So.N HPPG
Southern Nevada HIV Prevention Planning Group

MINUTES
Northern/Southern Nevada HIV Prevention Planning Group
April 23, 2025 2:00 PM – 3:30 PM
Calico Hills Conf. Room/ 280 S Decatur Blvd, Las Vegas 89107/(TEAMS)

MEMBERS/VISITORS/PUBLIC ATTENDANCE

Please see attached sign-in sheet for further information on attendance.

Voting Members Present:

Albert Sedano	Chris Reynolds	Preston Tang
Robert Harding	Bishop Bonnie	Xavier Foster
Scott Benton	Jennifer Howell – proxy for Doug Hodges	

I. CALL TO ORDER - NOTICE OF POSTING AGENDA

NoNHPPG Co-Chair Jennifer Howell and SoNHPPG Cheryl Radeloff called the meeting to order at 2:05pm. Quorum was met.

II. WELCOME AND INTRODUCTIONS OF MEMBERS AND GUESTS

Cheryl Radeloff and Jennifer Howell welcomed all attendees; however, due to time limitations, individual introductions were not made.

III. PUBLIC COMMENT – Robert Harding - Jennifer Howell

Public comment is a period devoted to comments by the general public on items appearing on the agenda. All comments are limited to five (5) minutes. Public Health Co-Chair Jennifer Howell asked if anyone wished to address the group pertaining to items appearing on the agenda.
No public comments were presented.

IV. CONSENT AGENDA – Chris Reynolds

Items for action to be considered by the Northern/Southern Nevada HIV Prevention Planning Group was given via email. Co-Chair Chris Reynolds asked if the agenda is accepted; motioned by Cheryl Radeloff to accept the agenda; seconded by Jennifer Howell; all were in favor.

- Lyell Collins reminded all voting members to turn on their cameras during voting to comply with open meeting laws.

V. VOTING ITEMS/INFORMATIONAL ITEM/DISCUSSION ONLY

A. Epidemiological Plan: NDPBH Staff
See presentation *"2018-2022 Epidemiological HIV Profile"*
The purpose of an epidemiological profile is to provide an overview of the HIV landscape and distribution in terms of socio-demographic, geographic and behavioral characteristics, and illustrate how HIV is evolving so it could be used as a tool for resource allocation, program planning as well as evaluation.

- Landscape analysis – included access to care, demographics, housing, stigma, sex work, chemsex, harm reduction and substance use

- Comprehensive data – included historical trends, NV vs. US incidence and prevalence selected by age, gender, race, etc., transmission category incidence, heat maps (statewide and Clark County), continuums of care, and syndemic data (hep B, hep C, TB and syphilis)
- Historical overview – new HIV and Stage 3 (AIDS) diagnoses in NV – 1982-2022
  - First documented HIV infection in Nevada was in 1982
  - Peak in 1990 with 744 new diagnoses of HIV
  - Since 2013 new HIV diagnoses have increased
- Heat map – zip codes 89109, 89169, 89101 in Clark County have the highest rates of new diagnoses; Washoe and Nye Counties follow
- Rates of persons living with HIV in Las Vegas – 89102, 89106, 89101, 89109, 89104, 89169, 89119
- HIV prevalence, incidence and deaths – see chart on page 11
  - Persons living with HIV has increased from 12,160 in 2018 to 13,299 in 2022
  - 108 deaths in 2022
  - New diagnosis of HIV increased by about 5.7% between 2018 and 2022; about 535 per year
- Diagnosis by age group – see chart on page 12
- Incident rates among selected age groups – see chart on page 13
- Incidence by race/ethnicity, and select race/ethnicities - see chart on page 14/15
- Stage 3 incidence by race/ethnicity
- Incidence by gender identity - see chart on page 17
- Incidence by transmission category - see chart on page 18

  The 2018-2022 Epi Profile features modified care continuums which depict the number of individuals **diagnosed with HIV** by region in 2022, excluding anyone who was deceased or moved out of state by the time of follow up (15 months post- diagnosis). Additionally, the continuums show the percentage of those who were **connected to care within 90 days** and who **achieved viral suppression** by the point of follow-up.
- Modified care by race per County, 2022 – see chart on page 20
- Key takeaways
  - NV new diagnosis rate is consistently higher than US rate (16.6 per 100,000 vs 11.3 per 100,000)
  - Clark County and Washoe County had the largest burdens during 2018-2022
  - Number of people living with HIV increasing annually
  - Vulnerable and marginalized populations remain disproportionately impacted by HIV.
  - More diagnoses among people of Hispanic origin
  - Disproportionate rate of non-Hispanic Black people impacted
  - MSM remains the most common transmission mode, followed by IDU and MSM+IDU
  - Decrease in rate of diagnoses among 25-29 age group, may be observing rate increase in new diagnoses among 30-34 age group

Q: The question is around testing and testing rates, because sometimes providers will only ask certain people if they want to test for HIV versus others. How is that accounted for, especially when we talk about things like age, demographics and racial demographics. Who's getting tested versus who's not getting tested?

A: That would be from a different data source than the one we used for the EPI profile. in terms of testing in Nevada, to monitor testing that is funded through our grant through the CDC. We don't unfortunately have a great way to measure who is getting tested, at what frequency certain groups are getting tested.

Q: Laboratories are required to report both negative and positive results. What about agencies doing community testing? Are they required to also report negatives?

A: If those are sent to a lab, then yes, the lab will be reporting like physicians are not required to report non-reactive tests, and then anything we would be missing such as self-tests and rapid tests that might be done in a doctor's office.

Q: With SB211, can't this be used as a requirement for testing, to track testing and who's being offered testing?

The NIR/NRR – is there a way to determine the percentage of each to get a better idea of how many of those were just non identified risks versus where they would not report a risk, or they did not report?

A: That's hard to comb out. DIS need to document why no risks were identified so that we have that data to distinguish in the future.

C: Another part of no identified risk is that the surveillance definition for that is, especially for males, is very strict.

And so, there's going to be a lot more no identified risk for males, if they report heterosexual contact because for that to be reported as heterosexual contact, a partner, a female partner. There needs to be documentation that they have HIV or that the female partner has sex with men who have sex with men, or as an injection drug user.

It's very specific and very narrow and that nuance and that surveillance definition hampers our ability to really know what the risk is, especially for males. This definition is set by CDC.

Q: For the NIR from 2022 and you said it was in the 40 percentile? Did this number account for the correction that Clark County had? Originally after the data was frozen, I analyzed it too, and we were like in the mid-40s, I believe, so I sent it out back to our DIS team for QA, and they went back and fixed it, and it brought us down to the 20 something percent. I informed the state to take the frozen data set and update the transmission risk with the current the current eHARS data set at the time. (submitted by Angel Stachnik)

A: From the frozen data set, it remained frozen and was not updated accordingly. Looking at the 2023 fast facts that were corrected and are trending more at the 20 like mid 20% in terms of the corrections that you've identified as well. It is corrected for future iterations of data pools.

C: You said for 2023 it corrected, but this EPI profile was created afterwards, right? I see what happened because, for every year, we have frozen datasets that we pull in. You know the new diagnosis numbers from, but for us to prevent that from happening, I actually went in and updated the frozen 2022 data set to make sure that the Clark County's NIR percent was accurate. It doesn't look like it was done, so the best solution would be to update 2022 because those are frozen datasets. (submitted by Angel Stachnik)

Q: Was this not done because since the data was already frozen, CDC wouldn't allow us to make any changes?

A: No, it doesn't have anything with the CDC frozen. These frozen datasets are frozen for the purpose of fast facts. I've been following the same process as you guys over here is to like anytime you want to go back and look at the new diagnosis numbers we would go back to each individual year of frozen data. If you wanted to look at the 2022 numbers, then you would look at the 2023 frozen data set that happened between February and April.

So those are the frozen data sets that are used for fast facts, but when I have to do the STI clinical update presentation every year in May, I use the most recent data at that time, to go and like fix. If I'm doing a 10-year trend, then I will rerun all the 10 years. Whichever years you want to run, I will use the recent one to make sure that it reflects the correct one. And then I always give a caveat that states if you're comparing these numbers to the published fast facts, understand at that time it's a snapshot of what was recorded at that time, and as we get more data, we as a state, the CIDR/RIDR, that these change. (submitted by Angel Stachnik)

Q: Can you contact Ted and see if we can get this updated so we can make sure we have accurate numbers?

A: Yes.

C: You might need to change that one for the table just to make sure we have the change.

C: We do put in the data considerations like you had identified Angel in our footnotes of our data tables, and we also assess what data set we're utilizing. I believe with this one we highlighted, it was from April 2022, which was prior to us correcting that data set that you're referring to. This also comes into play of having non-co-located analysis versus data interpretation going on.

C: We really have to circle around 2020 and 2021 because if the rates really dropped, and I think that special attention to COVID, it really dashed in terms of how we look at the rates of diagnosis, like new HIV and also new or stage 3 diagnosis. Then we're starting to see it climb up again. Hopefully that will be highlighted in the EPI Profile. Another topic I was really intrigued by is with the years, age 40 to 44. It seems like that's gone up quite

a bit. It dipped from down to 7.9 in 2020 and it's up at 26, which is not as high as the others, but it seems like that's quite a big gain. Or am I mistaken about that?

A: No, that's right. That's age group 40 to 44 with an increase of about 13 cases, about 6 per 100,000. It's worth noting that overall, the age groups converged a little bit more towards 2022 where there were less differences, and the trend is more new diagnosis among slightly older age groups.

C: Also, what a dramatic dip from age group 25 to 29. Rates went from 55.1 and again, during the COVID years, that's an aberration, right? It's kind of gradually gone up and I know we don't have any of this too, but it would be interesting to know what the impact of things like PEP and PrEP potentially have on some of these lower rates.

I'm just going to hypothesize because I don't know, but I'd assume probably there's higher PrEP and PEP rates among younger age groups like the ones highlighted; 25 to 29, 20 to 24, 30 to 34 versus the lower ones. I could be wrong on that, but that's just kind of my educated guess on that. (submitted by Cheryl Radeloff)

C: We can definitely see if access is more in that age range.

Q: You mean access for the younger folks or for the older?

A: Younger.

Q: Interesting. Can we go over Linkage to care? I was surprised by some that in terms of the percentage of new diagnosis linked to care and then the percentage of new diagnosis. I think those are areas that you know what I mean in terms of some of our goals as the 95/95/95. It seems like for some groups we're kind of close to that, but for most of them we're not. Am I wrong on that?

A: Caress might have the integrated plan goals up, so she might be able to speak to that. I definitely noticed that difference in Clark County among black persons newly diagnosed in 2022. There are only 66% that are virally suppressed at that 15-month mark, and although this is a small 67% of multiracial and biracial, it does kind of seem to vary quite a bit. Overall, the goal is certainly to improve the percentage of people who are virally suppressed 15 months out.

C/Q: Hearing you talk about that and really looking at this chart, one of the things that looks kind of bad is when you look at the black community of saying 90% were linked to care, but then when we look 15 months down the road, that only 66% were virally suppressed. There's nothing that refers to how many of those people were retained in care of that 90%. If there were a column that talked about being retained in care, then be able to show it, we may see that 66% of those could be actually a much higher number if only say 74% of those people were retained in care, then 60% of the people retained in care were virally suppressed. That could be a much higher number. The way I'm reading this is that you're saying 90% were linked to care and in 15 months only 66% of those people were virally suppressed.

A: It would actually be the column on the right on the third column it’s not impacted by the middle column. So basically 66% of the 115 people who met follow up criteria were virally suppressed, so these two are unrelated. I want to make sure that everyone kind of does understand that. Does anyone have any questions about how this one was done?

C: I still have the question about how many of those 115 were retained in care at 15 months, or if it was just like that had fallen out of care and then happened to be, they had a viral load right around that 15-month mark.

A: That's a good question that hopefully we can figure out how to measure that for future reports.

Q: Is this data coming from CAREWEAR?

A: No, this data is from eHARS. This is the entire state.

C: If people are in seeing a doctor in private practice, it would be hard for us to be able to track why they're not retained in care, what's happening to why they're not being retained in care, but as part of our out of care program, maybe that shouldn't be what should be asked.

A: Definitely a good point. If we're looking at eHARS data, the only way to track whether someone is in care is whether they are getting their CD4 and viral loads tested. For the out of care definition, I think we use about a year and so we would have to definitely think through whether that is something we can add a column for or

whether like Lyle said, we kind of work closely with the care side, the out of care side and see what analysis we can do with the data available.

C: The problem exists is that the definition for out of care for HRSA is different from the definition of out of care from eHARS. They're not the same, so.

C: The measures are completely different.

C: We should probably be looking at some kind of standardized way of doing that.

C: I just wanted to acknowledge how beautiful this report is. I am so impressed by the environmental factors and influences that you guys went through on this report. I see that a lot of nods were given to sexual education to sex work and the sex tourism industry in Nevada. It's just so thorough and I just want to say thank you. It's awesome. I also appreciate the back and forth about the data questions and discrepancies. Thank you to everyone who worked on this report. It's beautiful.

C: Thanks Victoria and huge shout out to Leo Fulwider. He was our HIV assignee who did all the legwork for this and just did an incredible huge job. Thanks to our community partners who helped review this document several times.

Q: The 15-month criteria, we define it as somebody who was living in Nevada at that time point, not at the time of their diagnosis?

A: It's both. They are a new person being diagnosed living in Nevada and are they still living in Nevada 15 months after.

Q: Is that based on a lab around that 15-month time frame?

A: Yes, exactly. If they had a lab that showed viral suppression within those 15 months.

C: We see a lot of people leave Las Vegas, and to say there were 115 black individuals newly diagnosed in 2022, and let's say 40 of them left the state, they wouldn't be counted as having resided in Nevada 15 months later. We're going get that 66% of virally suppressed. But really, what that shows us is that everybody who's still in Nevada is virally suppressed. But the people who left, well, we don't know because they left. I think the denominator should account for people who've left the state. It's kind of hard to count that or find that number in terms of data.

C: That number is also a little bit difficult too, because if they get labs done anywhere, they could get labs done at the emergency room and as long as they're HIV related labs, it counts as having labs done. It's not always the best measurement of whether they are in care or not.

B. Action Item: Vote on Prioritized Populations for 2027-2031 Nevada Integrated Prevention and Care Plan
    a. People living with HIV in Nevada
    b. Men who have sex with men
    c. People who are sexually active
    d. People who use substances
    e. Youth and young adults
    f. Emphasis in communities of color

Jennifer Howell moved to accept the target populations to continue.

Chris Reynolds seconded the motion.

All approved.

C. AMPED Research Study Presentation: Robert Harding
    See presentation *"Project AMPED - Experiences with methamphetamine and opioid use in Nevada and New Mexico"*
    a. Aim 1: To estimate the prevalence and risk of factors associated with methamphetamine use and harms
    b. Aim 2: To describe the experiences and rational for methamphetamine use, polydrug use, and misuse

c. Aim 3: to examine feasibility and acceptability of prevention, treatment, and harm reduction strategies
d. Participants – see page 4
e. RQ2: What's happening with methamphetamine and opioids in NV and NM – see page 5
f. Fentanyl prevalence – see pages 9, 10 and 11
g. What is meth overdose and overamping? – see pages 12 and 13
h. Opioid with stimulant mixture overdose symptoms – see page 14
i. Mixed toxicities – see pages 15 and 16
j. Response to overamping - see page 17
k. Methamphetamine harm reduction – see page 18, 19 and 20

D. Update on current bills in the Nevada Legislature: Jennifer Howell

Both bills are sponsored by Assemblyperson Heather Golding (Northern NV)

a. AB205 – Sex Education
   - Now requiring it changes from opt in to opt out, so it maintains parental rights.
   - It maintains parental control, but it's to lessen the gap of the number of students that don't return permission slips because you know the paper got lost or things like that.
   - Also allows for the parent or guardian to change their preference anytime throughout the year or throughout the instruction; whereas previous legislation had said that they could only do it once a year.

b. AB360 - prenatal testing bill
   - Requires rapid syphilis tests for people that are pregnant that present for any reason.
   - Requires when a rapid syphilis test is done, if that is reactive, that treatment is initiated.

Q: What kind of support are we planning around actual implementation of the bill passed this in terms of point of care testing for syphilis? What kind of resources are we prepared for in terms of assisting the public in getting this work done?

A: There's no fiscal note attached to it, so there's no funds attached to this at all. This is going to be an unfunded mandate. The cost of averting congenital syphilis cases is what we're focusing on in that being able to prevent cases of congenital syphilis and those costs are what we're kind of selling the bill on. It did come up in in some discussion, but there's been no opposition. There was neutral testimony in the Assembly, Health and Human Services Committee, and that was from insurance companies. In terms of the Hospital Association and Primary Care Association, there was support. It is within the bill that only if the results can be available before the person is discharged. And the person can also decline testing.

E. Location of past SoN HPPG agendas and minutes

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

F. Public Comment

- Latinx – NALA – April 29 – May 1, 2025 at the Palms Hotel
  https://www.latinosandhiv.org
  Still need volunteers. Bishop Bonnie volunteered.
- Raveduction – May 10, 2025 from 12-4 at Trac-B; offering many services in PrEP for EDC
- Furcon – distributed 236 doses of Narcan, fentanyl and Xylanzine test strips and provided 18 rapid syphilis tests and 90 rapid HIV tests
- Injectable Naloxone: https://remedyallianceftp.org

VI. ADJOURN

Motion to adjourn made by Chris Reynolds, seconded by Robert Harding.
Meeting adjourned at 3:44pm.

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

HIV/AIDS INTEGRATED EPIDEMIOLOGICAL PROFILE 2018-2022

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ACKNOWLEDGEMENTS AND CONTRIBUTORS

Following the guidance provided by the Centers for Disease Control and Prevention (CDC), select staff members from the Nevada Department of Health and Human Services (DHHS), Division of Public and Behavioral Health (DPBH), HIV Prevention and Surveillance Program (HPSP) collaborated to submit the Nevada 2018-2022 HIV Epidemiological Profile.

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ACRONYMS

AFAB	Assigned Female at Birth
AI/AN	American Indian/Alaskan Native
API	Asian/Hawaiian/Pacific Islander
AMAB	Assigned Male at Birth
AB	Assembly Bill
BRFSS	Behavioral Risk Factor Surveillance System
CCHHS	Carson City Health and Human Services
CDC	Centers for Disease Control and Prevention
CD-4	Cluster of Differentiation 4 Cell (T4 cell, a receptor for HIV in humans)
CI	95% Confidence Interval
COVID-19	Coronavirus Disease 2019
DPBH	Division of Public and Behavioral Health
eHARS	Enhanced HIV/AIDS Reporting System
EHE	Ending the HIV Epidemic
EPI	Epidemiology
FTM	Female to Male
HCV	Hepatitis C Virus (also known as hep C)
HHS	U.S. Department of Health and Human Services

HIV	Human Immunodeficiency Virus
IDU	Injection Drug Use
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer
LSD	Lysergic Acid Diethylamide
MSM	Men Who Have Sex with Men
MSM+IDU	Men Who Have Sex with Men and Use Injection Drugs
MTF	Male to Female
NA	Not Applicable
NH	Non-Hispanic
NHM&E	National HIV Monitoring and Evaluation
NIR	No Identified Risk
NNPH	Northern Nevada Public Health (formerly known as Washoe County Health District)
NRR	No Reported Risk
PEP	Post Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
PWID	Person(s) Who Inject Drugs
SAMHSA	Substance Abuse and Mental Health Service Administration
SB	Senate Bill
SDOH	Social Determinants of Health
SNHD	Southern Nevada Health District

STI	Sexually Transmitted Infection (also known as STD)
THC	Tetrahydrocannabinol
WCHD	Washoe County Health District (now known as Northern Nevada Public Health)
YRBS	Youth Risk Behavior Survey
YRBSS	Youth Risk Behavior Surveillance System

EXECUTIVE SUMMARY

Epidemic at a Glance

- In 2022, Nevada had a total of 13,299 persons living with HIV. The total number of persons living with HIV in Nevada increased by 9.3% from 12,160 in 2018 to 13,299 in 2022.
- The annual number of persons newly diagnosed with HIV infection increased by 5.7% from 506 diagnoses in 2018 to 535 diagnoses in 2022.
- The annual number of new Stage 3 diagnoses has also increased by 3% during this period, from 202 diagnoses in 2018 to 208 in 2022.
- Nevada experienced a peak of new HIV diagnoses in 1990 (with 744 new diagnoses). Since then, the annual number of new HIV diagnoses, new Stage 3 diagnoses, and deaths has decreased overall. However, new HIV diagnoses have trended upward since 2010.
- Although there has been an overall decline in new HIV cases, vulnerable and historically marginalized populations remain disproportionately impacted. Significant disparities exist in rates of HIV prevalence and incidence, especially among men who have sex with men (MSM) and non-Hispanic Black people.

Trends in New HIV Diagnoses

- The rate of new HIV diagnoses in Nevada has been consistently higher than the rate nationwide from 2018-2022. In 2022, the HIV incidence rate in Nevada was 16.6 new cases per 100,000 people, compared to the U.S. incidence rate of 11.3 new cases per 100,000.
- Clark County and Washoe County accounted for the highest number of newly diagnosed HIV cases and HIV Stage 3 cases between 2018-2022. Nye County, Lincoln County, and Carson City also had high burdens of HIV and HIV Stage 3.
- Male-to-male sexual contact remained the predominant transmission mode from 2018-2022.
- Cases with IDU or MSM+IDU as the reported transmission mode accounted for 7% of all cases in Nevada in 2022.
- Those with no identified risk (NIR) comprised the second largest reported transmission group in 2022, accounting for 40% of new HIV diagnoses. Cases with no identified risk have increased by 214% from 2018 to 2022.

- Black (non-Hispanic) and Hispanic/Latinx individuals were diagnosed with HIV at rates six and two times that of White (non-Hispanic) individuals, respectively, in 2022.
- During 2022, 54% of all individuals newly diagnosed with HIV in Nevada were born outside the United States. This number has more than doubled since 2018.

People Living with HIV

- Between 2018 and 2022, the majority of people living with HIV in Nevada were White and cisgender men.
- Non-Hispanic Black people are disproportionately affected by HIV in Nevada, at a rate nearly three times higher than any other race/ethnicity from 2018-2022.
- Cisgender men made up 83% of all people living with HIV in Nevada from 2018-2022.
- Men who have sex with men (MSM) represented the largest proportion of people living with HIV (64%) from 2018-2022.

Continuums of Care / Viral Suppression

- Across Nevada, an estimated 88% of all newly diagnosed persons who met the follow up criteria were linked to care in 2022.
- In Clark County, 77% of all newly diagnosed persons who met the follow up criteria were virally suppressed at follow-up. This was true for 76% of new diagnoses in Washoe County, and 71% in All Other Counties. Non-Hispanic Black and Multi-Racial people had the lowest rates of viral suppression in Clark County in 2022.

There have been many successes in the trajectory of HIV in Nevada. At the height of the epidemic, as many as 744 people were being diagnosed every year; that number has decreased to 535 new diagnoses in 2022. There were only six perinatal HIV transmissions between 2018 and 2022. Legislative changes have improved access to care and prevention, while recent modernization policies represent an overall shift to destigmatize HIV statewide. Harm reduction services have expanded greatly within the last decade.

However, as the data in this document show, there is still work to do to reduce the burden of HIV statewide, especially among vulnerable and historically marginalized communities. Clark County continues to have one of the highest rates of HIV in the country, highlighting a need for expanded services in the Las Vegas metropolitan area especially. Targeted approaches and sustained efforts are needed to ensure that gains are experienced by all Nevadans.

INTRODUCTION

The Office of HIV, under the Nevada Division of Public and Behavioral Health, has written this epidemiological report to present comprehensive data on human immunodeficiency virus (HIV) in Nevada. Data in this report include persons who were diagnosed with HIV, living with HIV, at-risk of HIV, or died of HIV in Nevada through 2018-2022. This report was informed by guidance from the Centers for Disease Control and Prevention (CDC).

The goal of this document is to illustrate the landscape and burden of HIV across Nevada over the five-year span of 2018-2022. In this profile, you can expect to find data presented by geographic region, demographic group, and transmission group. Throughout this report, you will see many abbreviations and scientific terms. You can find a guide to these acronyms on page 6 and an appendix of commonly used terms on page 73. This report is intended to serve as a resource for state, county, and community-based organizations to evaluate and make recommendations for allocating resources to HIV planning, prevention, and care programs.

This epidemiological profile has two main sections. Section I provides a broad overview of Nevada's landscape, including factors that influence population health and HIV transmission rates across the state. Section II includes HIV data and analysis spanning 2018-2022.

The most current HIV surveillance data may be found on the State of Nevada's HIV Surveillance Dashboard (updated annually).

SECTION I: LANDSCAPE ANALYSIS

Nevada Population Overview

Nevada is a diverse and unique state in the American Southwest. Nevada is the seventh largest state (by geographic area) in the United States. There are 17 counties spread across 110,577 square miles. Nevada has an estimated population of 3,177,772 (based on 2022 census data)[1] and has grown approximately 4.9% between 2018-2022[2]. Nevada is unique in that nearly three-fourths (73.8%) of the total population reside in Clark County, where Las Vegas is located. Washoe County contains Reno, the second largest city in Nevada, and 15.1% of the population. About a tenth (11.1%) of the population live in the remaining 15 counties. Between 2018 and 2022, Clark County had the largest total growth (+94,015 people), while White Pine County had the largest total decline (-744 people)[3].

The vast majority of Nevada's geographic area is defined as rural or frontier; however, 91% of Nevada's population lives in urban areas. Per the 2020 Census, Nevada's overall population density is 28.1 people per square mile (28.1/sq.mi), making it the 9th least densely populated state in the United States. The federal government owns approximately 80.1% of Nevada's land area, with 67% administered by the Bureau of Land Management. The remaining 19.9% is sovereign tribal land, state/local jurisdiction, or privately owned[4].

Nevada's population has dramatically increased by 17.6% from 2010 to 2022[5]. Nevada was the fifth fastest growing state in the United States between 2010 and 2020 and continues to grow rapidly[6]. Migration to Nevada is fueled by a variety of factors, such as lower housing prices, no state income tax, overall lower cost of living compared to neighboring California, and the COVID-19 pandemic. In 2022, 40% of all new Nevada residents had moved from California, reflecting this trend of migration in pursuit of lower cost of living[7].

According to 2020 Census data, the racial composition of Nevada was 72.1% White, 10.8% Black or African American, 10.3% Asian/Pacific Islander, 5.1% two or more races, and 1.7% American Indian or Alaska Native. Nearly 30% of the population ethnically identifies as Hispanic or Latino. As of 2019, Nevada is one of seven states that are a "majority-minority" state, defined as a U.S. state or jurisdiction whose population is composed of less than 50%

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[1] U.S. Census Bureau, "Nevada Quick Facts."
[2] State of Nevada Department of Taxation, "2022 Population of Nevada's Counties and Incorp Cities - Governor's Certified Series."
[3] State of Nevada Department of Taxation.
[4] Congressional Research Service, "Federal Land Ownership: Overview and Data."
[5] U.S. Census Bureau, "Nevada Quick Facts."
[6] Associated Press, "Census Data Shows Nevada 5th Fastest Growing State."
[7] Schultz, "More People and More Californians Moving to Nevada, UNLV Research Shows."

non-Hispanic whites. In Nevada, 45.7% of the population identifies as non-Hispanic white only. Between 2018-2022, the Hispanic/Latino population had the most growth in Nevada, increasing from 875,341 in 2018 to 961,354 in 2022[8].

