3. Follow the Bylaws.
3. Support the Code of Conduct defined in this document (Section XI).

**F. HHS HIV Program responsibilities will be as follows:**

1. The HHS HIV Program is required to determine how best to achieve and integrate statewide, regional, and local community HIV planning within their jurisdictions. As such, the HHS HIV Program will establish and maintain the NHCPC, which meets the principles outlined in the CDC Community Planning Guidance and the HRSA Ryan White CARE Act Manual.
2. Identify a health and human service department employee, or a designated representative, to serve as Co-Chair for the NHCPC.
3. Each standing committee will have a State Liaison appointed by the HIV Program Administrator. The role of the liaison will be to facilitate the work of the committee and serve as a resource for materials, information, and direction.
4. Identify and assist in obtaining key leadership and expertise supporting the purpose and mission of the NHCPC including supporting P.I.R. principles within the process.
5. Ensure the NHCPC understands its roles and responsibilities.

6. Keep the NHCPC focused on the context within which the issues of HIV care and prevention take place: assessment, recommendation, evaluation, etc., not funding decisions.
7. Provide guidance and support to the community and state appointed co-chairs, standing committees, and members as necessary.
8. Provide technical assistance and support which may include but not limited to:
  - a. Epidemiological information
  - b. Descriptions of target populations
  - c. Profiles of existing regional resources
  - d. Information about strategies for HIV prevention
  - e. Information about existing care and support services
  - f. Support in conducting ongoing needs assessment
  - g. Compile, collect, and analyze data as necessary
  - h. Necessary information and materials to NHCPC
  - i. Facilitate specific group activities
  - j. Deal with logistics in setting up and facilitating meetings
9. Develop an application for HIV prevention cooperative agreement funds and Ryan White Title II funds per processes identified through the federal guidances provided by CDC and HRSA respectively. This includes seeking review of the HIV Prevention application as required and obtaining letters of concurrence/nonconcurrence from the NHCPC.
10. Provide periodic feedback to the NHCPC on the successes and barriers encountered implementing HIV prevention and care services statewide.

## **V. Standing Committees**

The NHCPC will have six standing committees designated below. Committee members may be selected from the NHCPC membership and/or selected from the community at large. The committee chair must be a member of the NHCPC. The committee chair must have attended three consecutive meetings prior to election and ensures the committee operates under the Bylaws and Operational Guidelines. Whenever possible members of committees should follow the principles of parity, inclusion, and representation as set forth in the Community Planning Guidance. The NHCPC chair(s) may create additional standing committees, ad hoc groups, or task forces as deemed appropriate to ensure that the mission of the NHCPC is successfully met.

### **A. CARE Services Committee**

Purpose:

- ◆ Review the menu of Direct Client Services (limited to support services) and provide feedback to the Title II Program Manager regarding the adequacy of services.
- ◆ Provide recommendations to the Title II Program Manager regarding the addition or deletion of provided services.
- ◆ Research and provide information as necessary to identify additional services and assist in their procurement as necessary.
- ◆ This committee will not have authority for making client financial determinations or service limit.
- ◆ Assist in the development of additional resources for service provision.

### **B. Assessment and Evaluation Committee**

Purpose:

- ◆ To review, identify strengths and weaknesses, and provide recommendations regarding prevention and care evaluation and assessment processes and results.

Duties:

- ◆ Review the comprehensive evaluation plan developed according to CDC and HRSA instructions and make recommendations for implementation.
- ◆ Review prevention and care assessment data and make recommendations as to services, gaps, barriers, and unmet needs.
- ◆ Review evaluation data and make recommendations as requested based on data type.
- ◆ Review the community planning process and survey data and make recommendations regarding the five core objectives.
- ◆ Recommend additional evaluation, assessment, and quality assurance activities based on pertinent data, trends and programmatic needs.

### **C. Interventions Committee**

Purpose:

- ◆ To utilize statewide needs assessment information for the purpose of identifying, prioritizing, and recommending behavioral interventions for funding with HIV prevention funds. The effectiveness and support of the implementation of these recommended interventions should be based in behavior change theory, be cost effective, and compatible with the norms, values and relevance for the communities where they will be introduced.

Duties:

- ◆ Review recommended interventions from regional areas and target populations.
- ◆ Prioritize interventions based on social science theory, cost effectiveness, and acceptability of local norms and values.

- ◆ Work with HHS HIV program on viability of implementation of interventions being assessed.
- ◆ Recommend prioritized interventions for funding by HHS.

#### **D. Membership Committee**

##### Purpose:

- ◆ Recruit elected members and orient all participants. The Membership Committee will solicit new members under the guiding principles of achieving parity, inclusion, and representation of the epidemic for the NHCPC. Personal knowledge and expertise will be sought for positions, which contribute critical information to the development of a comprehensive HIV CARE and prevention plan.

