END HIV Nevada

The time is now.

Clark County
Ending the HIV Epidemic Plan

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

SNHD
Southern Nevada Health District

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EXECUTIVE SUMMARY

The Clark County Ending the HIV Epidemic Plan 2021-2026 was developed in response to the guidance provided by the Centers for Disease Control and Prevention (CDC) in November 2019. Clark County has been identified as one of the 48 priority jurisdictions in the United States that have been targeted for Phase I of America's Ending the HIV Epidemic (EHE) initiative. Since 2012, Clark County has experienced a continuous increase in both the number of new HIV diagnoses (incidence) and in people living with HIV (prevalence). To address this issue, the HIV Prevention Program at the Nevada Department of Public and Behavioral Health (NDPBH) contracted with the Pacific AIDS Education and Training Center-Nevada (PAETC-NV) to complete a needs assessment and draft a plan for Clark County's EHE initiative. Starting in January 2019, well before the CDC announced its funding opportunity for the development of EHE plans, PAETC-NV launched Nevada's EHE Workgroup. The EHE Workgroup includes over sixty individuals across the state, including representatives from HIV Prevention and Ryan White planning groups, local community partners, healthcare providers, health district staff, universities in both Las Vegas and Reno, and community members. The monthly EHE Workgroup meetings have maintained the momentum of planning the EHE needs assessment while enhancing communication and collaboration across all entities.

The EHE Workgroup, along with Southern Nevada Health District, the Nevada Division of Public and Behavioral Health HIV Prevention Program, and Ryan White Part A, guided the planning and development of this plan. The state of Nevada has been unquestionably impacted by the HIV epidemic, with the highest rate (16.6) of new infections in the Western U.S. Clark County is the most populous county in Nevada, and has a new HIV infection rate of 19.8, which is higher than the overall state rate. Only 41% of Clark County's population has ever been tested for HIV, and only 11% had been tested in the past year. In 2018, the CDC estimated that just 79.3% of those living with HIV in Clark County had been diagnosed. This signifies that approximately one in five people living with HIV in Clark County are unaware of their status. The majority of Nevada's population resides in Clark County (74%), the county that bears the heaviest burden of HIV in the state. In 2019, 88% of people newly diagnosed with HIV and 86% of all people living with HIV (PWH) resided in Clark County. In 2019, Clark County had a total of 10,110 persons living with HIV or AIDS and 448 persons newly diagnosed with HIV. In 2019, 85% of persons newly diagnosed with HIV in Nevada were male; and 61% of newly diagnosed males reported a transmission category of male-to-male sexual contact. Large racial/ethnic disparities exist in HIV transmission, particularly among Blacks/African Americans. In 2019, the rate of new HIV diagnoses among Black men was over five times that of White men (108.1 vs. 21.5 per 100,000 population).

Of the 448 newly diagnosed cases of HIV in Clark County in 2019, 72.8% were linked to care within one month after diagnosis. Of the 9,009 PWH in Clark County, 30.4% were retained in care (percentage of persons who had >= 2 CD4 or viral load tests at least three months apart during 2019, among those diagnosed with HIV through year-end 2018, and alive at year-end 2019). Among those retained in care at the end of 2019, 85.9% had suppressed viral load (<=200 copies/mL) at the most recent test during 2019. Among PWH year-end 2018 and alive at year-end 2019, 27.6% had suppressed viral load (<=200 copies/ML) at most recent test during 2019.

The needs assessment to develop and draft the Clark County EHE Plan 2021-2026 was conducted between February and June 2020. The purpose of this process was to gain a better understand of needs and gaps related to addressing the HIV epidemic in Clark County. The aim of the plan is to improve the already exceptional HIV prevention and care services offered within

the Clark County community. The data collection for the needs assessment included both focus groups and surveys with a variety of stakeholders—persons at risk for HIV, people living with HIV, a wide range of healthcare and service providers, and providers-in-training. Nineteen HIV client and prevention focus groups were held in Clark County between March and June 2020, with 94 people participating. Four groups were specifically held for HIV positive individuals, while five groups were conducted with people at risk for HIV and which focused on HIV prevention. Three focus groups were conducted in Spanish to ensure inclusion from the Latinx/Hispanic community. Three provider focus groups were held with primary care and HIV service providers, with 94 people participating. Three surveys (community, provider, and provider-in-training) were administered between February and June 2020. The EHE Workgroup, which includes over 60 individuals from various organizations, was used to disseminate the surveys.

The situational analysis findings are separated into the four CDC-defined pillars: diagnose, treat, prevent and respond.

Pillar One: Diagnose

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

Pillar Two: Treat

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

Pillar Three: Prevent

Common themes among focus group and survey respondents included the need for comprehensive sex education in schools, as well as culturally and linguistically appropriate HIV education for Black and Latinx/Hispanic populations. Participants who inject drugs stressed the need for more discreet information on testing, condoms, rehabilitation, and clean needles. Participants were in favor of advertisements, billboards, social media, community events, small groups, and programs in schools to increase community awareness of HIV. Increased access to, and knowledge of PrEP and PEP is another important strategy. One notable strength related to this pillar includes the trust people had in local community clinics and community organizations to provide them with messages about health. Another strength is the increase in available syringe

services programs (SSPs) in Clark County through the installation of SSP vending machines. Lack of knowledge about PrEP and PEP was evident in community focus group and survey responses. Provider and providers-in-training reported a lack of knowledge on how to counsel and follow up with a patient requesting preventative therapies such as PrEP and PEP. In addition, 30% of providers reported they would not recommend needle exchange to patients who inject drugs. Harm reduction is an important strategy to minimize HIV infection. Barriers to prevention efforts included stigma related to HIV and injection drug use, inaccurate information about HIV, and insufficient funding for HIV prevention.

Pillar Four: Respond

The Southern Nevada Health District (SNHD) and the Nevada Department of Public and Behavioral Health (NDPBH) have robust HIV surveillance programs and collaborate well in this work. As the science of HIV surveillance moves towards molecular epidemiology, however, Clark County and Nevada will need to expand their technological capacity and potentially partner with more advanced partners outside of Nevada. The state has requested capacity building assistance regarding molecular surveillance to assist in these efforts.

A stakeholders meeting was held in July 2020 to review the needs assessment data and to initiate the process of setting goals and objectives for the Clark County EHE plan. This meeting was attended by 31 participants, not including the facilitators, and represented a wide variety of participants including PWH and representatives from providers, prevention agencies, health districts and other community-based organizations. Subsequent to this meeting, the Southern Nevada Health District, Ryan White Part A, NDPBH HIV Prevention Program, and the PAETC-NV team further developed the objectives, strategies, and activities and requested review and feedback from the Southern Nevada HIV Prevention Planning Group (SoNV HPPG).

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

As required in the EHE Guidance, Clark County's plan is separated into four pillars: diagnose, treat, prevent and respond. For each of these pillars, one goal was developed, with two to five key activities and strategies.

Plan to End the HIV Epidemic in Clark County. 2021-2026

Pillar One: Diagnose

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

Key Strategies and Activities:

1) By 2026, 85% of people living with HIV in Clark County will know their serostatus.
2) By 2026, 55% of all people living in Clark County will have been tested for HIV at least once.
3) By 2026, at least 14 more clinics in Clark County will be routinely screening for HIV.
4) Proposed policy changes and their impact on Pillar One

Pillar Two: Treat

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

Key Activities and Strategies:

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

Pillar Three: Prevent

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

Key Activities and Strategies:

1) By 2026, reduce by 10% the rate of new HIV diagnoses (to 17.8 or 403 cases)
2) By 2026, reduce to 20% the incidence of infectious syphilis among PWH in Clark County
3) By 2026, increase the percentage PrEP coverage in Clark County to 30%
4) By 2026, increase the number of access points to syringe services programs (SSPs) in Clark County to 10
5) Policy changes and their impact on Pillar Three

Pillar Four: Respond

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

Key Activities and Strategies:

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

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

INTRODUCTION

Clark County has been identified as one of the 48 priority jurisdictions in the United States that have been targeted for Phase I of America's Ending the HIV Epidemic (EHE) initiative. Since 2012, Clark County has experienced a continuous increase in both the number of new HIV diagnoses (incidence) and in people living with HIV (prevalence).[1] To address this issue, the HIV Prevention Program at the Nevada Department of Public and Behavioral Health (NDPBH) contracted with the Pacific AIDS Education and Training Center-Nevada (PAETC-NV) to complete a needs assessment and draft a plan for Clark County's Ending the HIV Epidemic (EHE) initiative. In January 2019, well before the CDC announced its funding opportunity for the development of EHE plans, PAETC-NV launched Nevada's EHE workgroup. Participants include a range of service providers, concerned citizens, and people living with HIV. Throughout the EHE process, the Nevada EHE workgroup has supported the design and implementation of the EHE needs assessment and contributed to the development of the EHE plan. This EHE plan has been drafted based on goals from Fast Track Cities, Getting to Zero, and Ending the HIV Epidemic. The overarching goals of these initiatives are what all states and jurisdictions are striving for and serve as guideposts for this work:

- Fast-Track Cities, Nevada: 90% of people living with HIV know their HIV status; 90% of people who know their HIV-positive status are on treatment; 90% of people on treatment have suppressed viral loads; and zero discrimination.
- Getting to Zero: Get to, and remain at, zero new HIV infections, zero HIV-related deaths, and zero stigma associated with HIV infection.
- Ending the HIV Epidemic: Reduce the number of new HIV infections in the United States by 75 percent within five years, and then by at least 90 percent within ten years.