Nevada is located on the traditional homelands of the Nüümü (Northern Paiute), Shoshone-Bannock, Newe Sogobia (Western Shoshone), Nuwuvi (Southern Paiute), Goshute, Wá·šiw (Washoe), Nüwüwü (Chemehuevi), Hualapai, and Pipa Aha Macav (Mojave) tribal nations[9]. Today, there are four main tribal groups who live in Nevada: the Northern Paiute, the Shoshone, the Southern Paiute, and the Washoe. In total, there are 21 federally recognized tribes in Nevada, each holding sovereign authority over their respective territories. Approximately 32 Indian Reservations, Colonies, and Communities are located within the borders of Nevada[10]. They maintain their own tribal governments, court systems, and law enforcement, separate from state and local jurisdictions. Tribal nations own and operate 1.6% of Nevada's geographic area[11].

Immigrants and Foreign-Born Residents in Nevada

Nevada has a large population of people born outside the United States. One in five Nevada residents is an immigrant, and one in six residents is a native-born U.S. citizen with at least one immigrant parent. In 2022, approximately 600,957 foreign-born individuals comprised 18.9% of the population[12]. About 55% of all immigrants in Nevada were born in Latin America[13].

The top countries of origin among immigrants living in Nevada are Mexico (36.5% of immigrants), the Philippines (15.5%), El Salvador (4.5%), China (4%), and Cuba (3%). Half (51%) of all immigrants in Nevada are naturalized U.S. citizens. Based on data from the 2022 American Community Survey, three in four (75.2%) immigrants reported speaking English "well" or "very well." Immigrants in Nevada are distributed across the educational spectrum. In 2021, more than one-fifth (23.4%) of adult immigrants had a college degree or post-secondary education, while more than one-fourth (29.5%) had less than a high school diploma[14]. Nearly 136,000 U.S. citizens in Nevada live with at least one family member who is

[8] U.S. Census Bureau, "Nevada Quick Facts."
[9] "Native Land Digital."
[10] Nevada Indian Commission, "Map of Nevada Tribes."
[11] University of Nevada, Reno, "Our Communities - Office of Indigenous Relations."
[12] Census Bureau, "2022 American Community Survey."
[13] Census Bureau, "Selected Social Characteristics in the United States."
[14] Census Bureau, "2021 American Community Survey."

undocumented. Approximately 210,000 undocumented immigrants comprised 35% of the immigrant population and 7% of the total state population in 2016[15].

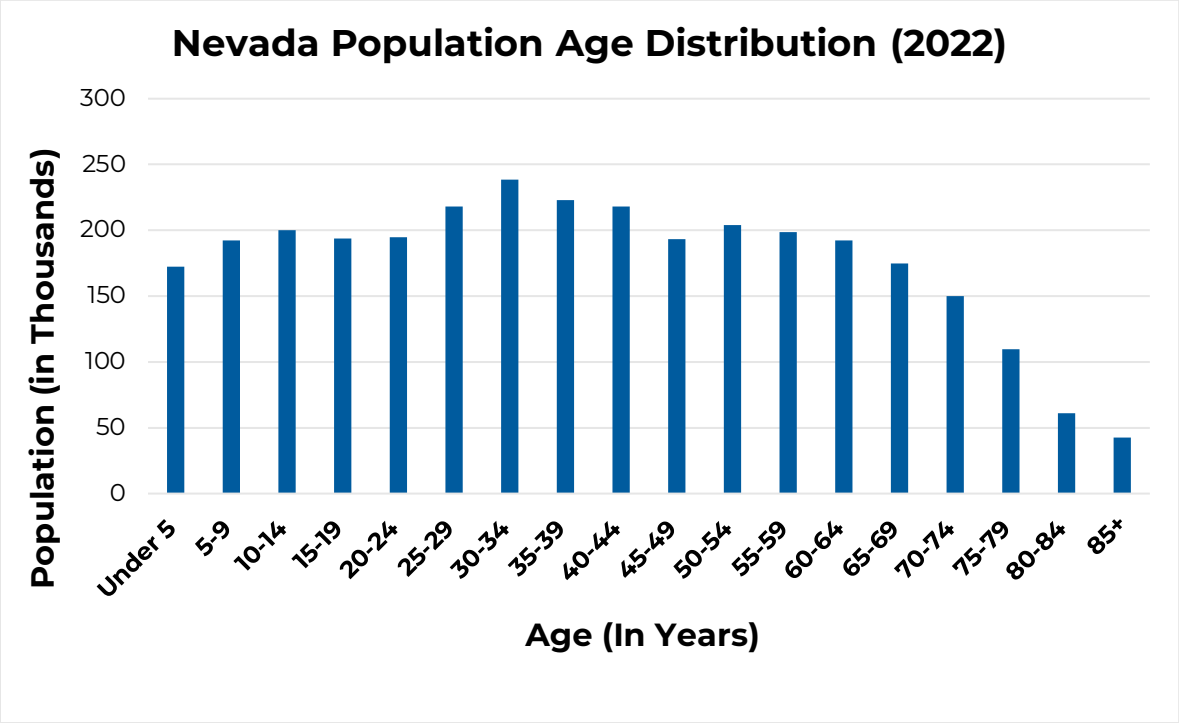
Nevada is also home to a small population of refugees, predominantly from Afghanistan, Syria, Congo. Nevada resettles numerous refugees annually (163 refugees resettled between October 1, 2021, and September 30, 2022)[16].

Nevada's Age Distribution

Over half of Nevada's population is between the ages of 25 and 64 (53.4%). About one-third of the population is between the ages of 0 and 24 (30.8%), and the remaining population are age 65 and older (15.8%). By age cohort, Nevada's population closely mirrors the national age distribution. The 2022 U.S. Census Bureau American Community Survey reported 22.7% of Nevada's population was under the age of 18 (compared to 22.5% nationwide), Nevada's working cohort (between 18 and 64) was 61.5% (compared to 61.5% nationwide) and Nevada's senior cohort (over 65 age) was 15.8% (compared to 16.0% nationwide)[17].

[15] Pew Research Center, "U.S. Unauthorized Immigrant Population Estimates by State, 2016."
[16] Salahi, Saladino, and Brown, "Refugee Arrivals in the Mountain West, FY 2021-2022."
[17] Census Bureau, "2022 American Community Survey."

Figure 1 | Nevada Population Age Distribution



Nevada's child dependency ratio is 36.1, which reflects the number of children and adolescents under age 18 per 100 persons aged 18-64. Nevada's old-age dependency ratio, the number of persons aged 65 or over per 100 persons aged 18-64, is 26.3. Nevada's total dependency ratio is 52.9 (similar to the national ratio), which means that for every 10 people of working age (ages 15-64), there are about 5 people who need to be supported in some capacity (as a youth dependent or elderly person receiving social security benefits)[18]. This number does not account for the proportion of the population that is disabled and in need of caretaking services.

Aging Population

Nevada has a growing aging population. In 2022, 16.9% of the population was 65+, compared to 15.7% in 2018 and 13% in 2012. The growth trend of the age 65 and older population continues to outpace growth in other younger age groups as of 2022. Nevada has a similar

[18] U.S. Census Bureau, "2022 American Community Survey 5-Year Estimates."

proportion of the population aged 65 and older compared to the United States (14.1% in 2018 and 17.3% in 2022).

The vast majority (87%) of Nevada's 65 and older population lives in Nevada's three metropolitan areas (Las Vegas, Reno, and Carson City)[19]. In 2022, approximately 10.8% households with an individual over age 65 were living in poverty statewide[20]. These Nevadans face significant challenges in meeting their daily needs including food, housing, and medical care. The rural counties of Nevada had the highest share of older adults living in poverty at 11.1%[21].

Social Security benefits are a major source of income for many older adults in the U.S. The average monthly Social Security payment for Nevadans is $1,422, which aligns with the national average. Among Nevadans aged 65-74 years old, 24.6% continue to participate in the labor force[22], often out of financial necessity or to retain healthcare benefits.

Nevada's Sexual Orientation and Gender Identity (SOGI) Distribution

As of 2021, 50.4% of the Nevada population was assigned male at birth and 49.6% were assigned female at birth. This ratio remains constant across all age groups[23]. This breakdown does not account for gender expansive people whose gender may fall outside of the binary categories assigned at birth. Data on gender expansive individuals nationwide is still limited, though some independent research groups have conducted surveys to better understand the representation of transgender people in the U.S. Based on data for Nevada from CDC's Behavior Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey (YRBS), the UCLA Williams Institute reported that an estimated 8,100 people (0.3%) over age 18 identify as transgender in Nevada. Furthermore, approximately 3,300 (1.7%) youth aged 13-17 identified as transgender[24].

Nevada is home to a large population of LGBTQIA+ individuals. An estimated 5.5% (145,000) of Nevadans aged 13+ identify as part of the LGBTQ spectrum as of 2020. Among LGBTQ adults aged 25+ in Nevada, approximately 22% are currently raising children[25].

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[19] Nevada State Demographer, "Nevada County Age, Sex, Race, and Hispanic Origin Estimates and Projections."
[20] Census Bureau, "2022 American Community Survey."
[21] Nevada Aging and Disability Services Division, "Elders Count 2023."
[22] U.S. Census Bureau, "2022 American Community Survey 5-Year Estimates."
[23] Census Bureau, "2021 American Community Survey."
[24] Herman, Flores, and O'Neill, "How Many Adults and Youth Identify as Transgender in the United States?"
[25] The Williams Institute, "LGBT Demographic Data Interactive."

ENVIRONMENTAL FACTORS AND INFLUENCES ON HIV IN NEVADA

Health is influenced by a wide range of factors often called "determinants of health." Determinants of health are interconnected and may be tied to a person's identity (such as race, gender, sexuality, etc.), education, income, occupation, geographic location, and more. The term "socioeconomic status" refers to the money, power, and resources that people have, all of which are influenced by socioeconomic and political factors (e.g., policies, culture, and societal values). Socioeconomic status is an important determinant of health and is closely related to HIV status and risk. The following section will explore social and environmental factors unique to Nevada to contextualize the data found in this report. It will also explore various protective factors that may reduce risk, offset harms, and contribute to HIV prevention and treatment statewide.

Socioeconomic Status, Poverty, and Income Inequality in Nevada

Many Nevadans struggle with poverty and unemployment. Nevada has a poverty rate of 12.5%, meaning that for every 100 people, about 12 people live under the poverty threshold (<$29,678 annual income for a family of four). Nevada ranks 29th in the nation and has a higher poverty rate than the national average. Nevada's child poverty rate, the percentage of children under 18 living with families below the poverty threshold, is 15.8[26].

Poverty disproportionately impacts different racial groups in Nevada. The group most impacted by poverty is Black/African Americans, with a poverty rate of 20.7%, far higher than the overall state average. Native Americans have the next highest poverty rate, at 17.7%. The Hispanic/Latino population has a poverty rate of 13.2%, followed by the Asian American population at 12.5%. Non-Hispanic/Latino Whites have a poverty rate of 9.9%, the lowest of all racial/ethnic groups in Nevada[27].

Nevada's median household income 2018-2022 was $71,646. The per capita income in 2022 was $62,085, which was a dramatic increase from $49,278 in 2018[28]. Nevertheless, income inequality is a pressing issue in Nevada. One way to measure income distribution is called a "Gini coefficient," which is a number between 0 (meaning complete equality, where all households receive the same income) and 1 (meaning complete inequality where one household receives all income). As of 2022, Nevada's Gini coefficient is 0.47 which means there are noticeable variations in income distribution across households, with certain

[26] Census Bureau, "2022 American Community Survey."
[27] Census Bureau.
[28] U.S. Census Bureau, "Nevada Quick Facts."

segments of the population holding a larger share of income compared to others. This is on par with the 2022 U.S. Gini coefficient, of 0.49[29].

Another way to look at income inequality is a “top-to-bottom" ratio, which shows how large the gap is between the top 1% of earners and the rest of the population. In 2015, the wealthiest 1% of Nevadans on average made 32.7 times more than those in the bottom 99%. Based on this metric, Nevada ranked 4th in the nation for income inequality and was one of only eight states with a top-to-bottom ratio higher than the national average ratio of 26.3[30].

In 2019, the minimum wage in Nevada was $8.25 per hour. That same year, the Nevada Legislature passed Assembly Bill 456 which approved an incremental minimum wage increase of $0.75 annually, starting on July 1, 2022, and through 2024. Nevada has a two-tier minimum wage system based on whether the position offers health benefits. However, a ballot measure passed in November 2022 eliminated this two-tier system and raised the state minimum wage to $12.00 per hour starting July 1, 2024 (aside from positions federally exempted from minimum wage requirements)[31].

Housing Insecurity

Nevada is experiencing a shortage of available and affordable housing. Many factors have contributed to this shortage, such as an influx of new residents from neighboring California, nationwide inflation, and a growing population outpacing the housing supply. Housing costs are also rising disproportionately compared to wages, creating strain

In Nevada, nearly 40% of all households were cost-burdened (spending 30% or more of their income on housing costs) in 2022. Residents with disabilities and seniors are disproportionately affected by the affordable housing shortage and make up nearly half of all extremely low-income households in Nevada (extremely low income is defined as making <30% of the area median income). Nearly 90% of extremely low-income households in Nevada are cost-burdened[32]. State efforts to address the problem include 2019 legislation that created the Nevada Affordable Housing Tax Credit program, subsidized impact fees to reduce the cost of construction of affordable housing, and improved data collection on housing needs.

Homelessness is prevalent across the state, with an estimated 7,618 people sleeping outside on any given night in Nevada in 2022. This number was on a steady decline over the last 10

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[29] Census Bureau, “2022 American Community Survey.”
[30] Sommeiller and Price, “The New Gilded Age.”
[31] State of Nevada Department of Business and Industry, “Nevada’s Minimum Wage and Daily Overtime Rates to Increase July 1, 2023.”
[32] Census Bureau, “2022 American Community Survey.”

years, however the number has increased since 2020 and is now higher than the 2018 estimate (7,544). The number of homeless youths has decreased by 72% between 2018-2022, yet the number of chronically homeless individuals has increased by 332% in the same timeframe. Clark County has the highest concentration of people experiencing homelessness in Nevada. Washoe County's total homeless population has increased by 35% between 2018-2022 (an estimated 1,605 people experiencing homelessness in 2022). Meanwhile, Clark County's total homeless population has decreased by 7% in the same timeframe, but still has the highest amount of people experiencing homelessness in the state (5,645 individuals in 2022)[33].

Despite temporary housing shelters helping to alleviate the impact of homelessness, only 48% of those needing shelter could be sheltered in 2022.

Homelessness and unstable housing contribute significantly to an individual's overall health and wellbeing. It can also be a major structural barrier to maintaining effective antiretroviral therapy among people living with HIV. Research has shown that people experiencing homelessness are nearly four times more likely to have incomplete viral suppression, compared to those with stable housing[34].

Higher Education Attainment

In 2022, Nevada had the lowest higher education attainment rate in the nation (defined as the successful completion of a collegiate associate degree or higher, or a certified trade program). Approximately 42.7% of Nevadans ages 25-64 had achieved education credentials (including an associate degree or trade certification) beyond high school graduation in 2022. This is over 10% below the national average of 54.3%. Of Nevada's counties, Mineral County had the lowest higher education attainment rate, at 16.4%, followed by Pershing (17.7%) and Nye (17.7%). Clark County had an attainment rate of 34.6% and Washoe had a rate of 40.6%. These rates are unevenly distributed across racial/ethnic groups, with Asian/Pacific Islanders having the highest rate of higher education attainment at 51.2%, followed by non-Hispanic whites at 42.8%, while Hispanic/Latino Nevadans had the lowest rate at 18.9%[35].

[33] National Alliance to End Homelessness, "State of Homelessness Nevada Dashboard."
[34] Thakarar et al., "Homelessness, HIV, and Incomplete Viral Suppression."
[35] Lumina Foundation, "A Stronger Nation: Nevada Progress Report."

Sexual Health Education

Sexual health education contributes to youth awareness of HIV and sexual wellness practices. In Nevada, public schools are required to provide a human sexuality course, however the course cannot be a graduation requirement. This means that not all students will receive sexual health education as a part of their curriculum. Current Nevada state law only requires school districts to establish a sex education curriculum that includes factual information on HIV, the reproductive system, related communicable diseases, and sexual responsibility[36], but state law does not provide specific regulations or standards to be met. Nevada law mandates an "opt-in" policy, requiring parents to provide written consent for their children to participate in human sexuality education[37].

Youth Risk Behavior Survey

The Youth Risk Behavior Survey (YRBS) is a national surveillance system that was established in 1991 by the CDC to monitor the prevalence of health risk behaviors among youth. This survey is offered to high school students in public, private, and charter/alternative schools nationwide. Nevada is one of few states that offers the YRBS to middle school students as well. The survey asks students to self-report their behaviors in six major areas of health that directly lead to morbidity and mortality, including: 1) Behaviors that contribute to unintentional injuries and violence; 2) Sexual behaviors that contribute to HIV infection, other sexually transmitted diseases, and unintended pregnancy; 3) Tobacco use; 4) Alcohol and other drug use; 5) Unhealthy dietary behaviors; and 6) Physical inactivity.

Several aspects of these survey results can provide insight into the unique traits of Nevada's youth population. The proportion of high school youth respondents in 2021 who identified as transgender was 4.0%, up from 1.9% in 2019. In 2021, 14% of high school respondents indicated that they had experienced sexual dating violence within the year (including kissing, touching, or physically forced to have sexual intercourse when they did not want to by someone they were dating or going out with), an increase from 12.9% in 2019. Approximately 2% of high school respondents stated that they had used drugs intravenously at least once.

In 2021, approximately one in four high school respondents reported having sexual intercourse at least once. Among those respondents, 49.3% said they used a condom during their most recent sexual encounter. About 11% of respondents shared they either had sexual contact with the "same sex" or "both sexes" before.

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[36] Nevada Revised Statute 389.036.
[37] SIECUS, "Nevada's State of Sex Ed."

Research suggests adverse childhood experiences (ACEs), including sexual, emotional, or physical abuse; neglect; parental loss; and exposure to parental mental illness, substance misuse or domestic violence, may contribute to or predict HIV risk behaviors and HIV-related disease burden[38]. The 2021 Nevada YRBS included questions about ACEs. More than one in ten (11.2%) high school respondents reported that "an adult or person at least 5 years older than them" made them do sexual things they did not want to do. One in ten (10.5%) respondents also reported that they "never/rarely" had an adult in their household "who tried hard to make sure their basic needs were met." At least 35% of respondents shared they had lived with someone who was having a problem with alcohol or drug use.

Access to Care and Medical Provider Shortages in Nevada

Access to quality medical care is an ongoing issue that many Nevadans face. One of the primary barriers to care in Nevada is a severe physician shortage statewide. Approximately two-thirds of Nevada's population (nearly two million people) live in an area with a shortage of physicians, according to Health Resources and Services Administration (HRSA). Nevada consistently ranks near the bottom among states for doctors per capita. Eight counties in Nevada (Churchill, Esmeralda, Eureka, Lander, Lincoln, Lyon, Mineral, and Pershing) are classified by HRSA as Health Professional Shortage Areas (HPSAs), and all counties in Nevada are at least partially designated as a medically underserved area. In 2022, Nevada ranked 49th in the nation for primary care physicians per capita with only 190.2 active physicians per 100,000 residents, much lower than the national average of 247.5 physicians per 100,000 people.

Nevada also suffers from shortages of nursing professionals as well, ranking among the lowest in the nation for nurses per 1,000 residents. Despite steady growth in the number of new nursing graduates and registered nurses relocating to Nevada, over 4,000 additional registered nurses are needed to meet the national nurse-to-resident ratio of 9.22 nurses per 1,000 residents[39].

The healthcare professional shortage is especially dire in rural areas of Nevada, where some residents must travel over two hours to access the nearest healthcare facility. Those who cannot drive or afford transportation costs may suffer disproportionately from these shortages. Several efforts have been launched to address the shortage and attract rural health care providers such as mobile health clinics, provider incentives, and more

[38] Brown and Anda, "Adverse Childhood Experiences."
[39] Nevada Health Workforce Research Center, "Addressing Nevada's Nursing Workforce Shortages: A Call to Action."

competitive wages. The State of Nevada also funds and oversees a team of rural health nurses based in 16 outpatient behavioral health clinics across 12 counties in rural Nevada.

Due to the lack of both primary and specialty care providers in Nevada, many patients must go to the emergency rooms or urgent care, even for non-emergent medical conditions. As a result, patients may not remain in the continuum of care or receive preventive care on a consistent basis. This can also make it more difficult to manage complex conditions requiring ongoing care needs, such as HIV.

Community Health Workers in Nevada

Nevada has a strong network of community health workers (CHW) who help bridge the gap for underserved communities across the state. A CHW is defined as a frontline public health worker who is a trusted member of and/or has a close understanding of the community served, allowing them to facilitate access to services and improve the quality and cultural competence of service delivery.[40]. The CHW workforce includes many types of roles, such as navigators, health advocates, case managers, community outreach educators, peer leaders, and promotoras. CHWs play unique, diverse, and important roles in the community, often employing innovative techniques and working in nontraditional environments to reach community members.

Promotoras Las Vegas (PLV) is a non-profit organization focusing on the Latino/Hispanic community that aims to reduce health and social disparities by creating strategic community partnerships, preventive health programs, educational and cultural programs, and general health promotion campaigns geared towards underinsured and underserved minorities in Las Vegas. The Las Vegas Regional Committee of the Network of Promotoras also has a strong community presence, offering trainings and professional development for promotoras in the area.

Community Health Workers can offset the impact of Nevada's healthcare provider shortage by improving the efficiency/reach of health systems, empowering the community to engage in preventative care, and reducing the burden on clinical care staff. A study conducted by University of Nevada, Reno in 2017 found that when CHWs were added to a clinical team providing health and medical services in Nevada, there was a return of nearly $2 for every $1 spent.[41]. The same study indicated that strategic CHW intervention resulted in a drastic decrease in ER visits (14%), urgent care (6%), acute admits (18%) and repeat

[40] American Public Health Association, "Recognition and Support for Community Health Workers' Contributions to Meeting Our Nations Health Care Needs."
[41] Center for Program Evaluation, University of Nevada, Reno, "Community Health Worker Return on Investment Study Final Report."

hospital visits (20%). Additionally, the path to becoming a CHW is lower cost and more accessible than other clinical care positions, allowing the CHW workforce to be scaled up more quickly statewide.

Health Insurance Coverage in Nevada

Another key barrier to accessing care is lack of health insurance coverage. In 2022, 11.1% of Nevada population was uninsured with the 6th highest proportion of uninsured residents in the nation. Among all insured Nevadans in 2022, 63.4% were enrolled in private insurance (either alone or in combination with other insurance). There is also a reliance on public health insurance as 20.7% of the population receives Medicaid while 17.9% receive Medicare. Through the Nevada Public Option starting in 2026, an estimated 50,000 Nevadans, predominantly those who do not have private insurance and are ineligible for Medicaid/Medicare, are expected to enroll[42].

In 2022, Latino and American Indian/Alaska Native populations in Nevada had the highest proportion of uninsured individuals, with 19.7% and 22.5% of each population being uninsured respectively. Comparatively, lower rates of uninsured individuals are among White, Black, and Asian Nevadans at 7.2%, 10.3%, and 8.4% respectively[43].

Mental Health in Nevada

Nevada has a severe shortage of mental health professionals, including clinical psychologists, psychiatrists, licensed clinical social workers, and clinical professional counselors. As a result, access to mental health care is a challenge for many Nevadans. In 2022, Nevada ranked last in the nation for providing mental health services for both adults and children. Nevada currently has only one mental health professional available for every 460 Nevadans and each county is federally designated as having a mental health provider shortage[44].

Nevada falls far behind the national average of provider-to-population ratio for all types of mental health professionals. In 2022, Nevada had 10.3 clinical professional counselors per 100,000, compared to the national average of 45.4. The ratio of clinical psychiatrists is low as well, with only 9 psychiatrists for every 100,000 residents, compared to the national average of 15.9. Youth mental health services are similarly lacking, especially within schools. Nevada

[42] Nevada DHHS, “Nevada Public Option Fact Sheet.”
[43] Census Bureau, “2022 American Community Survey.”
[44] The Lincy Institute, University of Nevada, Las Vegas, “The State of Mental Health in the Mountain West.”

had the third lowest ratio of school psychologists and the lowest ratio of school social workers in the nation (one school social worker per 8,730 students, compared to the recommended ratio of 1 to 250)[45].

Despite the challenges, many efforts are being made to address the mental health crisis taking place in Nevada. In 2023, Assembly Bill 37 allocated $2 million to establish the Behavioral Health Workforce Development Center of Nevada, which aims to increase the number of mental health providers statewide. UNLV PRACTICE (Partnership for Research, Assessment, Counseling, Therapy, and Innovative Clinical Education) opened a satellite clinic offering low-cost mental health services to youth and adolescents in 2022 as well.

Research shows that mental health impacts one's ability to achieve and maintain HIV viral suppression, along with engagement in prevention practices[46]. Therefore, access to mental health care and services is an important consideration in the overall landscape of HIV in Nevada.

Sex Work and Sexual Tourism Industry in Nevada

Sex work (legally referred to as prostitution) is a part of Nevada's tourism industry. Nevada is the only state in the country where sex work is legal, however, it is only permitted by law in licensed brothels. As of 2023, there are 19 legal brothels open in Nevada and 10 counties legally allowing brothels. Sex work is still criminalized in Clark County and Washoe County, the two main entertainment and tourism hubs of Nevada.

The maximum jail sentence for sex work (among those aged 18 and older) in Nevada is six months, though courts typically impose probation, up to $1,000 in fines, and an HIV/AIDS Awareness class. Legal brothels operate under strict regulations and oversight, with the requirement that all employed sex workers must be at least 18, test regularly for STIs, and use condoms in every encounter[47].

Regardless of legal status, sex work exists in all of Nevada's counties. Las Vegas is commonly considered the symbolic center of the commercial sex industry in the United States[48]. Beyond Nevada's legal brothels, the sex industry also encompasses all legal and non-legal adult businesses that sell sexual products, sexual services, sexual fantasies, and sexual contact for profit in the commercial marketplace. Nevada's sex industry continues to

[45] Hopeful Futures Campaign, "America's School Mental Health Report Card."
[46] Centers for Disease Control and Prevention, "Data Tables: Quality of Life and HIV Stigma— Indicators for the National HIV/AIDS Strategy 2022–2025, by Priority Populations, CDC Medical Monitoring Project, 2017–2021 Data Cycles."
[47] Nevada Administrative Code 441A.777-441A.815.
[48] Macfarlane et al., "Sex Industry and Sex Workers in Nevada."

grow annually, with a wide range of formal and informal, legal and non-legal businesses, as well as a wide range of individuals who work in and around the industry.