##### Duties:

- ◆ Recruit candidates for Community Co-Chair and conduct Community Co-Chair elections.
- ◆ Recruit new members for position vacancies (new members should be identified and recommended for appointment to begin positions each January).
- ◆ Recommend new recruits for acceptance for NHCPC membership.
  - Advertisement for recruitment should be done statewide
  - Recruitment should follow PIR guidelines
  - Consideration should be given to achieve membership balance in the areas of geographic representation, race/ethnicity, age, gender, sexual identity, risk behavior, and ability to actively participate
- ◆ Assign members to standing committees after reviewing applications/request forms and consulting with the NHCPC Co-chairs and the standing committee chairpersons.
  - Contact individuals who have been recommended to participate as a non-voting member serving on a standing committee to obtain application.
  - Review written requests from current standing committee members to be transferred to another standing committee.
- ◆ Fill positions that may be vacated prior to end of membership term.
- ◆ Orient new members to NHCPC purpose and goals.
- ◆ Ensure barriers for membership participation is minimized, (i.e. application forms in are multi-language, translation and/or other special needs addressed).
- ◆ Maintain and update member notebooks as necessary.

## **E. Public Information Committee**

### Purpose:

- ◆ To review proposed educational materials, to discuss media and education that is made available to communities, make recommendations for educational materials, and participate in the development of a public information plan.

### Duties:

- ◆ Review educational materials including brochures, videos, etc. to ensure they meet CDC guidelines.
- ◆ Build a resource inventory of approved materials.
- ◆ Provide input and recommendations to the annual public information plan.
- ◆ Recommend new educational material for purchase.

## **F. Co-Infection Committee**

### Purpose:

- ◆ To monitor emerging HIV co-infection issues (ie: HCV, HBV, syphilis, HPV, and chlamydia-LGV).

### Duties:

- ◆ Review and report on mortality/morbidity issues related to co-infection
- ◆ Establish a co-infection response that could be incorporated in the Nebraska HIV Comprehensive Plan.
- ◆ Data analysis for priority populations related to co-infection impact and potential risk factors in Nebraska.
- ◆ Explore potential funding opportunities based on identified needs.
- ◆ Develop educational/awareness materials for professionals and public.

## **G. Executive Committee**

### Purpose:

- ◆ To provide decision making capability on behalf of the NHCPC between meetings for specific and emerging functions.

### Duties:

- ◆ Carry on the business of the NHCPC between meetings as needed.
- ◆ Assist in the revision of the NHCPC Comprehensive Plan.
- ◆ Review annual CDC grant applications and provide concurrence, non-concurrence or concurrence with recommendations.
- ◆ Review and recommend revisions to the NHCPC Operational Guidelines and By Laws on an as needed basis but no less than annually.
- ◆ Review the Statewide Coordinated Statement of Need
- ◆ Act on behalf of the NHCPC in the event of unforeseen circumstances.



## **H. Committee Chair Role**

1. Call and facilitate a minimum of three committee meetings each calendar year.
2. In collaboration with State Liaison for the committee, set agenda for meeting and make arrangements.
3. Ensure minutes, sign-in sheets, and expense documents are utilized and forwarded to HHS.
4. Provide summary of meeting outcomes to NHCPC co-chairs and report to NHCPC membership as necessary.
5. Recruit non-NHCPC members as needed to fulfill the duties of the committee.
6. Request technical assistance as needed to fulfill the duties of the committee.

## **I. Committee Member Role**

1. Participate in a minimum of three committee meetings each calendar year.
2. Actively participate in work of the committee to fulfill committee duties.
3. Assist in recruiting additional non-NHCPC members as needed to fulfill the duties of the committee.
4. Solicit information and perform activities as necessary to fulfill committee duties.
5. Ask for technical assistance as necessary to participate as an active member on committee and in committee activities.

## **VII. Orientation**

Active participation from members and non-voting members serving on standing committees is critical for the work of the NHCPC to be accomplished in a timely and efficient manner. The membership structure of the NHCPC is designed to bring new voices to the “table” on a rotating basis to allow for comprehensive involvement by the community. Because the number of meetings for the NHCPC and its standing committees will be limited, it is important that all participants are prepared to fully participate at each meeting.

New members and non-voting members serving on standing committees will be provided an orientation session prior to their attendance at their first meeting. The Membership Committee, in collaboration with the NHCPC Co-Chairs, will provide orientation sessions, as needed, prior to each regular meeting for new members and non-voting members serving on standing committees joining the group. Orientation materials and a membership binder will be given to each new member and non-voting member serving on a standing committee.

Any member currently on the NHCPC may request update training or technical assistance if such training/assistance is felt to be needed to more fully participate or understand the group’s process. The Membership Committee, with the assistance of the NHCPC Co-

Chairs, will facilitate access to the requested training as appropriate and upon approval by the HHS HIV Program.

