

END **NH**W Nevada

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State of Nevada Ending the HIV Epidemic (EHE) Plan



Nevada Department of
Health and Human Services
DIVISION OF PUBLIC AND
BEHAVIORAL HEALTH



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HEALTH DISTRICT
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EXECUTIVE SUMMARY

The Nevada Ending the HIV Epidemic Plan 2021-2026 was developed in response to the guidance provided by the Centers for Disease Control and Prevention (CDC) in November 2019. Clark County has been identified as one of the 48 priority jurisdictions in the United States that have been targeted for Phase I of America's Ending the HIV Epidemic (EHE) initiative and as a state Nevada has chosen to join this effort. Since 2012, Nevada has experienced an increase in both the number of new HIV diagnoses (incidence) and in people living with HIV (prevalence).¹ To address this issue, the HIV Prevention Program at the Nevada Division of Public and Behavioral Health (NDPBH) contracted with the Pacific AIDS Education and Training Center-Nevada (PAETC-NV) to complete a needs assessment and draft a plan for Nevada's Ending the HIV Epidemic (EHE) initiative. In January 2019, well before the CDC announced its funding opportunity for the development of EHE plans, PAETC-NV launched Nevada's EHE workgroup. The EHE Workgroup participants include a range of service providers, concerned citizens, and people living with HIV. Throughout the EHE process, the Nevada EHE workgroup has supported the design and implementation of the EHE needs assessment and contributed to the development of the EHE plan.

Carson City Health and Human Services, the statewide EHE Workgroup, the Nevada Division of Public and Behavioral Health HIV Prevention Program, Ryan White Parts A and B, Southern Nevada Health District, and Washoe County Health District guided the planning and development of this plan.

The state of Nevada has been unquestionably impacted by the HIV epidemic, with the highest rate (19.8) of new infections in the Western U.S. The CDC estimates that only 41.7% of Nevada's population has ever been tested for HIV. In 2018, the CDC estimated that just 79.7% of those living with HIV infection in Nevada had been diagnosed. This signifies that approximately one in five people living with HIV in Nevada are unaware of their status.

In 2019, Nevada had a total of 11,769 persons living with HIV or AIDS and 506 persons newly diagnosed with HIV. In 2019, 86% of persons newly-diagnosed with HIV in Nevada were male; and 70% of newly-diagnosed males reported a transmission category of male-to-male sexual contact. Large racial/ethnic disparities exist in HIV transmission, particularly among the Black/African American population. In 2019, the rate of new HIV diagnoses among Black men was six times greater than that of White men (105.1 vs. 17.1 per 100,000 population).

Of the 506 newly diagnosed HIV cases in Nevada in 2019, 72.3% were linked to care within one month after diagnosis. Of the 11,161 PLHIV, 28.8% were retained in care (percentage of persons who had ≥ 2 CD4 or viral load tests at least three months apart during 2019, among those diagnosed with HIV through year-end 2018 and alive at year-end 2019). Among those retained in care at the end of 2019, 84.2% had suppressed viral load (≤ 200 copies/mL) at the most recent test during 2019. Among PLHIV retained in care at year-end 2018 and alive at year-end 2019, just 25.9% had suppressed viral load (≤ 200 copies/mL) at most recent test during 2019.

A needs assessment was conducted between February and June 2020 to develop and draft the Nevada 2021-2026 Ending the Epidemic Plan. The purpose of this process was to gain a better understanding of the gaps and needs related to addressing the HIV epidemic in Nevada. The aim of the plan is to continue to improve the already exceptional HIV prevention and care services offered, and ultimately to prevent new HIV infections while engaging everyone living with HIV in

care. Data collection for the needs assessment included both focus groups and surveys with a variety of stakeholders—persons at risk for HIV, people living with HIV, a wide range of healthcare and service providers, and providers-in-training. Sixteen HIV client and prevention focus groups were held in Nevada between March and June 2020, with 149 people participating, representing six Nevada counties. Six groups were specifically held for HIV positive individuals, while ten groups were conducted with people at risk for HIV and which focused on HIV prevention. Four focus groups were conducted in Spanish to accommodate the Hispanic/Latinx community. Three provider focus groups were held with primary care and HIV service providers, with 94 people participating. Three surveys (community, provider, and provider-in-training) were administered between February and June 2020. The statewide EHE Workgroup, which includes over 70 individuals from various organizations, helped to disseminate the surveys and recruit participants for the focus groups.

The situational analysis findings are separated into the four CDC-defined pillars: Diagnose, Treat, Prevent and Respond.

Pillar One: Diagnose

Top needs for this pillar are for increased testing—universal testing, rapid testing, free or low-cost testing, discreet and convenient testing; increased awareness of the importance of HIV screening among the general public and high-risk populations; and a reduction of stigma related to HIV. Survey and focus group respondents mentioned the importance of normalizing HIV testing—to make it something that is routine—not something to be ashamed of nor to be feared. The need for discreet testing was stressed particularly among people who were transgender or living in rural Nevada. A majority of primary care providers reported that they only screen for HIV and STDs if requested or based on presenting factors, and a majority of providers reported they were unprepared to conduct three-site STD testing or take a comprehensive sexual history. Less than a quarter of providers reported they had a policy in place that requires all patients to be screened for HIV. Barriers for diagnosis include stigma, a general lack of awareness of HIV risk, and lack of provider awareness around the importance of routinely screening patients.

Pillar Two: Treat

PLHIV found peer navigators to be helpful when learning where to find resources and information about HIV care. PLHIV also reported that their case managers were essential to their care. Focus group and survey respondents had mixed experiences with HIV care with equal amounts reporting positive and negative experiences accessing care. In addition to medical needs, PLHIV reported needing a variety of other resources and support such as financial assistance, housing, job rehabilitation, drug rehabilitation, transportation, and social support. Dental care, vision care, financial assistance, transportation, and peer support were some of the mentioned gaps in care. Poor experiences with medical providers, substance addictions, and fear were frequently mentioned as barriers to retaining PLHIV in care, as was HIV stigma. In addition, primary care providers and providers-in-training reported insufficient preparation for treating people living with HIV and those who are facing housing insecurity.

Pillar Three: Prevent

Common themes among the focus group and survey respondents included the need for comprehensive sex education in schools, as well as culturally and linguistically appropriate HIV education for Black and Latinx populations. People who use drugs (PWUD) stressed the need for discreet information on testing, condoms, rehabilitation, and clean needles. Participants were in favor of ads, billboards, social media, community events, small groups, and programs in schools to increase community awareness of HIV. Increased access to, and knowledge of PrEP and PEP

is another important strategy. A strength related to this pillar includes the trust people had in local community clinics and community organizations to provide them with messages about health. Another strength is the increase in available syringe services programs (SSPs) through the installation of SSP vending machines. Lack of knowledge about PrEP and PEP was evident in community focus group and survey responses. Providers and providers-in-training reported a general lack of knowledge on how to counsel and follow-up with a patient requesting preventative therapies such as PrEP and PEP. In addition, 30% of providers reported they would not recommend needle exchange programs to patients using intravenous drugs. Harm reduction is an important strategy to minimize HIV infection. Barriers to prevention efforts included stigma related to HIV and drug use, inaccurate information about HIV, and lack of funding for HIV prevention.

Pillar Four: Respond

The Nevada Division of Public and Behavioral Health and the local health districts have robust HIV surveillance programs and collaborate well in this work. As the science of HIV surveillance moves towards molecular epidemiology, however, Nevada will need to expand its technological capacity and potentially partner with more advanced organizations outside of Nevada. The state has requested capacity building assistance regarding molecular surveillance to assist in these efforts.

Carson City Health and Human Services, NDPBH HIV Prevention and Surveillance Program, Ryan White Parts A and B, PAETC-NV, Southern Nevada Health District, and Washoe County Health District developed the objectives, strategies, and activities and requested review and feedback from the EHE Workgroup and the prevention planning groups.

A diverse group of community members, PLHIV, and people at risk for HIV infection contributed to the development of the plan through participation in the community survey and a variety of focus groups. HIV healthcare service providers, primary care providers and providers-in-training also contributed to the development of the plan through participation in the provider and provider-in-training surveys and focus groups. Achieving this greatly diverse representation of voices to develop this plan was an important goal for this work.

As required in the EHE Guidance, Nevada's plan is separated into four pillars: Diagnose, Treat, Prevent and Respond. For each of these pillars, one goal was developed, with two to five key activities and strategies.

Plan to End the HIV Epidemic in Nevada. 2021-2026

Pillar One: Diagnose

Goal: Diagnose all individuals with HIV as early as possible after infection.

Key Strategies and Activities:

- 1) By 2026, 85% of people living with HIV in Nevada will know their serostatus.
- 2) By 2026, 55% of all people living in Nevada will have been tested for HIV at least once.
- 3) By 2026, increase the number of clinics in Nevada routinely screening for HIV.
- 4) Proposed policy changes and their impact on Pillar One

Pillar Two: Treat

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

Key Activities and Strategies:

- 1) (Linkage to Care) By 2026, increase to 85% the percentage of people newly diagnosed with HIV who have been linked to a medical provider and had a medical visit within the first 30 days
- 2) (Retention in Care) By 2026, 50% of people diagnosed with HIV will have had at least two medical visits each year, including CD4 count and/ or viral load test at least three months apart.
- 3) (Viral Suppression) By 2026, 90% of people diagnosed with HIV who had ≥ 2 CD4 or viral load tests at least three months apart during the course of one year, will be virally suppressed (V.L. <200)
- 4) By 2026, increase re-engagement to HIV treatment services for PLHIV not in care
- 5) Policy changes and their impact on Pillar Two

Pillar Three: Prevent

Goal: Prevent new HIV transmissions by using proven interventions, including condom use, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and syringe services programs (SSPs).

Key Activities and Strategies:

- 1) By 2026, reduce by 10% the rate of new HIV diagnoses (to 14.8 or 455 cases)
- 2) By 2026, reduce the incidence of STDs among PLHIV in Nevada
- 3) By 2026, increase the percentage of PrEP coverage in Nevada to 30%
- 4) By 2026, increase the number of access points to syringe services programs (SSPs) in Nevada
- 5) Policy changes and their impact on Pillar Three

Pillar Four: Respond

Goal: Respond quickly to potential HIV outbreaks to get necessary prevention and treatment services to people who need them.

Key Activities and Strategies:

- 1) Increase the capacity to identify and investigate active HIV transmission clusters and respond to HIV outbreaks by 2026.
- 2) Policy changes and their impact on Pillar Four

The Nevada EHE plan includes ongoing monitoring and improvement. The EHE Workgroup will continue to meet every month to review progress on the plan implementation. The Nevada EHE will contribute to the development of the upcoming Integrated Plan

INTRODUCTION

Since 2012, Nevada has experienced an increase in both the number of new HIV diagnoses (incidence) and in people living with HIV (prevalence).¹ To address this issue, the HIV Prevention and Surveillance Program at the Nevada Division of Public and Behavioral Health (NDPBH) contracted with the Pacific AIDS Education and Training Center-Nevada (PAETC-NV) to complete a needs assessment and draft a plan for Nevada's Ending the HIV Epidemic (EHE) initiative. In January 2019, well before the CDC announced its funding opportunity for the development of EHE plans, PAETC-NV launched Nevada's EHE workgroup. The EHE Workgroup participants include a range of service providers, concerned citizens, and people living with HIV. Throughout the EHE process, the Nevada EHE workgroup has supported the design and implementation of the EHE needs assessment and contributed to the development of the EHE plan.

Community Engagement

From January 2019 to December 2020 (and ongoing), the PAETC-NV has hosted 34 in-person meetings and group conference calls via Zoom to engage local and statewide stakeholders in the planning process of the Nevada Ending the HIV Epidemic Plan. This Ending the HIV Epidemic Workgroup contact list includes more than seventy individuals across the state, including representatives from HIV Prevention and Ryan White planning groups, local community partners, healthcare providers, health district staff, universities in both Las Vegas and Reno, and community members. The monthly EHE meetings have included updates and discussions on plan development, handouts with event descriptions, and the CDC's feedback from the December 2019 draft EHE plan. These monthly workgroup meetings have maintained the momentum of planning the EHE needs assessment while enhancing communication and collaboration among all entities mentioned above. Because this planning process began in January 2019, these conversations contributed to the application for the EHE planning grant in summer 2019.

Community engagement strategies included partnering with the EHE Workgroup to implement focus groups and surveys to engage community members, healthcare providers, and healthcare providers-in-training. Local organizations assisted with marketing the focus group and surveys through posting and sharing them on their social media accounts, radio ads, email listservs, and organizational websites. These community organizations have deep relationships and direct experience working closely with members of key priority communities, including:

- 1) People living with HIV/AIDS (PLHIV/A)
- 2) Men who have sex with men (MSM)
- 3) Black/African American and Hispanic/Latinx communities
- 4) People who use drugs, including people who inject drugs (PWUD/PWID)
- 5) Transgender and gender non-conforming individuals

Data collected from surveys and focus groups was used not only to inform the needs assessment and situational analysis, but also to supplement the existing community engagement structure and provide new insights and ideas towards the effort to end the HIV epidemic in Clark County.

The PAETC-NV released a draft of the Nevada EHE Plan to key stakeholders for review and feedback, then presented it with edits and recommendations to the statewide EHE Workgroup. The Nevada EHE plan was posted on the website of the Nevada Division of Public and Behavioral

Health's Office of HIV, and will be linked to by many other community organizations across the state.

COVID-19 Impact

The COVID-19 pandemic significantly impacted the needs assessment for this project. Primary data collection for the needs assessment and subsequent situational analysis in this report was conducted from February to June, 2020. On March 5, 2020, Clark County reported its first COVID-19 case, and on March 12, Nevada Governor Steve Sisolak declared a statewide state of emergency. On March 17, 2020, Sisolak ordered the closure of non-essential businesses in the state. Due to these closures and subsequent travel restrictions, seven scheduled focus groups were cancelled. Fortunately, four of these were rescheduled utilizing a virtual platform, but three of the focus groups were unable to be rescheduled, as they targeted the youth population. This was a challenge due to schools, universities, and clinics being closed, and community contacts for these groups were unable to bring these participants together.

Survey participation was also impacted by the pandemic, as survey responses were robust until mid-March then dramatically declined. To compensate for the decline in survey responses, the survey closing date was extended from May 31st to June 30th. As an additional challenge, many of the EHE community partners were on the front line of the local COVID-19 response and were unable to engage with the EHE project as much as they had been prior to the pandemic. Of course, quantifying the level of impact the COVID-19 pandemic has had on this project is practically impossible, but it has, no doubt, been tremendous.



Images provided by Planned Parenthood of the Rocky Mountains, SNHD Office of Communications, and the Nevada Department of Health and Human Services

STATE OF NEVADA OVERVIEW

Nevada is the seventh largest state (geographically) in the nation.² It is comprised of 17 counties spread across 110,572 square miles.³ Nevada is a frontier state with a 2019 population estimate of almost three million and is traditionally divided into three regions: Clark County (73% of the population), Washoe County (15 % of the population), and all other counties (11% of the population).³ Nevada is one of fastest growing state (percent growth) in the nation, and is a minority majority state.⁴ This fact is of great importance to the EHE plan, as racial/ethnic minorities carry a greater burden of HIV infection in Nevada compared to White individuals. This disparity will be addressed at greater length in the epidemiological profile of Nevada later in this report.