Many sex clubs and bathhouses legally operate in Nevada, with the greatest concentration in Las Vegas. These private clubs commonly operate under a membership or fee-based structure. Regulations surrounding condom use varies based on location, however community health agencies frequently partner with local businesses to provide free or low-cost HIV and STI testing on-site. People of all sexual orientations and gender identities, visiting and local, frequent these businesses in Nevada.

Nevada has a large adult film industry as well. Policy changes in California, including a ballot measure requiring condoms to be used in all pornographic projects filmed in Los Angeles County, have contributed to the growth of the porn industry in Nevada. Although condoms are not required by law for adult films in Nevada, entertainers generally undergo strict and frequent HIV/STI testing as part of rigorous industry standards. HIV transmission rates related to film projects are extremely low, with the last recorded occupational transmission occurring in 2014[49].

Non-legal sex work in Nevada is extremely diverse and caters to a wide variety of clientele. Common non-legal types of sex work roles include high end/elite escort services, house workers (unofficially contracted by casino, bar, or nightclub for “preferred customers”), outcall referrals (contractors utilizing legal referral agencies to sell sex illegally at private premises/hotels), unlicensed brothel work, solicitation at bars/casinos, and street-based solicitation. Data on the demographics of people engaging in sex work in Nevada is limited. Although the majority of sex workers in Nevada are cisgender women, trans women compose a large proportion of sex workers as well. People of all genders, sexualities, ages, races, and classes engage in sex work in Nevada. It is also important to note many sex workers move between legal and non-legal sectors based on demand, safety concerns, and circumstance.

Data on people under the age of 18 trading for sex is difficult to capture. The Department of Justice funded a study published in 2016 that interviewed nearly a thousand individuals who sold sex aged 13-24 in six cities, including Las Vegas. The results of this study revealed the demographics and motives of youth trading sex may differ from adults over 18 working in the sex industry. The data indicated that around 40% of youth trading sex were male or transgender. A large proportion of youth trading sex in Las Vegas identified as LGBTQ+ and approximately 78% were non-White[50]. While Nevada law defines all youth who trade sex under 18 as trafficked, the study results indicated coercion from a third party is not the

[49] Wilken et al., “Occupational HIV Transmission Among Male Adult Film Performers — Multiple States, 2014.”
[50] Swaner et al., “Youth Involvement in the Sex Trade: A National Study.”

primary pattern of entry for youth. Only 13% of youth respondents in Nevada reported that they were working under a pimp (defined as a person who exploits an individual in the sex market through coercion, control, or force). Many youth begin trading sex after being forced to flee threatening, abusive, or insecure home environments. There is a high correlation between homelessness and survival sex for LGBTQ youth especially. Data on HIV and STI transmission among youth trading sex is extremely limited and difficult to measure.

Substance Use and Harm Reduction in Nevada

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health (NSDUH), conducted in 2021-2022, 4.5% of Nevada's population 18 and over reported using illicit drugs within "the past month," the 4th highest rate in the nation. In this survey, illicit drug use was defined as the misuse of prescription psychotherapeutics or the use of cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. This rate has risen since the 2018-2019 NSDUH, with 3.8% of respondents 18 and over reporting illicit drug use (an increase of 0.7%).

Based on the 2021-2022 NSDUH, Nevada had the highest percentage of methamphetamine use in the nation, with 2.4% of respondents stating that they had used methamphetamines in the last year (compared to the national rate of 1.0%). Nevada also had the highest rate of prescription pain reliever "misuse" at 4.5%. These rates have also risen since 2018-2019, with 1.3% reporting meth use (an increase of 1.1%) and 4% reporting prescription pain "misuse" (an increase of 0.5%) in 2018-2019.

In 2018-2019, the prevalence of past-year substance use disorder (SUD) in Nevada was estimated to be 9.3%, higher than the national average of 7.7%. Due to SAMHSA's reclassification of substance use disorder based on the updated DSM-V criteria, 2021-2022 SUD data cannot be compared in this report.

Nevada is currently experiencing an overdose epidemic. A major outbreak of overdoses occurred in 2022 when Nevada emergency department visits increased by 66% for opioid-related overdose and 50% for stimulant-related overdose between July 2022 and August 2022.[51] Though the rate of overdoses has since decreased, Nevada's statewide overdose death rate (30.3 deaths per 100,000 in 2022) continues to mirror the national average (32.4 per 100,000). Overdose deaths have risen dramatically overall in both Nevada and the United States since 2018.[52].

In Nevada, opioids (including illicitly manufactured fentanyl) and methamphetamines were consistently involved in the highest number of overdose deaths between 2018 and 2022.

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[51] Nevada Overdose Response, "Suspected Nevada Drug Overdose Surveillance Monthly Report, September 2022."
[52] Centers for Disease Control and Prevention, "Drug Overdose Mortality by State."

Nearly 3 in 5 deaths involved an opioid, over two-thirds of deaths involved a stimulant (67%), and 28% of deaths involved both an opioid and stimulant[53].

Many programs and organizations exist in Nevada to address substance use and provide resources for people who use drugs.

The PACT (Prevention, Advocacy, Choices, Teamwork) Coalition was formed in 2010 to address substance use in southern Nevada. The PACT Coalition is composed of a diverse group of over 450 community-based stakeholders and uses a strategic prevention framework to address policy, system, and environmental change surrounding substance use in Clark County. The coalition serves as pass-through entity for funds that are given to direct service providers. Many other programs are operated by the PACT such as educational campaigns, naloxone distribution network, safe medication disposal, and other prevention models.

The Washoe County Substance Abuse Task Force was formed in 2019 as a way for organizations to collaborate to reduce addiction, overdose deaths, and improve quality of life for impacted communities across Washoe County.

The Statewide Substance Use Response Working Group (SURG) was created by Assembly Bill 374 in 2022 as a multi-disciplinary task force to develop recommendations to improve Nevada's statewide substance use prevention and response efforts.

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. One core part of a community-based harm reduction framework is the use of Syringe Service Programs (SSPs), also colloquially known as needle exchanges. SSPs are community-based prevention programs that can provide a range of services, including access to sterile syringes and injection equipment; linkage to treatment for substance use disorder; and vaccination, testing, linkage to care, and treatment for infectious diseases[54]. SSPs also protect the public and first responders by facilitating the safe disposal of used needles and syringes. Providing testing, counseling, and sterile injection supplies also helps prevent outbreaks of HIV, viral hepatitis, and other infectious diseases.

Nevada has a strong harm reduction network. Trac-B Exchange is the largest SSP in Nevada. Trac-B opened southern Nevada's first storefront harm reduction supply exchange in 2013, the same year Nevada Senate Bill 410 was passed, allowing community-based organizations to provide sterile hypodermic devices to reduce the transmission of disease. Trac-B operates self-service harm reduction vending machines offering supplies such as

[53] Thomas, "Nevada State Unintentional Drug Overdose Reporting System, Report of Deaths January to June 2022."
[54] Centers for Disease Control and Prevention, "Syringe Service Programs."

syringes, condoms, wound care, and pregnancy tests. As of 2024, Trac-B offers harm reduction services in Clark, Washoe, Mineral and Elko Counties.

The Southern Nevada Harm Reduction Alliance (SNHRA) is a coalition of public health professionals, HIV providers, addiction and recovery specialists, and harm reduction advocates that works to reduce drug related stigma, overdoses, and the harmful effects of drugs within the southern Nevada community through education and outreach. SNHRA partners with Southern Nevada Health District to provide monthly testing for HIV and hep C, along with sterile syringes and overdose prevention tools.

Chemsex and Sexual Subcultures

Chemsex, also referred to as Party and Play (PNP) and/or wired play, is defined as the use of any legal or illegal psychoactive substance before or during sex. Chemsex is a part of the many sexual subcultures in Nevada, however little data exists on the regional chemsex landscape. International research from the last few decades has shown that chemsex may be more frequent among the LGBTQIA+ community than other populations, though people of all sexualities and identities may engage in chemsex. Chemsex may especially appeal to those experiencing "minority stress" associated with their marginalized identity, therefore creating an additional need for escape or connection[55]. It can also allow those with commonly stigmatized sexualities to experience pleasure with fewer inhibitions.

The substances most used in chemsex (often referred to as chems), are crystal methamphetamine, GHB/GBL (gamma-hydroxybutyrate / gamma-butyrolactone), and cathinones (mephedrone, 3MMC, 4MMC), which are commonly used in combination with ketamine, cocaine, alcohol, erectile dysfunction drugs, MDMA, amyl-nitrates (poppers) and antidepressants[56]. The substances used in chemsex vary significantly based on cultural, geographic, and demographic factors.

While there is evidence those who engage in chemsex have a higher probability of contracting STIs and/or blood-borne infections, including HIV, multiple confounding factors make it difficult to determine whether there is a causal relationship. Risks associated with chemsex include impaired decision making (potentially impacting safer sex practices) and potential opportunities for blood-to-blood contact through the sharing of injection equipment. However, many who engage in chemsex are also well-versed in harm reduction and prevention practices. For example, some may choose to "serosort" (the practice of having sex with partners who have the same HIV status), get tested more frequently, use

[55] Jaspal, "Chemsex, Identity and Sexual Health among Gay and Bisexual Men."
[56] Poulios, "Harm Reduction in the Context of Chemsex: Training Manual."

PrEP and PEP, and/or incorporate other safer sex and drug use techniques[57]. Little data is available to show how prevalent HIV transmission is among groups who engage in chemsex.

Social Media and Dating

Social media and dating apps are a common way for individuals to connect in a digital age. Some of the most popular apps include Grindr, Tinder, Hinge, Bumble, Scruff, Jack'd, Feeld, Facebook, or Instagram and can be used to meet potential romantic and/or sexual partners. Many use dating apps to find partners with specific identities, sexualities, and interests. Some dating apps specifically cater to those living with HIV and other STIs, such as HIV People Meet, Positives Dating, Positive Singles, PozMatch, and MeetPositives.com. Other apps offer ways to self-identify HIV status and provide up-to-date testing results.

According to a survey conducted by Pew Research Center in 2022, 3 in 10 U.S. adults said they have previously used a dating site or app. Online dating is more common among younger adults than older people. About half of those under age 30 (53%) report having used a dating site or app, compared with 37% of those ages 30 to 49, 20% of those 50 to 64 and 13% of those 65 and older. When looking at sexual orientation, lesbian, gay or bisexual adults are more likely than straight adults to say they have ever used a dating site or app (51% vs. 28%)[58].

Among those who have used a dating site or app, slightly more say their personal experiences have been very or somewhat positive compared to those with very or somewhat negative experiences (53% vs. 46%). Some demographic groups are more likely to report positive experiences. For example, 57% of men who have dated online say their experiences have been positive, while women users are roughly split down the middle (48% positive, 51% negative). In addition, lesbian, gay, and bisexual users of these platforms are more likely than straight users to report positive experiences (61% vs. 53%)[59].

Many agencies in Nevada have recognized the important role social media and dating apps may play in dating encounters and HIV prevention, especially among young people. In recent years, organizations like Southern Nevada Health District, Silver State Equality, and Ryan White Part A have launched targeted ads on apps like Grindr to encourage testing and other prevention techniques.

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[57] Jaspal, "Chemsex, Identity and Sexual Health among Gay and Bisexual Men."
[58] Vogels and McClain, "Key Findings about Online Dating in the U.S."
[59] Vogels and McClain.

Gambling Disorder

Nevada legalized gambling in the 1930s and allows casino-style gambling statewide. Gambling is a large part of the entertainment industry across Nevada. Gambling disorder, defined as repeated, problem gambling behavior that is damaging to an individual or those around them, affects thousands of Nevadans annually. In 2017, Nevada had a 29.3% increase in residential enrollments, and in 2018, a 23.3% outpatient enrollment increase for problem gambling treatment services[60]. These percentages do not account for those who are not seeking help. Gambling disorder is shown to lead to financial loss, anxiety, depression, substance use disorders, and behavioral changes.

About 4% of people being treated for substance use also have gambling disorder, as do nearly 7% of psychiatric patients. An estimated 96% of people with gambling problems have at least one other psychiatric disorder[61]. Substance use disorders, impulse-control disorders, mood disorders, and anxiety disorders are particularly common among people with gambling problems. Research has also indicated that gambling disorder may be a risk factor for contracting HIV, highlighting the need for HIV prevention activities geared towards this population[62].

Social Vulnerability Index

"Social vulnerability" refers to the potential negative effects on communities caused by external stresses on human health. Such stresses include natural or human-caused disasters, or disease outbreaks. The CDC Social Vulnerability Index (SVI) uses 16 U.S. census variables to help local officials identify socially vulnerable populations that may be especially at risk during public health emergencies because of factors like socioeconomic status, household characteristics, racial and ethnic minority status, or housing type and transportation.

SVI scores range from 0 (lowest vulnerability) to 1 (highest vulnerability). In 2022, Esmerelda County had an SVI score of 0.9077, the highest score out of all counties and jurisdictions in Nevada. Clark, Carson City, and Nye counties also fell into the "high" range of vulnerability[63].

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[60] UNLV International Gaming Institute, "Nevada Problem Gambling Study Annual Report, Fiscal Year 2018."
[61] Potenza et al., "Gambling Disorder."
[62] Langan et al., "Prevalence and Potential Predictors of Gambling Disorder among People Living with HIV."
[63] Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry, "CDC/ATSDR Social Vulnerability Index Interactive Map."

Social Stigma in Nevada

HIV stigma is defined as negative attitudes and beliefs about people with HIV. Stigma surrounding HIV has existed since the beginning of the epidemic and continues to impact community perceptions of people living with and at-risk for HIV. Stigma often leads to discrimination, which can significantly affect the health and well-being of people living with HIV. Research shows stigma can also discourage people from getting tested, talking about HIV with others, or accessing HIV services. Stigma can also discourage patients from self-disclosing their identities and risk factors to healthcare providers in fear of poor treatment or judgement. Limited data exists on the specific impacts of HIV stigma in Nevada; however, anecdotal evidence suggests it plays a significant role in how community members interact with HIV services statewide.

HIV criminalization is a term used to describe laws criminalizing otherwise legal conduct or increasing the penalties for illegal conduct based on a person's HIV-positive status. In 2021, Nevada repealed NRS 201.205 through SB 275 to decriminalize HIV and therefore decrease stigma around the illness[64]. NRS 201.205 was an HIV-specific criminal offense carrying a penalty of up to ten years in prison; it was replaced by a misdemeanor offense with more specific restrictions and only applying to those who knew their status and intentionally transmitted the virus.

In recent years, Nevada has repealed several other HIV-related laws, such as the category-B felony for engaging in or soliciting prostitution after a positive HIV test, and a set of mandatory HIV testing provisions that had applied to individuals arrested for prostitution, arrested for a sexual offense, or entering the custody of the Department of Corrections. Many stigmatizing references to HIV and AIDS have been removed from the public health code as well.

Stigma impacts HIV care and services on multiple levels. Efforts have been made in recent years to address stigma among healthcare providers to provide more culturally competent and inclusive care to patients. University of Nevada, Reno (UNR) created a free course for medical providers titled, "Sexual History Taking and Sex Positivity," to provide strategies for talking about sex with patients in a less-stigmatizing way through a sex positivity framework. Southern Nevada Health District also offers "Empower Change Testing & Counseling Testing Program" to train community-based HIV testing staff in motivational interviewing and counseling through a sex positivity lens.

The concept of Status Neutral HIV Prevention and Care, often simply called Status Neutral, is another helpful stigma reduction tool increasingly being implemented in healthcare practices. According to CDC, Status Neutral is "a whole person approach to HIV prevention

[64] Prison Policy Initiative, "Nevada Profile."

and care that emphasizes high-quality care to engage and retain people in services regardless of if the services are for HIV treatment or prevention." A status neutral approach involves engaging and assessing a patient's needs before an HIV test is conducted, utilizing a "no-wrong-door" model to care for all people affected by HIV. "No-wrong-door" means designing and integrating systems so that a person can access all of the services they need regardless of where they seek care, such as offering HIV testing at retail pharmacies or other non-clinical spaces.

Incarceration in Nevada

Nevada has an incarceration rate of 610 per 100,000 people (including prisons, jails, immigration detention, and juvenile justice facilities). Approximately 20,000 people are currently incarcerated in Nevada, and around 38,000 people are booked in local Nevada jails annually[65].

All state prisons test for HIV upon intake, though treatment policies are not standardized across the state. Testing is not required within jails, however the jails in Clark County and Washoe County offer voluntary testing at intake. In 2021, Nevada Department of Corrections reached a settlement with the U.S. Department of Justice to eliminate the practice of separating incarcerated individuals living with HIV from the rest of the HIV-negative prison population[66]. Part of the settlement also required all Nevada prison staff and inmates undergo training on HIV discrimination and implement an anti-HIV bias grievance policy.

[65] Prison Policy Initiative.
[66] U.S. Department of Justice, "Justice Department Reaches Agreement with Nevada to End Discriminatory Policies Against Inmates with HIV and Inmates with Disabilities."

SECTION II – HIV IN NEVADA

History of HIV in Nevada

The first case of HIV in Nevada was recorded in 1982, and the first Nevadan died of complications from HIV Stage 3 on March 11, 1983. HIV spread rapidly in Nevada through the 1980s, with new diagnoses reaching its peak in 1990 when 751 people were diagnosed that year (60.8 per 100,000 population). Thousands of Nevadans have died from HIV since 1982, and the death rate peaked in 1995 with 381 deaths. Deaths related to HIV Stage 3 drastically declined after 1995 when highly active antiretroviral therapy (HAART) was approved by the FDA and became widely available.

After the peaks of new diagnoses of HIV and HIV Stage 3, in conjunction with decreasing deaths, the number of persons living with HIV in Nevada has steadily increased over the years. Individuals are becoming infected at a lower rate than the early years of the epidemic, and people are living longer once they do become infected due to better access to care and improved antiretroviral therapies.

New HIV diagnoses have started to trend upward again since 2012. This trend is not solely attributed to increased transmission, but a variety of factors, such as more widespread utilization of electronic lab reporting, improved access to care through Nevada's adoption of Medicaid expansion in 2014, and increased testing capabilities due to advanced rapid technologies and community health campaigns. In 2012, Nevada began receiving electronic lab reports which increased the timeliness and efficiency of HIV case reporting. The expansion of reporting requirements in 2015[67] has also contributed to the increase in new diagnoses within the state. Comprehensive lab reporting directly from the laboratories can help identify probable or previously unreported cases who may already be in care, thereby increasing the number of new reported diagnoses.

Nevada is disproportionately impacted by HIV, with the highest rate (16.6 per 100,000 in 2022) of new diagnoses in the western U.S. The Nevada BRFSS is conducted annually and assesses a set of standardized population behavioral risk factors. Results from this survey have indicated only about 40% of Nevada's population has ever been tested for HIV (excluding tests from blood donation). Testing rates among individuals aged 18-24 have increased from 22% in 2018 to 26.6% in 2022. However, lifetime testing percentages have dropped in other age brackets, indicating challenges with testing Nevadans.

[67] Nevada Administrative Code 441A.225.

In 2022, the CDC estimated 82.5% of those living with HIV infection in Nevada had been diagnosed.[68]. This signifies that approximately one in five people living with HIV in Nevada are unaware of their status.

While HIV diagnoses have been on a steady decline since the mid-2000s, the number of new HIV diagnoses has remained relatively stable until 2020, when COVID-19 severely impacted the HIV testing and care infrastructure in Nevada. As of 2022, there were an estimated 13,299 people living with diagnosed HIV (PLWDH) in Nevada, of whom 535 were newly diagnosed in 2022. This number has increased since 2018, when an estimated 12,120 people were living with diagnosed HIV in Nevada and 444 people were newly diagnosed that same year.

HIV continues to predominantly impact men who have sex with men (MSM) and people who inject drugs (PWID). Overall, Black and Brown communities across Nevada are also disproportionately impacted by HIV and other social inequities. This report will examine the inequities surrounding HIV and highlight populations that must be prioritized by treatment and prevention efforts in the future.

In 2019, Clark County was 1 of 48 counties in the United States selected to receive federal funding to combat the HIV epidemic under the Ending the HIV Epidemic: A Plan for America (EHE) initiative. The plan's overall goal is a 75% reduction in new HIV diagnoses by 2025 and a 90% reduction in new HIV diagnoses by 2030. This initiative is centered around 5 Key Pillars: Diagnosis, Treatment, Prevention, Response, with an added pillar for an overarching approach centered in health equity and radical customer service. More information about the EHE Initiative and Nevada's efforts can be found here.

A note on HIV transmission "risk" factors:

Only certain bodily fluids can transmit HIV. These fluids include blood, semen (cum), pre-seminal fluid (pre-cum), rectal fluids, vaginal fluids, and breast milk. For HIV to be transmitted, fluids from a person living with HIV must come in direct contact with a mucous membrane or damaged tissue or be directly injected into the bloodstream (from a needle or syringe). Mucous membranes are found inside the rectum, vagina, penis, and mouth.

Some behaviors have a higher risk for HIV being transmitted. The CDC has established a system of "transmission categories" representing a person's possible HIV risk factors and categorizes cases by which factor is most likely to have resulted in HIV transmission.

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[68] Centers for Disease Control and Prevention, "HIV Surveillance Data Tables: Core Indicators for Monitoring the Ending the HIV Epidemic Initiative: National HIV Surveillance System Data Reported Through December 2023."

Epidemiologists use these categories to show how HIV is likely being transmitted throughout a population. The CDC has identified six core categories that HIV may be transmitted: male-to-male sexual contact (MSMC), injection drug use (IDU), male-to-male sexual contact and injection drug use (MSM+IDU), heterosexual contact, perinatal transmission, and "other." These categories are on a hierarchy of highest to lowest risk. Because some people have more than one reported "risk factor," this system helps show how HIV was most likely transmitted to that person based on probability.

The risk of contracting HIV varies widely, depending on the type of exposure or behavior (such as sharing needles or condomless sex). Some exposures to HIV carry a much higher risk of transmission than other exposures. Other exposures may have an extremely low risk, but risks can add up over time and lead to a high lifetime risk of contracting HIV. In other words, there may be a relatively small chance of acquiring HIV when engaging in a risk behavior with an infected partner only once, but if repeated many times, the overall likelihood of becoming infected after repeated exposures is higher.

When we talk about transmission factors, it is important to note that no individual person is intrinsically more at-risk for acquiring HIV. However, certain behaviors might have a "higher risk" of transmitting HIV, which any person can engage in. Although "transmission categories" help explain how HIV is currently being spread, this must not be equated with any group or type of person being deemed more or less "risky." By separating the individual from the "risk," it can help to destigmatize HIV as a condition.

COVID-19 Impact

The COVID-19 pandemic had a substantial impact on the HIV prevention and care infrastructure in Nevada during 2020. On March 5, 2020, Clark County reported its first COVID-19 case. On March 12, 2020, Nevada Governor Steve Sisolak declared a state of emergency, and on March 17, 2020, non-essential businesses were ordered to close statewide, including many sites where HIV services were provided such as community-based organizations and the AIDS Healthcare Foundation's mobile unit. HIV testing remained available at local health departments despite the closure; however, most clients elected to stay home out of precaution for COVID-19.

In addition to the impact on service delivery, the COVID-19 pandemic created gaps in surveillance data. Although surveillance systems remained active for the full duration of the pandemic, data entry was significantly impacted due to competing public health priorities across all levels of the surveillance continuum.

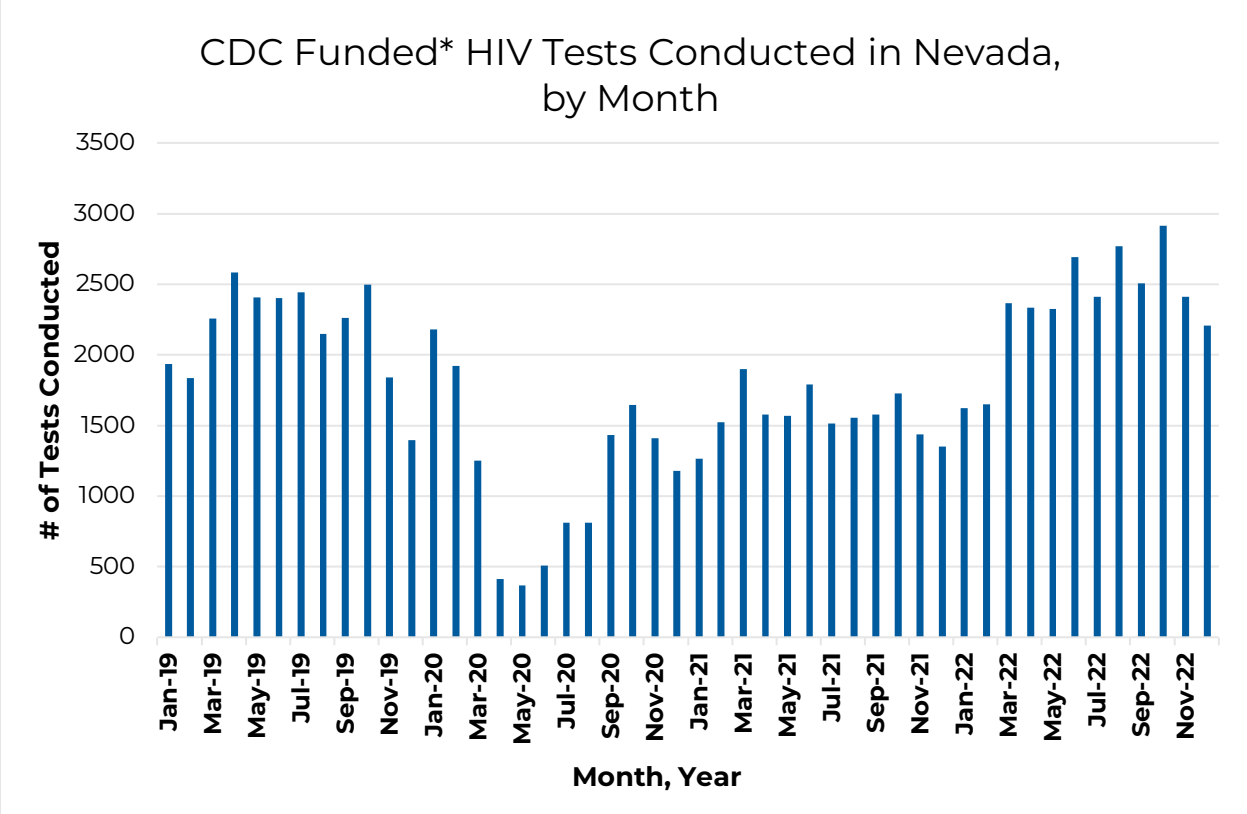
Restoring HIV services and improving access to care has been key priority among HIV stakeholders since 2021. Service providers pursued innovative approaches to reach the community in a time when conventional methods were no longer accessible. Since 2020, many new programs have been launched such as at-home HIV testing kits, including a

counseling component allowing for risk assessment and risk reduction to be part of the process.