## **VIII. Open Meeting Laws**

The basic statement of Nebraska State policy on public meetings is found at Neb.Rev.Stat. §84-1408. This statute provides, “It is hereby declared to be the policy of this state that the formation of public policy is public business and may not be conducted in secret. Every meeting of a public body shall be open to the public in order that citizens may exercise their democratic privilege of attending and speaking at meetings of public bodies, except as otherwise provided by the Constitution of the State of Nebraska, federal statutes, and sections 79-327, 84-1408 to 84-1414, and 85-104.”

Open meetings provisions apply to meetings of any “public body”, which includes governing bodies of local and state governmental units; independent boards, commissions, councils, and other similar bodies; advisory groups to the executive branch and to public bodies, and instrumentalities exercising essentially public functions.

The NHCPC will follow the Open Meeting Laws for the State of Nebraska and follow the accepted guidelines and definitions outlined in the Handbook on Public Meetings. A notebook containing a regular and large print version of the Nebraska Open Meeting Law Statute will be displayed prominently at each NHCPC meeting. Each NHCPC member will also have a regular print copy of the statute in their membership binder.

## **IX. Expenses**

Reimbursement of expenses for volunteer members of State affiliated boards, committees, commissions, and task forces may be provided per HHS DAS Administrative Policy, pursuant to Section 81-118L.01. State law prohibits the payment for services until the service has been provided which in turn requires the HIV program to reimburse a member’s expenses *after* the NHCPC meetings occur. Mileage at the state reimbursement rate, meals at per diem rates, lodging and parking expenses may be reimbursed to members and non-voting members serving on standing committees. The HHS HIV Program cannot reimburse agencies or reimburse for the use of agency vehicles. If more than one member or non-voting member serving on a standing committee shares transportation to a meeting, only reimbursement to the owner/driver of the vehicle used will be given.

The process and details for reimbursement of expenses will be covered in new member orientation and may be found in the member handbook, (example: lodging for attending a meeting of the NHCPC will be reimbursed at the state approved rate when the participant is traveling more than 60 miles one-way to the meeting).

Should a member or non-voting member serving on a standing committee require “special assistance” to attend meetings or standing committee functions on behalf of the NHCPC, a process is in place to assist members and non-voting members serving on

standing committees prior to their arrival at the meeting/function. Details and management of this process may be accessed through the State Co-Chair.

## **X. Lobbying**

The NHCPC operates under direct affiliation with Nebraska Health & Human Services HIV Program and its cooperative agreements with the Centers for Disease Control and Prevention and the Health Resources and Services Administration. Funding for support of this advisory group and its related functions are provided through these federal cooperative agreement funds. Therefore, the NHCPC, its activities, and the activities of its designated standing committees, ad hoc groups, or task forces must follow restrictions determined by federal guidelines.

Under the provisions of 31 U.S.C. Section 1352 (which has been in effect since December 23, 1989), recipients (and their sub-tier contractors) are prohibited from using appropriated Federal funds (other than profits from a Federal contract) for lobbying Congress or any Federal agency in connection with the award of a particular contract, grant, cooperative agreement, or loan. This includes grants/cooperative agreements that, in whole or in part, involve conferences for which Federal funds cannot be used directly or indirectly to encourage participant to lobby or to instruct participants on how to lobby.

In addition, no part of any appropriation may be used for publicity, propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to defeat legislation pending before the Congress or any State legislature. No part of any appropriation contained in Public Law 105-78 can be used to pay the salary or expenses of any grant, contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

## **XI. Code Of Conduct**

The following ground rules define appropriate group behavior standards. The standards provide guidance for member and non-voting member serving on standing committee functions within the group and within their respective agencies and/or communities as representatives of the Nebraska HIV CARE and Prevention Consortium.

- A. Commit to regular meeting attendance and active participation. Members and non-voting members serving on standing committees are required to attend meetings as scheduled;
- B. Act first and foremost as a participant of the NHCPC and within the best interest of the group;
- C. Put aside personal agendas;

- D. Separate agency/organizational goals and needs from those of the NHCPC, standing committees, ad hoc groups, or task forces.
- E. Share all pertinent feedback, both positive and negative, within the group;
- F. Discuss/resolve concerns during meetings, not behind closed doors or outside the advisory group;
- G. Be positive about the advisory group, its mission and purpose;
- H. Exercise discretion to maintain the group's integrity (i.e., not airing "dirty laundry" in public);
- I. Acknowledge and respect all variant views;
- J. Respect each other's differences, knowledge, experience and frame of reference;
- K. All comments will be made in a respectful and reasonable timeframe; filibustering will not be considered respectful or reasonable as applicable to the purpose and mission of the NHCPC.