In Clark County, these overarching goals provide guidance for our work in ending the HIV epidemic, however, a stepwise approach will be utilized in order to measure and achieve successful milestones. See the Plan section for more detail regarding Clark County's specific goals, objectives, and activities.

Community Engagement

From January 2019 to September 2020 (and ongoing), the PAETC-NV has hosted 31 in-person meetings and group conference calls via Zoom to engage local and statewide stakeholders in the planning process of the Clark County Ending the HIV Epidemic Plan. This Ending the HIV Epidemic Workgroup contact list includes over sixty individuals across the state, including representatives from HIV Prevention and Ryan White planning groups, local community partners, healthcare providers, health district staff, universities in both Las Vegas and Reno, and community members. Key stakeholders for the Clark County EHE Plan are the Southern Nevada HIV Prevention Planning Group (SoN HPPG), the Southern Nevada Health District (SNHD), the Nevada Division of Public and Behavioral Health, and Ryan White Part A, who are all represented on the EHE Workgroup. The monthly EHE meetings have included updates and discussions on plan development, handouts with event descriptions, and the CDC's feedback from the December 2019 draft EHE plan. These monthly workgroup meetings have maintained the momentum of planning the EHE needs assessment while enhancing communication and collaboration among all entities mentioned above. Because this planning process began in January 2019, these conversations contributed to the application for the EHE planning grant in summer 2019. Due to prior planning efforts, the State of Nevada HIV Prevention Program applied for funding through CDC PS19-1906 to develop the Ending the HIV Epidemic plan for Clark County.

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

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

Data collected from surveys and focus groups will be used not only to inform the needs assessment and situational analysis, but also to supplement the existing community engagement structure and provide new insights and ideas towards the effort to end the HIV epidemic in Clark County. The Clark County EHE plan was posted on the website of the Nevada Department of Public and Behavioral Health's Office of HIV Prevention and will be linked to by many other community organizations in Clark County.

COVID-19 Impact

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

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

CLARK COUNTY OVERVIEW

Clark County is the most populous of Nevada's 17 counties and is the nation's 13th-largest county (geographically), providing services to more than 2.3 million citizens and nearly 46 million visitors a year (2019), primarily in the city of Las Vegas.[2,3] The county is comprised of 7,891 square miles with 282.8 people per square mile.[3] Nevada is the nation's second-fastest growing state (percent growth), and Clark County is Nevada's largest and most diverse county.[4] This fact is of great importance to the EHE plan, as racial/ethnic minorities carry a greater burden of HIV infection in Clark County compared to White individuals, as is the case in most Phase I jurisdictions across

the country. This disparity will be addressed at greater length in the epidemiological profile of Clark County later in this report.

Demographic Characteristics

Clark County is a minority-majority county with a minority population of 56%.[3] In 2019, the racial and ethnic composition of Clark County was 41.7% White, 31.6% Latinx/Hispanic, 13.1% Black, 10.4% Asian, 0.9% Native Hawaiian and Other Pacific Islander, and 1.2% American Indian and Alaska Native.[3] Foreign-born persons make up 22.2 % of these populations.[3] As of 2018, 89.3% of Clark County residents were U.S. citizens, which is below the national average of 93.2%.[3,5] Over half of the population in Clark County was between the ages of 19 and 64 (55.7%), less than a quarter was between the ages of 0 and 18 (23.0%), and the remaining 15.1% of the population was ages 65 and older.[3]

Socioeconomic Status

Las Vegas, the largest city in Clark County, relies heavily on tourism and has been disproportionately impacted by the COVID-19 pandemic. Clark County's unemployment rate was 4.8% in May of 2019, however, it jumped to 29.0% in May of 2020 in the midst of the pandemic, which is significantly higher than the overall U.S. unemployment rate at 13% in May of 2020.[6,7] Even prior to the pandemic, however, the county had marked socioeconomic disparities among racial and ethnic minorities.[8] In 2017, in a report produced for the Nevada governor's office, analysts found that Black/ African Americans' unemployment rate was almost double that of Whites, and the unemployment rate among Latinx/Hispanic workers was also significantly higher than that of Whites.[8] The unemployment rate among women was 0.8 of a percentage point below the jobless rate for men.[8] In 2019, before the COVID-19 pandemic, the median household income in Clark County was $56,802, which is lower than the national median household income of $57,652.[3,9] Men in Clark County have an average income ($62,797) that is 1.29 times higher than the average income of women, which is $48,620. [9]Nevada ranks 26th in the country for persons living below the poverty level.[10] Fourteen percent of Clark County's population was living below the poverty level compared to 13.1% of the U.S. population.[5,11] The largest demographic living in poverty are females 25 - 34, followed by females 35 - 44, and then males ages 6 - 11.[5] Also, an estimated 19% of children under 18 years old were living below the poverty level.[3] Regarding education level, the U.S. Census Bureau (2018) estimated that 85.9% of Clark County's population had a high school diploma or higher, compared to the U.S. at 88.3%; and 24.6% of Clark County's population had a bachelor's degree or higher compared to the U.S. at 32.6%.[12]

POPULATIONS OF INTEREST

Sexual Orientation and Gender Identity

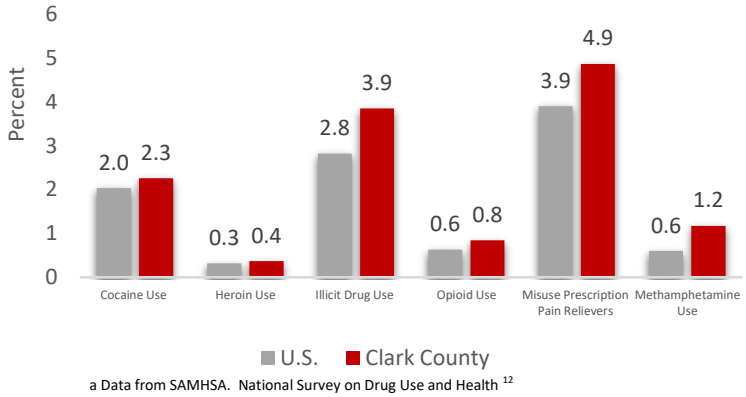
Not only does Clark County have a racially diverse population, but it also has great diversity in sexual orientation and gender identity within the community. According to the UCLA Williams Institute, Nevada ranks third in the nation for the percent of the population identifying as lesbian, gay, bisexual, and transgender (LGBT), at 5.5%.[13] Clark County contains 73% of Nevada's population and 78% of the LGBTQ population.[3,13] In 2019, 57% of the Clark County LGBTQ population identified as male, 64% was White, 18% was Latinx/Hispanic, 8% were Black or African American, and 4% were all other races.[13] A large majority, 59%, of the LGBTQ population was under the age of 35, while 15% were between the ages of 35-49, 17% were between the ages of 50-64, and 9% were over the age of 65.[13] Men who have sex with men (MSM) and transgender women are at higher risk for HIV acquisition in Clark County (as in all states and the nation), and MSM of color are at particularly high risk as well as those MSM who also use

substances. Populations identifying as sexual minorities often face stigma and related health disparities, including HIV and many social determinants of health. These are key populations identified in this needs assessment that will be part of the focus of the Clark County EHE Plan 2020-2026.

People Who Use Substances

Substance use in Clark County is higher than the national average, and can be associated with HIV infection.[14] According to the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2018, among Clark County residents over age 12, 3.9% report illicit drug use disorder in the past year.[14] Two percent reported cocaine use in the past year, and another 0.3% reported heroin use in the past year.[14] For opioid use disorder (OUD), 0.8% reported OUD, and 4.9% reported having misused prescription pain relievers during the past year.[14] Methamphetamine use is reported by 1.2% in the past year.
See Figure 1 for details.

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

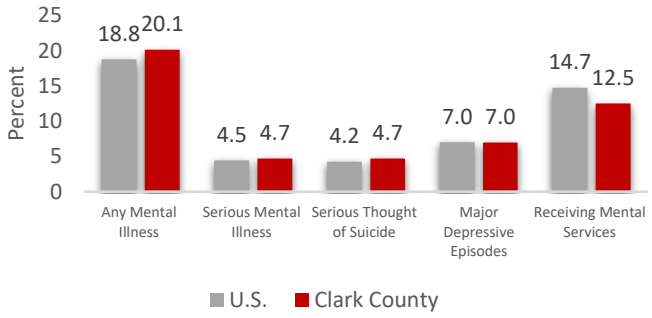


a Data from SAMHSA. National Survey on Drug Use and Health [12]

People Experiencing Mental Health Problems

Clark County residents also carry a higher burden of mental health problems compared to the rest of the nation. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2018, among those aged 12 and over, 20.1% reported mental health problems (any) in the past year; of these, 4.7% reported serious mental illness.[14] Serious thought of suicide in the past year was reported by 4.7%, while only 12.5% reported receiving mental health services to address these issues.[14] See Figure 2 for details.