It is important to interpret the following data in context of the COVID-19 pandemic. Data collected in 2020 does not represent the full picture of HIV burden in Nevada.

The following graph shows how HIV testing in Nevada was impacted by COVID-19. CDC-funded HIV testing sharply decreased in March 2020, reaching a low in May 2020 and gradually increasing back to pre-pandemic levels throughout 2021 and 2022. Note that this data only represents CDC-funded HIV tests as data was unavailable for total tests (including positive and negative tests) conducted statewide.

Figure 2 | CDC Funded HIV Tests Conducted in Nevada, by Month



*Note that the above graphic does not account for all HIV tests in Nevada, only tests funded by CDC grants.

The impact of COVID-19 can also be seen across HIV Care Continuum measures. While continuum measures have improved since 2020, retention in care and viral suppression have not returned to those observed pre-pandemic. See page 66 for Care Continuum metrics.

History of HIV Epidemiological Profiles and Data Reporting in Nevada

This epidemiologic profile is based on the *Integrated Guidance for Developing Epidemiologic Profiles*, updated March 2022, issued by the CDC and HRSA.

To date, Nevada DPBH has published two integrated profiles prior to the current edition: "HIV and AIDS in Nevada 2000-2006" and "HIV/AIDS Integrated Epidemiological Profile, 2009-2013." Updates to each profile were published annually until 2015, when budgetary and staff limitations prevented additional updates. This profile will cover HIV data between the years 2018 and 2022. This report provides an in-depth description of how HIV impacts the population of Nevada through sociodemographic, geographic, behavioral, and clinical lenses. This description will include data on people living with, or at risk for HIV, and those who may need prevention and/or care services. This profile may be a helpful resource for HIV stakeholders statewide to use in the coordination of care and services.

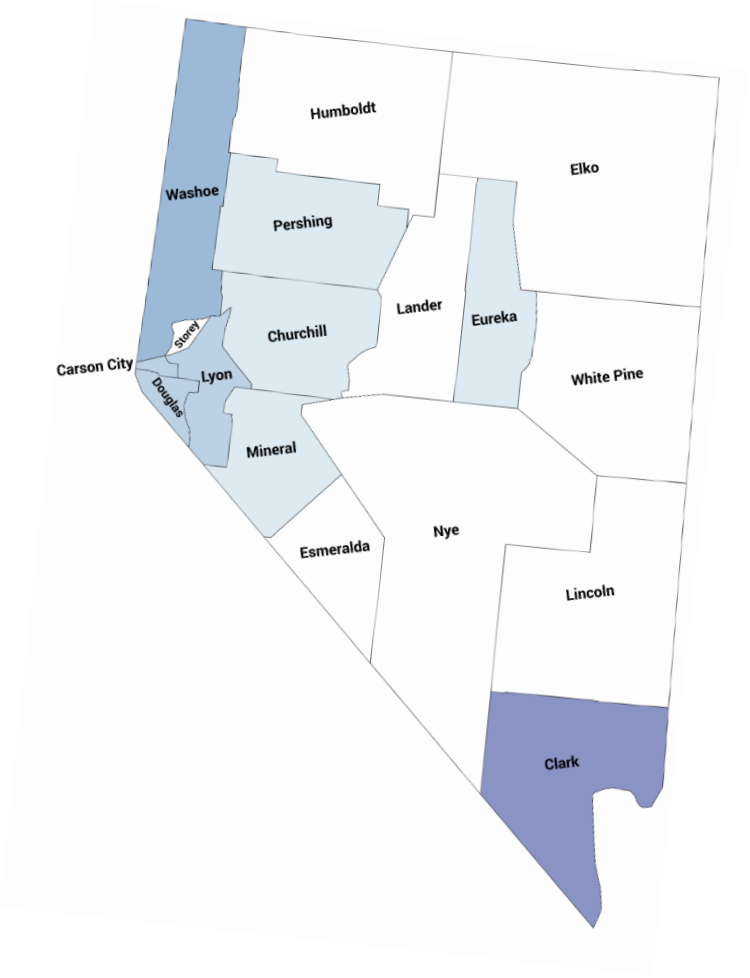
HIV Case Reporting Process in Nevada

Direct public health services, as they relate to surveillance, investigation, and response to infectious diseases of public health importance, are the responsibility of the four county health departments and the tribal health departments or Indian Health Service Units in Nevada. Those departments and respective jurisdictions are listed below:

- Southern Nevada Health District (SNHD)
    - Clark County
- Northern Nevada Public Health (NNPH) [Formerly Washoe County Health District]
    - Washoe County
- Carson City Health & Human Services (CCHHS)
    - Carson City, Douglas, and Lyon County
- Central Nevada Health District (CNHD)*
    - Churchill County, the City of Fallon, Pershing County, Mineral County, and Eureka County

Nevada Division of Public and Behavioral Health (DPBH) oversees all other counties.

*Surveillance activities in Fallon, Churchill County, Pershing County, Mineral County, and Eureka County were conducted by Nevada DPBH between 2018 and 2022.



Nevada Local Health Districts

- Nevada Division of Public and Behavioral Health (DPBH)
- Southern Nevada Health District (SNHD)
- Northern Nevada Public Health (NNPH)
- Carson City Health and Human Services (CCHHS)
- Central Nevada Health District (CNHD)

The Nevada Administrative Code (NAC) Chapter 441A requires reports of specified diseases, food borne illness outbreaks and extraordinary occurrences of illness be made to the local health authority. The purpose of disease reporting is to recognize trends in diseases of public health importance and to intervene in outbreaks or epidemic situations. HIV is included in the state code as a required reportable disease.

Physicians, veterinarians, dentists, chiropractors, registered nurses, directors of medical facilities, medical laboratories, blood banks, school authorities, college administrators, directors of childcare facilities, nursing homes, and correctional institutions are required to report when a case passes through their system.

Mandatory reporting is an important tool in disease surveillance and response. State and local public health officials rely on this mandated reporting to have a complete picture of HIV data and trends across the state.

Historically, reports were submitted manually through mail, fax, or phone calls, however modern advancements have allowed for reports to be submitted through electronic laboratory reporting (ELR) systems. ELR is a powerful tool because it automates a large portion of the reporting process by translating the information in a laboratory system into an electronic message that can be automatically sent and processed by the public health agency. ELR allows agencies to identify and respond to outbreaks more quickly and efficiently.

Although not all facilities regularly use ELR systems, this method is strongly preferred by public health authorities and is becoming the standard of practice.

Once a report of HIV is received, local public health staff conduct investigations of reported cases by contacting the patient and gathering information about their risk factors, demographics, symptoms, and potential contacts. During this investigation, prevention education or linkage to care services may also be provided.

Local health jurisdictions and NV DPBH add the information to the enhanced HIV/AIDS Reporting System (eHARS), the CDC's national HIV surveillance system.

Data Sources

The data presented in this profile comes from the following sources:

Enhanced HIV/AIDS Reporting System (eHARS) is a browser-based, CDC-developed application that assists health departments with reporting, data management, analysis, and transfer of HIV data to CDC. eHARS is used by all 50 states, the District of Columbia, and all six territories. Each surveillance program maintains a separate eHARS installation and submits de-identified data monthly to CDC through a secure data network.

The **U.S. Census Bureau** is the federal government's largest statistical agency. The Census Bureau operates under Title 13 and Title 26 of the U.S. Code and provides current facts and figures about America's people, places, and economy. The Census Bureau collects data through a variety of methods, including the Decennial Census, the Economic Census, the American Community Survey (ACS), ongoing demographic and economic surveys related to income, poverty, education, health insurance coverage, housing quality, and more. The Census Bureau also publishes annual population estimates and demographic components of change to supplement data from the Decennial Census. Data from the U.S. Census Bureau is publicly available at data.census.gov.

Behavioral Risk Factor Surveillance System (BRFSS) is a nationally standardized set of health surveys conducted by state health departments by telephone that collects information on health risk behaviors, preventive health practices, chronic health conditions, and use of preventive services. The survey consists of a set of federally grant funded core questions and states may customize the survey with their own questions as well. BRFSS surveys are updated annually and conducted continuously throughout the year.

The **National Survey of Drug Use and Health (NSDUH)** is a survey conducted by SAMHSA (Substance Abuse and Mental Health Services Administration) on the use of drugs, alcohol, tobacco, and mental health issues in the United States. The study includes those aged 12 years or older at the time of the survey. The NSDUH is updated every other year and is conducted continuously throughout the year. Data reports are released in two-year increments.

The **Nevada State Demographer's Office** is funded by the Nevada Department of Taxation and is part of the Nevada Small Business Development Center. It is responsible for conducting annual population estimates for Nevada's counties, cities, and towns. Data from the Nevada State Demographer's office was used in this profile to supplement the population data from the U.S. Census Bureau.

For the most up-to-date HIV surveillance data, visit the State of Nevada's HIV Surveillance Dashboard.

Limitations of HIV Reporting Systems

Incomplete reporting is inherent to any surveillance system. Knowledge and awareness of current reporting rules, willingness to comply, available diagnostic tests, or mechanisms of reporting, may influence the likelihood of a case being reported as required. Additionally, many factors may affect whether a person seeks healthcare for the condition, and whether a diagnosis or laboratory test is considered. These may include severity of the disease, age of the patient, confidentiality issues or sensitivity of the disease, general patterns of health-seeking behavior, and access to or availability of healthcare services. Within the public health system, changes in case definitions over time, changes in administrative rules, changes in personnel and funding, changes in investigation practices, and other factors may also contribute to some variation over time or place.

Additionally, entities located on tribal lands are not held to the same mandatory reporting rules, although they serve Nevada residents who are included in census and population counts. Under A.A.C. R9-6-207 (“Federal or Tribal Entity Reporting”), these facilities are requested to report communicable diseases and laboratory results in the same manner as nontribal or non-federal providers, laboratories, or schools; this code also provides the same privacy and confidentiality protections for these records as for reports from other entities. For this reason, state HIV data for tribal jurisdictions may be incomplete.

Historical Trends

Figure 3 | New HIV Infections and Stage 3 Diagnoses in Nevada, 1982-2022

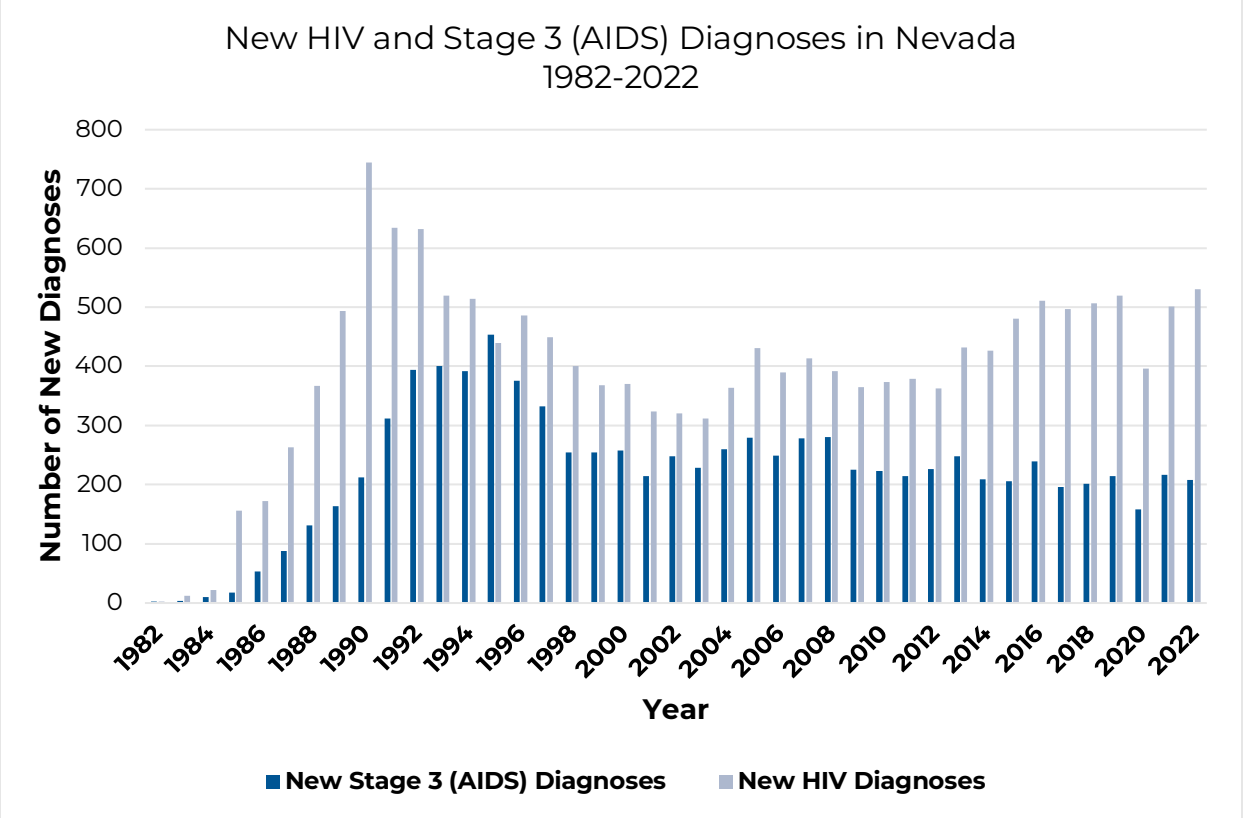


Figure 3: The first documented HIV infection in Nevada was diagnosed in 1982. Nevada experienced a peak of new HIV diagnoses in 1990 (with 744 new diagnoses). Since then, the annual number of new HIV infections, new Stage 3 diagnoses, and deaths has decreased overall. However, new HIV diagnoses have trended upward since 2010.

In the last five years (2018 to 2022), the annual number of persons newly diagnosed with HIV infection increased by 5.7% from 506 to 535. The notable decrease of new diagnoses in 2020 may be attributed to decreased testing services available during the COVID-19 pandemic. The number of new Stage 3 diagnoses has also increased by 3% during this time period, from 202 diagnoses in 2018 to 208 in 2022.

In 2022, Nevada had a total of 13,299 persons living with HIV. The total number of persons living with HIV in Nevada increased from 12,160 in 2018 to 13,299 in 2022.

Figure 4 | NV HIV Incidence Rate vs U.S. Incidence Rate, 2018-2022

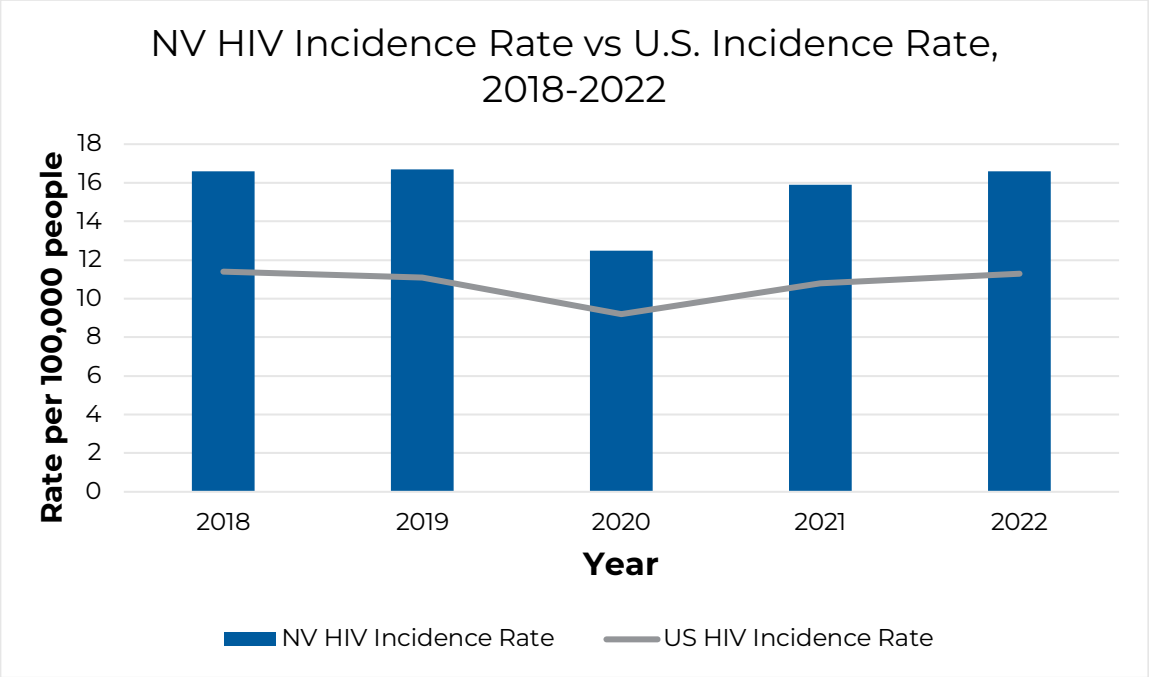


Figure 4: The HIV incidence rate (per 100,000 people) in Nevada has been consistently higher than the U.S. incidence rate from 2018-2022. In 2022, the HIV incidence rate in Nevada was 16.6 new cases per 100,000 people, compared to the U.S. incidence of 11.3 new cases per 100,000.

What is Incidence?

Incidence is how we measure new cases of HIV.

An "incidence rate" tells us how many people were newly diagnosed with HIV per 100,000 people. "Total incidence" tells us the total number of people who were diagnosed with HIV in a given time frame.

Figure 5 | Total NV HIV Incidence vs U.S. Incidence, 2018-2022

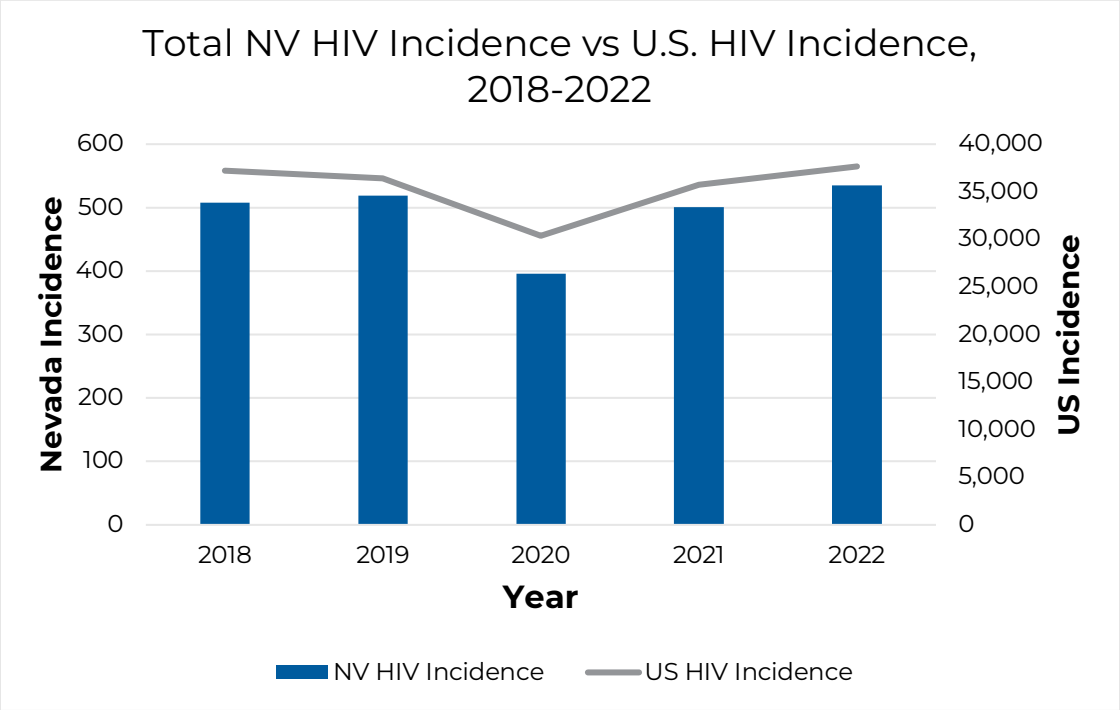


Figure 5: The total HIV incidence in Nevada in 2022 was 535. This number is higher than the incidence in 2018, which was 508. This means that the total incidence of new HIV cases in Nevada has increased between 2018-2022.

The total incidence of HIV in the United States was 37,663 in 2022. Total incidence of new HIV cases has increased nationwide between 2018-2022.

By geographic area

Figure 6 | New HIV Cases Diagnosed in Nevada in 2022, by County

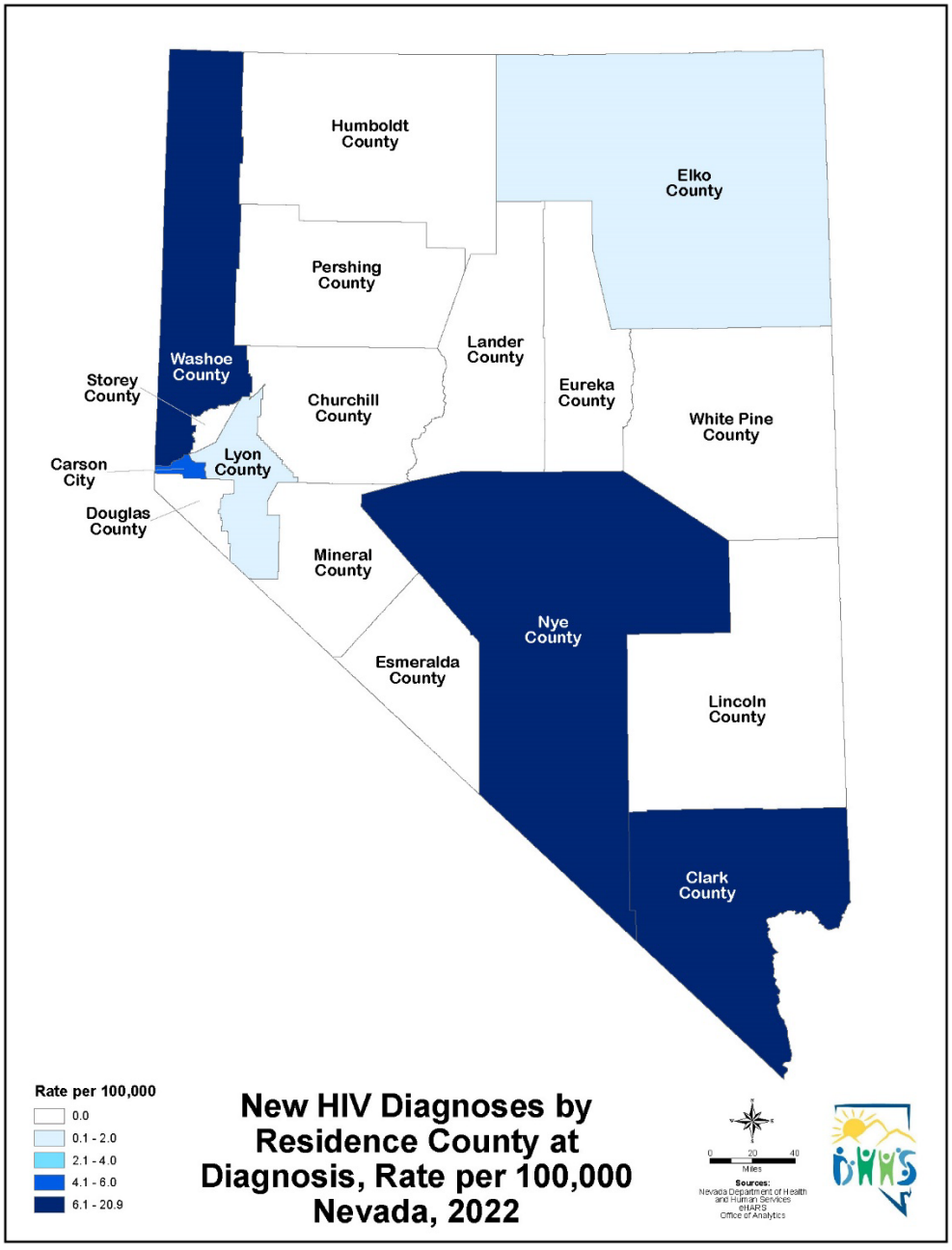


Figure 6: Clark County. Nye County, and Washoe County accounted for the highest rate of newly diagnosed HIV cases in 2022, followed by Carson City.

Figure 7 | New HIV Diagnoses in the Las Vegas Area in 2022, by Zip Code

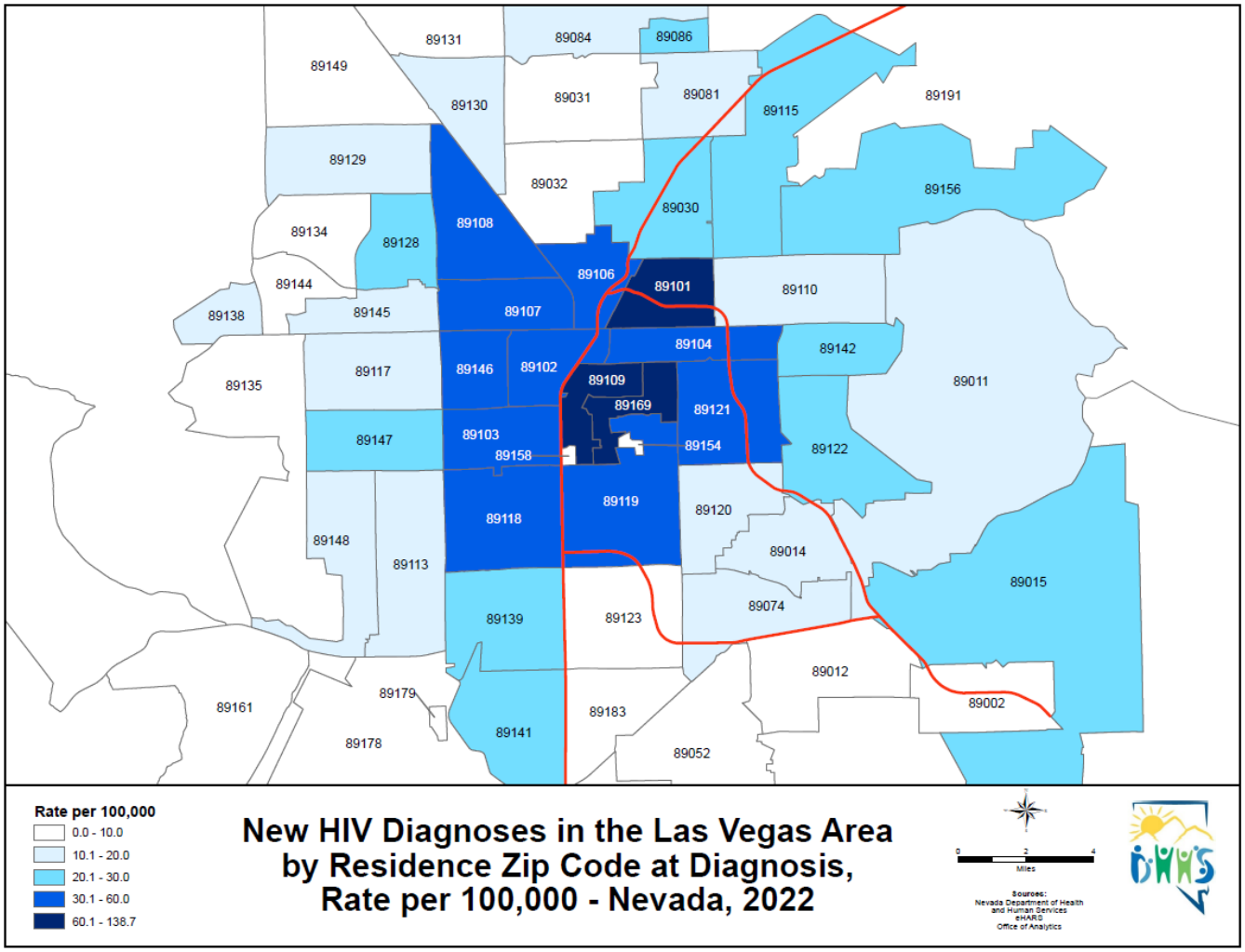


Figure 7: The following zip codes represent the highest rate of newly diagnosed HIV cases in 2022: 89109, 89169, and 89101. The areas with the highest rate of new HIV diagnoses in 2022 are clustered around Paradise, Downtown Las Vegas, North Las Vegas, and Sunrise Manor.