## **XII. Conflict of Interest/Confidentiality**

A conflict of interest can be defined as a conflict between one's obligation to the public good and one's self interest, whether that interest be a personal interest, or interest of family, friend or work related. A conflict of interest occurs when a member or non-voting member serving on a standing committee knowingly takes action or makes a statement intended to influence the conduct/decisions of the public body of which he or she is a participant. If the action in any way confers any financial or programmatic benefit to the participant the organization, persons, program, etc., the participant is affiliated with, a conflict of interest is present.

The Nebraska HIV CARE and Prevention Consortium, in their advisory relationship to the HHS HIV Program, functions as a public body. The mission and purpose of the NHCPC is to address the HIV issues impacting all Nebraskans and thus work on behalf of the "public good". A NHCPC member or non-voting member serving on a standing committee who also serves as a director, trustee, salaried employee, volunteer, or otherwise benefiting from any HIV / AIDS prevention or CARE funds is deemed to have an "interest" in the decisions of the NHCPC and must declare their conflict openly and be excluded from voting on those decisions.

Meetings of the NHCPC adhere to Nebraska statutes, policies, and procedures concerning Open Meeting Laws. However, disclosures or discussions which place a member at possible risk of harm to person or reputation shall be kept confidential and restricted to the business of the NHCPC. Information discussed and provided, whether written or oral, is for the purpose of accomplishing the missions and objectives of the advisory

group. Members may share as much personal information as they feel comfortable with in the course of the NHCPC process, but should be fully cognizant of the parameters of the Nebraska Open Meeting Laws. Members should be aware that staff of HHS adhere to confidentiality principles, but accept no responsibility for disclosures or actions by members that violate these principles. Confidentiality principles follow guidelines established by CDC and HRSA. Additional comments or questions should be referred to the Program Administrator for the HIV Program.

### **XIII. Dispute Resolution**

To develop an inclusive approach for addressing the HIV prevention and care needs of a particular community, a wide range of representatives and information must be involved in the planning processes. This variety and diversity of opinions, beliefs, values, and ways of communicating add the needed ingredients for developing a comprehensive plan for addressing both prevention and care needs. Despite careful organizational development, effectiveness of meetings and commitment of participants, disagreements and conflicts inevitably arise and may become disputes. Conflicts among members and non-voting members serving on standing committees may arise within meetings and outside of meetings, (i.e., ad-hoc meetings, special activities, committee meetings).

When conflicts arise in the process of making decisions at NHCPC meetings, an attempt will be made to work through the conflict and achieve consensus among participants of the issue at hand. Consensus decision making is defined as a decision in which all participants of the group support or can live with the decision in question.

Consensus decision making is not easy. This is especially true when the decision making body is comprised of individuals representing diverse points of view. Consensus decision making requires full discussion, individual and collective honesty, and sharing of all relevant information. In order for a consensus decision making process to be successful:

- A. Each participant's view on the issue at hand needs to be shared with the group.
- B. The interests of each participant must be identified. (An interest is the core or driving force that makes that issue important to that person. A participant's interest can usually be identified by asking, "Why is this issue important to you?")
- C. The interests of each participant need to be able to be understood by all of the participants. (This does not mean everyone must agree with the interests identified but it does mean that everyone understands what the interests of each participant are.)
- D. Once the interests of the participants are understood, several options to resolve the issue at hand must be generated by the group.
- E. Any option selected to resolve the issue must meet at least some of the interest of all participants.

In order to meet open meeting law requirements, any consensus decision will then be recorded in a roll call vote. In the event that the group, after identifying interests and generating options, cannot reach consensus, the NHCPC will resort to the use of a roll call vote.

When conflicts arise outside of NHCPC meetings concerning NHCPC business, members and non-voting members serving on standing committees are urged to use the same model as above in resolving the issue at hand.

#### **XIV. Grievance – Statement of Concern Procedures**

Grievances concerning decisions made or actions taken by NHCPC must be filed in writing with the HIV Program Administrator. The HIV Program Administrator will establish an oversight committee to deal with the filed grievance. The oversight committee will consist of:

- ◆ HIV Program Administrator
- ◆ State Co-Chair
- ◆ Community Co-Chair
- ◆ Two members of the NHCPC selected by the HIV Program Administrator and agreed upon by the Co-Chairs.

The oversight committee will review the filed grievance. The committee, upon reviewing the grievance, may:

- A. Request a meeting with the individual who has filed the grievance if the committee feels such a meeting would be helpful in understanding the grievance.
- B. Request that the party filing the grievance mediate with representatives of the oversight committee as appointed by the HIV Program Administrator. The mediator in such a situation would be a neutral third party who has no vested interest in the outcome of the mediation. If the mediation is successful (agreement is reached between the parties), a part of the mediated agreement would be the withdrawal of the grievance by the party who filed the grievance.
- C. Investigate the grievance, respecting the confidentiality of all concerned parties, and present recommendations to NHCPC as to an appropriate disposition of the matter. Once a decision is made by NHCPC, a written response to the individual who filed the grievance will be made within 30 days. The committee, in its written response, will either uphold the original decision by NHCPC or will request that NHCPC re-examine the issue raised in the grievance and take new action of the issue raised in the grievance.