Demographic Characteristics

Nevada is a minority-majority state with a minority population of 52%.³ In 2019, the racial and ethnic composition of Nevada was 48.2% White, 29.2% Hispanic/Latinx, 10.3% Black, 8.7% Asian, 0.8% Native Hawaiian and Other Pacific Islander, and 1.7% American Indian and Alaska Native.³ Foreign-born persons make up 19.4% of these populations.⁵ As of 2018, 90.3% of Nevada residents were U.S. citizens, which is below the national average of 93.2%.⁶ Just under half, or 49.8% of the Nevada population was female.³ Over half of the population in Nevada was between the ages of 19 and 64 (61.4%), less than a quarter was between the ages of 0 and 18 (22.5%), and the remaining 16.1% of the population was ages 65 and older.³

Socioeconomic Status

Nevada relies heavily on tourism and has been disproportionately impacted by the COVID-19 pandemic. Nevada's unemployment rate was 4.1% in June of 2019, however, it jumped to 18.0% in June of 2020 in the midst of the pandemic, which is significantly higher than the overall U.S. unemployment rate at 11.2% in June of 2020.⁷ Even prior to the pandemic, however, Nevada had marked socioeconomic disparities among racial and ethnic minorities.⁸ In 2017, in a report produced for the Nevada Governor's Office, analysts found that Black/ African Americans' unemployment rate was almost twice that of Whites, and the unemployment rate among Hispanic/Latinx workers was also significantly higher than that of Whites.⁸ The unemployment rate among women was 4.5%, which was slightly lower than the unemployment rate of men 5.4%.⁸ In 2019, before the COVID-19 pandemic struck, the median household income in Nevada was \$58,646, which is lower than the national median household income of \$61,937.^{9, 10} Males in Nevada have an average income (\$62,797) that is 1.29 times higher than the average income of females, which is \$48,620.⁶ Nevada ranks 26th in the country for persons living below the poverty level, and 14.2% of Nevada's population was living below the poverty level, compared to 13.1% of the U.S. population. ^{5, 6} The largest population segment living in poverty are females ages 25 - 34, followed by females ages 35 - 44, and then males ages 6 - 11.⁶ In addition, an estimated 19% of children under 18 years old were living below the poverty level.¹⁰ Regarding education level, the U.S. Census Bureau (2018) estimated that 86.3% of Nevada's population had a high school diploma or higher, compared to the U.S. at 88.3%, and just 24.2% of Nevada's population had a bachelor's degree or higher compared to the U.S. at 32.6%.¹⁰

POPULATIONS OF INTEREST

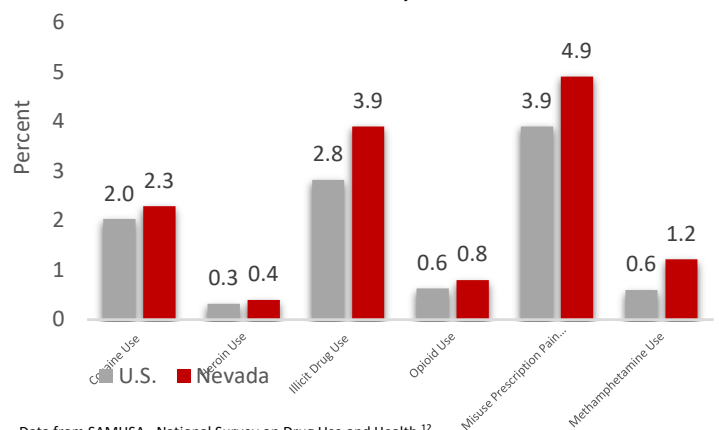
Sexual Orientation and Gender Identity

Not only does Nevada have a racially diverse population, but it also has great diversity in sexual orientation and gender identity within its population. According to the UCLA Williams Institute, Nevada ranks third in the nation for the percent of the population identifying as lesbian, gay, bisexual, and transgender (LGBT), at 5.5%.¹¹ In 2019, 47% of the Nevada's LGBTQ population identified as male, 49% was White, 33% was Hispanic/Latinx, and 19% were all other races.¹¹ A large majority, 59%, of the LGBTQ population was under the age of 35, while 15% were between the ages of 35-49, 17% were between the ages of 50-64, and 9% were over the age of 65.¹¹ Men who have sex with men (MSM) and transgender women are at higher risk for HIV acquisition in Nevada (as in all states and the nation), and MSM of color are at particularly high risk as well as those MSM who also use substances. Populations identifying as sexual minorities often face stigma and related health disparities, including HIV and many social determinants of health. These are key populations identified in this needs assessment that will be part of the focus of the Nevada EHE Plan 2021-2026.

People Who Use Substances

Substance use in Nevada is higher than the national average, and can be associated with HIV infection.¹² According to the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2018, among Nevada residents over age 12, 3.9% report illicit drug use disorder in the past year.¹² Of these, 2.3% reported cocaine use in the past year, and another 0.3% reported heroin use in the past year.¹² Opioid use disorder was reported by 0.8%, and 4.9% reported having misused prescription pain relievers during the past year.¹² Methamphetamine use was reported by 1.2% in the past year.¹² See Figure 1 for details.

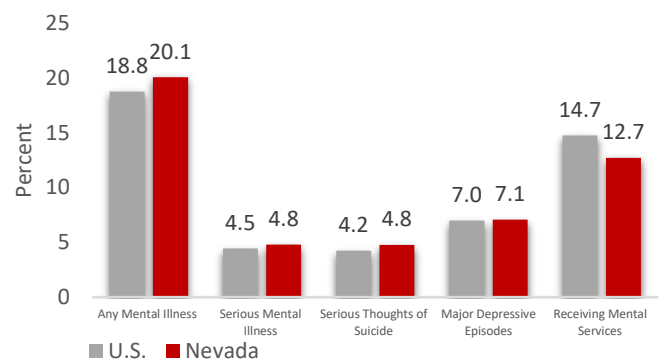
Figure 1. Percent of Population Reporting Substance Use, 2018^a



People Experiencing Mental Health Problems

Nevada residents also carry a higher burden of mental health problems compared to the rest of the nation.¹² According to SAMHSA in 2018, among those aged 12 and over, 20.1% reported mental health problems (any) in the past year; of these, 4.8% reported serious mental illness.¹² Major depressive episode was reported by 7.1% and serious thought of suicide in the past year was reported by 4.8%, while only 12.7% reported receiving mental health services to address any of these issues, which is lower than the national average of 14.7%.¹² See Figure 2 for details.

Figure 2. Percent of Population Reporting Mental Health Problems, 2018^a



People Experiencing Homelessness

Adults and youth who are without homes are at higher risk for HIV infection, and have a harder time maintaining viral suppression. The U.S. Department of Housing and Urban Development (HUD) defines homelessness as “people who are living in a place not meant for human habitation, in emergency shelters, transitional housing, or exiting an institution where they temporarily resided.”¹³ These could also be people who are losing their primary residence where they sleep, which may include motels or hotels, and have no resources or supports to find housing.¹³ Nevada has a high homeless rate compared to the rest of the nation. There are approximately 7,169 individuals experiencing homelessness on any given night in Nevada, and an estimated 20,685 public school students experienced homelessness over the course of the year.¹⁴ Of public school students, 727 students were unsheltered, 1,592 were in shelters, 2,858 were living in hotels/motels, and 15,508 were doubled up.¹⁴ The homeless rate in Nevada is 23.6 per 10,000 people in the general population compared to the U.S. rate of 17 per 10,000 people.¹³ People without homes are at higher risk for HIV than the general population due to the intersectionality of substance use, mental health issues, poverty, racism, and stigma. These issues are not unique to Nevada; this is a widespread, nationwide problem. LGBTQ+ youth are at particular risk. Nationally, approximately 40% of youth who are without homes self-identify as LGBTQ+.¹³ Youth who are without homes are 16 times more likely to be diagnosed with HIV, and 7 times more likely to die from AIDS as the general youth population.¹³

Sexually Transmitted Diseases (STDs)

The population of Nevada has higher rates of STDs compared to the nation.^{15, 16} In 2018, Nevada’s chlamydia rate was 577.5, and the gonorrhea rate was 213.6.^{15, 16} Nevada's primary & secondary syphilis rate was 22.5, well above the U.S. rate (10.8).^{15, 16} Nevada's early latent syphilis rate was 16.9, again, a much higher rate than the national comparison (11.8).^{15, 16} These data highlight a complex problem with high STD and HIV rates; as we know, HIV is more easily transmitted in the presence of STDs.¹⁶ See Table 1 for details and comparison rates for Nevada and the U.S. as a whole.

Table 1 | Nevada’s STD Rates Compared to U.S. STD Rates, 2018

Nevada’s STD Rates Compared to U.S. STD Rates, 2018				
Sexually Transmitted Diseases	Nevada ^a		U.S. ^b	
	N	Rate*	N	Rate*
Chlamydia Cases	17,508	577.5	1,758,668	539.9
Gonorrhea Cases	6,475	213.6	583,405	179.1
Primary & Secondary Syphilis Cases	682	22.5	35,063	10.8
Early Latent Syphilis Cases	512	16.9	38,539	11.8

^a Data from OPHIE. State of Nevada 2018 STD Fast Facts¹⁵

^b Data from CDC. STDs and HIV-CDC Fact Sheet¹⁶

* Rate per 100,000 population

Viral Hepatitis

In 2019, Nevada’s rate of acute viral hepatitis A is 3.3 per 100,000, the rate for acute viral hepatitis B is 0.7 per 100,000, and the rate for acute viral hepatitis C is 0.5 per 100,000.¹⁷ The populations at increased risk for viral hepatitis infection are men who have sex with men, people who use drugs, those who are without homes, and people living with HIV.¹⁸ Viral hepatitis progresses faster and causes more liver-related health problems among people with HIV than among those who do not have HIV.¹⁸

Table 2 | Nevada’s Viral Hepatitis Rates, 2019

Viral Hepatitis in Nevada, 2019		
Infection Type	Nevada ^a	
	N	Rate*
Acute Viral Hepatitis A	102	3.3
Acute Viral Hepatitis B	23	0.7
Acute Viral Hepatitis C	15	0.5

*Rate per 100,000 population
a. Nevada Department of Health and Human Services, Office of Analytics, on behalf of the Nevada Division of Public and Behavioral Health, 2018

COVID-19 IMPACT

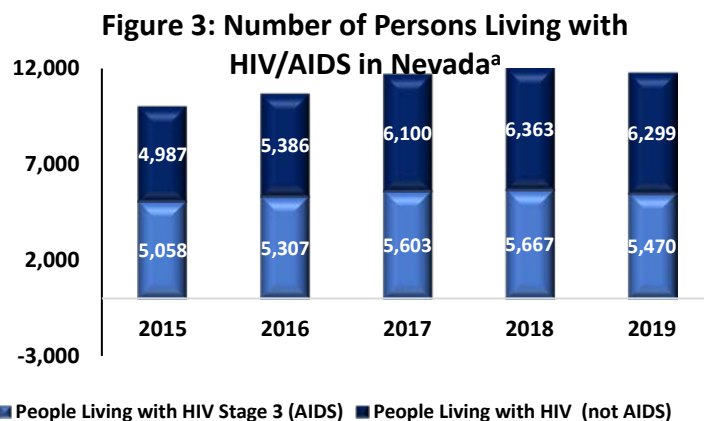
As this plan is being drafted, Nevada has confirmed over 196,000 COVID-19 cases (rate 4,937 per 100,000) and 2,673 deaths, and the numbers continue to rise.¹⁹ The racial/ethnic background and sex of those with confirmed COVID-19 cases are 40% Hispanic/Latinx, 34% White, 8% Black or African American, 8% Asian, and cases by gender are 51% female and 49% male.¹⁹ The extent of the impact of the COVID-19 pandemic in Nevada is difficult to assess, but it has been disastrous. As noted above, the pandemic has impacted the data gathered for this report for the EHE situational analysis. Anecdotally speaking, the pandemic has also strained healthcare systems in Nevada, including HIV providers, many of whom are finding themselves at the front lines of the COVID-19 response. HIV testing and treatment services have become challenging to provide in social distancing environments, and the extent of barriers to care has increased. As noted above, unemployment in the area has skyrocketed due to plummeting tourism rates, and Nevada has yet to see the far-reaching economic and health impacts of COVID-19.

EPIDEMIOLOGICAL PROFILE: OVERVIEW OF HIV IN NEVADA

The state of Nevada has been unquestionably impacted by the HIV epidemic, with the highest rate (19.8) of new infections in the Western U.S.²⁰ The CDC estimates that only 41.7% of Nevada’s population has ever been tested for HIV.¹ In 2018, the Nevada Behavioral Risk Factor Surveillance Survey (BRFSS) results showed the percentage of people who had ever been tested for HIV was just 22% among individuals aged 18-24 years.²¹ In 2018, the CDC estimated that just 79.7% of those living with HIV infection in Nevada had been diagnosed.²² This signifies that approximately one in five people living with HIV in Nevada are unaware of their status.²²

Persons Living with HIV in Nevada 2015 – 2019

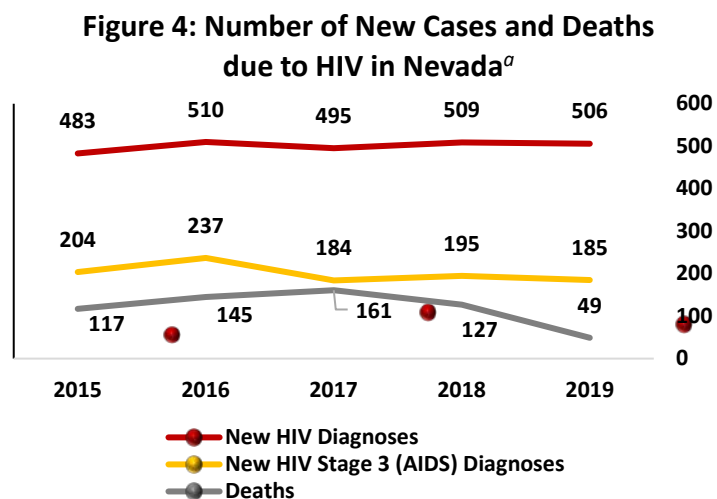
In 2019, there were 6,299 persons living with HIV (not AIDS or HIV stage 3) in Nevada, 5,470 persons living with HIV stage 3: AIDS, and a total of 11,769 persons living with HIV.¹⁷ From 2015 to 2019, the number of persons living with HIV (excluding HIV stage 3 [AIDS]) increased by 26%, while those living with HIV stage 3 (AIDS) increased 8%.¹⁷ See Figure 3 for more details.



^a Nevada Department of Health and Human Services, Office of Analytics, on behalf of the Nevada Division of Public and Behavioral Health¹⁷

New HIV Diagnoses, AIDS Diagnoses, and Deaths in Nevada, 2015 – 2019

In the last five years (2015 to 2019), the number of persons newly diagnosed with HIV infection in Nevada increased over 4.7%.¹⁷ In this same time frame, the number of persons newly diagnosed with AIDS decreased by about 9%.¹⁷ In 2019, 86% of those newly diagnosed were male, and 14% were female.²³ In 2019, there were 49 deaths among people living with HIV in Nevada.¹⁷ Overall, from 2015 to 2019, the number of deaths among persons living with HIV, including HIV stage 3 decreased by 58%.¹⁷ In 2019, there was a dramatic decrease in deaths. If the deaths from the years 2015 to 2018 were examined alone, the number of deaths among persons living with HIV, including HIV stage 3 increased by 8.5%.¹⁷ See figure 4 for more details.