Figure 8 | Persons Living with HIV in Nevada, by County (2022)

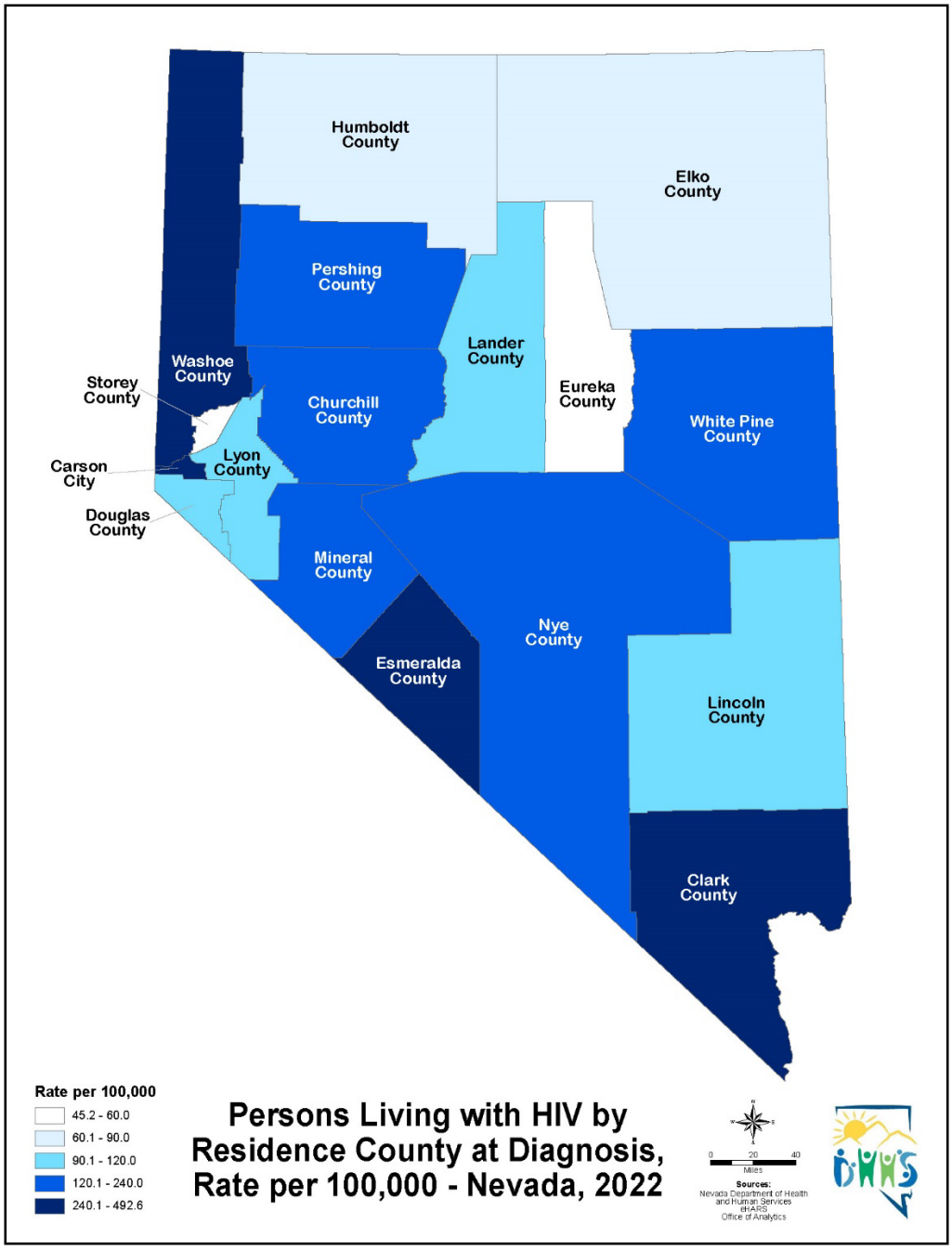


Figure 8: Clark County and Washoe County had the highest total number of people living with HIV 2018-2022, followed by Carson City, Douglas County, Lyon County, and Nye County.

Figure 9 | Persons Living with HIV in the Las Vegas Metro Area, by Zip Code (2022)

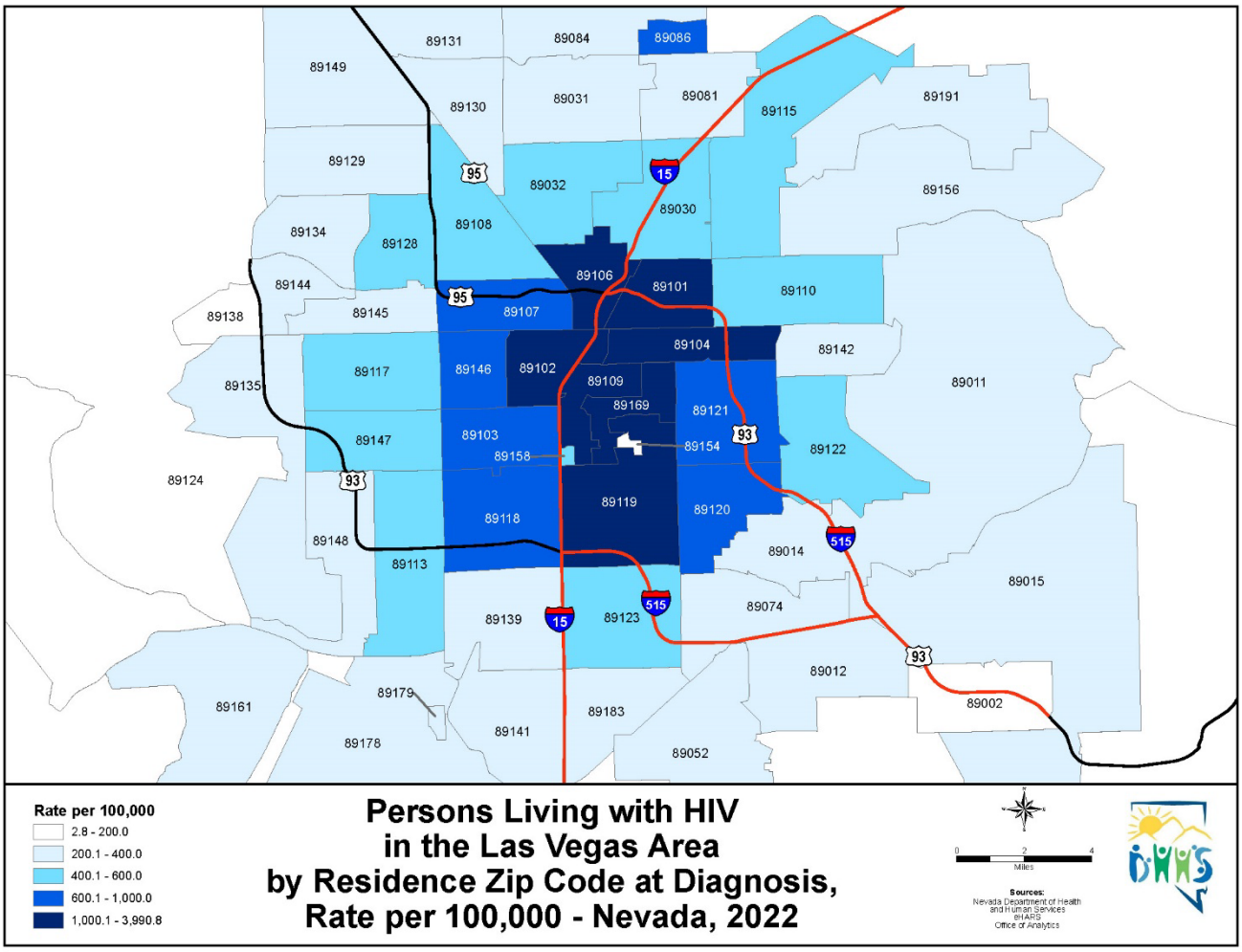


Figure 9: The following zip codes represented the highest rate of people living with HIV in 2022: 89102, 89106, 89101, 89109, 89104, 89169, and 89119. The areas with the highest rate of persons living with HIV are predominantly clustered around Paradise and Downtown Las Vegas.

Figure 10 | New HIV Stage 3 Diagnoses in Nevada, by County (2022)

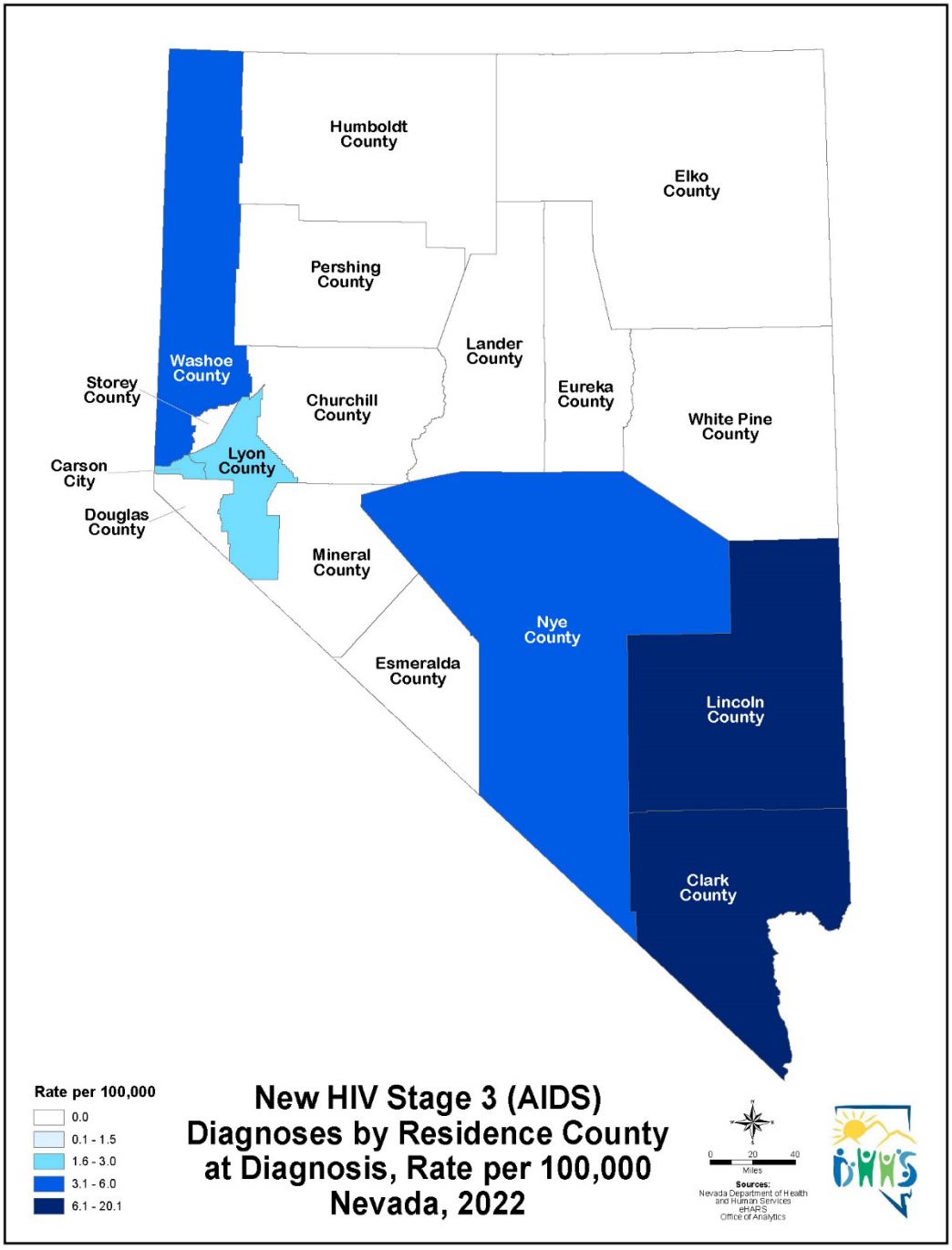


Figure 10: Clark County and Lincoln County accounted for the highest rate of newly diagnosed HIV cases in 2022, followed by Nye County and Washoe County.

Figure 11 | New Stage 3 HIV Case Diagnoses in Clark County, by Zip Code (2022)

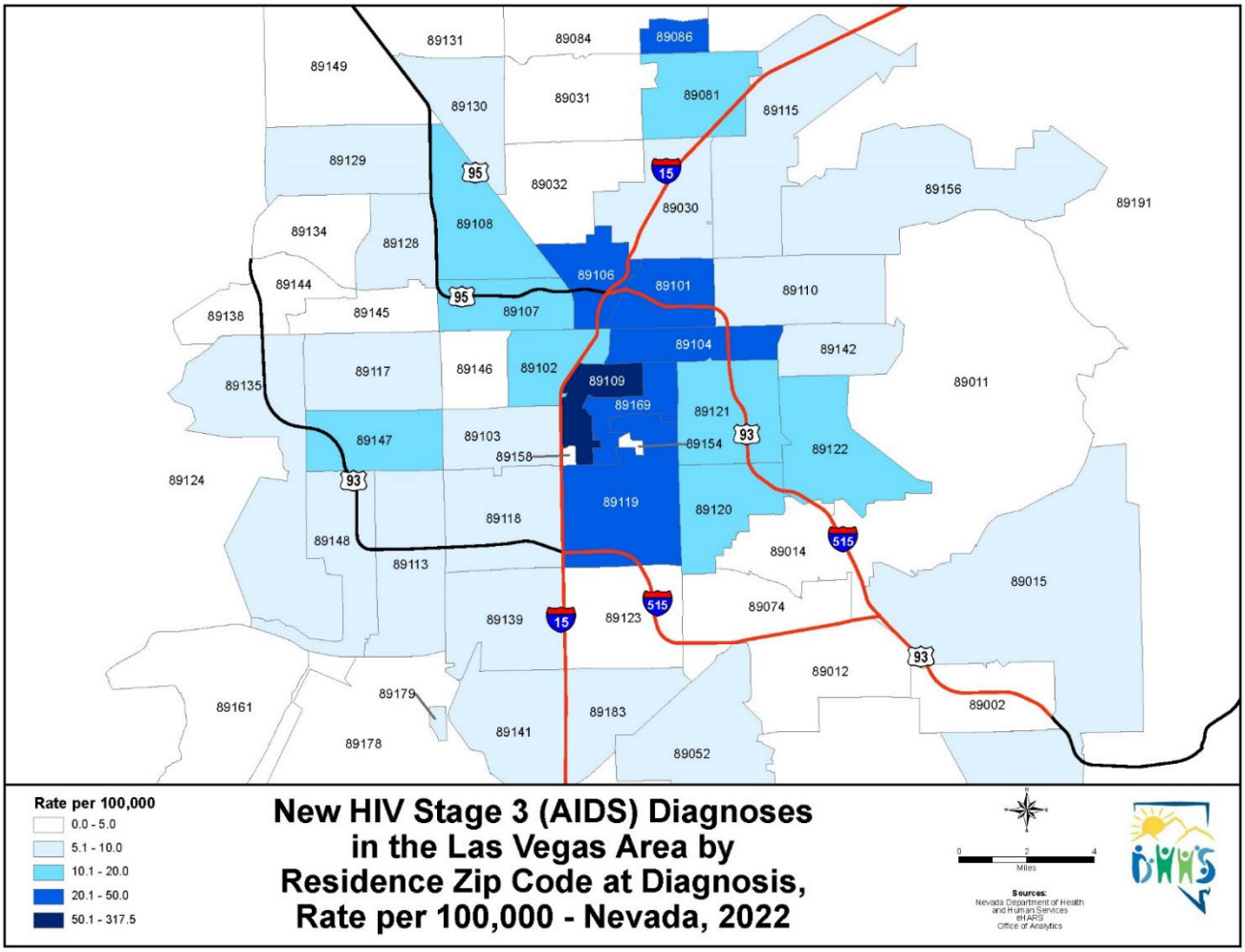


Figure 11: The following Zip Codes represent the highest rate of newly diagnosed HIV Stage 3 cases in 2022: 89109, 89106, 89104, 89119, 89086, 89169, and 89101. The areas with the highest rate of new HIV Stage 3 diagnoses in 2022 are clustered around Paradise, Downtown Las Vegas, and North Las Vegas.

HIV Prevalence, Incidence, and Deaths Comparison

Figure 12 | HIV Prevalence, Incidence, and Deaths in Clark County, 2018-2022*

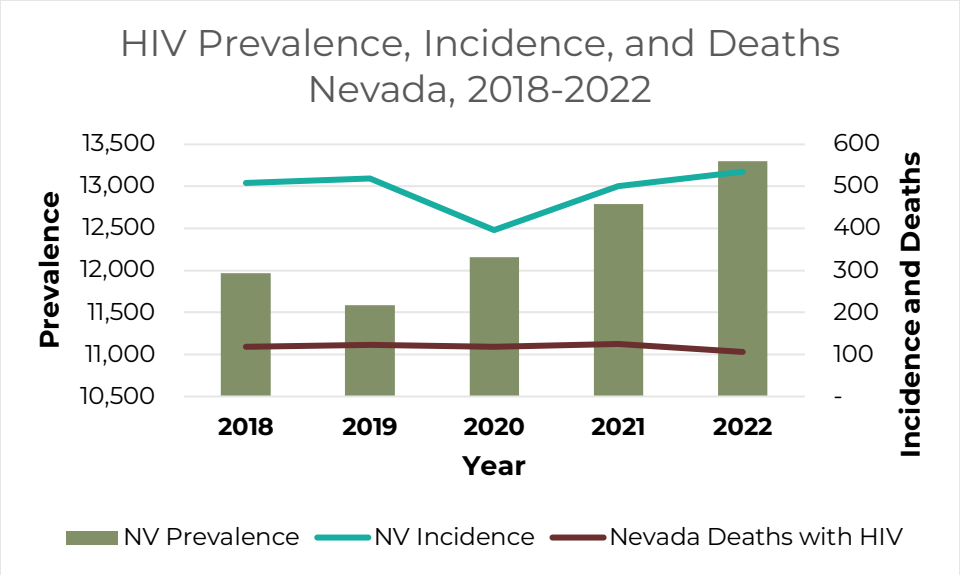


Figure 12: HIV Prevalence in Nevada has trended upward between 2018-2022. After a slight increase, deaths among people living with HIV in Nevada reached a five-year low in 2022 (106 deaths). Reported incidence in Nevada decreased in 2020 but has since increased to the highest level in five years (535 diagnoses in 2022).

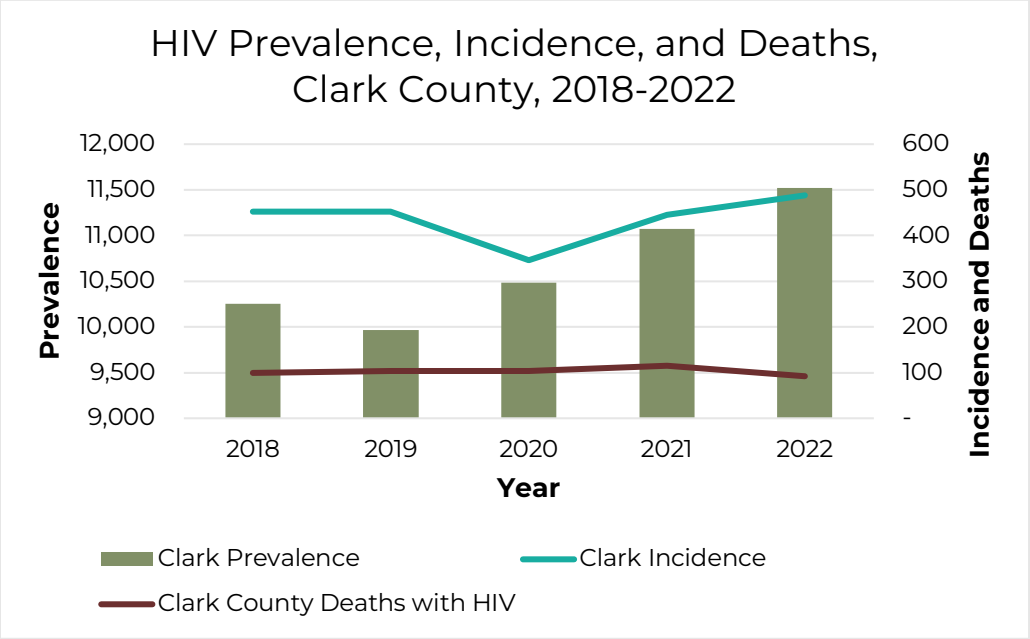
**Note: Deaths of persons with a diagnosis of HIV may be due to any cause.*

What is Prevalence?

Prevalence measures the **total** cases of HIV.

Prevalence includes the total number of new and preexisting cases in a population. It identifies how common HIV is in the population at a given point in time.

Figure 13 | HIV Prevalence, Incidence, and Deaths in Clark County, 2018-2022*



**Note: Deaths of persons with a diagnosis of HIV may be due to any cause.*

Figure 13: Overall trends in HIV prevalence, incidence, and deaths in Clark County have mirrored the trends statewide. Prevalence of HIV trended upward between 2018-2022. Reported incidence in Clark County decreased in 2020 but has since increased to the highest level in five years (488 new diagnoses in 2022).

HIV and HIV Stage 3 Incidence by Demographic

Tables 1 - 10 provide the following data for new cases for each year between 2018 and 2022. The tables include:

- The number of new cases within each demographic group (presented as "N")
- The proportion of new cases for each demographic group (aka the column percent; presented as "%")
- The number of new cases per 100,000 persons within each demographic group (presented as "Rate")
- The difference in proportion of new cases (column %) in that demographic between 2022 and 2018 (presented as % change 2018-2022).

It is important to note that fluctuations in the column percent could be due to changes in data entry, variable definitions, and investigative challenges.

Table 1 | HIV Incidence by Race/Ethnicity, 2018-2022

Year of Diagnosis	2018			2019			2020			2021			2022			% Change 2018-2022
RACE/ETHNICITY	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	
NH White	158	31%	10.2	160	31%	10.2	120	30%	7.6	134	27%	8.6	126	24%	8.0	-7%
NH Black	154	30%	57.3	168	32%	60.9	121	31%	42.7	149	30%	51.8	143	27%	48.2	-3%
Hispanic	153	30%	17.0	155	30%	16.7	125	32%	13.0	181	36%	18.9	228	43%	23.0	13%
NH Asian	32	6%	10.8	22	4%	7.2	21	5%	6.6	27	5%	8.6	19	4%	5.8	-2%
NH AI/AN	2	0%	5.7	2	0%	5.6	1	0%	2.8	4	1%	11.3	3	1%	8.4	<1%
Multi-Race	9	2%	N/A	12	2%	N/A	8	2%	N/A	6	1%	N/A	16	3%	N/A	1%

Table 1: NH Black people are disproportionately affected by HIV, consistently at a rate nearly three times higher than any other race/ethnicity from 2018-2021. Throughout 2018-2022, HIV incidence rates have been highest among NH Black people, followed by Hispanic people. While HIV incidence rates have been declining annually for most race/ethnicity groups, HIV incidence rate has been increasing among Hispanic people (23 per 100,000 in 2022 as compared to 17 per 100,000 in 2018).

Table 2 | HIV STAGE 3 Incidence by Race/Ethnicity, 2018-2022

Year of Diagnosis	2018			2019			2020			2021			2022			% Change 2018-2022
RACE/ETHNICITY	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	
NH White	67	33%	4.3	83	39%	5.3	46	29%	2.9	67	31%	4.3	56	27%	3.6	-6%
NH Black	63	31%	23.4	53	25%	19.2	47	30%	16.6	66	31%	22.9	69	33%	23.3	2%
Hispanic	56	28%	6.2	67	31%	7.2	49	31%	5.1	65	30%	6.8	64	31%	6.5	3%
NH Asian	10	5%	3.4	7	3%	2.3	9	6%	2.8	9	4%	2.9	11	5%	3.4	<1%
NH AI/AN	1	0%	2.8	1	0%	2.8	1	1%	2.8	2	1%	5.6	0	0%	0.0	-<1%
Multi-Race	5	2%	N/A	4	2%	N/A	5	3%	N/A	7	3%	N/A	9	4%	N/A	2%

Table 2: HIV Stage 3 diagnoses are highest among NH Black people. At a rate of 23.3 per 100,000 for NH Black people and 6.5 per 100,000 for Hispanic people in 2022, these race/ethnicity groups have among the highest rates of HIV Stage 3 incidence throughout 2018-2022. Since 2018, rates of HIV Stage 3 incidence have remained relatively consistent for all race/ethnicity groups except NH White people (decreased from 4.3 per 100,000 in 2018 to 3.6 per 100,000 in 2022) and NH American Indian/Alaska Native people (decreased from 2.8 per 100,000 in 2018 to 0 per 100,000 in 2022).

Table 3 | HIV Incidence by Nativity, 2018-2022

Year of Diagnosis	2018		2019		2020		2021		2022		% Change 2018-2022
Nativity	N	%	N	%	N	%	N	%	N	%	
Foreign-Born/Unknown	116	23%	123	24%	108	27%	199	40%	287	54%	31%
US-Born	392	77%	396	76%	288	73%	302	60%	248	46%	-31%

Table 3: HIV Incidence in Nevada among people of foreign-born/unknown nativity has increased significantly between 2018-2022. In 2022, people of foreign-born nativity/unknown nativity made up more than half of all new HIV cases in Nevada (287 diagnoses in 2022). Population rates were unavailable.

Table 4 | HIV STAGE 3 Incidence by Nativity, 2018-2022

Year of Diagnosis	2018		2019		2020		2021		2022		% Change 2018-2022
Nativity	N	%	N	%	N	%	N	%	N	%	
Foreign-Born/Unknown	45	22%	55	26%	36	23%	77	36%	87	42%	19%
US-Born	157	78%	160	74%	121	77%	139	64%	122	58%	-19%

Table 4: HIV Stage 3 incidence in Nevada among people of foreign-born/unknown nativity has increased between 2018-2022. In 2022, US-born patients made up 58% of all new Stage 3 diagnoses, compared to 78% in 2018. Population rates were unavailable.