Grievances concerning the performance or conduct of a member or non-voting member serving on a standing committee must be filed in writing with the HIV Program Administrator. The HIV Program Administrator will establish an oversight committee to

deal with the filed grievance. The oversight committee will consist of:

- ◆ HIV Program Administrator
- ◆ State Co-Chair
- ◆ Community Co-Chair
- ◆ Two members of the NHCPC selected by the HIV Program Administrator and agreed upon by the Co-Chairs.

The oversight committee will review the filed grievance. The committee, upon reviewing the grievance, may:

- A. Request a meeting with the individual who has filed the grievance if the committee feels such a meeting would be helpful in understanding the grievance.
- B. Request that the party filing the grievance mediate with the individual who they have filed the grievance about. The mediator in such a situation would be a neutral third party who has no vested interest in the outcome of the mediation. If the mediation is successful (agreement is reached between the parties) a part of the mediated agreement would be the withdrawal of the grievance by the party who filed the grievance.
- C. Investigate the grievance, respecting the confidentiality of all concerned parties, and present recommendations to NHCPC as to an appropriate disposition of the matter. Options for consideration by NHCPC include:
  1. A motion may be made to vote to remove the individual from NHCPC pursuant to ARTICLE IV., Section 3 of the Bylaws.
  2. A motion may be made to call the question and the topic is tabled.
  3. A motion may be made and a vote taken to take no further action on the grievance filed. Once a decision is made by NHCPC, a written response to the individual who filed the grievance will be sent within 30 days.

*Changes Approved: 3/26/2002*

*Changes Approved: 1/23/2003*

*Changes Approved: 2/14/2004*

*Changes Approved: 4/22/2004*

*Changes Approved: 6/24/2004*

*Changes Approved: 8/19/2004*

*Changes Approved: 10/21/2004*

*Changes Approved: 1/27/2005*

*Changes Approved: 4/20/2005*

*Changes Approved: 7/20/2006*

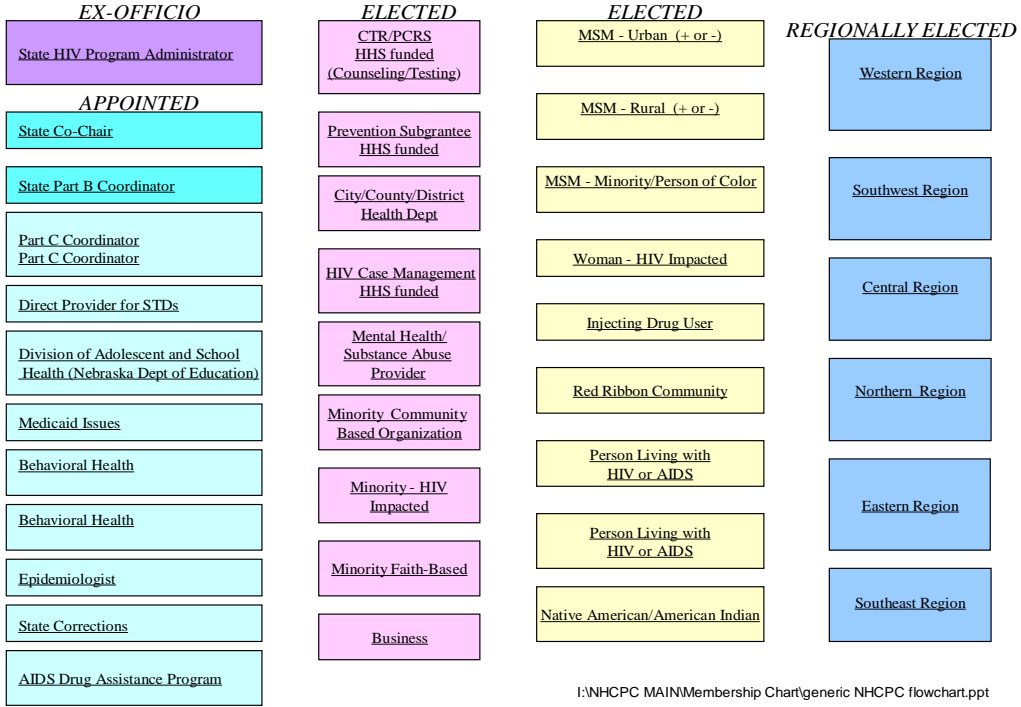
*Changes Approved: 4/19/2007*

*No Changes: 1/24/2008*





## Nebraska HIV CARE and Prevention Consortium



I:\NHCPC MAIN\Membership Chart\generic NHCPC flowchart.ppt



## **APPENDIX 4**

### **HIV/AIDS Case Management Standards**

#### **INTAKE**

- I. Prospective clients who request or are referred for case management services are properly screened and evaluated for eligibility through a brief information gathering and decision making process.