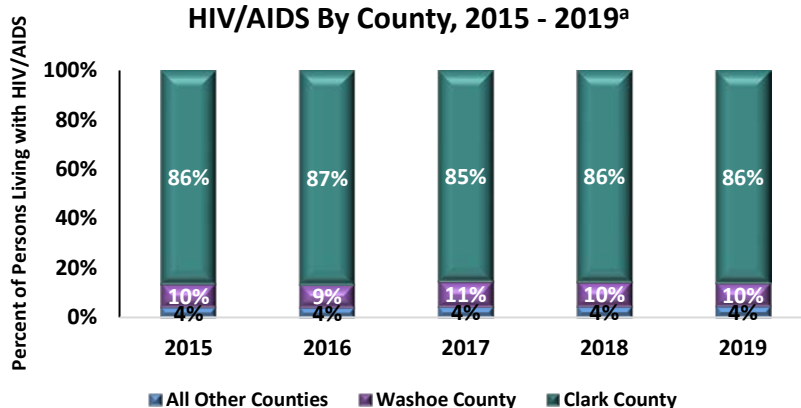
^a Nevada Department of Health and Human Services, Office of Analytics, on behalf of the Nevada Division of Public and Behavioral Health¹⁷

Between 2016 to 2018, Nevada’s HIV mortality rate among persons living with HIV (PLHIV), including HIV stage 3 (AIDS), was 5.8 per 100,000 population, compared to the U.S. rate of 5.6.^{1,24} Nevada’s mortality rate for PLHIV is higher than that of the U.S., but reduced significantly between 2018 and 2019.^{17, 24}

Percentage of Persons Living with HIV/AIDS by County, 2015 – 2019

Between 2015 and 2019, 86% of the population living with HIV/AIDS in Nevada resided in Clark County, which contains 74% of Nevada’s population.¹⁷ Another 10% of those living with HIV/AIDS resided in Washoe County, which contains 15% of Nevada’s population.¹⁷ And 4% of PLHIV in Nevada resided in all of the other counties, which contains just 11% of the state’s total population.¹⁷ See figure 5 for more details.

Figure 5: Percentage of Persons Living with HIV/AIDS By County, 2015 - 2019^a

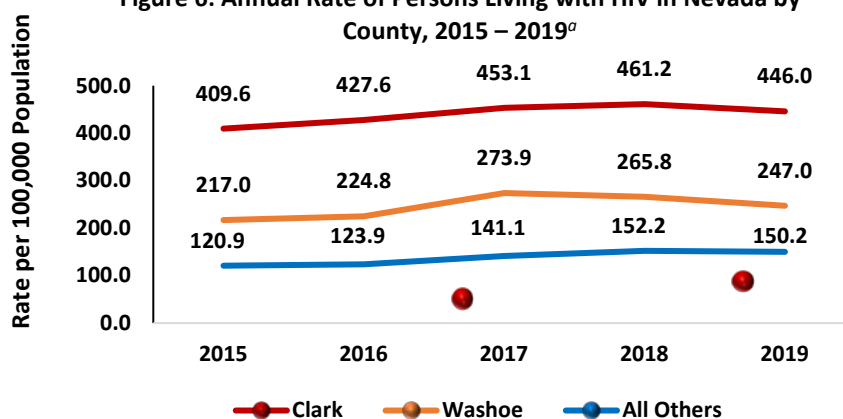


^a Nevada Department of Health and Human Services, Office of Analytics, on behalf of the Nevada Division of Public and Behavioral Health ¹⁷

Annual Rate of Persons Living with HIV in Nevada by County, 2015 – 2019

In 2019, Clark County had the highest rate of people living with HIV with a rate of 446.0 (per 100,000 population), which is 1.8 times higher than the rate in Washoe County (247.0) and 2.9 times higher than the rate in all other counties (150.2).¹⁷ From 2015 to 2019, the rates of PLHIV have increased in all counties in Nevada.¹⁷ See Figure 6 for more details.

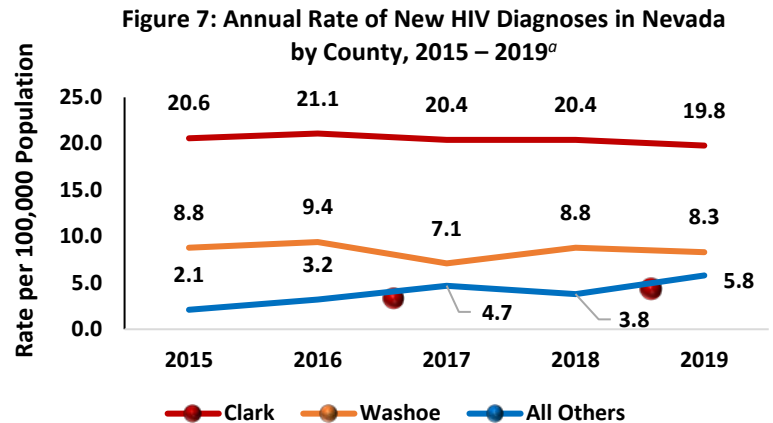
Figure 6: Annual Rate of Persons Living with HIV in Nevada by County, 2015 – 2019^a



^a Nevada Department of Health and Human Services, Office of Analytics, on behalf of the Nevada Division of Public and Behavioral Health ¹⁷

Annual Rate of New HIV Diagnoses in Nevada by County, 2015 – 2019

In 2019, the rate of new HIV diagnoses in Clark County (19.8 per 100,000 population) was more than double that of Washoe County (8.3) and more than three times greater than that of all other counties in Nevada (5.8).¹⁷ From 2015 to 2019, the rate of new diagnoses in Clark County has remained constant.¹⁷ See Figure 7 for more details.



^a Nevada Department of Health and Human Services, Office of Analytics, on behalf of the Nevada Division of Public and Behavioral Health ¹⁷

Rates of New HIV Diagnoses in Nevada by Sex and Race/Ethnicity, and by Sex and Age, 2015 & 2019

In 2019, rates of new HIV diagnoses were highest among both Black males and females. The rate of new HIV diagnoses among Black males (105.1 per 100,000 population) was six times higher than that of White males (17.1).¹⁷ In comparison, the rate of new HIV diagnoses among Black females (21.5) was 4.7 times higher than that of White females (3.1).¹⁷ Hispanic/Latino males also experienced adversely high rates of new HIV diagnoses (29.5).¹⁷ Overall, minority populations experience the greatest burden of HIV in Nevada.¹⁷ See Figure 8 for more details.

In 2019, the highest rates of new HIV diagnoses in males were among 25 to 34-year-olds (83.4 per 100,000 population), 35 to 44-year-olds (40.2), and 13 to 24-year-olds (33.4), respectively.¹⁷ In Nevada, males under 35 have been identified as a high-risk population. In 2019, among females, rates of new HIV diagnoses were highest among 25 to 34-year-olds (9.9), followed by 45 to 54-year-olds (7.7).¹⁷ See Figure 9 for more details

Figure 8: Rate of New HIV Diagnoses in Nevada by Sex and Race/Ethnicity for 2015 & 2019^a

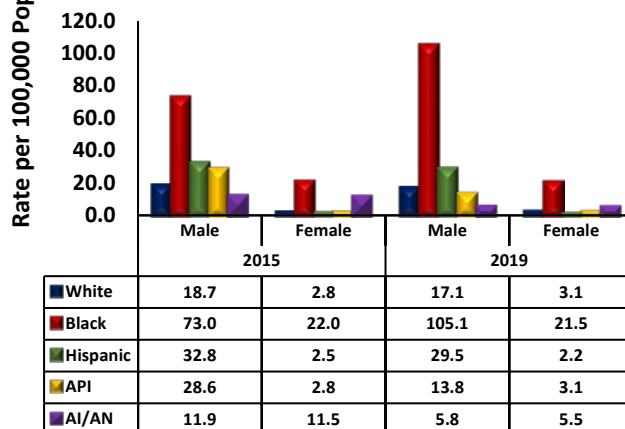
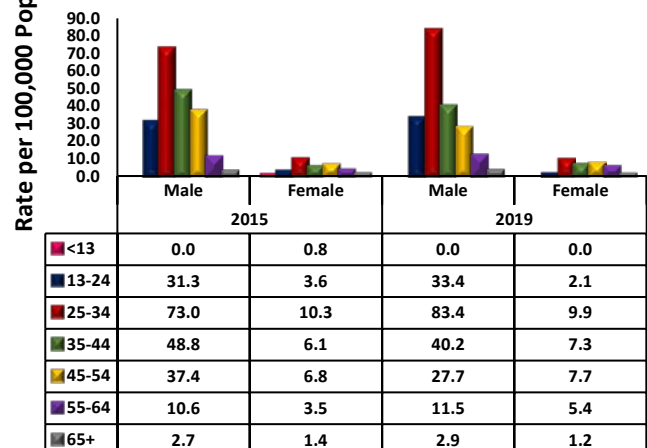


Figure 9: Rate of New HIV Diagnoses in Nevada by Sex and Age, 2015 & 2019^a



^a Nevada Department of Health and Human Services, Office of Analytics, on behalf of the Nevada Division of Public and Behavioral Health ¹⁷

Transmission Categories of New HIV Diagnoses by Sex, 2019

Among the transmission categories for all new diagnoses, MSM had the highest rate at 10.1 per 100,000 population and comprised 61.3% of new diagnoses in Nevada.²³ Among transmission categories for males only, the MSM rate increased to 20.1 and comprised 70.9% of new diagnoses.²³ Among all new HIV diagnoses, heterosexual contact had a rate of 1.0 and comprised 6.3% of new diagnoses. MSM+IDU had a rate of 0.8 and accounted for 5.1% of all new diagnoses.²³ The modes of transmission are risk categories identified by the CDC and used for data collection and surveillance. See Table 3 for more details.

Table 3 | Transmission Categories of New HIV Diagnoses by Sex, 2019

Transmission Category of New HIV Diagnoses by Sex, 2019 ^a									
Transmission Category	Total			Male			Female		
	N	Column %	Rate*	N	Column %	Rate*	N	Column %	Rate*
Male-to-male sexual contact (MSM)	310	61.3	10.1	310	70.9	20.1	-	-	-
Injection drug use (IDU)	24	4.7	0.8	15	3.4	1.0	9	13.0	0.6
MSM+IDU	26	5.1	0.8	26	5.9	1.7	-	-	-
Heterosexual contact	32	6.3	1.0	13	3.0	0.8	19	27.5	1.2
Perinatal exposure	2	0.4	0.1	2	0.5	0.1	0	0.0	0.0
Transfusion/Hemophilia	0	0.0	0.0	0	0.0	0.0	0	0.0	0.0
No identified risk (NIR)	112	22.1	3.6	71	16.2	4.6	41	59.4	2.7
Total	506	100.0	16.5	437	100.0	28.4	69	100.0	4.5

^a Nevada Department of Health and Human Services, Office of Analytics, on behalf of the Division of Public and Behavioral Health, 2019
HIV Fast Facts *Rate per 100,000

Transmission Categories of Persons Living with HIV by Sex, 2019

Among the transmission categories for all persons living with HIV, MSM had the highest rate at 244.6 per 100,000 population and comprised 63.9% of persons living with HIV.²³ Among transmission categories for males only, the MSM rate increased to 488.6 and comprised 75.8% of males living with HIV.²³ Among all persons living with HIV, heterosexual contact had a rate of 44.3 and comprised 11.6% of persons living with HIV.²³ IDU had a rate of 24.6 and accounted for 6.4% of all persons living with HIV.²³ The modes of transmission are risk categories identified by the CDC and used for data collection and surveillance. See Table 4 for more details.

Table 4 | Transmission Categories of Persons Living with HIV by Sex, 2019

Transmission Category of Persons Living with HIV by Sex, 2019 ^a									
Transmission Category§	Total			Male			Female		
	N	Column %	Rate*	N	Column %	Rate*	N	Column %	Rate*
Male-to-male sexual contact (MSM)	7,518	63.9	244.6	7,518	75.8	488.6	-	-	-
Injection drug use (IDU)	755	6.4	24.6	485	4.9	31.5	270	14.6	17.6
MSM+IDU	727	6.2	23.7	727	7.3	47.3	-	-	-
Heterosexual contact	1,361	11.6	44.3	328	3.3	21.3	1,033	55.7	67.3
Perinatal exposure	81	0.7	2.6	34	0.3	2.2	47	2.5	3.1
Transfusion/Hemophilia	9	0.1	0.3	6	0.1	0.4	3	0.2	0.2
No identified risk (NIR)	1,318	11.2	42.9	817	8.2	53.1	501	27.0	32.6
Total	11,769	100.0	382.9	9,915	100.0	644.4	1,854	100.0	120.8

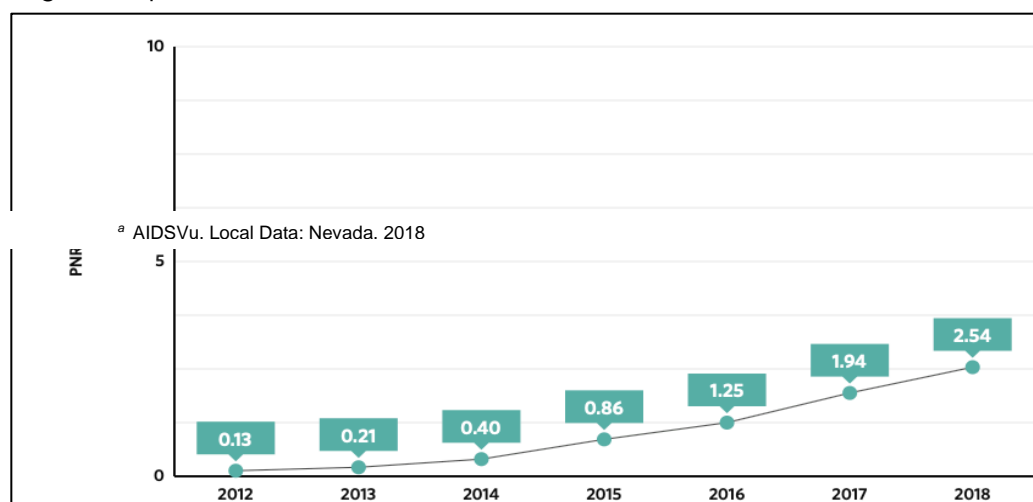
^a Nevada Department of Health and Human Services, Office of Analytics, on behalf of the Division of Public and Behavioral Health, 2019
HIV Fast Facts *Rate per 100,000 (Fast facts) §Persons Living with HIV indicate any person regardless of HIV staging, including HIV stage 3 (AIDS), living in Nevada in 2019.

PrEP Use in Nevada

In 2018, the CDC estimated approximately 10,904 persons in Nevada with indication for PrEP use.²² Using data from IQVIA pharmacy database, 1,477 persons were prescribed PrEP, which provides an estimated PrEP coverage (of those with indication) of 13.5% in Nevada.²² PrEP coverage, reported as a percentage, was calculated as the number who have been prescribed PrEP divided by the estimated number of persons who had indications for PrEP.²²

The 2018 PrEP-to-Need Ratio (PNR) is the ratio of PrEP users in 2018 to the number newly diagnosed with HIV in 2017.¹ PNR serves as an indicator for whether PrEP use appropriately reflects the need for biomedical HIV prevention. A lower PNR indicates more unmet need.¹ The max PNR is 10. Although Nevada's PNR has improved to 2.54 in recent years, it still reflects a high need for biomedical HIV prevention. In 2018, the PNR was 2.73 for males and 1.21 for females.¹ The PNR, by age, was 1.70 for ages 13-24; 2.43 ages 25-34; 3.62 ages 35-44; 3.21 ages 45-54; and 1.47 ages 55+.¹ See figure 10 for more details.