Figure 2: Percent of Population Reporting Mental Health Problems, 2018[a]



a Data from SAMHSA. National Survey on Drug Use and Health [12]

Homelessness

Adults and youth who are homeless are at higher risk for HIV infection, and have a harder time maintaining viral suppression. The U.S. Department of Housing and Urban Development (HUD) defines homelessness as “people who are living in a place not meant for human habitation, in emergency shelters, transitional housing, or exiting an institution where they temporarily resided.”[15] These could also be people who are losing their primary residence where they sleep, which may include motels or hotels, and have no resources or supports to find housing.[15] Clark County has a high homeless rate compared to the rest of the nation. There are approximately 5,530 individuals experiencing homelessness on any given night in Clark County, and more than

14,000 people will experience homelessness at least once during the year.[15,16] The homeless rate is 24 per 10,000 people in the general population compared to the U.S. rate of 17 per 10,000 people.[15] In an effort to combat homelessness, in 2019, the Las Vegas City Council passed an ordinance to criminalize homelessness.[17] The new law makes it a misdemeanor to camp or sleep on public streets if beds at established shelters are available.[17] This policy creates more barriers to health for an already marginalized population. People experiencing homelessness are at higher risk for HIV than the general population due to the intersectionality of substance use, mental health issues, poverty, racism, and stigma. These issues are not unique to Clark County; this is a widespread problem across the country. LGBTQ+ youth are at particular risk. Nationally, approximately 40% of homeless youth self-identify as LGBTQ+.[15] Homeless youth are 16 times more likely to be diagnosed with HIV, and 7 times more likely to die from AIDS as the general youth population.[15]

Sexually Transmitted Infections (STIs)

The population of Clark County has higher rates of STIs and viral hepatitis compared to both the state of Nevada and the nation.[18,19] In 2018, Clark County's chlamydia rate was 613.5, and the gonorrhea rate was 237.2.[18,19] Clark County's primary & secondary syphilis rate was 24.8, well above the rates for both Nevada and the U.S.[18,19] Clark County's early latent syphilis rate was 20.0, again, a much higher rate than comparison regions.[18,19] In 2018, Clark County had the second highest rates in the nation for congenital syphilis.[19] These data highlight a complex problem with high STI and HIV rates; as we know, HIV is more easily transmitted in the presence of STIs.[18] See Table 1 for details and comparison rates to Nevada and the U.S. as a whole.

Table 1 | Clark County's STI Rates Compared to Nevada and U.S. STI Rates, 2018

Clark County's STI Rates Compared to Nevada and U.S. STI Rates, 2018						
Sexually Transmitted Infections	**Clark County[a]**		**Nevada[a]**		**U.S.[b]**	
	N	**Rate***	**N**	**Rate***	**N**	**Rate***
Chlamydia Cases	13,695	613.5	17,508	577.5	1,758,668	539.9
Gonorrhea Cases	5,294	237.2	6,475	213.6	583,405	179.1
Primary & Secondary Syphilis Cases	554	24.8	682	22.5	35,063	10.8
Early Latent Syphilis Cases	447	20.0	512	16.9	38,539	11.8

[a] Data from OPHIE. State of Nevada 2018 STD Fast Facts[17]
[b] Data from CDC. STDs and HIV-CDC Fact Sheet[20]
* rate per 100,000 population

Viral Hepatitis

Clark County bears the burden of viral hepatitis cases in Nevada at 4.5 for acute viral hepatitis A, 0.8 for acute viral hepatitis B, and 0.5 for acute viral hepatitis C (see Table 2 for more details).[21] For comparison, in 2017 (most current data available), the U.S. rate of acute viral hepatitis A was 1.0, acute viral hepatitis B was 1.1, and the rate of acute viral hepatitis C was 1.0.[22] Populations at increased risk for viral hepatitis infection are men who have sex with men, people who inject drugs, those who are homeless, and people living with HIV.[22] Clark County experienced a hepatitis A outbreak in 2019, clustered in a population of people who use drugs and were experiencing homelessness (reported by the Southern Nevada Health District). These are the same populations being impacted by

HIV in Clark County. Viral hepatitis progresses faster and causes more liver-related health problems among people with HIV than among those who do not have HIV.[23]

Table 2 | Clark County's Hepatitis Infections Compared to Nevada Rate, 2019

Clark County's Rate of Hepatitis Infections Compared to Nevada Rate, 2019				
Infection Type	Clark County[a]		Nevada[a]	
	N	Rate*	N	Rate*
Acute Viral Hepatitis A	102	4.5	102	3.3
Acute Viral Hepatitis B	18	0.8	23	0.7
Acute Viral Hepatitis C	12	0.5	15	0.5

* rate per 100,000 population

[a] Nevada Department of Health and Human Services, Office of Analytics, on behalf of the Nevada Division of Public and Behavioral Health, 2020[21]

COVID-19 IMPACT

As this plan is being drafted, Clark County has confirmed over 43,147 COVID-19 cases (rate 1852.2 per 100,000) and 688 deaths (29.5 per 100,000) ,and the numbers continue to rise.[24] The racial/ethnic background and sex of those with confirmed COVID-19 cases are 41% Latinx/Hispanic, 31% White, 9% Black or African American, 8% Asian, and cases by gender are 52% female and 48% male.[24] The extent of the impact of the COVID-19 pandemic in Clark County is difficult to assess, but it has been disastrous. As noted above, the pandemic has impacted the data gathered for this report for the EHE situational analysis. Anecdotally speaking, the pandemic has also strained healthcare systems in Las Vegas, including HIV providers, many of whom are finding themselves at the front lines of the COVID-19 response. HIV testing and treatment services have become challenging to provide in social distancing environments, and the extent of barriers to care has increased. To highlight the needs in the area, the Ryan White Part A planning council was moved to approve changes to funding allocations around the areas of emergency housing and some other funding areas due to the pandemic. As noted above, unemployment in the area has skyrocketed due to plummeting tourism rates, and Clark County has yet to see the far-reaching economic and health impacts of COVID-19.

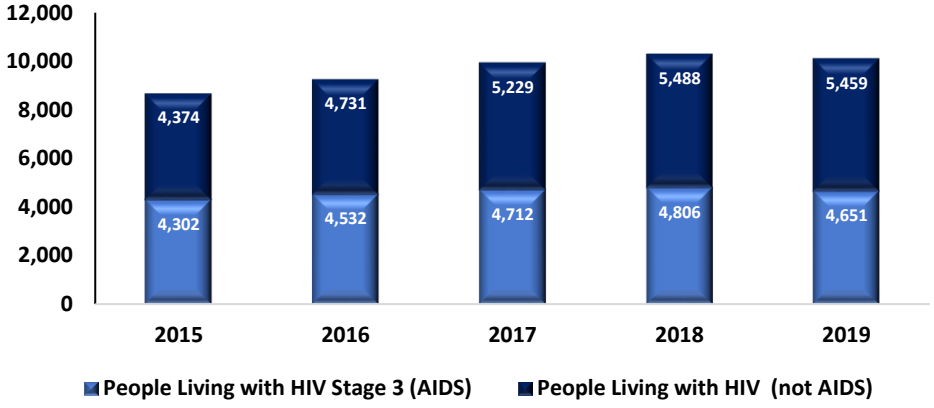
EPIDEMIOLOGICAL PROFILE: OVERVIEW OF HIV IN CLARK COUNTY

The state of Nevada has been unquestionably impacted by the HIV epidemic, with the highest rate (16.6) of new infections in the Western U.S.[25] Clark County is the most populous county in Nevada, and has a new infection rate of 19.8, higher than the state rate.[26] The CDC estimates that only 41% of Clark County's population has ever been tested for HIV, and only 11% had been tested in the past year.[1] In 2018, the CDC estimated that just 79.3% of those living with HIV infection in Clark County had been diagnosed.[27] This signifies that approximately one in five people living with HIV in Clark County are unaware of their status.[27] Clark County bears the heaviest burden of HIV in the state. In 2019, 88% of persons newly diagnosed with HIV and 86% of all people living with HIV (PWH) resided in Clark County.[21]

Persons Living with HIV in Clark County, 2015 – 2019

In 2019, there were 5,459 persons living with HIV (not AIDS or HIV stage 3) in Clark County, 4,651 persons living with HIV stage 3: AIDS, and a total of 10,110 persons living with HIV.[28] From 2015 to 2019, the number of persons living with HIV (excluding HIV stage 3 [AIDS]) increased by 25%, while those living with HIV stage 3 (AIDS) increased 8%. See Figure 3 for more details.[28]

Figure 3: Number of Persons Living with HIV/AIDS in Clark County[a]



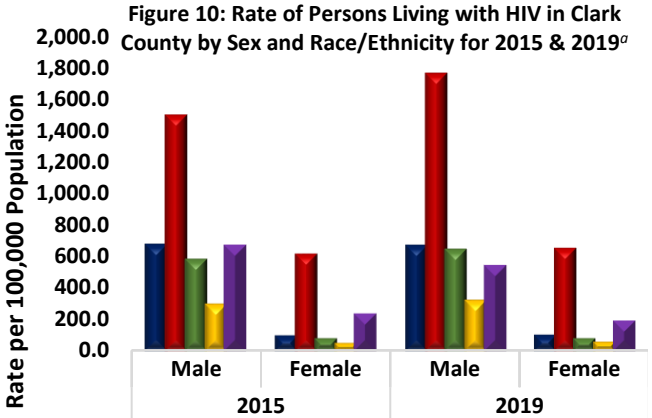
a Nevada Department of Health and Human Services, Office of Analytics, on behalf of the Nevada Division of Public and Behavioral Health [17]

Rates of Persons Living with HIV in Clark County by Sex and Age, Sex and Race/Ethnicity, 2015 & 2019

In 2019, rates of persons living with HIV were highest among both Black males and females. The HIV rate among Black males (1762.2 per 100,000 population) was 2.6 times higher than that of White males (661.1), while the HIV rate among Black females (646.6) was 7.3 times higher than that of White females (88. 5).[28] See Figure 10 for details.