#### **ASSESSMENT**

- II. Every client accepted through the intake process must receive a comprehensive assessment. Level of acuity will be developed for each client, utilizing the Nebraska Client Acuity Scale.

#### **CARE PLAN**

- III. An individualized care plan is developed, monitored, and revised in conjunction with the client. The client and case manager identify and prioritize immediate, short term and ongoing needs that will enhance the health status and self-sufficiency of the client.

#### **REASSESSMENT**

- IV. Reassessment will be completed whenever the client's condition or circumstances change, but at least every six months.

#### **REFERRALS**

- V. Referrals and follow-up to referrals are confidential and completed in accordance with the client's needs.

#### **PROVIDER LINKAGE**

- VI. All providers will function as part of a coordinated continuum of services for HIV/AIDS clients.

#### **PROVIDER PROFESSIONAL STANDARD**

- VII. HIV/AIDS service providers will adhere to professional, clinical, and programmatic standards and regulations stipulated by the licensure, regulation, certification and accreditation held by the provider.

#### **CULTURAL COMPETENCE**

- VIII. All clients receiving HIV case management services will receive care and services which are culturally sensitive, competent and appropriate, in language that the client can understand.

## **TRANSFER AND DISCHARGE**

- IX. A process shall be in place to guide transfer of the client to another program or case management service area, and to discharge the client from case management services. There will be clear documentation of the reason for discharge and notification of the client or family of closure of the case.

## **CLIENT RIGHTS AND RESPONSIBILITIES**

- X. Agency policies and procedures will assure and protect client rights and outline client responsibilities.

## **CONFIDENTIALITY**

- XI. Agencies will store and maintain client records in a confidential and secure manner. All personnel will maintain confidentiality of client information.

## **CLIENT GRIEVANCE**

- XII. The agency will have a grievance policy that is explained to the client, client representative, or family member.

## **QUALITY ASSURANCE/EVALUATION**

- XIII. Agency will have a method to monitor the appropriateness, adequacy and the effectiveness of the case management system, and to assure client satisfaction, cost effectiveness, quality of services and opportunities for continuous improvement.

## Priority Population Weight/Rank Score Sheet

Population \_\_\_\_\_

FACTOR	RATING INFORMATON	RANK/SCALE	WEIGHT	RANK SCORE	FINAL SCORE (Weight x Rank)
Predominant Mode/Risk Factor	What is the primary risk behavior known to occur among the target population?	1: None, unknown, or low risk 2: Unprotected Oral sex 3: Unprotected vaginal sex 4: Unprotected anal Sex 5: Blood to blood	5		
AIDS Prevalence	How many people in the target population are living with AIDS?	1: 0-25 2: 26-50 3: 51-75 4: 76-100 5: > 100	3		
HIV Prevalence	What is the estimated number of people living with HIV in the target population?	1: 0-25 2: 26-50 3: 51-75 4: 76-100 5: >100	3		
Barrier to Reaching the population/difficulty meeting population needs.	Are there significant barriers to reaching the target population with HIV prevention interventions..	1: Few or virtually no barriers 3: Moderate barriers 5: Substantial Barriers	1	Access: Language: Isolation: Provider: Testing access: Total score:	
Emerging Trends	Average HIV Incidence over 5 years.	1: 0-2 2: 3-5 3: 6-9 4: 10-12 5: > 12	4		
<b>Total Score:</b>					

APPENDIX 5

**Access:** A set of cultural, behavioral societal norms that may preclude the targeted population from allowing prevention outreach to permeate.

**Language:** (Barrier) Occurs when the primary language is one other than English.

**Isolation:** Geographic distance between members of the targeted population and prevention service providers.

**Providers:** Availability of prevention providers for the targeted population.

**Testing:** The availability of testing and/or test sites acceptable to the target population.



**APPENDIX 6**

**Race/Ethnicity and Age Factors  
Risk Factors**

Nebraska Priority Setting Process 2007  
For 2009-2013

Ethnicity/Race	HIV	AIDS	Rank/Scale	Weight	Score: Rank x Weight			Final Score
	Rate*	Rate*			HIV	AIDS	Risk Factors	
White <19 years			<b>Ranking Scale for HIV/AIDS Rates</b> 1: 0 – 50 2: 51-100 3: 101-150 4: 151-200 5: 200+	3				
20-29 years								
30-39 years								
40-49 years								
50+ years								
African/American < 19 years			<b>Ranking Scale for Other Risk Factors</b> 1: 0 factors 2: 1 factor 3: 2 factors 4: 3 factors 5: all 4 factors	2				
20-29 years								
30-39 years								
40-49 years								
50 + years								
Hispanic < 19 years			Risk Factors *High STD rates *High use of C & T *Drug & ETOH abuse *Multiple partners					
20-29 years								
30-39 years								
40-49 years								
50 + years								
American Indian/AN <19 years								
20-29 years								
30-39 years								
40-49 years								
50 + years								
Asian < 19 years								
20-29 years								
30-39 years								
40-49 years								
50 + years								

- Steps: 1. Determine rank for HIV and multiply by weight to calculate score for each age group in each race/ethnicity category. Enter score in appropriate box.  
 2. Repeat for AIDS data and enter in appropriate box.  
 3. Repeat for risk factors. If there is no clear age breakdown appropriate, score the race/ethnicity group.  
 4. Add the three scores: HIV, AIDS, Risk factors for the total score.  
 5. Circle the top six scores and transfer to Priority Population group sheet.