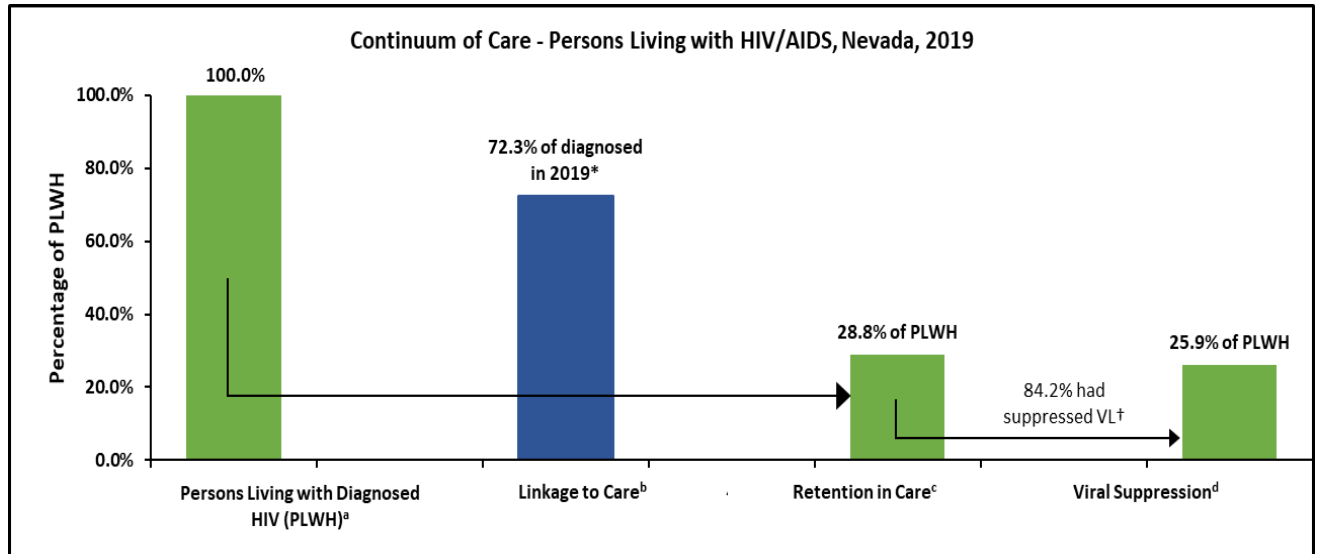
Figure 10 | PrEP-to-Need Ratio, Nevada, 2012 – 2018^a



Continuum of Care- Persons Living with HIV/AIDS, Nevada, 2019

Of persons who had been diagnosed with HIV through year-end 2018, 11,161 were alive at year-end 2019.¹⁷ Of the 11,161 PLHIV, 28.8% were retained in care (percentage of persons who had ≥ 2 CD4 or viral load tests at least three months apart during 2019 among those diagnosed with HIV through year-end 2018, and alive at year-end 2019).¹⁷ Among those retained in care at the end of 2019, 84.2% had suppressed viral load (≤ 200 copies/mL) at the most recent test during 2019.¹⁷ Among PLHIV year-end 2018 and alive at year-end 2019, 25.9% had suppressed viral load (≤ 200 copies/mL) at most recent test during 2019.¹⁷ Of the 506 newly diagnosed cases of HIV in 2019, 72.3% were linked to care within one month after diagnosis during 2019.¹⁷ See Figure 11 for more details.

Figure 11 | Continuum of Care- Persons Living with HIV/AIDS, Nevada, 2019^a

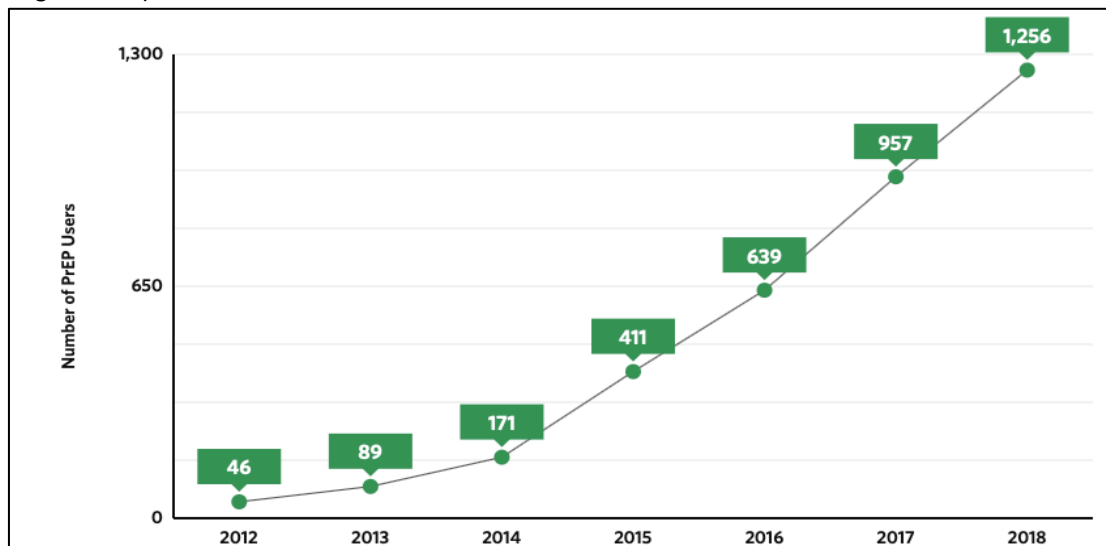


^a Nevada Department of Health and Human Services, Office of Analytics, on behalf of the Nevada Division of Public and Behavioral Health ¹⁷

Number of PrEP users in Nevada, 2012-2018^a

In 2018, PrEP was being used by 1,256 people, and the rate of PrEP use was 50 per 100,000 population.¹ PrEP use in Nevada has seen a steady increase since 2012. The majority of PrEP users, 93.6%, were male, and 6.1% of the users were female.¹ For age distribution, 10.7% of PrEP users were between the ages of 13-24, 38.9% were 25-34, 26.8% were 35-44, 19.4% were 45-54, and 5.3% were 55+.¹ See figure 12 for details.

Figure 12 | Number of PrEP users in Nevada, 2012-2018^a



^a AIDSvu, Local Data: Nevada¹



Images provided by Planned Parenthood of the Rocky Mountains, SNHD Office of Communications, and the Nevada Department of Health and Human Services

SITUATIONAL ANALYSIS

A needs assessment was conducted between February and June 2020 to develop and draft the Nevada 2021-2026 Ending the Epidemic Plan. The purpose of this process was to gain a better understanding of the gaps and needs related to addressing the HIV epidemic in Nevada. The aim of the plan is to continue to improve the already exceptional HIV prevention and care services offered in Nevada. Data collection for the needs assessment included both focus groups and surveys with a variety of stakeholders—persons at risk for HIV, people living with HIV, a wide range of healthcare and service providers, and providers-in-training. Sixteen HIV client and prevention focus groups were held in Nevada between March and June 2020, with 149 people participating, representing six Nevada counties. Seven groups were specifically held for HIV positive individuals, while nine groups were conducted with people at risk for HIV and which focused on HIV prevention. Four focus groups were conducted in Spanish to accommodate the Hispanic/Latinx community. Although we did not collect formal data on this demographic, some participants in the Hispanic/Latinx focus groups informed facilitators that they were undocumented workers. The prevention focus groups sometimes included people living with HIV/AIDS. Focus groups were conducted in HIV service offices, primary care clinics, social service offices, counseling centers, LGBTQ centers, bathhouses, medical schools, universities, and virtually. These locations enabled us to reach people living with HIV, racial/ethnic minorities, those who abuse drugs, those who are housing insecure, transgender women, MSM, and those who have mental health issues.

Table 5 | EHE Statewide Community Focus Groups Location

EHE Statewide Community Focus Groups – 2020			
Focus	Population	Number	Location
HIV Care	Community Members	6	Carson City
HIV Care	Community Members	14	Clark County
HIV Care	Latino Men	14	Clark County
HIV Care	Latina Women	1	Clark County
HIV Care	MSM	4	Clark County
HIV Prevention	PWUD	21	Clark County
HIV Prevention	MSM	4	Clark County
HIV Prevention	Hispanic/Latinx Community Members	7	Clark County
HIV Prevention	Transgender Women	3	Clark County
HIV Prevention	Community Members	26	Clark County
HIV Prevention	Community Members	5	Elko County
HIV Prevention	Community Members	4	Esmeralda County
HIV Prevention	Community Members	5	Storey County
HIV Prevention	Community Members	14	Washoe County
HIV Care	Community Members	9	Washoe County
HIV Care	Latinx/ Hispanic Community Members	12	Washoe County

People living with HIV represented nearly half of the focus group participants (46%). The majority of participants were male (61%). Twenty-six percent of the participants were below the age of 34, and 23% were between the ages of 35 and 44. Participants were well-distributed among various ethnic groups. Forty percent of participants were Hispanic/Latinx, 48% White, 17% Black, 4% Asian, 3% Native American, and 17% multi-race or other. Half of the participants (50%) indicated they were heterosexual; 36% gay/homosexual; and 8% bisexual. Sexual orientation and gender identity were asked to ensure a representative sample. Of particular note, 35% of participants identified as men who have sex with men, 7% were transgender individuals, 46% were people living with HIV/AIDS, and 14% identified as people who use injection drugs. Participants identified as one or more populations of interest on the focus group demographic form.

Table 6 | Nevada Community Focus Group Participants Representation

Nevada Statewide Community Focus Group Participants Representation*	
Population	Percentage
Men who have Sex with Men (MSM)	34.9
Transgender Individuals**	6.7
People living with HIV/AIDS (PLHIV/A)	45.6
Youth (13-34 years)	26.2
Black/African American	17.4
Hispanic/Latinx	39.6
Other Racial Minorities	24.8
People Who Use Drugs (PWUD)	14.1
Housing Insecure***	11.4

*Participants identified as one or more of the following populations of interest on the focus group demographic form

**Transgender identified as those whose reported gender on birth certificate differed from reported gender identity

***Defined as those who are without homes, housed in a rehab facility, using housing assistance, or live in weekly motels

Three provider focus groups were held with primary care and HIV service providers between February and June 2020, with 94 people participating. Primary care providers represented over half of the participants (53%), while the remainder were HIV service providers. The majority of the participants were female (68%). Twenty-seven percent of the participants were between the ages of 45 and 54, and 23% were between the ages of 35 and 44. Nearly 80 percent of the participants were white (79%); 24% identified as Hispanic/Latinx.

Table 7 | Provider Focus Group Participants

EHE Provider Focus Groups - 2020		
Provider Type	Number	Location
HIV Service Provider Focus Group	32	Statewide
HIV Service Provider Focus Group	12	Statewide
Primary Care Provider Focus Group	50	Statewide

The community, provider, and provider-in-training surveys were administered between February and June 2020. The EHE Workgroup, which includes over 70 individuals from various organizations, was used to help disseminate the surveys. As stated above, the EHE Workgroup

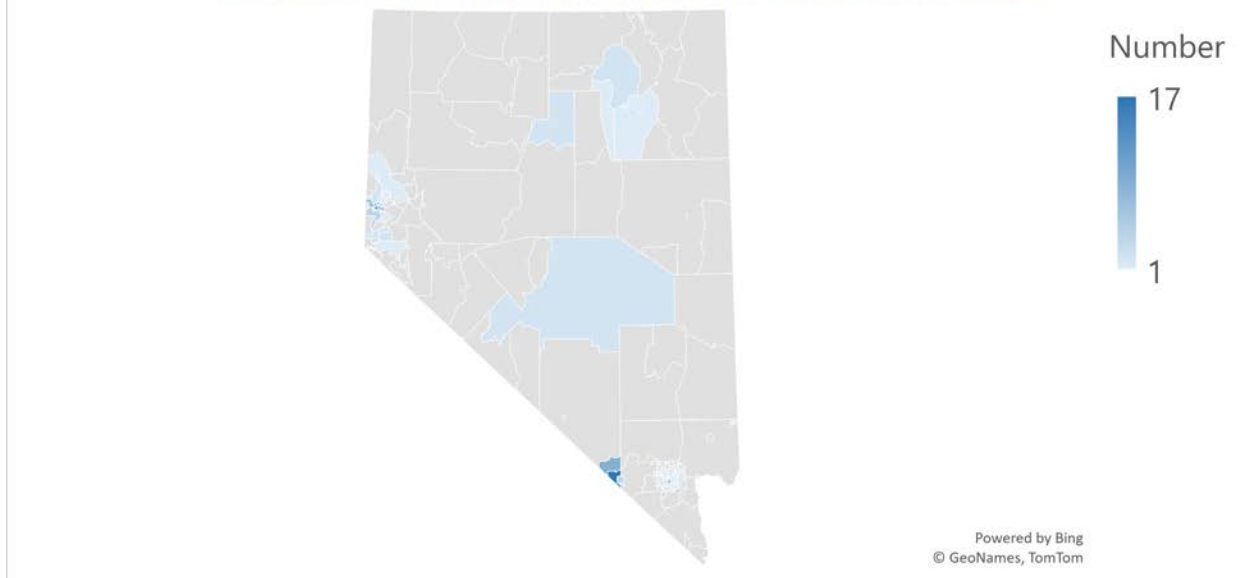
includes individuals who work for local organizations that have strong ties to the targeted populations. These local organizations include HIV and primary care clinics and hospitals, local health districts, jails, bathhouses, bars, medical schools, human rights advocate groups, legal professionals, HIV service organizations, food banks, counseling centers, social services, universities, pharmaceutical companies, homeless shelters, and many more. The EHE Workgroup members shared the community engagement surveys with their organization’s community email list serves, websites, and social media pages, including Facebook, Instagram, and Twitter. The community engagement survey was distributed every month from February to June 2020. The surveys were available in both Spanish and English, in order to reach the broader population. Paper copies of the survey were distributed to local organizations upon request. The Provider and Provider-in-Training Surveys were also distributed every month by EHE Workgroup members that worked in local clinics, hospitals, health professions schools, and healthcare training programs. The provider and provider-in-training surveys were primarily shared via professional email listservs and professional Facebook pages.

Table 8 | Needs Assessment Surveys Conducted for the Nevada EHE Plan

EHE Surveys- 2020	
Respondent Type	Number of Respondents
Community Survey	229
Provider Survey	126
Provider-In-Training Survey	122

The community survey was completed by 229 total Nevada respondents. The respondents represented 67 zip codes in seven Nevada counties—Clark, Washoe, Nye, Elko, Lander, Carson City, and Douglas. Forty percent of the respondents were interested community members and another 30% were consumers of HIV prevention and care services. Other respondents included public health professionals, healthcare providers, HIV service providers, and research or academic partners. Respondents between 25-34 years of age were most common (24%), followed by 20% ages 12-24 years; and 18% 55-64 years. With respect to gender identity, 46% identified as male; 46% as female and 7% as transgender. The sample of respondents included 69% White, 12% Black, 8% Asian/Pacific Islander, 14% other, and 3% American Indian/Native American. Ethnicity was asked separately, to which 23% responded they were Hispanic/Latinx. Eighty percent of the respondents had some college education or more. Forty-seven percent of respondents reported being straight; 29% gay; 13% bisexual, 4% lesbian and 3% other. Two percent of the respondents were people who use drugs (PWUD). Fifty-eight percent of the respondents were HIV negative, 35% were HIV positive, 6% did not know and 2% chose not to disclose.

Statewide Community Engagement Survey Respondent Zip Codes



The provider survey was completed by 126 providers, the majority of whom identified as White (61%), and female (59%, including one transgender woman). Eight percent of the provider respondents were African American, while 14% were of Hispanic/Latinx ethnicity. Together, nurse practitioners and physicians comprised half the sample. The most frequently cited employment settings were Federally Qualified Health Centers (17%), private practice (13%) and community-based organizations (13%). Of the providers, 19% indicated their primary role in HIV care and services was to provide clinical services to people living with HIV, but not HIV treatment; 17% provided HIV testing and counseling; 16% provided clinical HIV care and treatment; 15% provided education and training related to HIV care; 15% did not provide HIV care services, and 10% each provided mental and behavioral services or social services to PLHIV.