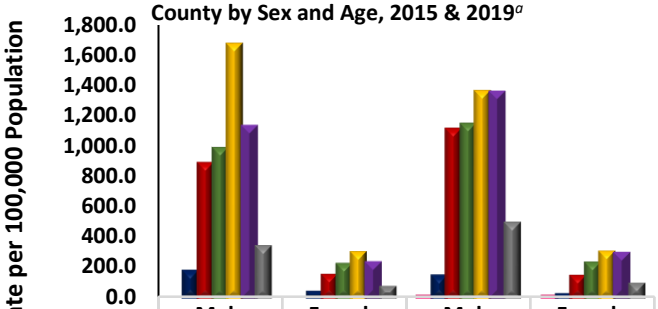
In 2019, among males, the highest rates of persons living with HIV were among 45 to 54-year-olds (1361.2 per 100,000 population), 55 to 64-year-olds (1352.4), and 35 to 44-year-olds (1138.0), respectively.[28] Among females, rates of persons living with HIV were highest among 45 to 54-year-olds (300.7), followed by 55 to 64-year-olds (290.2).[28] See Figure 11 for more details. The increasing age of persons living with HIV suggests that people are living longer and may reflect the effective treatment of HIV.

Figure 10: Rate of Persons Living with HIV in Clark County by Sex and Race/Ethnicity for 2015 & 2019[a]



	2015		2019	
	Male	Female	Male	Female
White	666.7	84.8	661.1	88.5
Black	1496.0	609.6	1762.2	646.6
Hispanic	570.5	67.6	634.1	67.0
API	285.0	36.5	310.3	45.0
AI/AN	660.1	224.2	533.0	179.2

Figure 11: Rate of Persons Living with HIV in Clark County by Sex and Age, 2015 & 2019[a]



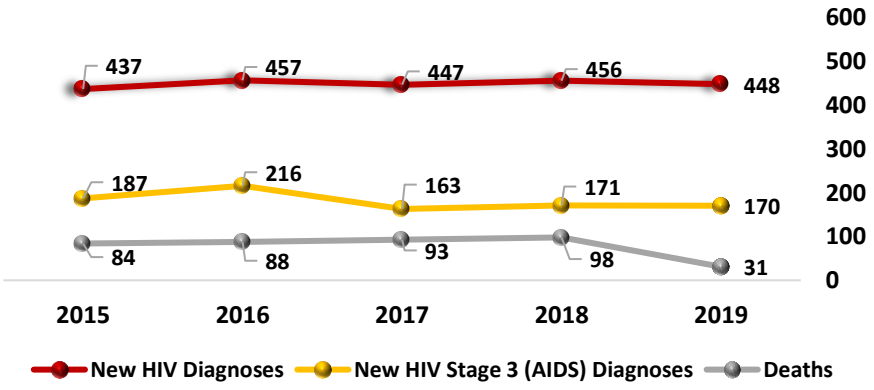
	2015		2019	
	Male	Female	Male	Female
<13	0	0.0	0.5	2.1
13-24	163.5	30.7	134.5	17.7
25-34	882.5	147.0	1107.4	140.0
35-44	978.6	217.9	1138.0	226.4
45-54	1672	296.8	1361.2	300.7
55-64	1128.0	228.0	1352.4	290.2

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

New HIV Diagnoses, New AIDS Diagnoses, and Deaths in Clark County, 2015 – 2019

In the last five years (2015 to 2019), the number of persons newly diagnosed with HIV infection in Clark County increased over 2.5%.[28] In this same time frame, the number of persons newly diagnosed with AIDS decreased by about 1%. In 2019, 85% of those newly diagnosed were male, and 15% were female.[21] In 2019, there were 31 deaths among people living with HIV in Clark County.[28] Overall, from 2015 to 2019, the number of deaths among persons living with HIV, including HIV stage 3 decreased by 63%.[28] Also, in 2019 there was a dramatic decrease in deaths. If the deaths from the years 2015 to 2018 were examined alone, the number of deaths among persons living with HIV, including HIV stage 3 increased by 17%.[28] See figure 4 for more details.

Figure 4: Number of New Cases and Deaths due to HIV in Clark County[a]



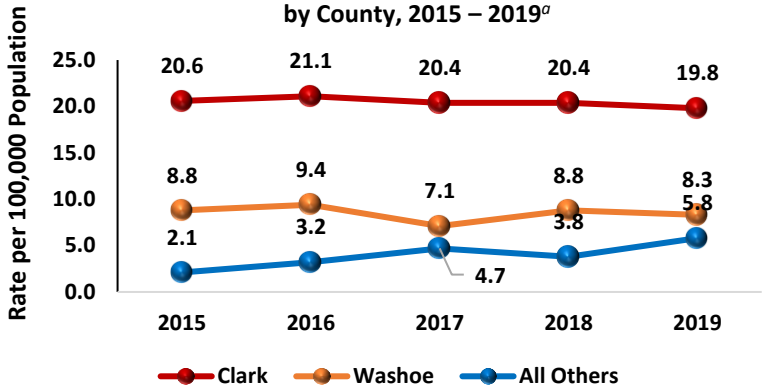
a Nevada Department of Health and Human Services, Office of Analytics, on behalf of the Nevada Division of Public and Behavioral Health [17]

In 2019, Clark County's HIV mortality rate among persons living with HIV, including HIV stage 3 (AIDS), was 3.8 per 100,000 population, compared to the US rate of 1.7.[25,28] Clark County's mortality rate for persons living with HIV is 2.2 times that of the U.S., but reduced significantly between 2018 and 2019.[28]

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

In 2019, the rate of new HIV diagnoses in Clark County (19.8 per 100,000 population) was more than double that of Washoe County (8.3) and more than three times greater than that of all other counties in Nevada (5.8).[28] From 2015 to 2019, the rate of new diagnoses in Clark County has remained constant.[28] See Figure 5 for more details.

Figure 5: Annual Rate of New HIV Diagnoses in Nevada by County, 2015 – 2019[a]



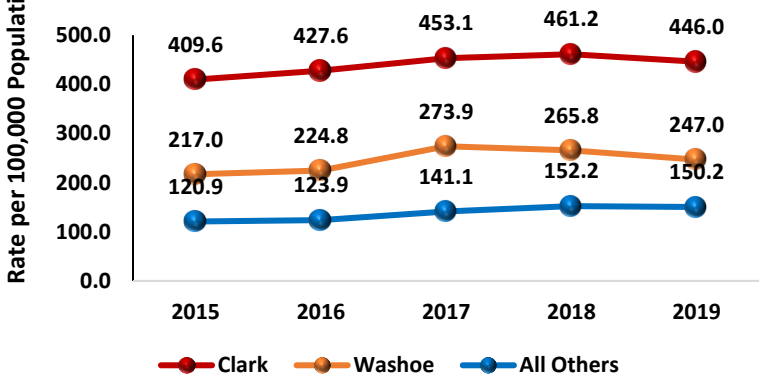
a Nevada Department of Health and Human Services, Office of Analytics, on behalf of the Nevada Division of Public and Behavioral Health [17]

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

Clark County accounts for a disproportionate number of people living with HIV/AIDS (PWH) in the state of Nevada. In 2019, 86% of PWH in Nevada resided in Clark County, which comprises just 73% of the state's population.

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

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



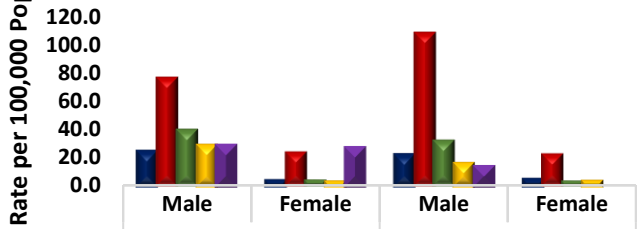
a Nevada Department of Health and Human Services, Office of Analytics, on behalf of the Nevada Division of Public and Behavioral Health [17]

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

In 2019, rates of new HIV diagnoses were highest among both Black males and females. The rate of new HIV diagnoses among Black males (108.1 per 100,000 population) was five times higher than that of White males (21.5).[28] In comparison, the rate of new HIV diagnoses among Black females (21.9) was 4.7 times higher than that of White females (4.7).[28] Latino/Hispanic males also experienced adversely high rates of new HIV diagnoses (31.0).[28] In 2019, among those newly diagnosed, 21% were foreign born.[29] From 2015-2019, there were 65 new diagnoses among transgender individuals.[29] Overall, minority populations experience the greatest burden of HIV in Nevada.[28] See Figure 7 for more details.