\* Based on occurrence per 100,000 population





## APPENDIX 7

### Population Summary Sheet

\_\_\_ MSM      \_\_\_ MSM/IDU      \_\_\_ Male IDU  
\_\_\_ Female IDU      \_\_\_ Male HRH      \_\_\_ Female HRH

(check only one population for this summary sheet)

Age/Ethnicity/Race Group	Score
1. _____	<input type="text"/>
2. _____	<input type="text"/>
3. _____	<input type="text"/>
4. _____	<input type="text"/>
5. _____	<input type="text"/>
6. _____	<input type="text"/>

**YOU ARE DONE. Scores will be transferred to the final summary sheet by your staff facilitator!**



## APPENDIX 8

### Final Score Summary Sheet Nebraska Priority Setting Process 2007 For 2009-20013

	MSM	MSM	MALE	FEMALE	MALE	FEMALE
		IDU	IDU	IDU	HRHetero	HRHetero
<b>Weight/Rank Score</b>						
<b>Factors →→→</b>	Score	Score	Score	Score	Score	Score
White						
<19 years						
20-29 years						
30-39 years						
40-49 years						
50+ years						
African/American						
< 19 years						
20-29 years						
30-39 years						
40-49 years						
50 + years						
Hispanic						
< 19 years						
20-29 years						
30-39 years						
40-49 years						
50 + years						
American Indian/AN						
<19 years						
20-29 years						
30-39 years						
40-49 years						
50 + years						
Asian						
< 19 years						
20-29 years						
30-39 years						
40-49 years						
50 + years						
<b>TOTALS</b>						

Transfer the top six scores from each Population Summary Sheet to this sheet into the corresponding cell. For tie scores that would include more than six scores, enter into appropriate cells. Total the top *six scores only* plus the weight/rank score for each column.



## APPENDIX 9

### Determine Factors for Interventions

**PURPOSE:**

To select specific factors to consider when assessing how well an intervention will reduce HIV infections in a target population.

**DIRECTIONS:**

- **Check off those factors** that your group will use to choose interventions. (The factors are recommended for consideration by the *Guidance*.)
- **Fill in the data source column** in the first table to show where your group found data for each factor you choose.
- **Use your understanding** of the local community to make thoughtful assessments if a data source can't easily back up an intervention factor.

FACTOR	QUESTIONS TO CONSIDER	DATA SOURCES
<input type="radio"/> Targets a specific population	Is the intervention specifically designed to reach the target population?	
<input type="radio"/> Targets a specific behavior	Is the intervention specifically designed to change the target behavior?	
Effectiveness	What evidence exists to show that this intervention is effective in averting or reducing high-risk behavior?	
<input type="radio"/> Sound theoretical basis	Was behavioral and/or social science research and theory used as a basis for designing the intervention?	
<input type="radio"/> Norms, values, consumer preferences	Is the intervention acceptable to the target population? Did members of the intended audience either develop the intervention themselves or provide input into its development?	
<input type="radio"/> Intervention feasibility	The factors listed below may be used to evaluate whether an intervention is feasible.	
- Capacity	Does the capacity exist to develop the interventions? Is the intervention practical, given available expertise, funding, and implementation time? Who can do this work? How much will it cost? How long will it take to be implemented?	
- Sustainability	Is the intervention sustainable over time? If federal dollars were not available, how might this intervention be sustained?	
- Resources	What are these resources? Are other resources available to assist delivery of the intervention?	
- Legality	Is this intervention legal? Do federal, state, or local laws or ordinances prohibit implementation of the intervention? If so, what are your funding sources?	
<input type="radio"/> Cost effectiveness	When choosing between two interventions for the same population, which one will reduce new infections for less money?	
<input type="radio"/> Other considerations based on state or local needs.	(Depends on state/local issues.)	