Table 5 | HIV Incidence by Gender Identity, 2018-2022*

Year of Diagnosis	2018			2019			2020			2021			2022			% Change 2018-2022
GENDER	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	
Cisgender Men	433	85%	29.1	432	83%	28.8	324	82%	21.5	398	79%	27.6	417	78%	27.9	-7%
Cisgender Women	61	12%	4.1	69	13%	4.5	55	14%	3.5	63	13%	4.2	80	15%	5.3	3%
Transgender Women	13	3%	N/A	17	3%	N/A	12	3%	N/A	17	3%	N/A	18	3%	N/A	<1%
Transgender Men	1	<1%	N/A	1	<1%	N/A	0	0%	N/A	0	0%	N/A	2	<1%	N/A	-<1%
Unknown, AMAB	0	0%	N/A	0	0%	N/A	5	1%	N/A	20	4%	N/A	14	3%	N/A	3%
Unknown, AFAB	0	0%	N/A	0	0%	N/A	0	0%	N/A	3	1%	N/A	4	1%	N/A	<1%

**Data regarding gender identity in Nevada is not standardized and therefore may not represent the true breakdown among trans and cisgender people. Currently testing centers may use their own discretion in the phrasing of gender-related questions.*

Table 5: Cisgender men consistently made up the largest proportion of new HIV diagnoses from 2018-2022. By 2022, the proportion of cisgender women among all new cases had increased by three percent, and the proportion among cisgender men decreased by seven percent. Transgender women also represented a greater proportion of new diagnoses in 2022, compared to 2018, as did individuals with an unknown gender, particularly if assigned male at birth.

What does Cisgender mean?

Cisgender is an adjective used to describe people who are not transgender.

"Cis-" is a Latin prefix meaning "on the same side as," and is therefore an antonym of "trans-." A cisgender person is a person whose gender identity is aligned with the sex they were assigned at birth.

Table 6 | HIV STAGE 3 Incidence by Gender Identity, 2018-2022*

Year of Diagnosis	2018			2019			2020			2021			2022			% Change 2018-2022
GENDER	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	
Cisgender Men	161	80%	10.8	174	81%	11.5	128	82%	8.3	182	84%	12.0	159	76%	10.8	-4%
Cisgender Women	36	18%	2.4	35	16%	2.3	26	17%	1.6	25	12%	1.6	35	17%	2.2	-1%
Transgender Women	5	2%	N/A	5	2%	N/A	2	1%	N/A	3	1%	N/A	9	4%	N/A	2%
Transgender Men	0	0%	N/A	1	<1%	N/A	0	0%	N/A	0	0%	N/A	1	<1%	N/A	<1%
Unknown, Male at Birth	0	0%	N/A	0	0%	N/A	1	1%	N/A	5	2%	N/A	5	2%	N/A	2%
Unknown, Female at Birth	0	0%	N/A	0	0%	N/A	0	0%	N/A	1	<1%	N/A	0	0%	N/A	0%

**Data regarding gender identity in Nevada is not standardized and therefore may not represent the true breakdown among trans and cisgender people. Currently testing centers may use their own discretion in the phrasing of gender-related questions.*

Table 6: Cisgender men consistently made up the largest proportion of new Stage 3 HIV diagnoses from 2018-2022. Transgender women and individuals assigned male at birth with an unknown gender contributed to an increased proportion of new cases in 2022 compared to 2018.

The rate of new HIV stage 3 among cisgender men and women was consistent in 2018 and 2022, with some fluctuations in 2020 and 2021, likely due to the impact of Covid-19 on healthcare access.

Table 7 | HIV Incidence by Transmission Category, 2018-2022*

Year of Diagnosis	2018		2019		2020		2021		2022		% Change 2018-2022
TRANSMISSION	N	%	N	%	N	%	N	%	N	%	
MSM	342	67%	316	61%	244	62%	261	52%	263	49%	-18%
IDU	17	3%	27	5%	17	4%	25	5%	16	3%	<1%
MSM+IDU	26	5%	29	6%	16	4%	31	6%	23	4%	-1%
Transfusion/ Hemophilia	0	0%	0	0%	0	0%	0	0%	0	0%	0%
Heterosexual contact	41	8%	34	7%	16	4%	9	2%	18	3%	-5%
NIR/NRR	79	16%	111	21%	103	26%	175	35%	214	40%	24%
Perinatal	3	1%	2	<1%	0	0%	0	0%	1	<1%	-<1%

**HIV transmission categories are defined by CDC guidelines. See page 34 for more information on transmission categorization.*

Table 7: Men having sex with men (MSM) represented the largest transmission category out of all new HIV diagnoses from 2018-2022. Decreases in proportions of new diagnoses in each exposure category may be due to an increase of individuals for whom an exposure category could not be determined (NIR/NRR). HIV incidence among the injection drug use (IDU) transmission category has fluctuated between 2018-2022 and made up 3% of all incidence in 2022. Rates could not be calculated as population-level exposures by sexual contact or use of nonprescription injection drugs is unknown.

Table 8 | HIV STAGE 3 Incidence by Transmission Category, 2018-2022*

Year of Diagnosis	2018		2019		2020		2021		2022		% Change 2018-2022
TRANSMISSION	N	%	N	%	N	%	N	%	N	%	
MSM	113	56%	117	54%	83	53%	112	52%	102	49%	-7%
IDU	9	4%	18	8%	8	5%	13	6%	7	3%	-1%
MSM+IDU	14	7%	15	7%	11	7%	13	6%	2	1%	-6%
Transfusion/ Hemophilia	0	0%	0	0%	0	0%	0	0%	0	0%	0%
Heterosexual contact	17	8%	19	9%	13	8%	16	7%	19	9%	1%
NIR/NRR	47	23%	45	21%	41	26%	62	26%	78	37%	14%
Perinatal	2	1%	1	<1%	1	1%	0	0%	1	<1%	-<1%

**HIV transmission categories are defined by CDC guidelines. See page 34 for more information on transmission categorization.*

Table 8: Men having sex with men (MSM) represented the largest proportion of Stage 3 HIV incidence from 2018-2022. Stage 3 incidence among the injection drug use (IDU) transmission category fluctuated during this timeframe and made up 3% of all incidence in 2022. Transmission from heterosexual contact represented 9% of total Stage 3 diagnoses in 2022.

Table 9 | HIV Incidence by Age, 2018-2022

Year of Diagnosis	2018			2019			2020			2021			2022			% Change 2018-2022
AGE	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	
< 13	1	<1%	0.2	0	0%	0.0	0	0%	0.0	0	0%	0.0	2	<1%	0.4	<1%
13 to 14	0	0%	0.0	1	<1%	1.1	0	0%	0.0	0	0%	0.0	0	0%	0.0	0%
15 to 19	15	3%	7.4	15	3%	7.2	10	3%	4.7	13	3%	5.9	14	3%	6.2	<1%
20 to 24	83	16%	40.9	78	15%	37.7	56	14%	26.5	62	12%	29.4	75	14%	34.0	-2%
25 to 29	127	25%	56.4	126	24%	55.1	83	21%	35.8	87	17%	38.6	103	19%	45.2	-6%
30 to 34	68	13%	33.1	82	16%	38.5	78	20%	35.4	103	21%	45.5	100	19%	42.8	5%
35 to 39	62	12%	29.9	59	11%	28.6	55	14%	26.7	66	13%	32.1	82	15%	38.6	3%
40 to 44	43	8%	20.9	43	8%	20.4	17	4%	7.9	46	9%	21.2	56	10%	26.0	2%
45 to 54	69	14%	17.3	72	14%	17.9	61	15%	15.0	70	14%	17.2	61	11%	14.8	-3%
55 to 64	29	6%	7.9	33	6%	8.8	30	8%	7.9	44	9%	11.6	32	6%	8.3	<1%
65 +	11	2%	2.5	10	2%	2.2	6	2%	1.3	10	2%	2.1	10	2%	2.0	-<1%

Table 9: In 2018-2022, HIV incidence rates were highest among the 20-34 age groups, accounting for over 50% of all cases. In 2022, HIV incidence was highest among people ages 25-29 at 45.2 per 100,000 persons, followed by those 30-34 years old at 42.8 per 100,000 persons. HIV incidence rates have steadily increased from 2018 to 2022 for people aged 30-34 (33.1 per 100,000 in 2018 as compared to 42.8 per 100,000 in 2022). Those with the least amount of change in HIV incidence from 2018-2022 were less than 13 years old and older than 65 years old.

Table 10 | HIV STAGE 3 Incidence by Age, 2018-2022

Year of Diagnosis	2018			2019			2020			2021			2022			% Change 2018-2022
AGE	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	
< 13	1	<1%	0.2	1	<1%	0.2	0	0%	0.0	0	0%	0.0	0	0%	0.0	-<1%
13 to 14	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0.0	0%
15 to 19	1	<1%	0.5	1	<1%	0.5	0	0%	0.0	2	1%	0.9	1	<1%	0.4	0%
20 to 24	12	6%	5.9	17	8%	8.2	7	4%	3.3	9	4%	4.3	11	5%	5.0	-1%
25 to 29	35	17%	15.6	35	16%	15.3	25	16%	10.8	23	11%	10.2	31	15%	13.6	-2%
30 to 34	30	15%	14.6	32	15%	15.0	18	11%	8.2	31	14%	13.7	33	16%	14.1	1%
35 to 39	29	14%	14.0	27	13%	13.1	30	19%	14.6	41	19%	19.9	26	12%	12.2	-2%
40 to 44	20	10%	9.7	18	8%	8.5	9	6%	4.2	29	13%	13.4	30	14%	13.9	4%
45 to 54	32	16%	8.0	44	20%	10.9	31	20%	7.6	43	20%	10.6	42	20%	10.2	4%
55 to 64	30	15%	8.2	30	14%	8.0	23	15%	6.1	28	13%	7.4	22	11%	5.7	-4%
65 +	12	6%	2.7	10	5%	2.2	14	9%	3.0	10	5%	2.1	13	6%	2.6	<1%

Table 10: From 2018-2020, HIV Stage 3 incidence rates were highest among the 25-39 age groups. However, in 2021 the highest HIV Stage 3 incidence rates shifted to encompass 30-44 age groups. In 2022, HIV Stage 3 incidence was highest among people ages 30-34 at 14.1 per 100,000 persons, followed by those 40-44 years old at 13.9 per 100,000 persons. While HIV Stage 3 incidence rates have either remained constant or decreased among other age groups, the HIV Stage 3 incidence rates have increased from 2018 to 2022 for people aged 40-54.

HIV Prevalence by Demographic

Table 11 | HIV Prevalence by Race/Ethnicity, 2018-2022

	2018			2019			2020			2021			2022			% Change 2018-2022
RACE/ETHNICITY	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	
NH White	5064	42%	325.7	4740	41%	303.0	4860	40%	309.4	4971	39%	318.3	5005	38%	318.4	-4%
NH Black	3247	27%	1207.3	3209	28%	1162.6	3419	28%	1207.0	3671	29%	1276.3	3739	28%	1261.5	1%
Hispanic	2925	24%	324.2	2913	25%	313.0	3096	25%	322.7	3304	26%	344.5	3613	27%	365.1	3%
NH Asian	455	4%	153.6	460	4%	150.2	491	4%	155.2	521	4%	165.7	507	4%	155.5	0%
NH AI/AN	82	1%	232.4	71	1%	199.6	74	1%	205.9	76	1%	214.0	65	<1%	182.5	-<1%
Multi-Race	9	2%	N/A	189	2%	N/A	217	2%	N/A	244	2%	N/A	368	3%	N/A	1%

Table 11: NH Black people are disproportionately affected by HIV, consistently at a rate nearly three times higher than any other race/ethnicity from 2018-2022. Throughout 2018-2022, HIV prevalence rates have been highest among NH Black people, followed by Hispanic people. From 2018 to 2022, HIV prevalence rates have increased from 324.2 per 100,000 to 365.1 per 100,000 for Hispanic people.

Table 12 | HIV Prevalence by Nativity, 2018-2022

Year of Diagnosis	2018		2019		2020		2021		2022		% Change 2018-2022
NATIVITY	No.	%	No.	%	No.	%	No.	%	No.	%	
Foreign-Born/Unknown	2634	22%	2643	23%	2811	23%	3084	24%	3474	26%	4%
US-Born	9331	78%	8941	77%	9348	77%	9705	76%	9825	74%	-4%

Table 12: HIV prevalence in Nevada among people of foreign-born/unknown nativity has increased between 2018-2022. In 2022, US-born patients made up 74% of all people living with HIV in Nevada, compared to 78% in 2018.

Table 13 | HIV Prevalence by Gender Identity, 2018-2022*

	2018			2019			2020			2021			2022			% Change 2018-2022
RACE/ETHNICITY	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	
Cisgender Men	9955	83%	660.2	9589	83%	626.8	10087	83%	650.3	10593	83%	687.1	11023	83%	703.5	<1%
Cisgender Women	1834	15%	121.3	1797	16%	116.8	1843	15%	117.7	1922	15%	123.0	1961	15%	123.2	<1%
Transgender Women	148	1%	N/A	168	1%	N/A	193	2%	N/A	219	2%	N/A	243	2%	N/A	1%
Transgender Men	15	<1%	N/A	17	<1%	N/A	17	<1%	N/A	19	<1%	N/A	19	<1%	N/A	<1%
Unknown, Male at Birth	12	<1%	N/A	11	<1%	N/A	17	<1%	N/A	33	<1%	N/A	47	<1%	N/A	<1%
Unknown, Female at Birth	1	<1%	N/A	2	<1%	N/A	2	<1%	N/A	3	<1%	N/A	6	<1%	N/A	<1%

Table 13: HIV prevalence in Nevada has consistently been highest among cisgender men between 2018-2022, making up 83% of all people living with HIV. The proportion of transgender women living with HIV has risen by 1% since 2018.

Table 14 | HIV Prevalence by Transmission Group, 2018-2022

	2018			2019			2020			2021			2022			% Change 2018-2022
RACE/ETHNICITY	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	
MSM	7701	64%	251.9	7423	64%	238.5	7865	65%	248.5	8217	64%	260.2	8528	64%	264.9	<1%
IDU	780	7%	25.5	728	6%	23.4	719	6%	22.7	750	6%	23.7	750	6%	23.3	-1%
MSM+IDU	737	6%	24.1	709	6%	22.8	729	6%	23.0	753	6%	23.8	776	6%	24.1	<1%
Transfusion/Hemophilia	10	<1%	0.3	9	<1%	0.3	7	<1%	0.2	6	<1%	0.2	6	<1%	0.2	-<1%
Heterosexual contact	1372	11%	44.9	1336	12%	42.9	1360	11%	43.0	1374	11%	43.5	1368	10%	42.5	-1%
Adult, other confirmed risk	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0.0	0	0%	0.0	0%
NIR/NRR	1290	11%	42.2	1299	11%	41.7	1392	11%	44.0	1602	13%	50.7	1786	13%	55.5	2%

*See page 34 for note on CDC Transmission Categories

Table 14: Men who have sex with men (MSM) represented the largest proportion of people living with HIV (64%) from 2018-2022. People who use injection drugs (IDU), including those who are MSM, made up 12% of all people living with HIV in 2022.

Continuums of Care / Viral Suppression

Connection to care among people living with HIV is an integral component of HIV prevention. Those in care can access treatment in the form of Antiretroviral therapy (ART), which allows people living with HIV to achieve viral suppression. Viral suppression occurs when the amount of HIV in the body is very low or undetectable. People living with HIV who are consistent with their ART can maintain viral suppression and have effectively no risk of passing HIV to others through sex.

To gain insight into the percentage of individuals who are virally suppressed, a care continuum can be used. The figures below show the care continuum for people with newly diagnosed HIV in 2022 throughout Nevada. They include the number of individuals diagnosed with HIV by region in 2022, excluding anyone who was deceased or moved out of state by the time of follow up (15 months post- diagnosis). Additionally, they provide the percentage of those who were connected to care within 90 days and who achieved viral suppression by the point of follow up. These data can be used to assess care, and therefore prevention, needs. Appendix B contains the above tables in graphic form, and includes the total number of diagnosed individuals, as well as those who were both linked to care and virally suppressed at follow up.

In Clark County, 77% of all newly diagnosed persons who met the follow up criteria were virally suppressed at follow-up (Table 15). This was true for 76% of new diagnoses in Washoe County, and 71% in All Other Counties (Table 16 and 17). There was some variability between racial groups within each county (Tables 15-17).

*Table 15 | Continuum of Care by Race, Clark County, 2022**

Race/Ethnicity	No. of New Diagnoses meeting Follow-up Criteria†	Percent of New Diagnoses Linked to Care‡	Percent of New Diagnoses Virally Suppressed at Follow-up¥
White	93	91%	73%
Black	115	90%	66%
Hispanic	197	85%	86%
Asian	17	76%	88%
Multi-race	12	100%	67%
Total	**435**	**88%**	**77%**

*To preserve confidentiality, data for racial/ethnic groups with fewer than five new diagnoses are not presented separately but are factored into the total.

†Follow-up criteria is defined as (1) Alive for at least 15 months from diagnosis date, and (2) Resided in Nevada when analysis file was created.

‡Linked to care is defined as having one lab completed within 90 days after initial diagnosis

¥Suppressed viral load is defined as having equal to or less than 200 copies of HIV per milliliter of blood, meeting follow-up criteria, and being linked to care within 90 days.

*Table 16 | Continuum of Care by Race, Washoe County, 2022**

Race/Ethnicity	No. of New Diagnoses meeting Follow-up Criteria†	Percent Linked to Care‡	Percent Virally Suppressed at Follow-up¥
White	11	82%	64%
Black	5	100%	80%
Hispanic	13	100%	85%
Total	**33**	**91%**	**76%**

*To preserve confidentiality, data for racial/ethnic groups with fewer than five new diagnoses are not presented separately but are factored into the total.

†Follow-up criteria is defined as (1) Alive for at least 15 months from diagnosis date, and (2) Resided in Nevada when analysis file was created.

‡Linked to care is defined as having one lab completed within 90 days after initial diagnosis

¥Suppressed viral load is defined as having equal to or less than 200 copies of HIV per milliliter of blood, meeting follow-up criteria, and being linked to care within 90 days.

Table 17 | Continuum of Care, All Other Counties by Race, 2022

Race/Ethnicity	No. of New Diagnoses meeting Follow-up Criteria†	Percent Linked to Care‡	Percent Virally Suppressed at Follow-up¥
White	5	80%	60%
Total	**7**	**86%**	**71%**

*To preserve confidentiality, data for racial/ethnic groups with fewer than five new diagnoses are not presented separately but are factored into the total.

†Follow-up criteria is defined as (1) Alive for at least 15 months from diagnosis date, and (2) Resided in Nevada when analysis file was created.

‡Linked to care is defined as having one lab completed within 90 days after initial diagnosis

¥Suppressed viral load is defined as having equal to or less than 200 copies of HIV per milliliter of blood, meeting follow-up criteria, and being linked to care within 90 days.

Population Comparisons by Demographic

The following graphics illustrate the disparities in HIV incidence and prevalence among different racial groups.

Figure 14 | HIV and HIV Stage 3 Incidence Rates by Race/Ethnicity, 2022

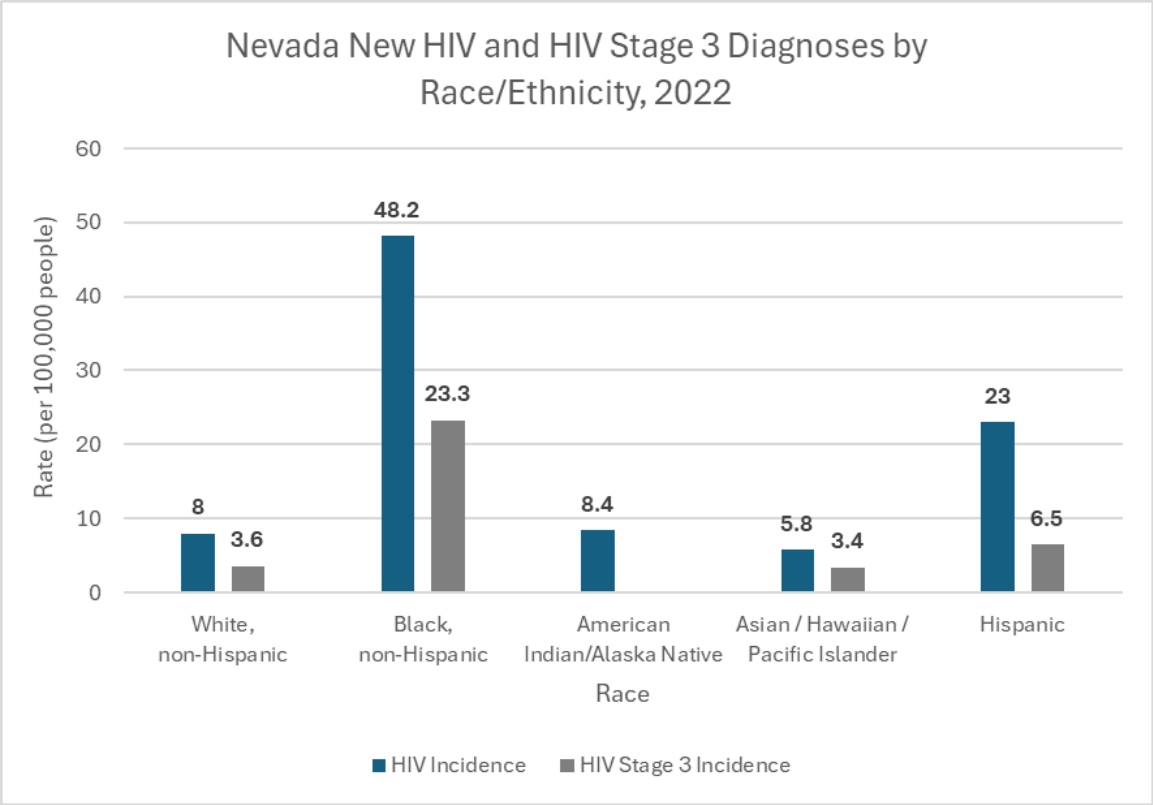


Figure 14: HIV disproportionately impacts Black, non-Hispanic people at a higher incidence rate than any other race/ethnicity groups in Nevada. In 2022, HIV incidence for Black, non-Hispanic people was three times higher than Hispanic people and seven times higher than White, non-Hispanic people or American Indian/Alaska Native people. With the second highest incidence rates, Hispanic people were nearly two times higher than for White, non-Hispanic or Asian/Hawaiian/Pacific Islander people.

HIV Stage 3 also disproportionately impacts Black, non-Hispanic people at a higher incidence rate than any other race/ethnicity groups in Nevada, with a rate seven times higher than White, non-Hispanic people and three times higher than Hispanic people.

Figure 15 | HIV Prevalence Rates by Race/Ethnicity, 2022

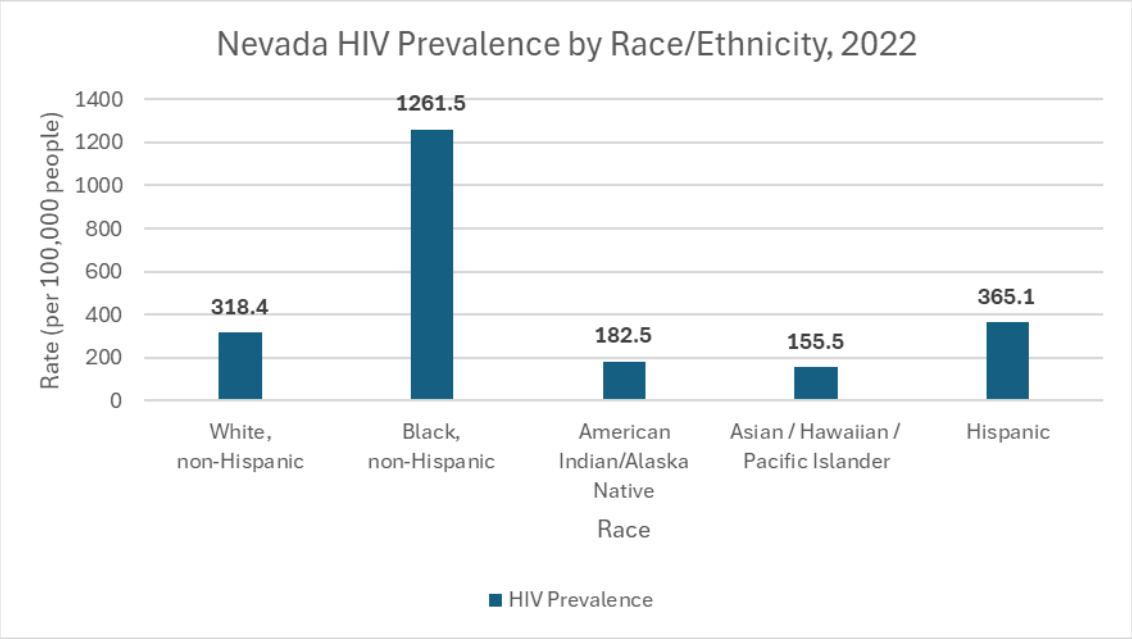


Figure 15: HIV disproportionately impacts Black, non-Hispanic people at nearly three times the prevalence of any other race/ethnicity in Nevada.

Syndemic Data

A "syndemic" is commonly defined as a population-level clustering of social and health problems, where (1) two (or more) diseases or health conditions cluster within a specific population; (2) contextual and social factors create the conditions in which two (or more) diseases or health conditions cluster; and (3) The clustering of diseases results in adverse disease interaction, either biologic or social or behavioral, increasing the health burden of affected populations[69]. In other words, a syndemic is when multiple diseases affect similar populations, with overlapping or related social and structural determinants.

HIV, viral hepatitis, STIs, and TB infections are often considered to be a part of the same syndemic. Applying a "syndemic approach" to HIV can result in more holistic, integrated care and therefore better health outcomes for the populations most impacted by these conditions.

Table 18 | Hepatitis B, Hepatitis C, and Tuberculosis Prevalence Among People Living with HIV

	2018		2019		2020		2021		2022	
	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate
Hepatitis B	2	0.1	9	0.3	11	0.3	16	0.5	4	0.1
Hepatitis C	51	1.7	95	3.1	43	1.4	39	1.2	34	1.1
TB	5	0.2	3	0.1	3	0.1	1	0.0	1	0.0

Table 18: An estimated 34 people were co-infected with HIV and hepatitis C in Nevada in 2022, at a rate of 1.1 per 100,000. This rate has decreased from 1.7 per 100,000 people in 2018. Very few people living with HIV are co-infected with hepatitis B or TB in Nevada. Rates of hepatitis B among people living with HIV has remained below 1 per 100,000 between 2018-2022. Rates of TB among people living with HIV has remained at or below 0.2 per 100,000 between 2018-2022.