The provider-in-training survey was completed by 122 health professions students who were training at schools in Nevada. Half the respondents were in medical school, 32% in pharmacy school, 12% in physician assistant (PA) school, and 5% were students in nursing or nurse practitioner programs. Sixty-four percent of respondents identified as female. Reported race/ethnicity of respondents was 68% White, 21% Asian, 5% black, and 9% Hispanic/Latinx.

Secondary data sources drawn upon for the needs assessment included epidemiologic data, 2018 Nevada Behavioral Risk Factor Surveillance Survey (BRFSS), 2019 Nevada Youth Risk Behavior Survey (YRBS) data, the 2019 Annual Monitoring Report for Nevada's Integrated HIV Prevention and Care Plan (IHPCP), the Ryan White Part A Program Las Vegas TGA Comprehensive HIV/AIDS Needs Assessment 2018, Needs Assessment and Resource Inventory: Nevada's Native American HIV/AIDS 2019, and the 2019 Nevada State Health Needs Assessment.

The following are strengths, needs, gaps, and barriers for each of the four pillars identified by CDC: Diagnose, Treat, Prevent, and Respond. These data were gathered from the needs assessment conducted in the community and will be addressed further in this plan.

WORKING IN OUR COMMUNITIES

AIDS HEALTHCARE FOUNDATION, PLANNED PARENTHOOD, WASHOE COUNTY HEALTH DISTRICT



Images provided by Planned Parenthood of the Rocky Mountains, AIDS Healthcare Foundation, and Washoe County Health District.



Pillar One: Diagnose

In Nevada, an estimated 1 in 5 persons with HIV are unaware of their status.

With an estimated 20% of persons living with HIV in Nevada (one in five) unaware of their status, and only 42% of the state's population ever been tested for HIV, there is great need for increased testing in Nevada.^{25, 26} In 2018, the Nevada Behavioral Risk Factor Surveillance Survey (BRFSS) results showed the percentage of people who had ever been tested for HIV was just 22% among individuals aged 18-24 years.²¹ Native American youth also reported not knowing where to go to be tested for HIV. More work is needed on this pillar, however; some strengths have been noted through the Integrated HIV Prevention and Care Plan (IHPCP) monitoring process. Capacity for rapid testing has increased over the past several years, facilitated by Southern Nevada Health District's (SNHD) development and administration of a train-the-trainer (TOT) curriculum to train and certify staff at community-based organizations (CBOs) to provide rapid testing to high-risk populations. The health districts, providers, and CBOs have been active in promoting rapid testing through social media and other channels. Top needs for this pillar are for increased testing—universal testing, rapid testing, free or low-cost testing, discreet and convenient testing; increased awareness of the importance of HIV screening among the general public and high-risk populations; and a reduction of stigma related to HIV. Survey and focus group respondents mentioned the importance of normalizing HIV testing—to make it something that is routine—not something to be ashamed of nor to be feared. The need for discreet testing was stressed particularly among transgender people and those living in rural parts of the state. A majority of primary care providers reported that they only screen for HIV and STDs if requested or based on presenting factors, and a majority of providers reported they were unprepared to conduct three-site STD testing or take a comprehensive sexual history. Less than a quarter of providers reported they had a policy in place that requires all patients to be screened for HIV. Barriers for diagnosis include stigma, a general lack of awareness of HIV risk, and lack of provider awareness around the importance of routinely screening patients for HIV.

*“In my practice, I don't have many patients with HIV...my patients are not at risk. I just don't see patients with HIV.”
– Primary Care Provider*



Pillar One: Strengths

- Increase in rapid testing over past several years
- Increased promotion of rapid testing and locations
- Training and certification for CBOs to provide rapid testing



Pillar One: Needs

- Expand testing availability
- Increase awareness of HIV risks in the community
- Awareness of the importance of HIV testing
- Reduction of stigma
- Primary care provider training on HIV and STD screening, and taking sexual history
- Awareness of testing locations in the community
- Free or low-cost testing
- Access to rapid HIV testing
- Discreet or private testing
- Increase the availability of mobile testing
- Normalization of HIV testing



Pillar One: Barriers

- Stigma related to HIV and STDs
- People fear testing and finding out they have HIV
- People think they are not at risk for HIV
- Many providers do not routinely screen all patients
- Many providers were unlikely to recommend, or understand, three-site STD testing
- Many providers say HIV testing is out of their scope of practice



Pillar One: Gaps

- Universal testing is not being done at all primary care settings, urgent cares, ERs and hospitals.
- Lack of education about risk
- Lack of knowledge about where to get tested
- Materials about HIV prevention, testing, and locations in other languages
- Access to community-based testing for high risk populations
- Expanded variety of locations and hours for community testing—rehabilitation centers, jails, social service offices
- At-home testing and pharmacist testing
- Non-stigmatizing programming and messaging



Pillar Two: Treat

While 84% of PLHIV in Nevada who were retained in care had a suppressed viral load in 2019, the percentage of PLHIV who were retained in care was just 29%.²⁷ Improving retention in care will be key to ending the epidemic in Nevada.

Linkage of newly-diagnosed individuals to high-quality care within 30 days of diagnosis could be improved as well, with just 72% of newly-diagnosed individuals linked to care within 30 days of diagnosis.²⁷ PLHIV found peer navigators to be helpful when learning where to find resources and information about HIV care. PLHIV also reported that their case managers were essential to their care. Focus group and survey respondents had mixed experiences with HIV care with equal amounts reporting positive and negative experiences accessing care. In addition to medical needs, PLHIV reported needing a variety of other resources and support such as financial assistance, housing, job rehabilitation, drug rehabilitation, transportation, and social support. Dental care, vision care, financial assistance, transportation, and peer support were some of the mentioned gaps in care. Poor experiences with medical providers, substance addictions, and fear were frequently mentioned as barriers to retaining PLHIV in care, as was HIV stigma. In addition, primary care providers and providers-in-training reported insufficient preparation for treating people living with HIV and those who are facing housing insecurity.

29% of PLHIV in Nevada were retained in care in 2019.

“HIV is an epidemic, but you can be on treatment and live a normal life. People are living much longer. I think having peers give information would help.” –Black/AA Transwoman



Pillar Two: Strengths

- 84% of PLHIV who are retained in care are virally suppressed.
- Peer-to-peer advocate programs have been put in place at SNHD and Community Counseling Center



Pillar Two: Needs

- Medical care
- Case management
- Specialty doctors
- Referrals
- Help paying for medicine
- Medication delivery
- Dental care
- Mental healthcare
- Train primary care provider and providers-in-training how to treat PLHIV
- Vision care
- Free condoms
- Support groups
- Peer navigators
- Help getting off drugs or alcohol
- Financial help
- Transportation
- Train providers-in-training how to treat those facing housing insecurity
- Utilize telemedicine
- Help with housing
- Nutrition help
- Care and medication being covered by insurance, Medicaid, Medicare, Ryan White, NMAP, etc.
- Job rehabilitation
- Social support
- Educational classes
- Follow up from doctors
- Psychiatric care



Pillar Two: Barriers

- Stigma related to HIV
- Fear of people knowing they have HIV
- Sprawl of Las Vegas TGA/distance between services
- Lack of providers in rural areas
- Lack of access to medication delivery in rural areas
- Transiency
- Lack of culturally and linguistically appropriate services
- Mental health issues
- Substance abuse issues
- Lack of housing
- Lack of transportation
- Lack of knowledge of where to go for services
- Past convictions or evictions impact qualifying for resources
- Being treated poorly by medical care staff;
- Long wait lists for services



Pillar Two: Gaps

- Financial assistance
- Housing services
- Mental healthcare
- Better dental care
- Reduced pre-authorization time for dental services
- Vision Care
- Transportation
- Job rehabilitation
- Drug rehabilitation
- Case management
- Improve patient understanding of U=U (Undetectable=Untransmittable)
- Increase the number of racial/ethnic and gender minorities health providers
- Peer advocates/ peer navigator/peer support
- Support groups
- Referrals to healthcare and other supportive services
- Help paying for medicine
- Awareness of available resources
- Expanded clinic hours after work
- Providers and Providers in-training curricula for ART and 3 site STD testing
- Legal assistance
- Culturally competent providers
- Services available in other languages
- Providers knowledgeable about HIV
- Primary care providers lack knowledge in HIV care and community services
- Provider-in-training curricula re: housing insecurity



Pillar Three: Prevent

Disparities in new HIV diagnoses are prevalent in Nevada. Black males and Black females have 6 times and 4.7 times the rates of new diagnoses than their White counterparts, respectively.¹⁷ Latino males and men under 35 also are at high risk of infection in Nevada.¹⁷ Men who have sex with men (MSM) have the highest rate of new diagnoses among the transmission categories.¹⁷ IDU are another group at higher risk. Common

themes among the focus group and survey respondents included the need for comprehensive sex education in schools, as well as culturally and linguistically appropriate HIV education for Blacks, Latinx/Hispanic, and Native American youth. PWUD stressed the need for discreet information on testing, condoms, rehabilitation, and clean needles. Participants were in favor of ads, billboards, social media, community events, small groups, and programs in schools to increase community awareness of HIV. Increased access and knowledge of PrEP and PEP is another important strategy. A strength related to this pillar includes the trust people had in local community clinics and community organizations to provide them with messages about health. Another strength is the increase in available syringe services programs (SSPs) through the installation of SSP vending machines. Lack of knowledge about PrEP and PEP was evident in community focus group and survey responses. Providers and providers-in-training reported a lack

The rate of new diagnoses among Black males was 6 times higher than White males.

“In the Hispanic community, the millennials are more concerned about herpes than with HIV. But with the older generation, they don’t talk about HIV because of the stigma. But we talk about cancer and diabetes, why not talk about HIV?”

- Latina Participant

of knowledge on how to counsel and follow up with a patient requesting preventative therapies, such as PrEP and PEP. In addition, 30% of providers reported they would not recommend needle exchange to patients using intravenous drugs. Harm reduction is an important strategy to minimize HIV infection. Barriers to prevention efforts included stigma related to HIV and IV drug use, inaccurate information about HIV, and lack of funding for HIV prevention.



Pillar Three: Strengths

- Trust in community clinics and organizations to provide health information
- Increase in available syringe services programs



Pillar Three: Needs

- Basic HIV prevention education
- Widespread community awareness
- Comprehensive sex education for youth
- Programs in schools
- Routine testing and sexual risk assessment by primary care providers
- Education for African Americans and Latinx/Hispanic
- Reduction of stigma around HIV and sexual health
- Free or low-cost access to condoms
- Education on harm reduction skills
- Drug rehabilitation
- Safe places to use intravenous drugs
- Curricula for providers and providers-in-training re: when to recommend needle exchange services
- Increase access to clean syringes
- Increase access to housing/ shelters
- Access to low-cost community health centers
- Routine testing and sexual risk assessment by primary care providers
- Culturally and linguistically appropriate education
- Education and awareness of PEP and PrEP
- Access to PEP and PrEP
- Discreet access to information and services
- Non-stigmatizing programming and messaging
- Curricula for provider and providers-in-training on how to counsel patients requesting PrEP and PEP



Pillar Three: Gaps

- Consistent comprehensive HIV prevention education in schools statewide
- Curricula for provider and providers-in-training on PrEP, PEP, and when to recommend needle exchange services
- Improve access to HIV prevention materials, programs, and campaigns for a variety of cultures and languages
- Access to community-based testing for high risk populations
- Lack of discreet testing and harm reduction services
- Wider availability of prevention services
- Increase awareness of syringe services programs
- Usage of condoms among high risk populations
- Knowledge and awareness of PrEP, PEP, and condoms availability in the community
- Access to PrEP and PEP
- Increase provider and community awareness of PrEP financial assistance program
- Services for those without homes
- Universal testing in medical settings



Pillar Three: Barriers

- Stigma related to HIV and drug use
- Fear of people knowing they have HIV
- Transiency
- Fear of deportation among undocumented immigrants
- False beliefs that HIV is non-life threatening
- Lack of funding and personnel for prevention efforts
- Resistance towards SSPs, particularly in rural areas



Pillar Four: Respond

The Nevada Division of Public and Behavioral Health and the local health districts have robust HIV surveillance programs and collaborate well in this work. As the science of HIV surveillance moves towards molecular epidemiology, however, Nevada will need to expand their technological capacity and potentially partner with more advanced partners outside of Nevada. The state has requested capacity building assistance regarding molecular surveillance to assist in these efforts.



Pillar Four: Strengths

- Clark County HIV Outbreak response plan already exists;
- Annual updates to the plan are happening



Pillar Four: Needs

- Increased capacity to identify and investigate active HIV transmission clusters
- Increase capacity of molecular surveillance
- Increased funding for surveillance and outreach efforts
- Hire a qualified staff person to be able to manage molecular surveillance
- Training for epidemiology staff to work on HIV-TRACE



Pillar Four: Gaps

- Limited eHARS system capacity to track this type of data
- Limited funding for surveillance and outreach



Pillar Four: Barriers

- Lack of funding for additional surveillance efforts
- Community member fear and mistrust of molecular surveillance



Images provided by Northern Nevada HOPES, University Medical Center, and the AIDS Healthcare Foundation

NEVADA'S ENDING THE HIV EPIDEMIC PLAN 2021-2026

The Nevada Plan to End the HIV Epidemic has been developed in response to the national Ending the HIV initiative, and is based on a number of resources. This plan incorporates ongoing activities from the Nevada Integrated HIV Prevention and Care Plan 2017-2021 (IHPCP) and was drafted after significant examination of the situational analysis and the most current epidemiology. The situational analysis in this report is based on focus group and survey data compiled from a diverse group of community members and partners, HIV and primary care providers, program staff and administrators, providers-in-training, and people living with HIV in Nevada. Based on the situational analysis, five target groups have been identified for addressing in this plan: People living with HIV (PLHIV), MSM of color, people who use drugs (PWUD), transgender women, and primary care and HIV providers. These groups will be identified throughout the plan.



PILLAR ONE: DIAGNOSE

The Nevada Plan to End the HIV Epidemic is largely based on the HIV care continuum, and following this framework, the first step is to identify and link anyone living with undiagnosed HIV to quality HIV care. Diagnosis is the first step in not only engaging an individual in care, but also in reducing community viral load and preventing further transmission. This plan will focus on one overarching goal for the Diagnosis Pillar: to diagnose all individuals with HIV as early as possible after infection. The activities for Pillar One focus on increasing access to routine HIV screening, particularly for high-risk populations. The diagnose pillar will focus on engaging populations at

“I don’t think people know where to get tested. They don’t know their doctor can give them an HIV test.”
– Rural County Participant

greatest risk, including MSM of color, people who use drugs (PWUD), and transgender women. This pillar also addresses boosting the knowledge and skills of primary care providers, particularly those in urgent care and FQHC settings, in order to increase the availability of HIV screening in these sites.

Goal: Diagnose all individuals with HIV as early as possible after infection.

Key Strategies and Activities:

- 1) **By 2026, 85% of people living with HIV in Nevada will know their serostatus.**
Baseline: 79.7%²²
 - a. Increase routine opt-out screenings in healthcare settings (E.R.s, quick care clinics, acute care, primary care, etc.)