**APPENDIX 10**  
**NHCPC Member Profile**  
**January 2008**

**INSTRUCTIONS:** *This survey is designed to assist the HIV Prevention & Ryan White Program staff in summarizing the demographic profile of the NHCPC for the Centers for Disease Control (CDC) and grant reports. Please respond to the items below, keeping in mind your responses will not be linked to you in any way.*

- 1) I am a: (check only one)  
a) NHCPC Voting Member   
b) NHCPC Non-voting member
- 2) How many NHCPC meetings did you attend in 2007? \_\_\_\_\_ (Range = 0-4)
- 3) Are you a NHCPC Standing Committee Member?  Yes  No
- 4) How many Standing Committee meetings did you attend in 2006? \_\_\_\_\_ (Range = 0-4)
- 5) What is your region of residence?  
 Western  Southwest  Central  Northern  Eastern  Southeast
- 6) What is the geographical location in which you live?  
 Rural (population less than 2,500)  
 Urban Non-Metropolitan (population between 2,500 and 100,000)  
 Urban Metropolitan (population greater than 100,000)
- 7) What is your age?  
 13-18  19-24  25-34  35-44  45-64  65+
- 8) What is your gender?  
 Male  Female  Transgender
- 9) What is your sexual orientation?  
 Heterosexual  Gay  Bisexual  Lesbian
- 10) What is your ethnicity?  
 Hispanic/Latino  Non-Hispanic/Non-Latino
- 11) What is your race?  
 American Indian/Alaska Native  Native Hawaiian/Pacific Islander  
 Asian  White  
 Black or African American
- 12) Are you an individual living with HIV/AIDS?  
 Yes  No  Unknown
- 13) Are you an individual affected by HIV/AIDS?  
 Yes  No  Unknown

(Definition of "Individual affected by HIV/AIDS": individual who is HIV+, or has a spouse, partner, significant other, family member or close friend who is living with HIV/AIDS or who has died from HIV/AIDS.)

14) The following are HIV risk populations whose perspectives you may represent on the NHCPC through personal life experiences, work responsibilities, or other affiliations. Mark all populations that you represent on the NHCPC.

- Men who have sex with men and are at risk through unsafe sex (MSM)

- Men who are at risk from both unsafe sex with other men and unsafe drug injection practices (MSM/IDU)
- Men and women who are at risk through unsafe injection drug practices (IDU)
- Men and women who are at risk through unsafe heterosexual sex with an infected partner
- Men and women who are at risk through unsafe sex with a transgender
- Men and women who are at risk from both unsafe sex with a transgender and unsafe injection drug practices
- Men and women not part of a specific population at risk for HIV

15) What type of organization(s) do you represent or are you affiliated with? (*Mark all that apply*)

(Note: Organizations that you are affiliated with may be through personal, work, volunteer or educational experiences.)

- |  |  |
|--|--|
| <input type="checkbox"/> Minority CBO                  | <input type="checkbox"/> Health Department: HIV/AIDS         |
| <input type="checkbox"/> Non-Minority CBO              | <input type="checkbox"/> Health Department: STD              |
| <input type="checkbox"/> Other Non-Profit              | <input type="checkbox"/> State/Local Education Agencies      |
| <input type="checkbox"/> Tribal/Native American        | <input type="checkbox"/> Academic Institution                |
| <input type="checkbox"/> Homeless Services             | <input type="checkbox"/> Research Center                     |
| <input type="checkbox"/> Substance Abuse               | <input type="checkbox"/> Corrections                         |
| <input type="checkbox"/> HIV Care and Social Services  | <input type="checkbox"/> Non-Agency/Community Representative |
| <input type="checkbox"/> Mental Health                 | <input type="checkbox"/> Business and Labor                  |
| <input type="checkbox"/> Faith Community               | <input type="checkbox"/> Insurance                           |
| <input type="checkbox"/> Federal/state agency          |  |
| <input type="checkbox"/> Other (please specify): _____ |  |

16) What type of expertise do you bring to the NHPCP? (*Mark all that apply*):

(Note: Areas of expertise may be gained through personal, work, volunteer or educational experiences.)

- |   |  |
|---|--|
| <input type="checkbox"/> Person living with HIV/AIDS    | <input type="checkbox"/> Epidemiologist              |
| <input type="checkbox"/> Person affected by HIV/AIDS    | <input type="checkbox"/> Evaluation                  |
| <input type="checkbox"/> Community Organization         | <input type="checkbox"/> Researcher                  |
| <input type="checkbox"/> Community Representative       | <input type="checkbox"/> Health Planner              |
| <input type="checkbox"/> Service Provider               | <input type="checkbox"/> Health Administration       |
| <input type="checkbox"/> Intervention Specialist        | <input type="checkbox"/> Medical (M.D., Nurse, etc.) |
| <input type="checkbox"/> Behavioral or Social Scientist | <input type="checkbox"/> Hepatitis C                 |
| <input type="checkbox"/> Education                      | <input type="checkbox"/> Insurance/Medicaid          |
| <input type="checkbox"/> Housing                        | <input type="checkbox"/> Religion/church             |
| <input type="checkbox"/> Transgender                    | <input type="checkbox"/> Bilingual                   |
| <input type="checkbox"/> Other (please specify): _____  |  |

Last updated: January 7, 2008







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