In 2019, the highest rates of new HIV diagnoses in males were among 25 to 34-year-olds (101.7 per 100,000 population), 35 to 44-year-olds (44.8), and 13 to 24-year-olds (39.6), respectively.[28] In Clark County, males under 35 have been identified as a high-risk population. In 2019, among females, rates of new HIV diagnoses were highest among 25 to 34-year-olds (12.8), followed by 45 to 54-year-olds (9.4). See Figure 8 for more details.

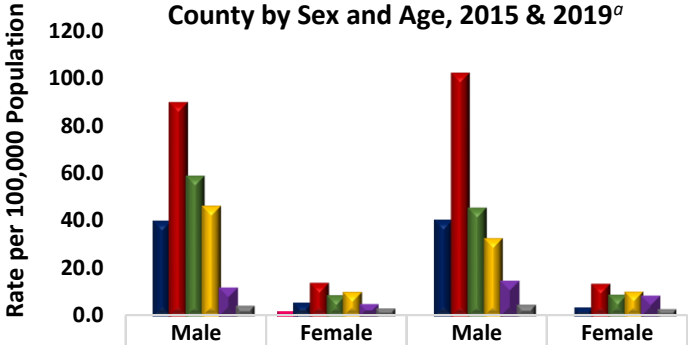
Figure 7: Rate of New HIV Diagnoses in Clark County by Sex and Race/Ethnicity for 2015 & 2019[a]



	2015 Male	2015 Female	2019 Male	2019 Female
White	23.7	3.9	21.5	4.7
Black	76.4	23.3	108.1	21.9
Hispanic	38.4	3.1	31.0	2.5
API	28.4	3.2	15.9	3.6
AI/AN	28.3	26.7	13.7	0.0

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

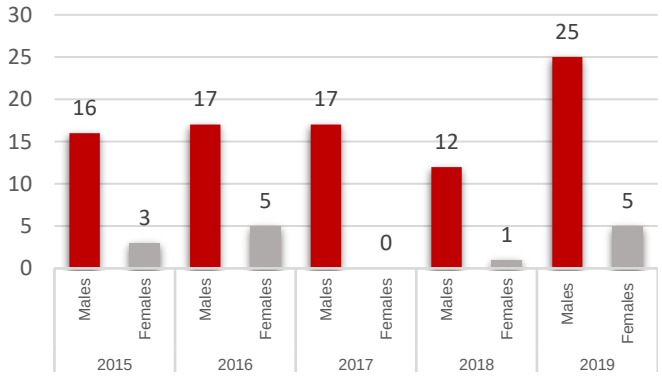
Figure 8: Rate of New HIV Diagnoses in Clark County by Sex and Age, 2015 & 2019[a]



	2015 Male	2015 Female	2019 Male	2019 Female
<13	0.0	1.1	0.0	0.0
13-24	39.2	4.8	39.6	2.8
25-34	89.4	13.2	101.7	12.8
35-44	58.3	7.9	44.8	8.2
45-54	45.2	9.3	31.7	9.4
55-64	11.0	4.1	13.8	7.6
65+	3.2	2.1	3.6	1.8

New HIV Infections in Correctional Facilities, NV, 2019

Figure 9: Number of New HIV Infections In Clark County Correctional Facilities[a]



[a] Southern Nevada Health District Unpublished Surveillance Data, 2019[25]

Clark County did not experience any HIV defined outbreaks in the general population for 2019. However, it did see a rise in the number of new HIV infections in Clark County correctional facilities compared to previous years. See figure 9 for more details. Males in this group experienced more new infections than females. The race/ethnicity of those infected was Black/African Americans (47%), Whites (27%), and Latinx/Hispanics (23%).[29] The categories of transmission mode were male to male sexual contact (MSM) (33%), MSM and injection drug use together (IDU + MSM) (17%), and injection drug use alone (IDU) (13%).[29]

Transmission Categories of New HIV Diagnoses by Sex, 2019

Among the transmission categories for all new diagnoses, MSM had the highest rate at 12.1 per 100,000 population and comprised 61.4% of new diagnoses. Among transmission categories for males only, the MSM rate increased to 24.3 and comprised 71.8% of new diagnoses. Among all new HIV diagnoses, heterosexual contact had a rate of 1.4 and comprised 6.9% of new diagnoses. MSM + IDU had a rate of 0.9 and accounted for 4.5% of all new diagnoses. The modes of transmission are risk categories identified by the CDC and used for data collection and surveillance. See Table 3 for more details.

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

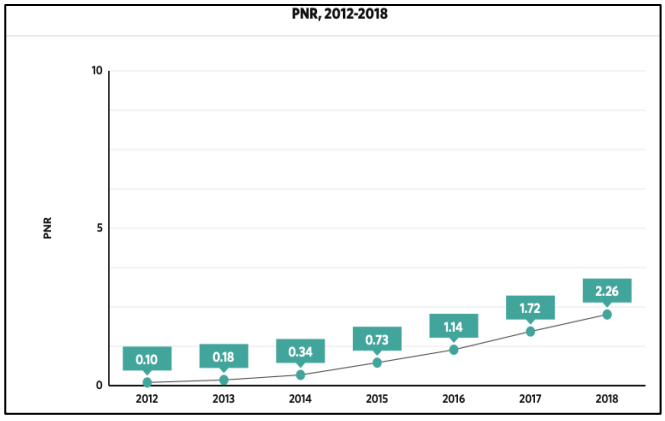
Transmission Category of New HIV Diagnoses by Sex, 2019[a]									
Transmission Category	Total			Male			Female		
	N	Column %	Rate*	N	Column %	Rate*	N	Column %	Rate*
Male-to-male sexual contact (MSM)	275	61.4	12.1	275	71.8	24.3	-	-	-
Injection drug use (IDU)	20	4.5	0.9	12	3.1	1.1	8	12.3	0.7
MSM+IDU	18	4.0	0.8	18	4.7	1.6	-	-	-
Heterosexual contact	31	6.9	1.4	12	3.1	1.1	19	29.2	1.7
Perinatal exposure	2	0.4	0.1	2	0.5	0.2	0	0.0	0.0
Transfusion/Hemophilia	0	0.0	0.0	0	0.0	0.0	0	0.0	0.0
No identified risk (NIR)	102	22.8	4.5	64	16.7	5.6	38	58.5	3.4
Total	**448**	**100.0**	**19.8**	**383**	**100.0**	**33.8**	**65**	**100.0**	**5.7**

a Nevada Department of Health and Human Services, Office of Analytics, on behalf of the Division of Public and Behavioral Health [17]
**Rate per 100,000*

PrEP Use in Clark County

In 2018, the CDC estimated approximately 8,847 persons in Clark County with indication for PrEP use. [27] Using data from IQVIA pharmacy database, 1,251 persons were prescribed PrEP, which provides an estimated PrEP coverage (of those with indication) of 14.1% in Clark County.[27] PrEP coverage, reported as a percentage, was calculated as the number who have been prescribed PrEP divided by the estimated number of persons who had indications for PrEP.[27]

Figure 12 | PrEP-to-Need Ratio, Clark County, 2012 – 2018[a]



[a] AIDSVu, Local Data: Clark County, NV[1]

The 2018 PrEP-to-Need Ratio (PNR) is the ratio of PrEP users in 2018 to the number newly diagnosed with HIV in 2017.[1] PNR serves as an indicator for whether PrEP use appropriately reflects the need for biomedical HIV prevention. A lower PNR indicates more unmet need.[1] The max PNR is 10. Although Clark County's PNR has improved to 2.26 in recent years, it still reflects a high need for biomedical HIV prevention. In 2018, the PNR was 2.42 for males and 1.00 for females.[1] The PNR, by age, was 1.47 for ages 13-24; 2.08 ages 25-34; 3.42 ages 35-44; 2.97 ages 45-54; and 1.29 ages 55+.[1] See figure 12 for more details.

Continuum of Care- Persons Living with HIV/AIDS, Clark County, NV, 2019

Of persons who had been diagnosed with HIV through year-end 2018, 9,009 were alive at year-end 2019. Of the 9,009 PWH, 30.4% were retained in care (percentage of persons who had >= 2 CD4 or viral load tests at least three months apart during 2019 among those diagnosed with HIV through year-end 2018, and alive at year-end 2019).[30] Among those retained in care at the end of 2019, 85.9% had suppressed viral load (<=200 copies/mL) at the most recent test during 2019.[30] Among PWH year-end 2018 and alive at year-end 2019, 27.6% had suppressed viral load (<=200 copies/ML) at their most recent test during 2019.[30] Of the 448 newly diagnosed cases of HIV in 2019, 72.3% were linked to care within one month after diagnosis during 2019.[30] See Appendix A for more details.