- b. Increase access to testing in non-healthcare settings and behavioral health sites for populations who are without homes or have mental health or substance abuse challenges. This activity includes providing at-home testing kits and increasing utilization of telemedicine and other innovative tools to reach people
- c. Investigate and/or establish partnerships to implement HIV screening in jails and other detention facilities
- d. Implement targeted HIV and STD testing strategies among priority populations, while utilizing testing and educational material in languages that are appropriate for those populations
- e. Increase engagement of minority population in testing initiatives, particularly targeting Black/African American and Latinx/Hispanic women and men
- f. Investigate community partnerships and nontraditional outreach efforts such as working with WIC, churches, mobile units, and other partners
- g. Develop public awareness campaign(s) with non-stigmatizing messaging that focuses on increasing testing, self-testing, and awareness of testing methodology and services, specifically targeting MSM, PWUD, and high risk cis and gender nonconforming communities, youth and young adults, communities of color, and sexually active heterosexuals
- h. Develop and implement a provider awareness campaign focused on improving primary care provider understanding of the need for HIV screening in primary care settings, that also includes information about the availability of self-testing kits
- i. Develop and implement provider trainings to increase the knowledge and HIV screening capacity of providers and providers-in-training (students: medical, nursing, PA, etc.)
- j. Partner with professional associations including statewide physician groups, nursing associations, and pharmacy groups to assist with increasing HIV testing in primary care settings
- k. Increase collaborations in care for new testing sites
- l. Increase testing in tribal communities
- m. Increase awareness of where to get tested for HIV in tribal communities
- n. Investigate resources and funding for potentially working with MSM apps to advertise self-testing and HIV prevention
- o. Promote Collect 2 Protect, a new program offered statewide through the Southern Nevada Health District that offers HIV self-testing

2) By 2026, 55% of all people living in Nevada will have been tested for HIV at least once.

Baseline 41.7%¹

- a. Increased routine opt-out screenings in healthcare settings (E.R.s, quick care clinics, acute care, primary care, etc.) for all patients seeking care
- b. Public awareness campaign focused on increasing testing and awareness of testing services, MSM, PWUD, and high risk cis and gender nonconforming communities, youth and young adults, communities of color, and sexually active heterosexuals.
- c. Increase access to testing in non-healthcare settings and behavioral health sites for populations who are without homes or have mental health or substance abuse challenges. This activity includes providing at-home testing kits and increasing utilization of telemedicine and other innovative tools to reach people

- d. Implement targeted HIV and STD testing strategies among priority populations, while utilizing testing and educational material in languages that are appropriate for those populations
- e. Increase engagement of minority population in testing initiatives, particularly targeting Black/African American and Latinx/Hispanic women and men
- f. Investigate community partnerships and nontraditional outreach efforts such as working with WIC, churches, mobile units, and other partners
- g. Develop public awareness campaigns with non-stigmatizing messaging that focuses on increasing testing and awareness of testing methodology and services, specifically targeting MSM, PWUD, and high risk cis and gender nonconforming communities, youth and young adults, communities of color, and sexually active heterosexuals
- h. Develop and implement a provider awareness campaign focused on improving primary care provider understanding of the need for HIV screening in primary care settings, that also includes information about the availability of self-testing kits
- i. Develop and implement provider trainings to increase the knowledge and HIV screening capacity of providers and providers-in-training (students: medical, nursing, PA, etc.)
- j. Partner with professional associations including statewide physician groups, nursing associations, and pharmacy groups to assist with increasing HIV testing in primary care settings
- k. Increase the number of certified and trained staff to provide rapid testing to high risk populations
- l. Increase the number of rapid tests conducted in Nevada by certified agencies
- m. Increase community awareness about location of testing sites via websites including Carson City Health and Human Services, Nevada Division of Public and Behavioral Health, Southern Nevada Health District, Washoe County Health District, and community partners
- n. Increase testing in rural communities by providing discreet information on testing location and information on how to access at-home testing kits
- o. Investigate funding to support and implement an EHE Campus Advisory Committee at Nevada's higher education institutions to increase testing in youth under the age of 24 and to encourage youth participation EHE initiatives
- p. Increase testing in tribal communities
- q. Increase awareness of where to get tested for HIV in tribal communities
- r. Investigate resources and funding to work with MSM apps to advertise self-testing and HIV prevention
- s. Promote Collect 2 Protect, a new program offered statewide through the Southern Nevada Health District that offers HIV self-testing

"I think it is hard for young people to talk about using condoms, their sexual history, and if they have been tested for STDs and HIV. It is such an awkward conversation. I think if you are not empowered for that conversation, you are not going to have it."

– Rural County Participant

- 3) **By 2026, increase the number of clinics in Nevada routinely screening for HIV.**
- a. Increase HIV screening and re-screening among persons at elevated risk for HIV at urgent cares, emergency departments, primary care providers, tribal sites, and community-based sites
 - b. Increased routine opt-out HIV screening at Federally Qualified Health Centers (FQHCs) in Nevada (based on new requirements for FQHCs to screen for HIV). Five FQHC's in Clark County received HRSA's Primary Care HIV Prevention Awards in the amount of \$250,000 or more to support development of routine screening practices. These sites are: First Person Care Clinic, FirstMed Health and Wellness Center, Nevada Health Centers, Inc., Silver State Health Services, and SNHD. The PAETC-NV is working with the Nevada Primary Care Association to support these clinics in implementing routine HIV screening
 - c. Investigate feasibility and support for implementing HIV and STD screening at school-based clinics
 - d. Collaborate with higher education entities to increase HIV and STD screening
 - e. Investigate support to implement HIV and STD screening at rural health clinics

4) **Policy changes and their impact on Pillar One:** In addition to the above strategies and activities, this plan will address recommendations for changes and updates to state policies that have been highlighted as challenges in ending the HIV epidemic as they currently stand. Many individuals, agencies, political leaders, and people living with HIV have championed Nevada's HIV modernization efforts. The EHE Team would like to acknowledge and thank those unsung heroes for their passion to increase equality for those living with HIV. The policies addressed in this plan have been reviewed by the Nevada Governor's Advisory Task Force on HIV Exposure Modernization, and will be put forth for consideration in the 2021 Nevada Legislative session. The EHE Team would also like to thank Senators Dallas and Parks for their effort to modernize HIV in Nevada.

- a. **Nevada Administrative Code (NAC) 441A.800-** Testing of sex workers [state board of health R089-10]. This regulation, which mandates cervical swab testing for sexually transmitted diseases (STDs), is outdated. Current standard of care for testing of individuals for gonorrhea and chlamydia trachomatis utilizes Nucleic Acid Amplification Test on properly collected urine, rectal and pharyngeal samples. This testing provides increased rates of sensitivity and specificity when compared to solely using cervical swabs for biologically female patients, or urethral swabs for biologically male patients.
- b. **Nevada Administrative Code (NAC) 652-** This section of the administrative code applies to Medical Laboratories. This NAC and the corresponding NRS need to be revised to allow for medical providers to test off-site. This addition for HIV and Hepatitis C testing would be a step forward while removing barriers to testing such as access to testing limited to clinical facilities, stigma of testing, and more. By creating a new level of certification allowing currently licensed exempt labs under existing CLIA waivers to test in the community such as mobile testing, community health events, community events, fairs, workshops, and other locations would expand access to testing for hundreds and possibly thousands of people at risk. This is done in many other states and works well. This change in policy would help increase access to testing and could identify new cases of both HIV and Hepatitis C. Under the existing NAC 652, CLIA waived/exempt labs can only test within their practice location or via a mobile unit. Mobile units are currently cost prohibitive for most agencies and clinics.

- c. **Proposed change in legislation in support of opt-out HIV, STD, and Hep C Screening-** Mandate opt-out HIV, STD, and Hepatitis C screening be offered in all primary care, urgent care, and emergency department settings in Nevada. With the broad reach of these clinical settings, this mandate could significantly alter Nevada's ability to identify people with previously undiagnosed HIV and link them to care, which is essential in slowing the spread of HIV. Other states have been successful with similar mandates, for instance, New York State passed legislation in 2017 that required all emergency departments to offer opt-out HIV screening for all patients seeking care in an emergency department. New York State is on the path to having zero new HIV infections. Patients seeking care in emergency departments, urgent cares, primary care clinics, and retail clinics should also be presented with information about HIV, STDs, and Hepatitis C testing and provided testing under an opt-out approach. The availability and routine practice of screening tests at all clinical sites will simultaneously identify people living with disease and reduce stigma associated with screening. Patients with a negative test but who have ongoing risk for HIV infection should be provided information about PrEP (biomedical interventions for the prevention of HIV are over 99% effective when taken daily as indicated in conjunction with other safer sex practices).
- d. **Proposed change in legislation in support of healthcare provider training-** Mandate continuing education for healthcare providers around HIV, viral hepatitis, STDs, sexual health, and social determinants of health. To end the HIV epidemic, Nevada needs all primary care providers to be conducting thorough, routine sexual histories with patients, and following up with appropriate STD and HIV testing and screening. As noted in the needs assessment, universal HIV screening is not yet being implemented in all primary care sites. Increasing provider knowledge and comfort level around sexual history taking, STD testing, and HIV screening is needed in order to increase the availability of these services. There are many oral manifestations of HIV, which makes dental and other health professionals important allies in this work to end the epidemic in Nevada. A legislative mandate to require 1-2 hours of continuing education for the full range of healthcare professionals should include information on conducting a sexual health history, talking to clients about their risk for HIV and viral hepatitis, risk reduction, HIV prevention, opt-out testing for HIV and hepatitis, and screening for social determinants of health such as homelessness, substance use disorder, intimate partner violence, human trafficking and food insecurity. Not only should providers be educated about these issues, but this education should include information about how to provide the best care to a patient at risk for HIV, and the resources available in their community. This education should be tailored to the specific community where the provider practices.
- e. **Nevada Revised Statutes (NRS) 201.205** - Modernize HIV statutes that criminalize exposure or potential exposure to HIV and which undermine a state's public health efforts by deterring people from getting tested for HIV. Laws criminalizing the conduct of people living with HIV may disincentivize people most at risk for HIV from getting tested. This includes Black and Hispanic/Latinx MSMs, women, people that identify as LGBTQ+ and formerly incarcerated people. HIV

modernization seeks to update current laws that target people living with HIV for prosecution and excessive punishment in an effort to make them solely responsible for the sexual risk behaviors of others. Many of these laws are based on decades old science and irrational fears of HIV. HIV Modernization is the modernization of current unwarranted use of criminal law to address a public health issue.

Pillar 1 Key Partners: Carson City Health and Human Services, Nevada Advisory Task Force on HIV Exposure Modernization, Nevada Division of Public and Behavioral Health, Nevada HIV Modernization Coalition, Nevada Primary Care Association, Silver State Equality Institute, Southern Nevada Health District (SNHD), Southern and Northern Nevada HIV Prevention Planning Groups, Northern Nevada HOPES, UMC, UNLV, UNR Med/ Pacific AETC-NV, Washoe County Health District, FQHC's, and health professions schools and associations

Potential Funding Resources: SNHD EHE (CDC PS 20-2010), FQHCs receiving supplemental HIV screening/prevention funds (HRSA-20-091), WCHD, CCHS, NDPBH

Estimated Funding Allocation: CDC PS 20-2010: \$2 million per year for 5 years, HRSA 20-091: \$1.28 million total

Outcomes (reported annually, locally monitored more frequently): The percent of people living with HIV who know their serostatus. Percent of people who have ever been tested. The number of clinics conducting routine screening.

Monitoring Data Source: CCHHS, SNHD, OPHIE, and WCHD Surveillance data, clinics reporting routine screening



PILLAR TWO: TREAT

After diagnosis, the next several steps of the HIV care continuum are related to treatment, and specifically target people living with HIV (PLHIV). These steps are linkage to care, retention in care, and the ultimate goal of treatment which is viral suppression. Each of these steps is crucial in engagement with treatment and ultimately to reduce transmission of HIV through treatment as prevention, or undetectable = untransmittable (U=U).

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

Key Activities and Strategies:

1) (Linkage to Care) By 2026, increase to 85% the percentage of people newly diagnosed with HIV who have been linked to a medical provider and had a medical visit within the first 30 days

Baseline: 72.3%¹⁷

- a. Increase early initiation of ART. Clinics implementing routine opt-out HIV screening will be trained in immediate linkage to care for persons testing positive. Several organizations already employ linkage navigators to assist people in linking with HIV care services.
- b. Increase awareness of regional patient flow chart that includes services and activities for HIV+ patients.
- c. Increase in improved communication between organizations with increased utilization of CAREWare referral system to coordinate intakes.
- d. Link high-risk individuals to care from both healthcare and non-healthcare settings to appropriate sexual health services
- e. Initiate RAPID stART linkage to care programs in Nevada to links newly diagnosed individuals to clinical care, with the goal of linking to care within 72 hours of diagnosis
- f. Increase referral partnership to link to care among those receiving behavioral health services
- g. Increase medical case management services to link those who are newly diagnosis
- h. Increase collaboration in care between organizations
- i. Create collaboration for prevention efforts with agencies who provide treatment
- j. Increase linkage to care services through reentry programs
- k. Increase health care providers and clinics use of telemedicine as a means to engage and link patients to care

“I want to be able to get the correct information to the people I will make the biggest impact with. A local organization has a lot of advertisements out right now, a lot of PSA for HIV with transmen and women and things of that nature. It was very moving because it gives trans people a face.” –Transwoman

- l. Investigate funding, resources, and programs to support partnerships with the Department of Housing, the Department of Transportation, the Department of Education etc. to address the basic needs that are missing for PLHIV
 - m. Investigate funding and other resources to increase education on HIV and U=U in MSM youth of color, working with high schools, community centers, dating apps, community colleges and other higher education institutions to increase awareness
- 2) (Retention in Care) By 2026, 50% of people diagnosed with HIV will have had at least two medical visits each year, including CD4 count and/ or viral load test at least three months apart.**
Baseline: 28.8%¹⁷
- a. Maintain current retention in care programs at Carson City Health and Human Services, Ryan White Part A, Southern Nevada Health District, and Washoe County Health District, and explore new opportunities to enhance retention in care efforts
 - b. Increase the use of telemedicine to engage patients in care
 - c. Investigate funding, resources, and programs to support partnership with the Department of Housing, the Department of Transportation, the Department of Education etc. to address the basic needs that are missing for PLHIV that may contribute to retention in care
- 3) (Viral Suppression) By 2026, 90% of people diagnosed with HIV who had ≥ 2 CD4 or viral load tests at least three months apart during the course of one year, will be virally suppressed (V.L. <200)**
Baseline: 84.2%¹⁷
- a. Increased viral suppression among persons living with diagnosed HIV with the continual evaluation of the continuum of care to understand status and establish a baseline looking at viral suppression to identify patterns and match the patient exams attended and services accessed
 - b. Increase availability of medication management materials, support, educational programs and counseling for all patients at clinical HIV treatment facilities
 - c. Increase patient education around the importance of obtaining and maintaining an undetectable viral load, and the importance of the individual viral load in relation to the community viral load
 - d. Increase community education about community viral load data
 - e. Increase clinician education on the importance of conducting at least two viral load tests per year
 - f. Increase the use of telemedicine to retain patients in care and to maintain viral load
 - g. Investigate best practices from organizations that have high retention in care rates, and organize training events for other organizations to share those best practices
- 4) By 2026, increase re-engagement to HIV treatment services for PLHIV not in care**
Baseline: Data currently unavailable
- a. Increased support to providers and clinics for re-engaging PLHIV in care and treatment
 - b. Increased immediate re-engagement to HIV prevention and treatment services for PLHIV who have disengaged from care.