[69] Singer et al., "Syndemics and the Biosocial Conception of Health."

Table 19 | Syphilis Incidence Among People Living with HIV

Year of Diagnosis	2018			2019			2020			2021			2022			% Change 2018-2022
	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate	
Syphilis*	54	11%	1.8	34	7%	1.1	30	8%	0.9	55	11%	1.7	40	8%	1.2	-3%

**Syphilis diagnosed within 30 days of HIV diagnosis*

Table 19: An estimated 40 people were diagnosed with syphilis within 30 days of their HIV diagnosis in Nevada in 2022, at a rate of 1.2 per 100,000. This rate has decreased from 1.8 per 100,000 people in 2018. Among all people diagnosed with HIV in 2022, 7.5% were also diagnosed with syphilis within 30 days of their HIV diagnosis.

LEGISLATIVE UPDATES

Nevada legislation is making continuous efforts to change history, promote equality, and reduce discrimination against the LGBTQ population with new pro-equality bills. The following legislative updates have influenced the state of HIV prevention, surveillance, and treatment in Nevada.

Nevada SB-410 (2013) legalized distribution of sterile hypodermic devices (Needle Exchange) in the state.

Nevada AB-192 (2021) requires physicians to test pregnant patients for certain sexually transmitted infections unless the patient opts-out.

Nevada SB-109 (2021) revised provisions related to the collection of certain sexual orientation and gender identity information by governmental agencies to support LGBTQ equality rights. SB-109 also required governmental agencies to annually report sexual orientation and gender identity to the Director of Legislative Counsel Bureau as long as the information is kept confidential.

Nevada SB-211 (2021) requires medical providers and emergency rooms to offer HIV and STD testing.

Nevada SB-237 (2021) revised provisions related to policies, programs, and procedures of small businesses to encourage and promote LGBTQ-owned businesses.

Nevada SB-275 (2021) reformed several discriminatory HIV criminal laws, including the repeal of a statute previously allowing HIV transmission to be punishable as a felony. SB-275 also provided greater protections for sex workers, updated references to HIV in the law to use person-first language, and reestablished the HIV Exposure Modernization advisory task force.

Nevada SB-325 (2021) authorized pharmacists to prescribe, dispense, and administer drugs to prevent HIV (such as PrEP and PEP), perform HIV lab tests, and allow health plans to include coverage for the drugs and testing offered at pharmacies.

Nevada SB-172 (2023) authorized minors to consent to services related to STD prevention, including HIV testing, without the consent or notification of the parent(s) or legal guardian of the minor.

Nevada SB-439 (2023) required detention facilities to ensure more equitable access to HIV treatment and prevention for incarcerated people.

APPENDIX A: DEFINITIONS OF COMMONLY USED TERMS

AIDS (Acquired Immune Deficiency Syndrome)	A result of Human Immunodeficiency Virus (HIV) infection, which disables the immune system from effectively fighting numerous opportunistic infections and cancers. Now referred to as HIV Stage 3.
Age at diagnosis	The age of the individual at the time they were diagnosed with HIV and/or HIV Stage 3.
Age at end of year	The age calculated from a person's date of birth until the person's age at the end of the report year. Age at the end of year cannot be calculated if the date of birth is incomplete or unknown.
Age group	The age of the individual at the time of the HIV and/or HIV Stage 3 diagnosis, previously referred to as AIDS.
All other counties	All counties in Nevada other than Clark and Washoe counties. These counties include Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine Counties.
Antiretroviral	A process working against retroviruses, such as HIV, usually in the form of medication or therapy.
Assigned Sex at Birth	A term used to describe the sex (male, female, or intersex) assigned to an infant at birth, based on the appearance of their external anatomy. It is important to note the distinction between assigned sex at birth and gender identity, which may not be the same.
CDC	A federal disease prevention agency, which is part of the U.S. Department of Health and Human Services, that provides national laboratory and health and safety guidelines and recommendations; tracks diseases throughout the world; and performs research involving laboratory, behavioral science,

	epidemiology and other studies of disease.
CD4 Lymphocyte Count	T Cells, or white blood cells, play an important role in the immune system by fighting infections within the body. In teens and adults, a normal CD4 count ranges between 500-1,200 cells/mm3. A CD4 count below 500 cells/mm3 indicates the immune system is fighting an infection. A CD4 count below 200 cells/mm3 may indicate that the immune system can no longer fight opportunistic infections such as HIV.
Chemsex	Chemsex, also known as Party and Play (PnP) or wired play, refers to the practice of consuming drugs to enhance sexual activity.
Cisgender	An adjective used to describe people who are not transgender. A cisgender person is a person whose gender identity is aligned with the sex they were assigned at birth.
Cumulative deaths	The total number of deaths from the beginning of the epidemic through the end of the report year.
Deaths among persons living with HIV	Counted deaths for persons living with HIV whose current residence was Nevada at the end of the report year. These counts may or may not have been due to HIV or HIV Stage 3, and cases that have died outside of Nevada may not be reflected in this data.
eHARS	A document-based data management system for tracking the surveillance of HIV, also known as Enhanced HIV Reporting System.
EHE	The U.S. Department of Health and Human Services (HHS) launched the Ending the HIV Epidemic in the U.S. (EHE) initiative in 2019. The initiative aims to reduce new HIV infections in the U.S. by 90% by 2030 by scaling up key HIV prevention and treatment

	strategies.
eCR (Electronic Case Reporting)	Electronic case reporting (eCR) is the automated, real-time exchange of case report information between electronic health records (EHRs) and public health agencies. It moves data quickly, securely, and seamlessly from EHRs in healthcare facilities to state and local public health agencies. eCR is a joint effort of the Association of Public Health Laboratories, the Council of State and Territorial Epidemiologists, and CDC. These organizations play key roles in leading, implementing, and operating eCR with healthcare organizations, EHR vendors, and public health agencies.
Ethnicity	A grouping of people who identify with others based on shared attributes that characterize them from other groups such as traditions, ancestry, and culture. Two ethnicity categories include: Hispanic/Latino and not Hispanic/Latino. All persons who identified as Hispanic/Latino are classified as Hispanic/Latino regardless of their racial identification.
Gender Identity	One's innermost concept of self as male or female or both or neither—how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different than the sex assigned at birth.
Harm Reduction	Harm reduction refers to a range of intentional practices and public health policies designed to lessen the negative social and/or physical consequences associated with various human behaviors, both legal and illegal. Harm reduction is

	used to decrease negative consequences of recreational drug use and sexual activity without requiring abstinence, recognizing that those unable or unwilling to stop can still make positive change to protect themselves and others.
HIV surveillance	The systematic collection, analysis, interpretation, dissemination, and evaluation of population-based information about persons with a diagnosis of HIV infection and persons with a diagnosis of HIV Stage 3.
Incidence	The number of new cases of a disease over a defined period of time and expressed as a proportion or rate.
LSD (Lysergic acid diethylamide)	A hallucinogenic drug that alters thoughts, feelings, and awareness of an individual's surroundings or actions.
Methamphetamine	Methamphetamine (often shortened to meth) is a stimulant drug usually used as a white, bitter-tasting powder or a pill. Crystal methamphetamine is a form of the drug that looks like glass fragments or shiny, bluish-white rocks. People can take methamphetamine by smoking, swallowing (pill), snorting, or injecting the powder that has been dissolved in water/alcohol.
Mode of Transmission	The route, means, or method of transferring disease from one place or host to another.
Morbidity	The occurrence of an illness, disease, or injury.
Mortality	The occurrence of death based on illness, disease, or injury.

N (incidence rate)	The measure of disease in the total population.
n (incidence rate)	The measure of disease for a given subpopulation, such as sex, race/ethnicity, age, or full address. The subpopulations may not equal the total incidence rate for the population due to unknown demographics such as sex, race/ethnicity, age, or full address.
N/A (Not Applicable)	Used to represent cases where the data may not meet the criteria for reliability, data quality, or confidentiality due to small counts or inability to calculate rates based on an equivalent population.
New HIV infections	The rate of persons newly diagnosed with HIV or HIV Stage 3 infection of those living in Nevada (both living and deceased). These rates may not include individuals who previously tested positive, or individuals who are infected but did not confirm a positive test result.
Opioids	Natural, synthetic, or semi-synthetic chemicals that interact with opioid receptors on nerve cells in the body and brain, and reduce the intensity of pain signals and feelings of pain. This class of drugs includes the illegal drug heroin, synthetic opioids such as fentanyl, and pain medications available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine, and many others. Prescription opioids are often referred to as “blues.”
Outbreak	An increase in diagnoses above what is normally expected in a geographic area or population during a particular period.
PEP (Post Exposure Prophylaxis)	Medication used in emergency situations that reduces the risk of acquiring HIV after possible exposure and must begin within 72 hours after the possible exposure to HIV.

Perinatal Transmission	Term used to describe the spread of HIV from a mother to her baby that can occur during pregnancy, labor, delivery or breastfeeding; also known as vertical transmission.
Persons living with HIV (not HIV Stage 3)	Individuals living in Nevada with an HIV (not HIV Stage 3) diagnosis, who may or may not have been diagnosed with HIV in Nevada, based on the most current address in eHARS.
Persons living with HIV Stage 3	Individuals currently living in Nevada with an HIV Stage 3 diagnosis, who may or may not have been diagnosed with HIV in Nevada, based on the most current address in eHARS.
Persons living with HIV	The total number of persons currently living with HIV and/or HIV Stage 3 in Nevada, based on the most current address in eHARS. These persons may or may not have been diagnosed with HIV or HIV Stage 3 in Nevada. The categories persons living with HIV (not HIV Stage 3) and persons living with HIV Stage 3 are mutually exclusive and can be combined to calculate the total number of persons living with HIV.
PrEP (Pre-Exposure Prophylaxis)	A highly effective prescription medication that at-risk for HIV individuals can take to prevent getting HIV from sex or injection drug use.
Prevalence	The proportion of persons in a population who have a particular disease or attribute at a specified point in time or over a specified period of time.
Race	A grouping of people who identify their ethnic origins with others based on their distinctive physical characteristics. Four race categories include: White, Black/African American, Asian/Native Hawaiian/Pacific Islander (API), and American Indian/Alaska Native (AI/AN). The categories Asian, Native Hawaiian, and Pacific Islander were combined into the single category API due to their small population size in Nevada. Persons categorized by race were not

	Hispanic/Latino.
Race/Ethnicity	The collection of race/ethnicity data in HIV surveillance which follows the guidelines set forth by the Office of Management and Budget (OMB) in 1997.
Rate	The rapidity at which a health event occurs as indicated by the number of cases per number of people during a specific time period. In this report, rates were calculated for the 12-month period per 100,000 population using population estimates from the Nevada State Demographer's Office.
Sexual Orientation	The sexual attraction people feel for others, whether of their own sex, the opposite sex, or both sexes.
Small Counts and Relative Standard Error (RSE)	Reported numbers less than 12, as well as estimated numbers, accompanying rates, and trends based on these numbers, should be interpreted with caution because the numbers have underlying relative standard errors greater than 30% and are considered unreliable. Standard Error measure indicates the extent to which a survey estimate is likely to deviate from the true population and is expressed as a number. Relative Standard Error (RSE) is the standard error expressed as a fraction of the estimate and is usually displayed as a percentage.
Stages of HIV	
Stage 0	Early signs of HIV are based on a negative or indeterminate HIV test result within 180 days before the first confirmed positive HIV test result of any type, and the individual has no Stage 3-related conditions.

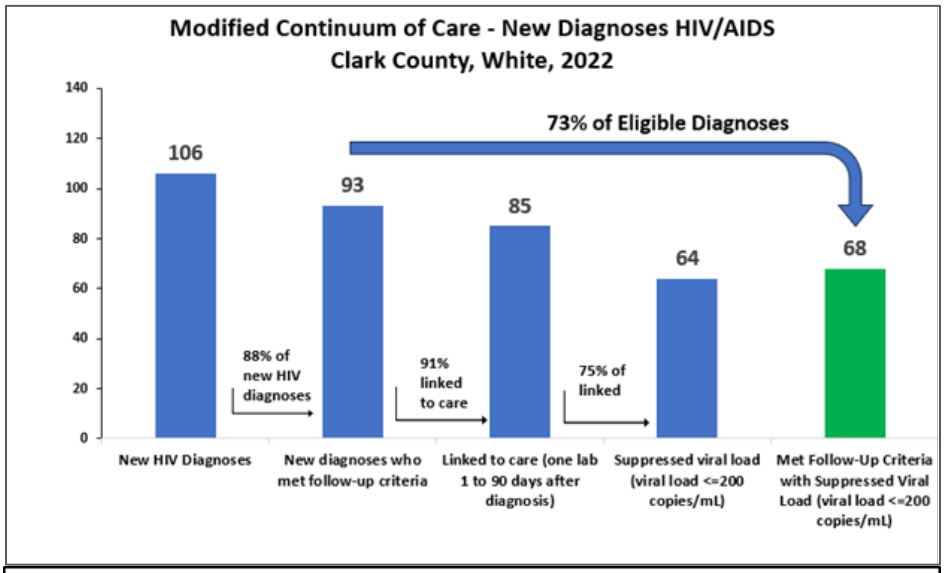
Stage 1 – Acute HIV Infection	Laboratory confirmation of HIV infection and CD4+ T-lymphocyte count of >500 cells/μL or CD4+ T-lymphocyte percentage of >29 and the individual have no Stage 3-related conditions. The virus replicated quickly in the infected individual and becomes easy to spread to others through blood, semen, pre-seminal fluids, rectal fluids, vaginal fluids, and breast milk. WIthin 2-4 weeks, the virus may present itself as Flu-like symptoms, lasting for several days to weeks. The virus begins to replicate in the body using and destroying CD4 T cells.
Stage 2 – Chronic HIV Infection	Laboratory confirmation of HIV infection and CD4+ T-lymphocyte count of 200–499 cells/μL or CD4+ T-lymphocyte percentage of 14–28 and the individual have no Stage 3-related conditions. The infected individual usually presents no symptoms or very mild ones at this stage. Without treatment, this stage can last for up to ten years.
Stage 3 – Acquired Immunodeficiency Syndrome (AIDS)	The criteria for an HIV Stage 3 diagnosis are: (1) a Laboratory confirmed HIV infection and (2) either an HIV Stage 3-defining opportunistic infection or a CD4+ T-lymphocyte count of less than 200 cells/μL or less than 14%.
Stage Unknown	Laboratory confirmation of HIV infection and no information on CD4+ T-lymphocyte count or percentage.
Stigma	An attitude of disapproval and discontent toward a person or group because of the presence of an attribute perceived as undesirable.
Syringe Service Programs (SSPs)	Syringe services programs (SSPs) are community-based prevention programs that can provide a range of services, including linkage to substance use

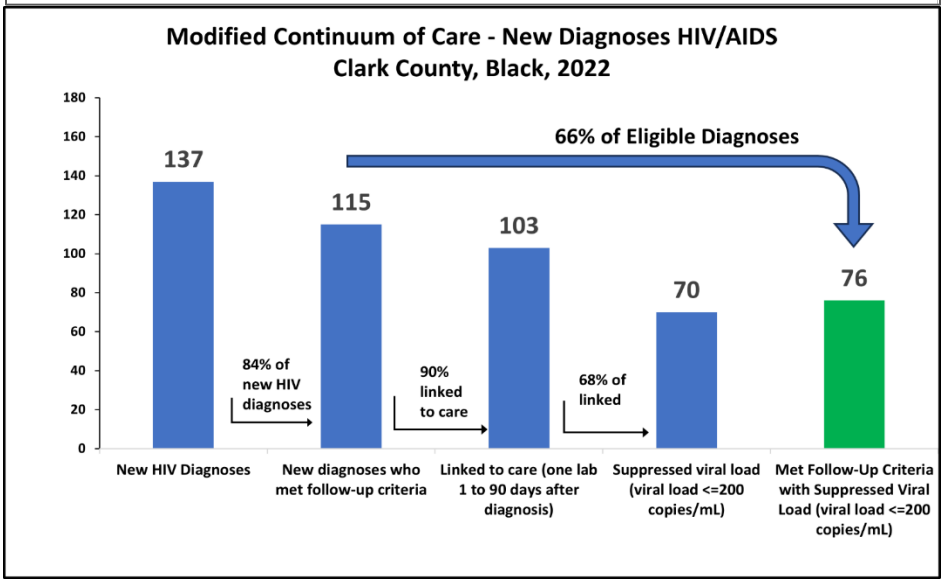
	disorder treatment; access to and disposal of sterile syringes and injection equipment; and vaccination, testing, and linkage to care and treatment for infectious diseases.
THC (Tetrahydrocannabinol)	The main active ingredient found in cannabis, also known as marijuana. A drug used to ease HIV-related symptoms like weight loss, appetite problems, and nerve pain.
Transgender	Persons whose gender identity, expression or behaviors are different from those typically associated with their assigned sex at birth. HIV surveillance programs use two variables, sex at birth and current gender identity, to identify transgender individuals and commonly use the following gender categories:
Male to Female (MTF)	An individual who was born as a male but currently identifies as a female.
Female to Male (FTM)	An individual who was born as a female but currently identifies as a male.
Additional Gender Identity	Gender identities other than male, female, MTF, and FTM. For example, genderqueer, gender fluid, and bigender.
Transmission Category	The term for summarizing a person's possible HIV risk factors and selecting the one most likely to have resulted in HIV transmission. For surveillance purposes, people with more than one reported risk factor are classified in the transmission category listed first in a hierarchy of transmission categories, and therefore counted only once. The exception is men who had sexual contact with other men and injected drugs; this group makes up a separate transmission category.

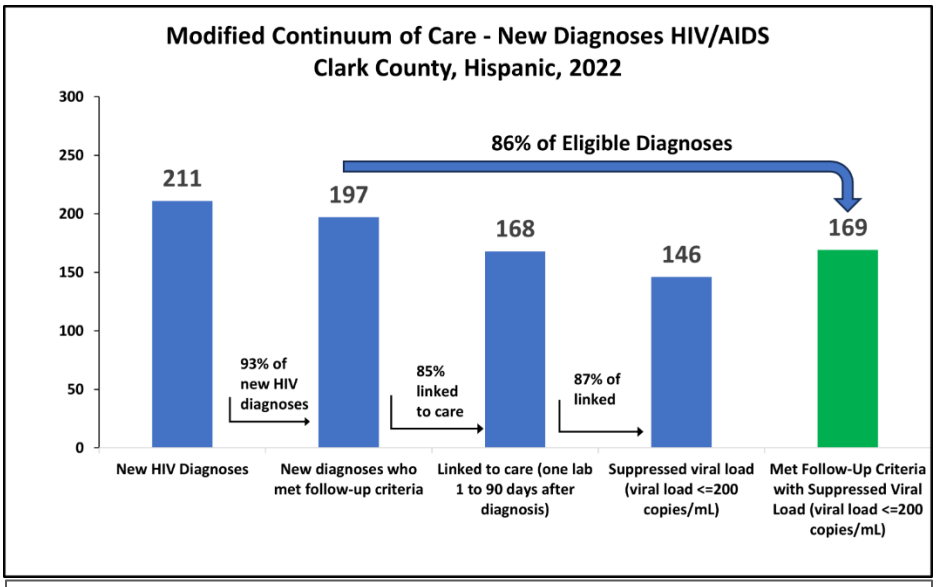
	The primary transmission categories that have been identified (per CDC guidance) are:
Male-to-male sexual contact (MSMC)	Includes individuals assigned male sex at birth, regardless of current gender identity, who have had sexual contact with other males, and individuals assigned male sex at birth who have had sexual contact with both males and females (i.e., bisexual contact).
Injection Drug Use (IDU)	Includes persons who injected nonprescription drugs or who injected prescription drugs for nonmedical purposes.
Male-to-male sexual contact and injection drug use (MSM+IDU)	Includes individuals assigned male sex at birth, regardless of current gender identity, who have had sexual contact with other males (or with both males and females [i.e., bisexual contact]) and injected nonprescription drugs or injected prescription drugs for nonmedical purposes.
Heterosexual contact	Includes persons who have ever had sexual contact with a person known to have, or with a risk factor for, HIV infection.
Perinatal transmission	Includes infants who were infected during gestation, birth, or postpartum (through breastfeeding) to an HIV-infected person.
Other	Includes persons with other risk factors (e.g., blood transfusion, hemophilia) or whose risk factor was not reported or not identified.
No Identified Risk / No Risk Reported (NIR/NRR)	Persons who have no risk information reported by the provider or no risk factor were identified during an expanded investigation.

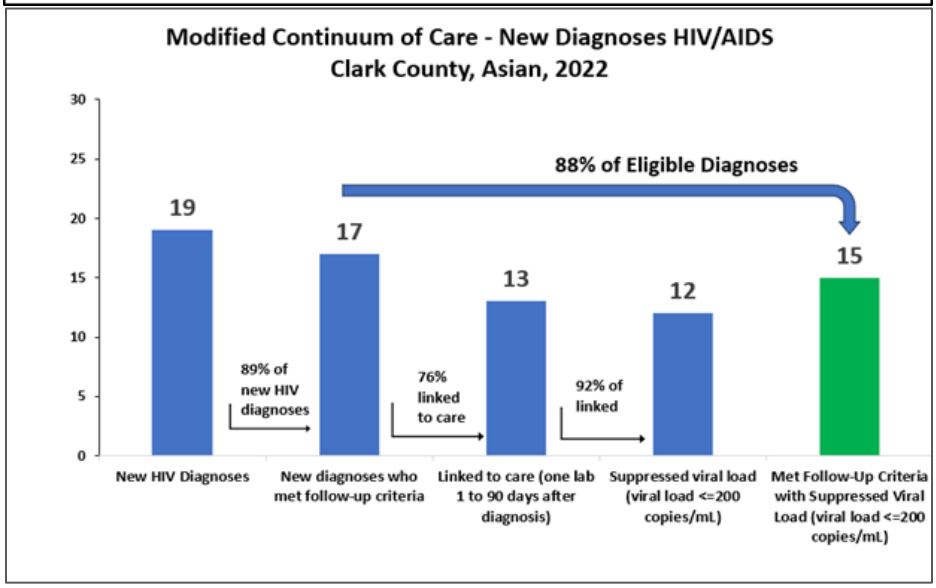
APPENDIX B. MODIFIED CONTINUUMS OF CARE BY COUNTY AND RACE

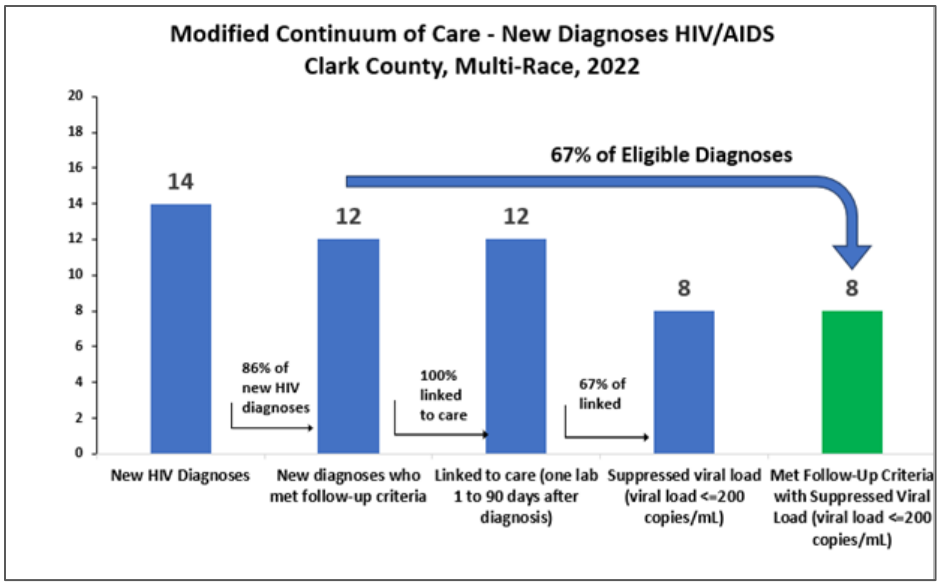
Clark County



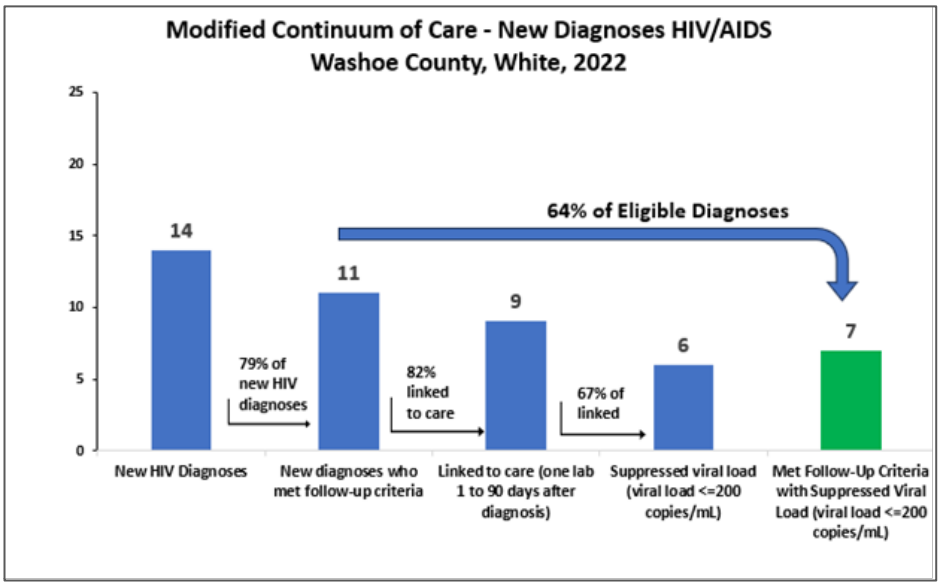


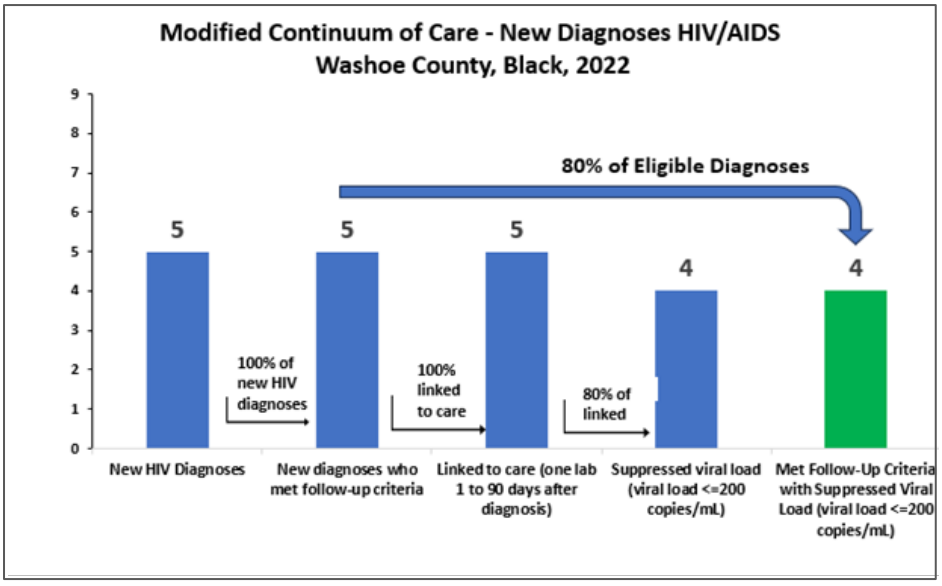

Modified Continuum of Care - New Diagnoses HIV/AIDS
Clark County, Hispanic, 2022
300
250
200
150
100
50
0
86% of Eligible Diagnoses
211
197
168
146
169
93% of new HIV diagnoses
85% linked to care
87% of linked
New HIV Diagnoses
New diagnoses who met follow-up criteria
Linked to care (one lab 1 to 90 days after diagnosis)
Suppressed viral load (viral load <=200 copies/mL)
Met Follow-Up Criteria with Suppressed Viral Load (viral load <=200 copies/mL)