For additional information on transmission categories for PWH, and PrEP use in Clark County, see appendices B and C.

SITUATIONAL ANALYSIS

A needs assessment was conducted between February and June 2020 to develop and draft the Clark County 2021-2026 Ending the Epidemic Plan. The purpose of this process was to gain a better understand of gaps and needs related to addressing the HIV epidemic in Clark County. The aim of the plan is to continue to improve the already exceptional HIV prevention and care services offered within the Clark County community. Data collection for the needs assessment included both focus groups and surveys with a variety of stakeholders—persons at risk for HIV, people living with HIV, a wide range of healthcare and service providers, and providers-in-training. Nineteen HIV client and prevention focus groups were held in Clark County between March and June 2020, with 94 people participating. Four groups were specifically held for HIV positive individuals, while five groups were conducted with people at risk for HIV and which focused on HIV prevention. Three focus groups were conducted in Spanish to accommodate the Latinx/Hispanic community. Although we did not collect formal data on this demographic, some participants in the Latinx/Hispanic focus groups informed facilitators that they were undocumented workers. The prevention focus groups sometimes included people living with HIV/AIDS. Focus groups were conducted in HIV service offices, primary care clinics, social services offices, counseling centers, LBGTQ centers, bathhouses, medical schools, and universities. These locations enabled us to reach people living with HIV, racial minorities, those who abuse drugs, those who are housing insecure, transgender women, MSM, and those who have mental health issues.

HIV-positive individuals represented nearly half of the focus group participants (43%). The majority of participants were male (60%). Thirty percent of the participants were below the age of 34, and 25% were between the ages of 35 and 44. Participants were well-distributed among various ethnic groups. Forty-two percent of participants were Latinx/Hispanic, 35% White, 27% Black, 5% Asian, 4% Native American, and 9% multi-race or other. Nearly half of the participants (46%) indicated they were heterosexual; 34% gay/homosexual; 7% bisexual; 2% lesbian/homosexual 2% other; and 1% reported don't know. Sexual orientation and gender identity were asked to ensure a representative sample. Of particular note, 34% of participants identified as men who have sex with men, 11% were transgender individuals, 43% were people living with HIV/AIDS, and 22.3% identified as people who use injection drugs. Participants identified as one or more populations of interest on the focus group demographic form, see Table 5 for more details.

Table 5 |Clark County Community Focus Group Participants

Clark County Community Focus Group Participants Representation *		
Population	**Number**	**Percentage**
Men who have Sex with Men (MSM)	32	34.0
Transgender Individuals**	10	10.6
People living with HIV/AIDS (PWH/A)	40	42.6
Youth (13-34 years)	28	29.8
Black/African American	25	26.6
Latinx/Hispanic	39	41.5
Other Racial Minorities	20	21.3
People Who Inject Drug (PWID)	21	22.3
Housing Insecure***	15	16.0

*Participants identified as one or more of the following populations of interest on the focus group demographic form
**Transgender identified by gender on birth certificate differs from gender identity
***Defined as those who are homeless, housed in a rehab facility, using housing assistance, or live in weekly motels

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

Table 6 | Provider Focus Group Participants

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

Three surveys were administered between February and June 2020. The EHE Workgroup, which includes over 60 individuals from various organizations, was used to disseminate the surveys. As stated above, the EHE Workgroup includes individuals who work for local organizations that have strong ties to the targeted populations. These local organizations include HIV and primary care clinics and hospitals, local health districts, jails, bathhouses, bars, medical schools, human rights advocate groups, legal professionals, HIV service organizations, food banks, counseling centers, social services, universities, pharmaceutical companies, homeless shelters, and many more. The EHE Workgroup members shared the community engagement surveys with their organization's community email list serves, websites, and social media pages, including Facebook, Instagram, and Twitter. The community engagement survey was distributed every month from February to June 2020. The surveys were available in both Spanish and English, in order to reach the broader population. Paper copies of the survey were distributed to local organizations upon request. The Provider and Provider-in-Training Surveys were also distributed every month by EHE Workgroup members that worked in local clinics, hospitals, health professions schools, and healthcare training programs. The provider and provider-in-training surveys were primarily shared via professional email listserves and professional Facebook pages.

Table 7 |Needs assessment surveys conducted for the Clark County EHE Plan

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

The community survey was completed by 229 total Nevada respondents. The responses from 122 Clark County residents (53% of the total sample) were used for this situational analysis. Twenty-eight percent of the Clark County respondents were interested community members and another 28% were consumers of HIV prevention and care services. Other respondents included public health professionals, healthcare providers, and HIV service providers. Respondents between 25-34 years of age were most common (35%), followed by 20% ages 45-54 years; and 18% 35-44 years. With respect to gender identity, 46% identified as male; 38% as female and 13% as transgender. The sample of respondents included 55% White, 23% Black, 13% Asian/Pacific Islander, 17% other, and 1% American Indian/Native American. Ethnicity was asked

separately, to which 21% responded they were Latinx/Hispanic. Three quarters of the respondents had some college education or more. Thirty-seven percent of respondents reported being gay; 37% straight; 16% bisexual and 10% other. Two percent of the respondents were people who inject drugs (PWID). Sixty-three percent of the respondents were HIV negative, 32% were HIV positive, 2% did not know and 2% chose not to disclose.

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

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

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

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

Pillar One: Diagnose

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

With an estimated 21% of persons in Clark County living with HIV (one in five) unaware of their status, and only 41% of the county's population ever been tested for HIV (11% in the past year), there is great need for increased testing in Clark County.[1,27] In 2018, Nevada Behavioral Risk Factor Surveillance Survey (BRFSS) results showed the percentage who had ever been tested for HIV was just 22% among individuals aged 18-24 years.[31] More work is needed on this pillar, however; some strengths have been noted through the Integrated HIV Care and Prevention Plan (IHPCP) monitoring process. Capacity for rapid testing has increased in Clark County over the past several years, facilitated by Southern Nevada Health District's (SNHD) development and administration of a train-the-trainer (TOT) curriculum to train and certify staff at community-based organizations (CBOs) to provide rapid testing to high-risk populations. SNHD and several CBOs have also been active in promoting rapid testing through social media and other channels. Top needs for this pillar are for increased testing—universal testing, rapid testing, free or low-cost testing, discreet and convenient testing; increased awareness of the importance of HIV screening among the general public and high-risk populations; and a reduction of stigma related to HIV. Survey and focus group respondents mentioned the importance of normalizing HIV testing—to make it something that is routine—not something to be ashamed of nor to be feared. A majority of primary care providers reported that they only screen for HIV and STIs if requested or based on presenting factors, and a majority of providers reported they were unprepared to conduct three site STI testing or take a comprehensive sexual history. Less than a quarter of providers reported they had a policy in place that requires all patients to be screened for HIV. Barriers for diagnosis include stigma, a general lack of awareness of HIV risk, and lack of provider awareness around the importance of routinely screening patients.

Pillar One: Strengths

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

Pillar One: Needs

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

Pillar One: Gaps

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

Pillar One: Barriers

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

Pillar Two: Treat

30% of PWH in Clark County were retained in care in 2019.

While 86% of Clark County PWH retained in care had a suppressed viral load in 2019, the percentage of PWH who were retained in care was just 30%.[32] Improving retention in care will be key to ending the epidemic in Clark County. Linkage of newly-diagnosed individuals to high-quality care within 30 days of diagnosis could be improved as well, with just 72.3% of newly-diagnosed individuals linked to care within 30 days of diagnosis.[32] PWH found peer navigators to be helpful when learning where to find resources and information about HIV care. PWH also reported that their case managers were essential to their care. Focus group and survey respondents had mixed experiences with HIV care with equal amounts reporting positive and negative experiences accessing care. In addition to medical needs, PWH reported needing a variety of other resources and support such as financial assistance, housing, job rehabilitation, drug rehabilitation, transportation, and social support. Dental care, vision care, financial assistance, transportation, and peer support were some of the mentioned gaps in care. Poor experiences with medical providers, substance addictions, and fear were frequently mentioned as barriers to retaining PWH in care, as was HIV stigma. In addition, primary care providers and provider-in-training reported insufficient preparation for treating people living with HIV and those who are facing housing insecurity.

Pillar Two: Strengths

- 86% of PWH who are retained in care are virally suppressed.
- Peer-to-peer advocate programs have been put in place at SNHD and Community Counseling Center

Pillar Two: Needs

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

Pillar Two: Gaps

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

Pillar Two: Barriers

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

Pillar Three: Prevent

The rate of new diagnoses among Black males was 5 times higher than White males.