- c. Increase evaluation to identify clients who have fallen out of care on a biannual basis. The HRSA baseline for out of care is one year, however, best practice for medical appointments is twice a year at least three months apart. Therefore, a biannual clinic evaluation for those out of care would be a practical means by which to reconnect and re-engage patients
- d. Investigate reengagement programs to use peer to peer reengagement, specifically focusing on Black/ African American and Hispanic/Latinx men and women
- e. Increase health care providers and clinics use of telehealth/telemedicine to re-engage patients in care

5) Policy changes and their impact on Pillar Two- In addition to the above strategies and activities, this plan will address recommendations for changes and updates to state policies that have been highlighted as challenges in ending the HIV epidemic as they currently stand.

- a. **Nevada Revised Statutes (NRS) 201.205 and NRS 201.358-** A person who, after testing positive in a test approved by the State Board of Health for exposure to the human immunodeficiency virus and receiving actual notice of that fact, intentionally, knowingly or willfully engages in conduct in a manner that is intended or likely to transmit the disease to another person is guilty of a category B felony and shall be punished by imprisonment in the state prison for a minimum term of not less than 2 years and a maximum term of not more than 10 years, or by a fine of not more than \$10,000, or by both fine and imprisonment.
- b. **Nevada Revised Statutes (NRS) 201.358-** Engaging in prostitution or solicitation for prostitution after testing positive for exposure to human immunodeficiency virus. HIV criminalization is outdated and serves to reinforce stigma around HIV infection. With the 2011 clinical trials of the HPTN052 study, and continuing with the PARTNER, Opposites Attract, and PARTNERS 2 studies, there has been a substantial amount of data indicating that Treatment as Prevention (TasP) is a successful strategy in eliminating new HIV infections. In 2017, the CDC joined other federal agencies in an effort led by the US Department of Health and Human Services (DHHS) putting forth a message of Undetectable = Untransmittable (U=U). This strategy successfully demonstrates that when patients are engaged in care and have suppression of the HIV viral load for at least six months, there is “effectively no risk” of sexual transmission of HIV to an uninfected partner. Nevada currently still has laws that criminalize intentional transmission of HIV or working in prostitution after testing positive for HIV. This outdated law does not align with the current science around HIV risk of transmission. These laws must be revisited, given the new evidence about risk of transmission, and revised accordingly, to ensure Nevada laws are consistent with science. This policy would also help to erase the stigma that surrounds HIV infection, which is a significant barrier to testing and treatment and therefore to ending the epidemic.
- c. **Proposed change in legislation that prohibits health insurance companies from disallowing copay assistance funds from being applied to insurance deductibles-**
Request legislation that prohibits health insurance companies from disallowing copay assistance funds from being applied to insurance deductibles. Legislation

aimed at protecting patient participation in copay assistance programs from pharmaceutical companies is vital for many people being able to access medications that are highly effective in treating diseases such as HIV and Hepatitis C. Currently, many insurance companies are informing plan members that effective January 2020 (and earlier), copay assistance program contributions to medication will NOT be counted toward deductible and out-of-pocket expenses. Year after year, insurance premiums, copays and deductibles are increased for participants. This proposal would greatly assist consumers in accessing life-saving medications.

- d. **Nevada Revised Statutes 441A.160 and Nev. Rev. Stat. 441A.300 - Proposed change in legislation in support of Pillar Two** – Chapter 441A grants Nevada health authority the ability to confine, isolate or quarantine anyone who transmits and/or spreads contagious and infectious diseases. Transmission and intent to transmit is not required to be ordered to isolation quarantine or treatment. If someone diagnosed with AIDS fails to comply with an order from a health authority, or engage in behavior that could spread HIV, they are subject to confinement. Therefore, and as noted above in NRS 201.205, laws criminalizing the conduct of people living with HIV may disincentivize people most at risk for HIV from disclosing their HIV status to healthcare providers and from accessing medical care, including testing and treatment for HIV.

Key Partners: Carson City Health and Human Services, Clark County Social Services Ryan White Part A, Nevada Advisory Task Force on HIV Exposure Modernization, Nevada Division of Public and Behavioral Health Ryan White Part B, Silver State Equality Institute, Southern Nevada Health District, University Medical Center, Washoe County Health District, Northern Nevada HOPES

Potential Funding Resources: HRSA Ryan White HIV/AIDS Program (RWHAP) EHE Funding, UMC Wellness Center Part C HRSA funding, , Northern Nevada HOPES Part C/D HRSA Funding, Clark County Part A funding, WCHD, CCHS, NDPBH

Estimated Funding Allocation: RWPA: \$850,000 for Year 1, unknown Years 2-5

Outcomes (reported annually, locally monitored more frequently): PLHIV continuum of care outcomes, number PLHIV who were reengaged in care and prevention

Monitoring Data Source: State of Nevada surveillance linkage data, RWHAP Careware



PILLAR THREE: PREVENT

The third pillar, Prevent, is not technically part of the HIV care continuum, however, a strong emphasis on HIV prevention will reduce the number of HIV cases and diagnoses, and therefore limit the number of people in the care continuum, which is ultimately the goal of ending the HIV epidemic. The Prevention Pillar focuses on reducing transmission of HIV through increasing evidence-based prevention practices such as condom distribution and use, pre- and post-

“I think we need to get to kids earlier in their education. I think the younger the age the better we can get to them because they are paying attention when they are younger and they are like, wait, I need to think about this. I remember when I got sex education, I was already sexually active so that didn't help me. –Black/AA Woman

exposure prophylaxis uptake, and use of syringe services programs. This pillar also includes reducing the transmission of STDs, primarily syphilis, as the presence of STDs increases HIV transmission. These activities will be aimed at high-risk populations, including MSM of color, people who use drugs (PWUD), and transgender women. Providers, pharmacies, and clinics will also be targeted for education and training around sexual history taking, HIV screening, and prescription of both PEP and PrEP.

Goal: Prevent new HIV transmissions by using proven interventions, including condom use, post-exposure prophylaxis (PEP), pre-exposure prophylaxis (PrEP), and syringe services programs (SSPs).

Key Activities and Strategies:

- 1) **By 2026, reduce by 10% the rate of new HIV diagnoses (to 14.8 or 455 cases)**
Baseline: 16.5 per 100,000 or 506 cases.¹⁷ (Note- this goal of 10% takes into consideration the increased testing goals stated in the Diagnose pillar which, in all likelihood, will increase the positivity rate rather than reduce it initially.)
 - a. Increase the number of primary care providers (family practice, gynecologists, urgent care providers), providers-in-training, and staff trained on PEP and PrEP
 - b. Improve collaboration with all school districts and the Nevada Department of Education and other non-school settings to link EHE goals to promote comprehensive sexual health education
 - c. Work with local health care and public health organization to provide sex education to tribal community members and tribal youth and young adults
 - d. Increased community awareness around where to get tested for HIV, use social medial platforms to increase awareness among youth
 - e. Create more statewide awareness of Medicaid coverage of condoms with a prescription
 - f. Implement and increase awareness of the statewide Condom Distribution Plan (CDP). The CDP target populations include Black/African American, Hispanic/Latinx, MSM, and other EHE target population listed above

- g. Work with rural stakeholders to increase discreet access to free condoms in rural communities
- h. The NDPBH have developed PEP and PrEP materials for survivors of sexual assault
- i. Create collaboration for treatment efforts with agencies who provide prevention services
- j. Identify champions from the community to promote HIV Prevention tools and awareness

2) By 2026, reduce the incidence of STDs among PLHIV in Nevada

Baseline: 7 per 100,000 or 1,273 cases.¹⁷ (Note- Number of persons diagnosed HIV/AIDS who were also diagnosed with an STD from 2015-2020. STD's included in analysis: chlamydia, gonorrhea, primary syphilis, secondary syphilis, early non-latent syphilis, late latent syphilis, and syphilis of unknown duration.)

- a. Develop ability to track this metric through NDPBH
- b. Provide STD trainings to primary care and HIV providers, encouraging routine sexual history evaluation and STD testing to determine PLHIV at risk
- c. Promote the use of the CDC's STD treatment guidelines
- d. Increase risk reduction and health education for patients to include STDs and the importance of screening and testing
- e. Explore different avenues to educate health care providers i.e. CME opportunities, academic detailing, and grand rounds

3) By 2026, increase the percentage of PrEP coverage in Nevada to 30%

Baseline: 13.5²²

- a. Increased screening for PrEP indications among HIV-negative clients
- b. Improve support to clinics who offer PrEP
- c. Increased referral and rapid linkage of persons with indications for PrEP
- d. Increased PrEP prescriptions among persons with indications for PrEP
- e. Investigate programs where pharmacists are PrEP providers and assess potential for implementation in Nevada
- f. Investigate funding and implementation of programs that implement PrEP services in mobile testing clinics
- g. Educate non-HIV providers and support staff about how to prescribe PrEP and PEP in their clinics
- h. Educate HIV providers, non-HIV providers, and support staff to promote and navigate patient assistant programs, such as Ready, Set, PrEP program statewide
- i. Increase providers tele-PrEP services through telemedicine utilization
- j. Development of public awareness campaign focused on increasing PrEP uptake among high-risk populations including MSM of color, PWUD, and transgender women
- k. Investigate support to implement prescribing PrEP and PEP at higher education institutions student clinic. Encourage university student health clinics to discuss PEP, and offer PrEP and condoms at STD and HIV screenings
- l. Increase PrEP use in rural communities by providing discreet information on location, providers, and pharmacies that provide PrEP
- m. Increase PrEP use in rural communities by promoting patient assistant programs like the Ready, Set, PrEP, and medication home delivery programs
- n. Increase PrEP use in tribal communities by providing discreet information on location, providers, and pharmacies that provide PrEP

- o. Increase PrEP use in tribal communities by promoting patient assistant programs like the Ready, Set, PrEP, and medication home delivery programs

4) By 2026, increase the number of access points to syringe services programs (SSPs) in Nevada

Baseline: 5

- a. Increased knowledge about the services and evidence-base of SSPs in communities through traditional and non-traditional educational venues
- b. Increased access to SSPs through non-traditional methods of service delivery including mobile outreach, vending machines, secondary exchange, and others
- c. Increase SSPs use in rural communities by providing discreet information on location of SSP mobile outreach, vending machines, secondary exchange, and others
- d. Educate the public on how acquire sterile syringes in the community, as well as where to dispose of used syringes

5) Policy changes and their impact on Pillar Three-

- a. **Nevada Revised Statutes (NRS) 129.060-** Provides authorization for a minor to be examined and treated for sexually transmitted disease without parental consent. To further support adolescents in advocating for their own health, this legislation needs to be updated to allow adolescents to consent for immunization for diseases such as hepatitis A, B and human papilloma virus (HPV). This policy must be revised to allow for biomedical HIV prevention in at-risk adolescents, a group whose STD and HIV infection rates are the fastest growing in the state (those ages 15-29). Providing adolescents access to these important preventive services is an important step in reducing the number of new STI's and HIV infections, preventing cancer, and avoiding long-term complications associated with repeat infections. HPV is known to cause head and neck cancer, cervical cancer, rectal cancer and penile cancers in all ages. This statute needs revision to allow Advanced Practice Registered Nurses, Physician Assistants, and Physicians to treat regardless of practice setting and funding source, and remove any Title X restrictions.

b. **Proposed change in legislation in support of Statewide comprehensive sexual education in K-12 schools-** Statewide comprehensive sexual education

in K-12 schools. Currently, NRS 389.065 mandates that all school districts in the state must teach sex education, including HIV/AIDS, reproductive health, communicable disease, and sexual responsibility. The problem lies in the fact that each district's Board of Trustees determines the content and extent of the curriculum, which varies greatly by county. Implementation of comprehensive, age-appropriate, medically accurate sex education is not promoted or required and every school district in the state has its own curriculum. Some students get little to no sex education at school. Providing this essential education is extremely important in preventing teen pregnancy and sexually transmitted infections, including HIV.

"We need better comprehensive reproductive health education. We know that presenting essential knowledge and skills to young adults, they will make better decisions in their life during a time period that will set the moral standard for their life. They will have better opportunities and better tools to utilize to delay sexual encounters or to make better choices for whoever they decide to be. -SoN HPPG Member

c. **Proposed change in legislation in support of modernizing HIV statutes-** State laws that target people living with HIV for prosecution and enhanced punishment as a way to address public health concerns need to be modernized. Research has demonstrated that laws criminalizing HIV infection can undermine public health efforts and state plans to address HIV. Additionally, the criminalization of HIV disproportionately impacts Black and Latino Men, members of the LGBTQ+ community, women, sex workers, and youth, making it difficult for these populations to engage in state plans and strategies to combat HIV when these are the very communities targeted for arrests and prosecutions. Moreover, these laws stigmatize those living with HIV and deter people from getting tested and knowing their status, measures which can thwart the transmission of HIV.

Key Partners: Carson City Health and Human Services, Clark County Medical Association, College of Southern Nevada, HRSA, Immunize Nevada, Nevada Advisory Task Force on HIV Exposure Modernization, Nevada Division of Public and Behavioral Health, Nevada State College, Northern Nevada HOPES, State Equality Institute, Southern Nevada Health District, Trac-B Syringe Services Program, UMC Wellness, UNLV, UNR, Washoe County Health District, healthcare providers, and local school districts

Potential Funding Resources: SNHD, CDC, WCHD, CCHS, NDPBH, RW

Estimated Funding Allocation: TBD

Outcomes (reported annually, locally monitored more frequently): Number of new HIV diagnoses, number of new infectious syphilis among PLHIV, percent of PrEP coverage, and number of access points for SSP

Monitoring Data Source: CCHHS surveillance data, CDC EHE indicators data, SAPTA, State of Nevada HIV Surveillance data, SNHD surveillance data, WCHD surveillance data



PILLAR FOUR: RESPOND

The last pillar, Respond, incorporates epidemiological surveillance into the Nevada EHE Plan. Surveillance is essential in ending the epidemic through data management and contact tracing, particularly for outbreak response. Local health districts work closely with the Nevada Division of Public and Behavioral Health to manage HIV surveillance and response.

Goal: Respond quickly to potential HIV outbreaks to get necessary prevention and treatment services to people who need them.

Key Activities and Strategies:

1) Increase the capacity to identify and investigate active HIV transmission clusters and respond to HIV outbreaks by 2026.

Baseline: Data currently unavailable

Note: The Enhanced HIV/AIDS Reporting System, eHARS, cannot consume molecular sequencing data; therefore, capacity building for these new technologies is currently at a standstill. Until this is resolved, progress cannot be made. The Nevada Division of Public and Behavioral Health is working to address this issue to be able to enhance surveillance technology in Nevada.