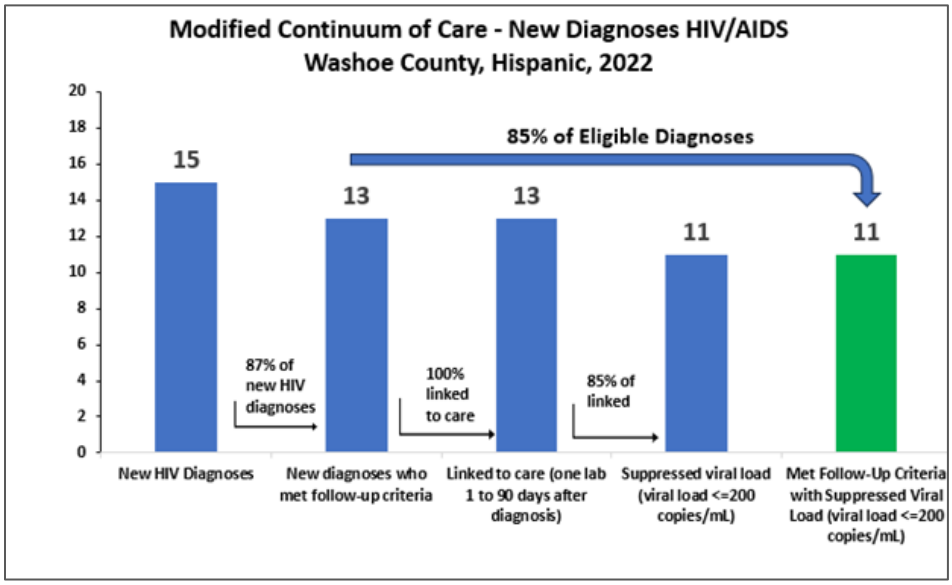

Modified Continuum of Care - New Diagnoses HIV/AIDS
Clark County, Asian, 2022
30
25
20
15
10
5
0
88% of Eligible Diagnoses
19
17
13
12
15
89% of new HIV diagnoses
76% linked to care
92% of linked
New HIV Diagnoses
New diagnoses who met follow-up criteria
Linked to care (one lab 1 to 90 days after diagnosis)
Suppressed viral load (viral load <=200 copies/mL)
Met Follow-Up Criteria with Suppressed Viral Load (viral load <=200 copies/mL)


Modified Continuum of Care - New Diagnoses HIV/AIDS
Clark County, Multi-Race, 2022
20
18
16
14
12
10
8
6
4
2
0
67% of Eligible Diagnoses
14
12
12
8
8
86% of new HIV diagnoses
100% linked to care
67% of linked
New HIV Diagnoses
New diagnoses who met follow-up criteria
Linked to care (one lab 1 to 90 days after diagnosis)
Suppressed viral load (viral load <=200 copies/mL)
Met Follow-Up Criteria with Suppressed Viral Load (viral load <=200 copies/mL)

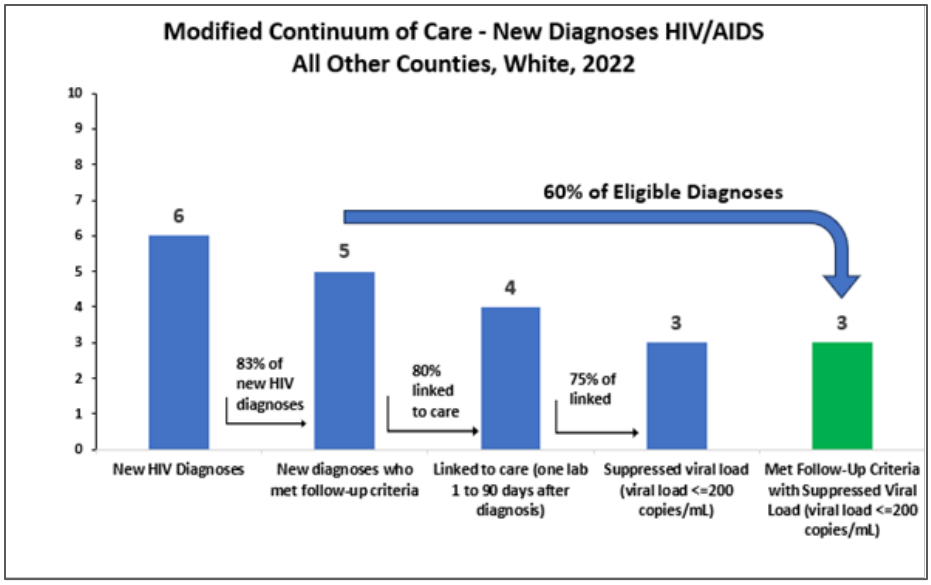
Washoe County







All other counties



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Project AMPED

Experiences with methamphetamine and opioid use in Nevada and New Mexico

Study team: Karla D. Wagner, Kimberly Page, Philip Fiuty, Benjamin Chase, Jessica Anderson, Andres Reyes, Robert Harding, Tristin Garcia, Philip Fiuty, Kat Reich, Megan McCarthy, Rebecca Martinez, Mia Kirk, Kelly Mytinger, Nathan Leach, Brittany Rhed, Olufemi Erinoso, Birgitta Biztray, Nicholas Dunkle, Hayley Etchart, Sarbyen Sheni, Robbie Daugherty,

Collaborating partners: The Mountain Center, Trac-B Exchange

Funding: Mountain West Clinical Trial Infrastructure Network (NIGMS U54GM104944) & CDC (R01CE003356)

HEALTH SCIENCES

PROJECT AMPED

C-DEPR
The Center for Drug Use, Equity and Policy Research
School of Public Health

THE MOUNTAIN CENTER

Trac-B Exchange
6114 W. Charleston Blvd. Las Vegas, NV 89146
Phone: 702.840.6693

Aim 1: To estimate prevalence of and identify risk and protective factors associated with methamphetamine use and harms

Aim 2: To describe the experiences and rationale for methamphetamine use , polydrug use, and progression to misuse and dependence

Aim 3: To examine the feasibility and acceptability of promising prevention, treatment, and harm reduction strategies for people who use MA

- Assess the feasibility and acceptability of potential biomedical interventions, such as pharmacotherapies to treat MA use disorder that are currently in the clinical pipeline
- Assess feasibility and acceptability of implementing harm reduction strategies for people who use MA

Participants:

AMPED 1.0 – 2019 to 2020 – Qual interviews with 21 adults who used methamphetamine in past 3 months

AMPED 2.0 – 2022 to 2023 - Cross sectional surveys with 420 adults who used non-medical drug use in past 3 months (half from NM, half from NV); qual interviews with sub-sample of 48

Recruitment: street outreach, incentivized snowball sampling

RQ2: What's happening with methamphetamine and opioids in NM and NV?

- 384/420 (91%) of AMPED 2.0 participants report past 3m methamphetamine use
- 191/420 (45%) report past 3m heroin use
- 247/420 (58%) report past 3m fentanyl use
- Polydrug use (sequential or simultaneous) is nearly universal in AMPED 2.0 participants
- People report using an average of 7 different drugs or drug combinations in the past 3 months (including cannabis, tobacco, and alcohol)

Methamphetamine use is functional for many people

Rhed BD, Harding RW, Marks C, Wagner KT, Fiuty P, Page K, Wagner KD. Patterns of and Rationale for the Co-use of Methamphetamine and Opioids: Findings From Qualitative Interviews in New Mexico and Nevada. Frontiers in Psychiatry. 2022;13.

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Methamphetamine and opioid co-use is also functional, and complex

Mode and timing

- Sequential vs. simultaneous
- Injection, smoking, oral

"If you're doing meth, you're sort of up and running around. ***If you get sick on heroin [i.e., experience withdrawal symptoms] and you do meth, you really don't feel sick on heroin anymore for quite a bit. So you can get a lot of shit done*** *like walk around and do whatever you're going to do."*

Rationale

- Enhance the effect of one drug or another
- Feel the "up and down" or "perfect ratio" of a goofball
- Counter over-sedation or over-stimulation

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What about fentanyl?

Concerns about ”universal” fentanyl adulteration in the illicit drug supply

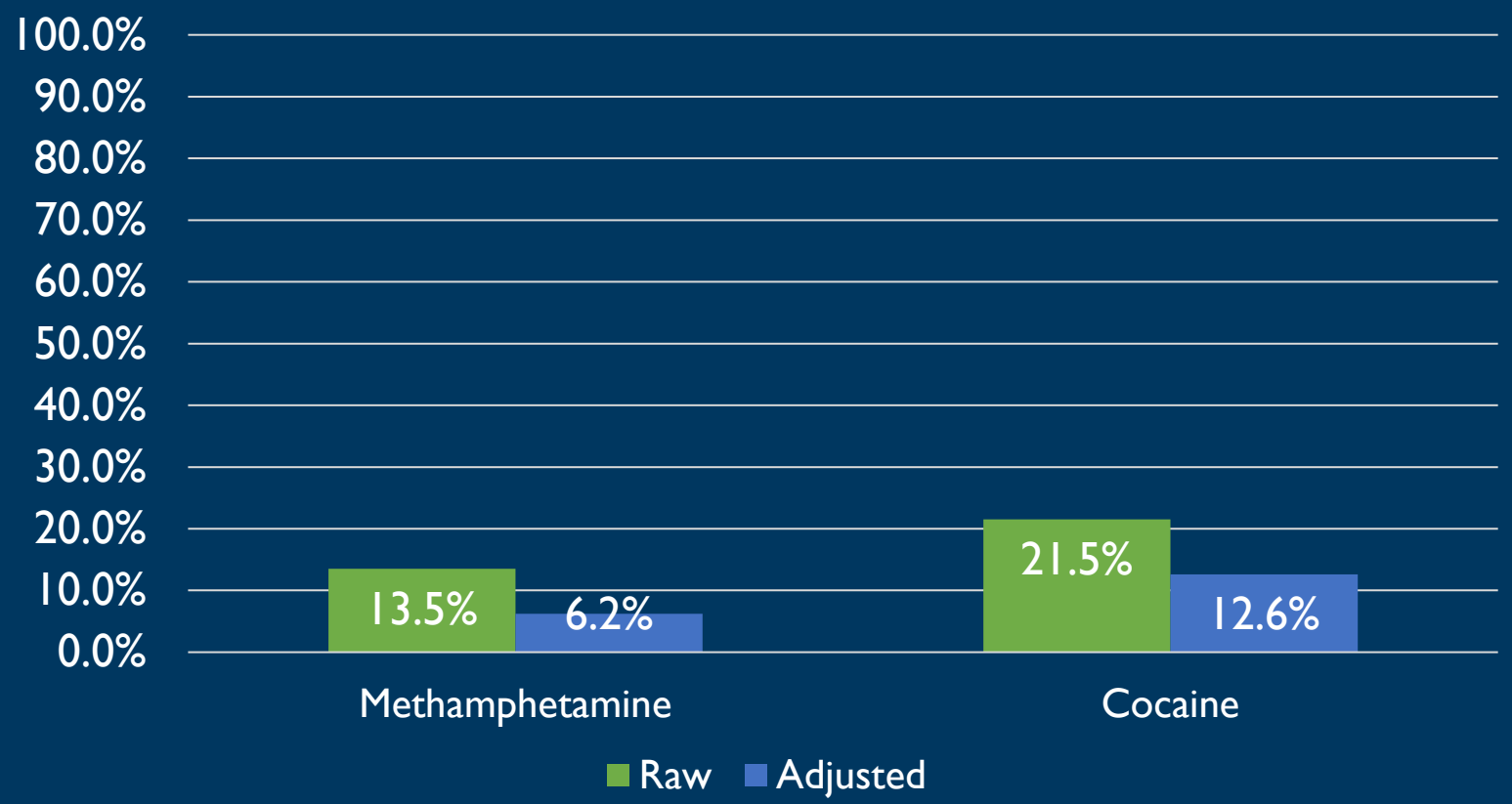
Increases in polysubstance-related deaths with methamphetamine and fentanyl in toxicology results

Fentanyl plus stimulants drives ‘fourth wave’ of overdose epidemic in the U.S.

Overdose deaths involving fentanyl plus a stimulant increased fiftyfold from 2010 to 2021.

A Drug Enforcement Administration chemist checks confiscated pills containing fentanyl at the DEA Northeast Regional Laboratory in New York in 2019. Don Emmert / AFP via Getty Images file

We found low (but non-zero) prevalence of fentanyl in methamphetamine samples submitted to a drug checking service



*Negative binomial GEE models adjusted for confounding by "weird", FTIR samples, swab-collected samples, used before submitting, xylazine

In AMPED 2.0, when people said they used fentanyl, they were right. When they say they had not used fentanyl, they were mostly right.

	Fentanyl positive UTS	**Fentanyl negative UTS**	Total
Self-reported past 3-day fentanyl use	**135** (True positive: had fentanyl in their urine, said they used it)	**2** (False positive: did not have fentanyl in their urine, said they used it)	137
No self-reported past 3-day fentanyl use	**10** (False negative: had fentanyl in their urine, said they didn't use it)	**120** (True negative: did not have fentanyl in their urine, said they did not use it)	130
Total	145	122	267

Sensitivity = 93%, self reports ability to find true positives; Specificity = 98%, self reports ability to find true negative
Positive predictive value = 99%, when respondents report fentanyl use, they are right
Negative predictive value = 92%, when respondents don't report fentanyl use, they are mostly right

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Buy from a trusted source

- Mentioned by almost everyone
- Easily disrupted by enforcement interventions

Fentanyl test strips

- Used selectively and on occasion (e.g., when trusted source isn't available)
- Not trustworthy due to false positives, challenges testing methamphetamine

Even though fentanyl adulteration rates are low, people are still worried and try to protect themselves

Spotting

- i.e., having someone watch you in case of overdose
- Selectively employed when source isn't trusted or quality unknown
- Relies on having someone there with naloxone

Evaluating physical appearance

- Frequently mentioned (smell, taste, appearance, blacklight)
- Avoiding powder might be minimally effective

RQ1: What is a meth "overdose"?

Methamphetamine has different mechanisms of action, not as clearly linked to "overdose" as opioids

- More difficult to recognize
- No medication like naloxone

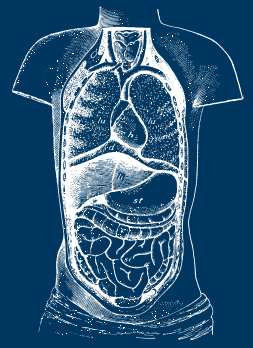
People who use methamphetamine don't think you can "overdose"

But they do describe worrisome symptoms that make them feel like they need care

> "They nod out. It's called overamping. Overamping, okay? You hit, your body [inaudible] because you had so much energy, your body can't take it. Your body will just shut the fuck down. Your heart cannot take that physical fucking rush and **people will shut down,** they go to sleep."

Overamping is a constellation of physical and psychiatric symptoms that range from very worrisome to not concerning at all

- Strong desire to sleep, "shutting down"
- Heart racing our pounding
- "Flailing" or uncontrollable movements
- Paranoia, delusions, hallucinations
- Blackouts, memory loss

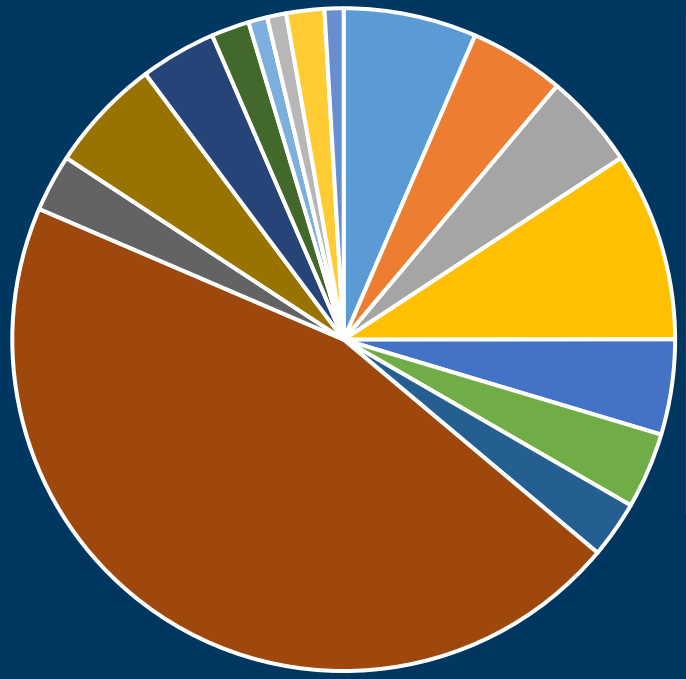


"It overwhelms your senses and then your body. Your body just -- it's going too fast. Your mind is going too fast or something. It shuts off, I guess. I don't really know the actual reason why, but you'll see people starting to nod out when they're doing it."

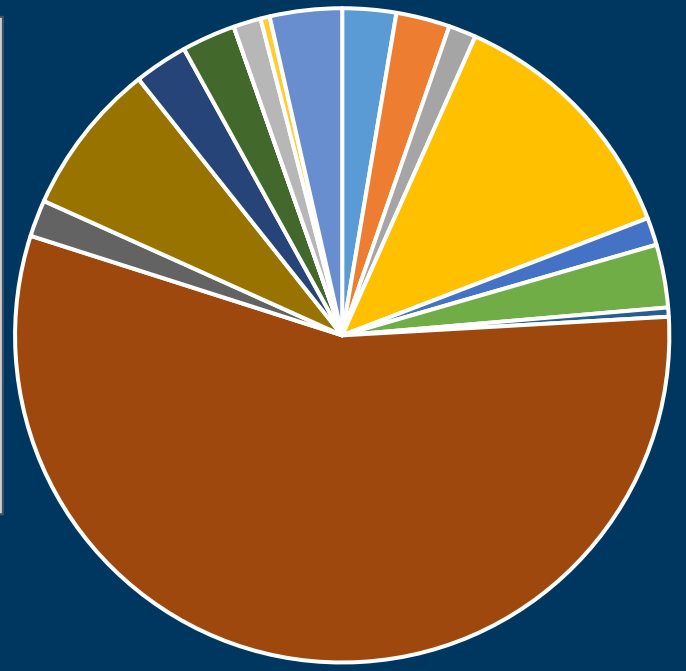
I turn into sort of introversion where I'm just super scared of everybody. I walk in the store, and oh, my god. Fucking everybody is looking,

I can't stop rocking back and forth. I can see myself doing it, but I couldn't stop. It scared the shit out of me…Like, "Stop doing that. Stop doing it." But I can't – it was a psychosis thing. I started freaking out.

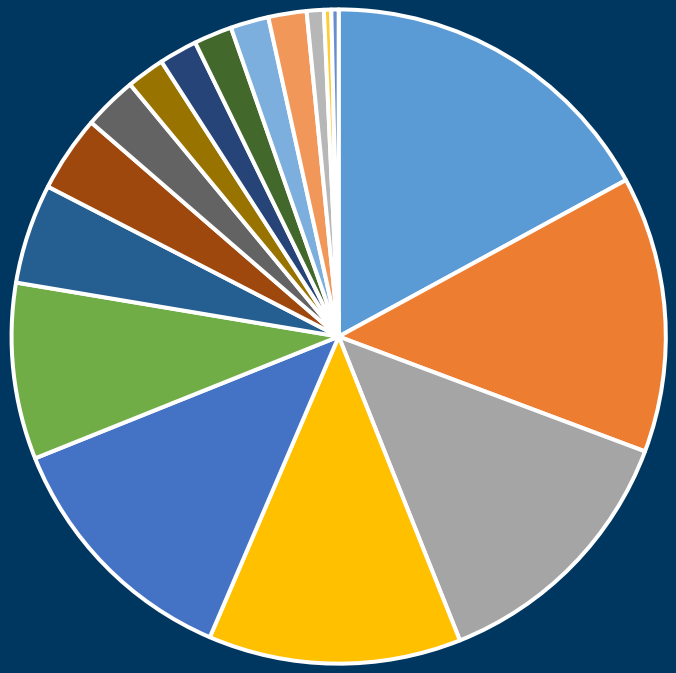
Opioid + stimulant mixture overdose symptoms



Opioid overdose symptoms



Methamphetamine toxicity symptoms



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Acute methamphetamine toxicity events were more common than opioid overdose events

	Ever experienced (n=217)	Experienced past 3m*	Median number of events past 3m (Q1, Q3)
Opioid overdose only	76 (35%)	20 (26%)	1 (1, 2)
Methamphetamine toxicity only	51 (24%)	41 (80%)	2 (1, 4)
Opioid+stimulant mixture only	11 (5%)	2 (18%)	1 (1, 1)
Multiple types	79 (36%)	15 (19%)	4 (3, 7)

*denominator is those who ever experienced this type of event

Only 13% of acute meth toxicity events in AMPED 2.0 resulted in care from EMS or ED.

When people sought care, they didn't get much help.

"We had went over there, took my sister over there [to the community program]. She was flipping out. They didn't know what to do. **They said, we don't know what to do about the meth yet. It's a big thing. No one knows how to address it. Everybody's going on these trips and we don't know how to reverse the trip.**"

R4, Hispanic/Latina, Black, Female, 20s, New Mexico, MA+methadone

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There is a disconnect between recommendations for responding to overamping and people's experiences

If someone is:

- Overheating: cool down, drink water
- Having a stroke: call 911
- Having a seizure: protect, call 911
- Having a heart attack: call 911

But few events result in seeking care from EMS/ED because:

- High enacted stigma scores = experiences of discrimination/mistreatment
- People experiencing overamping don't think EMS/ED can do anything to help
- ED personnel also find it challenging to help them

People who use methamphetamine want better options

RQ 3: What is available for methamphetamine harm reduction?

SUD Treatment and harm reduction strategies for methamphetamine are limited:

- Contingency Management and CBT have strongest evidence base, but are resource intensive and not durable
- Reduce use might improve cardiovascular outcomes, even without abstinence
- Smoking instead of injecting might reduce unwanted effects, reduce risk from fentanyl
- Hydration, rest, nutrition might reduce severity of acute toxicity or "overamping"

Medications trials to date yield poor effects on abstinence, but appear to impact other important outcomes

Importantly, medications for methamphetamine are broader in scope that MOUD

Outcomes	Drug classes
• Craving • Withdrawal • Dependence • Frequency of use • ER admissions for acute meth psychosis	• CNS stimulants • Antipsychotics • Antidepressants • Anticonvulsants • Opioid agonists/antagonists

AMPED participants are interested in medications, but their understanding of what's possible is bounded by their experience with opioids and MOUD

- Some want similar functional benefits (e.g., energy, focus, "get things done,"), suggesting a "substitution" logic, but others express concerns about "replacing one drug with another", similar to talk about methadone, suggesting a desire for abstinence
- Concerns about withdrawal: unclear how much is based on experiences of opioid withdrawal – requires a better understanding of what people experience with methamphetamine withdrawal
- "Tapering down" - some suggesting that people are interested in reducing intensity or frequency of use – for many, "tapering" is a way to achieve abstinence without going "cold turkey"
- Many express a desire to addresses social concerns or facilitate a "return to normalcy":
  - ✓ Less "chaos" in daily life, change in environment
  - ✓ Improved relationships with kids/family, social support
  - ✓ Employment & housing stability (maybe facilitated by the energy and focus that a stimulant provides, or maybe resulting from reducing chaos)
  - ✓ Less severe paranoia, hallucinations, delusions: "I would want it to reduce my anxiety, quiet the voices"
  - ✓ Address untreated physical and psychological pain and trauma

MEETING	NNHPPG ? SoNHPPG	DATE	4/23/25
FACILITATOR	C. Radcliff	TIME	2-3:30 PM
LOCATION	ON-LINE & Calico Hills		

Southern Nevada Health District

NO.	NAME (PLEASE PRINT)	PROGRAM/AGENCY/AFFILIATION	EMAIL	PHONE	SIGNATURE
1	Chris Reynolds	SNHC			
2	Krystal Cruz	SNHD			
3	Albert Sedrak	The Center			
4	Raychel Holbert	SNHD			
5					
6	VIRTUAL	ATTENDEES:			Jerrah Kilgore
7	Lyell Collins	NDPBH	Danielle Haldeman		Tonia Atencio
8	Caress Baltimore	NDPBH	Elizabeth Adelman	SNHD	Jason Saylor
9	Scarlett Cazares	NDPBH	Elizabeth Christiansen		Jacqueline Arizmendi
10	Robert Harding		Eric McIntyre	SNHD	Rob ?
11	Angel Stachnik	SNHD	Erick Lopez	SNHD	Gary Costa
12	Angelica Hall		Isabelle Rowland-S.	NDPBH	Gus Marquez
13	Anthony Snowden		Jennifer Howell - proxy: Doug Hodges		Xavier Foster - SNHD
14	Antiocha Carrillo		Jessica Connor		Allison Schneider
15	Autumn Sparlin	SNHD	Maggie Laterich	Trac-B	Heather Holmstadt
16	Brennan O'Toole	SNHD	Krystal Morales		Bonnie Bishop
17	Brian Oxhorn		Tiria Carr	UNLV	Mona Lisa Paulo
18	Bruce Eddins		Karley Crane		Tory Johnson
19	Carmen Hua	SNHD	Scott Banton		Karla Banda
20	Cassandra Martinez	SNHD	Anne Stoll-Truelock		Preston Tang

MEETING	NNHPPG & SNHPPG	DATE	4-23-2025
FACILITATOR	Cheryl Radeloff	TIME	2-3:30 pm
LOCATION	Calico Hills & on-line		

Southern Nevada Health District

cont.

NO.	NAME (PLEASE PRINT)	PROGRAM/AGENCY/AFFILIATION	EMAIL	PHONE	SIGNATURE
1	Victoria Young				
2	Jose Melendrez				
3	Gerald Permid				
4	Jacqueline Merino				
5	Heidi Laird	SNHD			
6	Krystal Griffin	SNHD			
7	Marco Paez				
8	Samantha Morales	SNHD			
9	John Sapero				
10	Heather Kerwin				
11	Gary				
12	Harmony				
13	Rosanne Sugay	SNHD			
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