Disparities in new diagnoses of HIV are prevalent in Clark County. Black males and Black females have 5 times and 4.7 times the rates of new diagnoses than their White counterparts.[28] Latino males and men under 35 also are at high risk of infection in Clark County.[28] Men who have sex with men (MSM) have the highest rate of new diagnoses among the transmission categories. IDU are another group at higher risk. Common themes among the focus group and survey respondents included the need for comprehensive sex education in schools, as well as culturally and linguistically appropriate HIV education for Blacks and Latinos. PWID participants stressed the need for discreet information on testing, condoms, rehabilitation, and clean needles. Participants were in favor of ads, billboards, social media, community events, small groups, and programs in schools to increase community awareness of HIV. Increased access and knowledge of PrEP and PEP is another important strategy. A strength related to this pillar includes the trust people had in local community clinics and community organizations to provide them with messages about health. Another strength is the increase in available syringe services programs (SSPs) in Clark County through the installation of SSP vending machines. Lack of knowledge about PrEP and PEP was evident in community focus group and survey responses. Provider and providers-in-training reported a lack of knowledge on how to counsel and follow up with a patient requesting preventative therapies, such as PrEP and PEP. In addition, 30% of providers reported they would not recommend needle exchange to patients using intravenous drugs. Harm reduction is an important strategy to minimize HIV infection. Barriers to prevention efforts included stigma related to HIV and IV drug use, inaccurate information about HIV, and lack of funding for HIV prevention.

Pillar Three: Strengths

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

Pillar Three: Needs

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

Pillar Three: Gaps

- Consistent comprehensive HIV prevention education in schools statewide
- Curricula for provider and providers-in-training on PrEP, PEP, and when to recommend needle exchange services
- Improve access to HIV prevention materials, programs, and campaigns for a variety of cultures and languages
- Access to community-based testing for high risk populations
- Lack of discreet testing and harm reduction services
- Lack of convenient services
- Increase awareness syringe services programs
- Usage of condoms among high risk populations
- Knowledge and awareness of PrEP, PEP, and condoms availability in the community
- Access to PrEP and PEP
- Increase provider and community awareness of PrEP financial assistance program
- Services for homeless
- Universal testing in medical settings

Pillar Three: Barriers

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

Pillar Four: Respond

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

Pillar Four: Strengths

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

Pillar Four: Needs

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

Pillar Four: Gaps

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

Pillar Four: Barriers

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

PLAN TO END THE HIV EPIDEMIC IN CLARK COUNTY 2021-2026

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

The Clark County Plan to End the HIV Epidemic is largely based on the HIV Care Continuum, and following this framework, the first step is to identify and link anyone living with undiagnosed HIV to quality HIV care. Diagnosis is the first step in not only engaging an individual in care, but also in reducing community viral load and preventing further transmission. This plan will focus on one overarching goal for the Diagnosis Pillar: to diagnose all individuals with HIV as early as possible after infection. The activities for Pillar One focus on increasing access to routine HIV screening, particularly for higher-risk populations. These activities are focused on a group of nine Quick Care sites and five Federally Qualified Health Center (FQHC) sites, as well as the development of a targeted public awareness campaign focused on increasing awareness of the importance of HIV screening and available services. The diagnose pillar will focus on reaching populations at greatest risk, including MSM of color, people who inject drugs (PWID), and transgender women. This pillar also addresses boosting the knowledge and skills of primary care providers, particularly those in urgent care and FQHC settings, in order to increase the availability of HIV screening in these sites.

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

Key Strategies and Activities:

5) **By 2026, 85% of people living with HIV in Clark County will know their serostatus.**
   Baseline: 77.3%[27]
   a. Increased routine opt-out screenings in healthcare settings (E.R.s, quick care clinics, acute care, primary care, etc.) for patients at risk
   b. Develop a program to increase access to at-home testing kits that includes wrap-around services for those testing positive
   c. Implementation of targeted testing strategies among priority populations

d. Public awareness campaign with non-stigmatizing messaging that focuses on increasing testing and awareness of testing services, specifically targeting MSM of color, PWID, and transgender women.
e. Provider awareness campaign focused on improving primary care provider understanding of the need for HIV screening in primary care settings, as well as the provision of trainings to increase provider capacity for HIV screening

6) **By 2026, 55% of all people living in Clark County will have been tested for HIV at least once**.
Baseline 41.8%[1,31]
   a. Increased routine opt-out screenings in healthcare settings (E.R.s, quick care clinics, acute care, primary care, etc.) for all patients seeking care
   b. Public awareness campaign focused on increasing testing and awareness of testing services, specifically targeting MSM of color, PWID, and transgender women.
   c. Increased promotion of rapid testing sites
   d. Provider awareness campaign focused on improving primary care provider understanding of the need for HIV screening in primary care settings, as well as the provision of trainings to increase provider capacity for HIV screening and counseling for positive tests or recommendations for PEP and PrEP.
   e. Increase the number of certified and trained staff to provide rapid testing to high risk populations
   f. Increase the number of rapid tests conducted in Clark County by certified agencies
   g. Increase community awareness about location of rapid testing sites via websites including Nevada Division of Public and Behavioral Health, Southern Nevada Health District, and community partners

7) By 2026, at least 14 more clinics in Clark County will be routinely screening for HIV.
Baseline: The initiation and development of routine opt-out HIV screening will be supported at nine UMC Quick Care clinics during this five-year period. Additionally, five FQHC's in Clark County will be implementing routine HIV screening. None of these clinics are currently conducting routine screening.
   a. Increased HIV screening and re-screening among persons at elevated risk for HIV at University Medical Center (UMC) Quick Care Clinics. These nine sites will be working with the SNHD, UMC Wellness Center, and PAETC-NV to build clinic capacity in HIV screening over the next five years.
   b. Increased routine opt-out screening for HIV at Federally Qualified Health Centers (FQHC) in Clark County (based on new requirements for FQHCs to screen for HIV). Five FQHC's in Clark County received HRSA's Primary Care HIV Prevention Awards in the amount of $250,000 or more to support development of routine screening practices. These sites are: First Person Care Clinic, FirstMed Health and Wellness Center, Nevada Health Centers, Inc., Silver State Health Services, and SNHD. The PAETC-NV is working with the Nevada Primary Care Association to support these clinics in implementing routine HIV screening.
   c. Investigate support to implement HIV and STI screening at school-based clinics in Clark County. UNLV Student Health Center and Clark County School District school-based clinics would be ideal partners in HIV screening.

8) **Policy changes and their impact on Pillar One:** In addition to the above strategies and activities, this plan will address recommendations for changes and updates to state policies that have been highlighted as challenges in ending the HIV epidemic as they

currently stand. These policies are being evaluated by Silver State Equality and the Nevada Governor's Advisory Task Force on HIV Exposure Modernization.

a. **Nevada Administrative Code (NAC) 441A.800**- Testing of sex workers [state board of health R089-10]. This regulation, which mandates cervical swab testing for sexually transmitted infections (STIs), is outdated. Current standard of care for testing of individuals for gonorrhea and chlamydia trachomatis utilizes Nucleic Acid Amplification Test on properly collected urine, rectal and pharyngeal samples. This testing provides increased rates of sensitivity and specificity when compared to solely using cervical swabs for biologically female patients, or urethral swabs for biologically male patients.
b. **Nevada Administrative Code (NAC) 652**- This section of the administrative code applies to Medical Laboratories. This NAC and the corresponding NRS need to be revised to allow for medical providers to test off-site. This addition for HIV and Hepatitis C testing would be a step forward while removing barriers to testing such as access to testing limited to clinical facilities, stigma of testing, and more. By creating a new level of certification allowing currently licensed exempt labs under existing CLIA waivers to test in the community such as at community health events, community events, fairs, workshops, and other locations would expand access to testing for hundreds and possibly thousands of people at risk. This is done in many other states and works well. This change in policy would help increase access to testing and could identify new cases of both HIV and Hepatitis C. Under the existing NAC 652, CLIA waived/exempt labs can only test within their practice location or via a mobile unit. Mobile units are cost prohibitive for most agencies and clinics.
c. **Proposed change in legislation in support of Pillar One**- Mandate opt-out HIV and Hepatitis C screening be offered in all primary care, urgent care, and emergency department settings in Nevada. With the broad reach of these clinical settings, this mandate could significantly alter Clark County (and Nevada's) ability to identify people with previously undiagnosed HIV and link them to care, which is essential in slowing the spread of HIV. Other states have been successful with similar mandates, for instance, New York State passed legislation in 2017 that required all emergency departments to offer opt-out HIV screening for all patients seeking care in an emergency department. New York State is on the path to having zero new HIV infections. Patients seeking care in emergency departments, urgent cares, primary care clinics, and retail clinics should also be presented with information about HIV and Hepatitis C testing and provided testing under an opt-out approach. The availability and routine practice of screening tests at all clinical sites will simultaneously identify people living with disease and reduce stigma associated with screening. Patients with a negative test but who have ongoing risk for HIV infection should be provided information about HIV prevention (biomedical interventions for the prevention of HIV are over 99% effective when taken daily as indicated in conjunction with other safer sex practices).