- a. Increased health department/community engagement for cluster detection and response. Nevada HIV Outbreak Response Plan is in process
- b. Increased funding for eHARS staff to maintain SAS code.
- c. NERD data uploaded in eHARS will allow zip code testing data to provide information about key populations.
- d. Improved surveillance data for real-time cluster detection and response. NDPBH are developing a partnership with University of California San Diego (UCSD) AntiViral Research Center (AVRC) to support molecular surveillance. This process is extremely expensive and is dependent on future funding.
- e. Improved policies and funding mechanisms to respond to and contain HIV clusters/outbreaks
- f. Improved response to HIV transmission clusters and outbreaks
- g. Investigate programs and initiatives of other jurisdictions for ideas and lessons learned in surveillance
- h. Propose development of a statewide task force to explore development and use of molecular surveillance in other jurisdictions and its impact on the community, including mistrust, hesitations in testing, and fear of criminal implications
- i. Develop a robust outbreak/strategic plan for communities that experience an HIV outbreak
- j. Investigate developing a partnership with neighboring states such as California and Arizona to identify ways to work together to respond to cases. The partnerships could help to identify individuals who have a home in multiple places, especially among individuals with unstable housing who perhaps go back and forth between states to work, play, and live due to the high cost of living
- k. Investigate programs that provide contact tracing education to non-HIV partners. DIS can help with providing training, for example, what are some key questions

that need to be asked for contact tracing, consider, homeless shelter staff, other non-profits serving communities as risk

2) Policy changes and their impact on Pillar Four

- a. **Proposed change in legislation in support of HIV modernization** –State laws that target people living with HIV for prosecution as a way to address public health concerns need to be modernized. Research has demonstrated that laws criminalizing HIV infection can undermine public health efforts and state plans to address HIV. These laws stigmatize those living with HIV and deter people from getting tested and knowing their status, measures which can thwart the transmission of HIV. Also, pertinent to this surveillance pillar, these antiquated laws may impact the development of molecular surveillance practices in Clark County; thus, reducing the jurisdiction’s potential surveillance capacity.
- b. **Proposed change in testing polic following WHO recommendations-** the World Health Organization (WHO) is now recommending focusing HIV testing efforts on simpler, rapid point of care tests in lieu of traditional western blot and line immunoassay testing. These rapid diagnostic tests (RDTs) are less expensive, faster, and can be conducted by many different provider types, making facilitation of them easier as well.

Key Partners: Nevada Division of Public and Behavioral Health (NDPBH) Office of Public Health Investigations and Epidemiology (OPHIE), Southern Nevada Health District

Potential Funding Resources: NDPBH, SNHD, WCHD, CCHS

Estimated Funding Allocation: TBD

Outcomes (reported annually, locally monitored more frequently): Establishment of protocols for cluster detection and response procedures.

Monitoring Data Source: CCHHS, OPHIE, SNHD and WCHD

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APPENDIX: DRAFT MARKETING MATERIAL

01. OVERVIEW OF HIV AND AIDS

HIV stands for the Human Immunodeficiency Virus. HIV directly attacks the immune system greatly impeding the body's ability to protect itself from sickness, viruses, and disease.

AIDS stands for Acquired Immuno Deficiency Syndrome. As HIV infection advances to AIDS, the number of individual HIV viruses increases while the number of CD4 cells decreases. We will talk about how this happens in the section on HIV biology. HIV medicines stop HIV infection from progressing to AIDS; however, in the absence of HIV medications, HIV infection will progress to AIDS related complications in about 10-12 years.



**SEX TALK
IS GOOD.**

GET TESTED



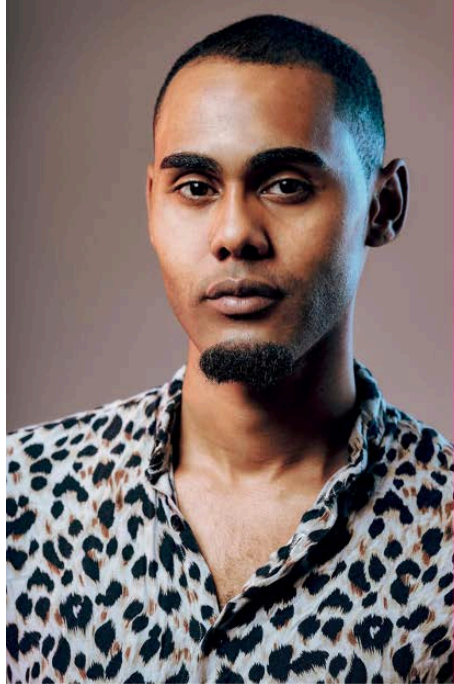
***I TAKE THE
TIME TO ASK
THE IMPORTANT
QUESTIONS.***



03. CURRENT HIV PREVENTION METHODS AND SERVICES

Prevention methods go beyond the simple technologies and medicines that can be used to help prevent new transmissions of HIV. Prevention methods also include the services provided by non-profit organizations centered around provision of stable housing, improving medical healthcare services and insurance coverage, and employment assistance.

Knowledge of the services available in your area, and the organizations that provide them, will greatly improve your ability to aid patients who are both HIV negative and positive.



**MY STATUS?
IT'S HEALTHY.**

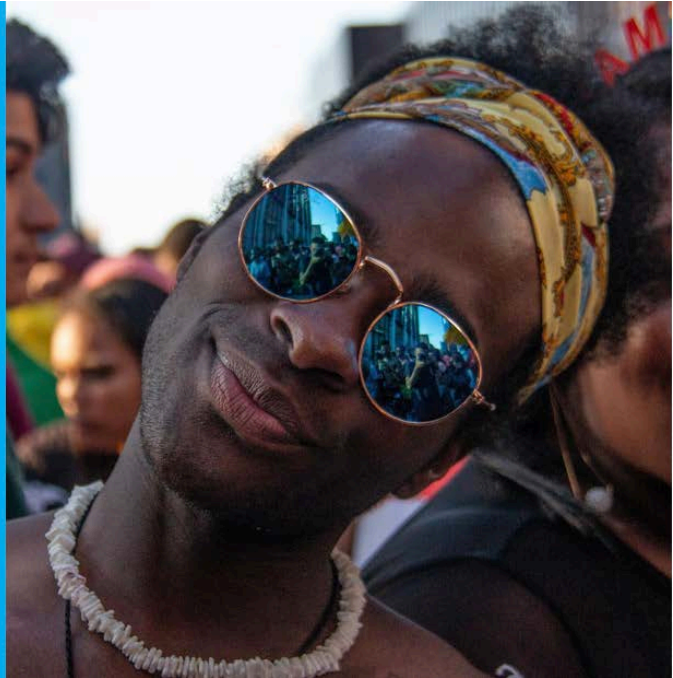
GET TESTED

**YOUR STATUS.
YOUR HEALTH.**

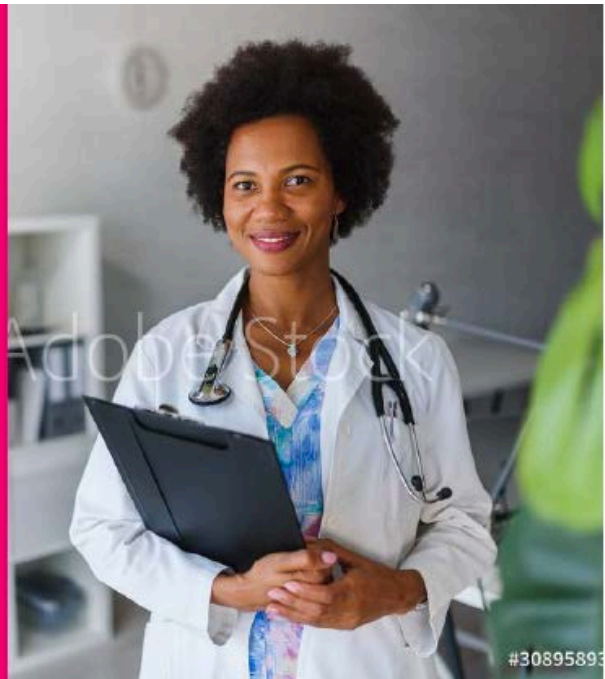
PROTECT IT



**EMBRACE *PrEP*.
PROTECT YOUR
HEALTH.**



**LET'S MAKE
HIV A THING
OF THE PAST.**



**I PREVENT
HIV.**

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**MY
STRENGTH
COMES
FROM MY
CHOICE.**

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A close-up portrait of a woman with long, wavy brown hair, wearing purple lipstick and silver earrings. The image is overlaid with several 'iStock by Getty Images' watermarks.

**ENBY.
GENDERQUEER.
AMAB.**

**HIV IS NOT PART
OF MY IDENTITY**

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**STRONG
CHOICES.
HEALTHY
BODY.**



HIV STOPS WITH ME

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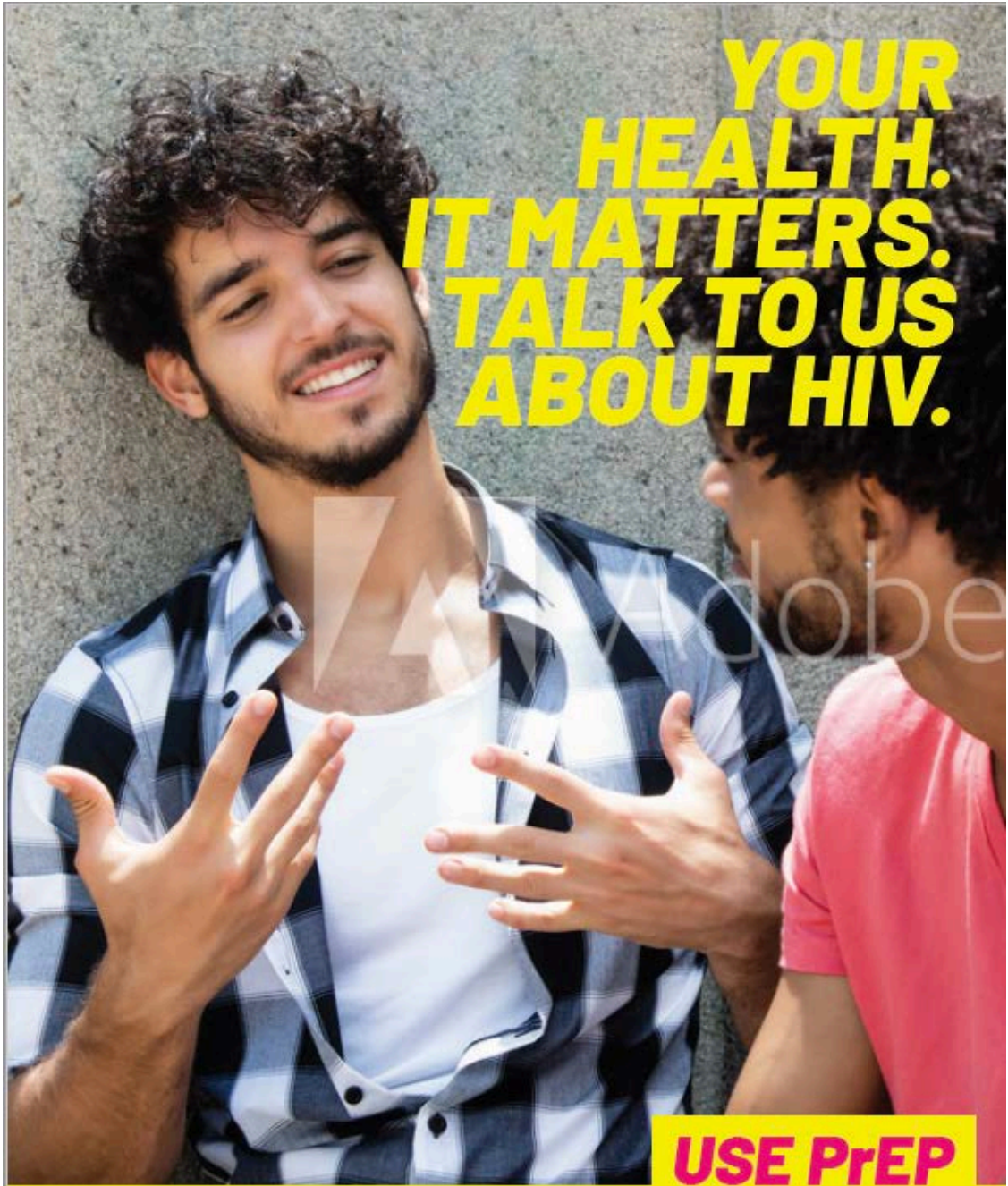
**REACH OUT
FOR MORE
INFORMATION.**

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**YOUR
HEALTH.
IT MATTERS.
TALK TO
US ABOUT
PrEP.**

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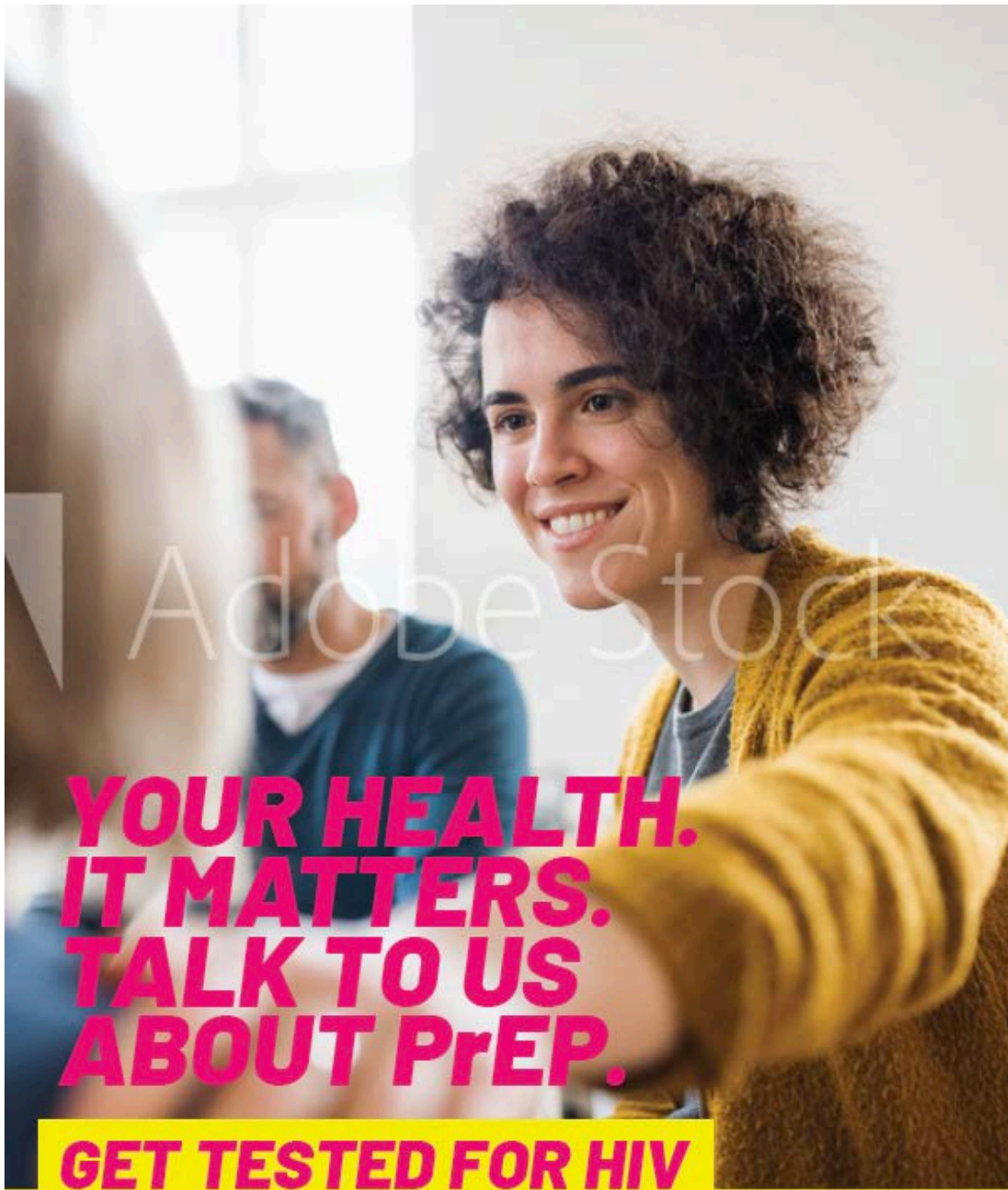


**YOUR
HEALTH.
IT MATTERS.
TALK TO US
ABOUT HIV.**

USE PrEP

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**YOUR HEALTH.
IT MATTERS.
TALK TO US
ABOUT PrEP.**

GET TESTED FOR HIV

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