d. **Proposed change in legislation in support of Pillar One-** Mandate continuing education for healthcare providers around HIV, viral hepatitis, STIs, sexual health, and social determinants of health. To end the HIV epidemic, Clark County needs all primary care providers to be conducting thorough, routine sexual histories with patients, and following up with appropriate STI and HIV testing and screening. As noted in the needs assessment, universal HIV screening is not yet being

implemented in all primary care sites. Increasing provider knowledge and comfort level around sexual history taking, STI testing, and HIV screening is needed in order to increase the availability of these services. There are many oral manifestations of HIV, which makes dental and other health professionals important allies in this work to end the epidemic in Nevada. A legislative mandate to require 1-2 hours of continuing education for the full range of healthcare professionals should include information on conducting a sexual health history, talking to clients about their risk for HIV and viral hepatitis, risk reduction, HIV prevention, opt-out testing for HIV and hepatitis, and screening for social determinants of health such as homelessness, substance use disorder, intimate partner violence, human trafficking and food insecurity. Not only should providers be educated about these issues, but this education should include information about how to provide the best care to a patient at risk for HIV, and the resources available in their community. This education should be tailored to the specific community where the provider practices.

e. **Nev. Rev. Stat. 201.205 -** Modernize HIV statutes that criminalize exposure or potential exposure to HIV and which undermine a state's public health efforts by deterring people from getting tested for HIV. Laws criminalizing the conduct of people living with HIV may disincentivize people most at risk for HIV from getting tested. This includes Black and Latinx/Hispanic MSMs, women, people that identify as LGBTQ+ and formerly incarcerated people. HIV modernization seeks to update current laws that target people living with HIV for prosecution and excessive punishment in an effort to make them solely responsible for the sexual risk behaviors of others. Many of these laws are based on decades old science and irrational fears of HIV. HIV Modernization is the modernization of current unwarranted use of criminal law to address a public health issue.

Pillar 1 Key Partners: FQHC's**,** Nevada Primary Care Association, Southern Nevada Health District (SNHD), Southern Nevada HIV Prevention Planning Group, UMC, UNLV, UNR Med/ Pacific AETC-NV, health professions schools and associations, Silver State Equality Institute, Nevada Advisory Task Force on HIV Exposure Modernization
Potential Funding Resources: SNHD EHE (CDC PS 20-2010), FQHCs receiving supplemental HIV screening/prevention funds (HRSA-20-091)
Estimated Funding Allocation: CDC PS 20-2010: $2 million per year for 5 years, HRSA 20-091: $1.28 million total
Outcomes (reported annually, locally monitored more frequently): The percent of people living with HIV who know their serostatus. Percent of people who have ever been tested. The number of clinics conducting routine screening.
Monitoring Data Source: Surveillance data, clinics reporting routine screening

PILLAR TWO: TREAT

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

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

Key Activities and Strategies:

1) **(Linkage to Care) By 2026, increase to 85% the percentage of people newly diagnosed with HIV who have been linked to a medical provider and had a medical visit within the first 30 days**
   Baseline: 72.3%[30]
   a. Increased early initiation of ART. Clinics implementing routine opt-out HIV screening will be trained in immediate linkage to care for persons testing positive. Several organizations already employ linkage navigators to assist people in linking with HIV care services.
   b. Increased awareness of regional patient flow chart that includes services and activities for HIV+ patients.
   c. Increase in improved communication between organizations with increased utilization of CAREWare referral system to coordinate intakes.
   d. RAPID stART linkage to care program links newly diagnosed individuals to clinical care within 72 hours of diagnosis. Implementation of RAPID stART community-wide with a specialized mobile team that will support clinics testing for, and treating, HIV. Currently partnering with UCSF, RWPA has held design meetings and is currently planning for Learning Session 1. UCSF collaboration is a three-year SPNS project through HRSA. RWPA will be hiring a RAPID stART coordinator, developing a data system compatible with CAREWare, developing a marketing campaign, and is developing plans for implementation.
   e. Ryan White Part A provides a case manager for new clients to review acuity and develop an individualized case or service plan. If housing is an issue, HOPWA or Ryan White EFA may be utilized to support that client. Additionally, the managed care organizations (MCO's) partner closely with various service providers and grant-funded programs to engage clients and provide services. Ryan White also offers support groups and classes (Chronic Disease Self-Management Program) that provide education, support and teach a variety of coping mechanisms. Several community-based organizations also provide mental health services.

2) **(Retention in Care) By 2026, 50% of people diagnosed with HIV will have had at least two medical visits each year, including CD4 count and/ or viral load test at least three months apart.**
   Baseline: 30.4% [30]

a. Increase delivery of 6-week Positive management program to HIV+ clients and chronic disease management through RWPA. This program also has a companion program, the Chronic Disease Self-Management Program. RWPA will be paying for peer navigators to become Certified Health Workers if they are associated with the RAPID stART initiative.

3) **(Viral Suppression) By 2026, 90% of people diagnosed with HIV who had >= 2 CD4 or viral load tests at least three months apart during the course of one year, will be virally suppressed (V.L. <200)**

Baseline: 85.9%[30]

a. Increased viral suppression among persons living with diagnosed HIV with the continual evaluation of the continuum of care to understand status and establish a baseline looking at viral suppression to identify patterns and match the patient exams attended and services accessed
b. Increase availability of medication management materials, support, educational programs and counseling for all patients at clinical HIV treatment facilities
c. Increase patient education around the importance of obtaining and maintaining an undetectable viral load, and the importance of the individual viral load in relation to the community viral load
d. Increase community education about community viral load data
e. Increase clinician education to conduct at least two viral load tests per year

4) **By 2026, increase re-engagement to HIV treatment services for PWH not in care**

Baseline: Data currently unavailable

a. Increased support to providers and clinics for re-engaging PWH in care and treatment
b. Increased immediate re-engagement to HIV prevention and treatment services for PWH who have disengaged from care. The SNHD Office of Epidemiology and Disease Surveillance (OEDS) attempts to re-engage those with a prior HIV/AIDS diagnosis through Out of Care efforts. The surveillance team has identified six priority groups for this effort.
    i. Priority 1 are those who had a reported STD in the last 365 days and are not on a previous Out of Care effort, as well as women who are out of care.
    ii. Priority 2 are those newly diagnosed or those who had a CD4/VL in the past two years but are not part of a previous Out of Care effort.
    iii. Priority 3 are those who have never had a CD4/VL reported and are not in previous Out of Care efforts.
    iv. Priority 4 are those who have been contacted for Out of Care in the past, yet refused Ryan White Part A care services.
    v. Priority 5 are those who were diagnosed after 2009 and were not successfully located in prior Out of Care efforts.
    vi. Priority 6 is anyone else who does not fit into the other five priorities.
c. Increase evaluation to identify clients who have fallen out of care on a biannual basis. The HRSA baseline for out of care is one year, however, best practice for medical appointments is twice a year at least three months apart. Therefore, a biannual clinic evaluation for those out of care would be a practical means by which to reconnect and re-engage patients. The SNHD has also been engaged in evaluating those out of care for many years. Historically, each year the Out of Care list is run and reviewed for moves, deaths, those in care but under a different system, and lab reporting issues. The remaining people are reviewed to

see if a disease investigator has attempted to locate them and engaged them in care. To further improve this process, a system could be developed to assist those who are resistant to returning to care, possibly utilizing telehealth or a quick care site specifically for people returning to care. This system could theoretically provide immediate, personalized service and reduce clinic flow issues that may arise.

5) **Policy changes and their impact on Pillar Two-** In addition to the above strategies and activities, this plan will address recommendations for changes and updates to state policies that have been highlighted as challenges in ending the HIV epidemic as they currently stand.
    a. **Nevada Revised Statutes (NRS) 201.205 and NRS 201.358**- A person who, after testing positive in a test approved by the State Board of Health for exposure to the human immunodeficiency virus and receiving actual notice of that fact, intentionally, knowingly or willfully engages in conduct in a manner that is intended or likely to transmit the disease to another person is guilty of a category B felony and shall be punished by imprisonment in the state prison for a minimum term of not less than 2 years and a maximum term of not more than 10 years, or by a fine of not more than $10,000, or by both fine and imprisonment.

    (NRS) 201.358- Engaging in prostitution or solicitation for prostitution after testing positive for exposure to human immunodeficiency virus. HIV criminalization is outdated and serves to reinforce stigma around HIV infection. With the 2011 clinical trials of the HPTN052 study, and continuing with the PARTNER, Opposites Attract, and PARTNERS 2 studies, there has been a substantial amount of data indicating that Treatment as Prevention (TasP) is a successful strategy in eliminating new HIV infections. In 2017, the CDC joined other federal agencies in an effort led by the US Department of Health and Human Services (DHHS) putting forth a message of Undetectable = Untransmittable (U=U). This strategy successfully demonstrates that when patients are engaged in care and have suppression of the HIV viral load for at least six months, there is “effectively no risk” of sexual transmission of HIV to an uninfected partner. Nevada currently still has laws that criminalize intentional transmission of HIV or working in prostitution after testing positive for HIV. This outdated law does not align with the current science around HIV risk of transmission. These laws must be revisited, given the new evidence about risk of transmission, and revised accordingly, to ensure Nevada laws are consistent with science. This policy would also help to erase the stigma that surrounds HIV infection, which is a significant barrier to testing and treatment and therefore to ending the epidemic.

    b. **Nevada Revised Statutes (NRS) 439.538 and Nevada Revised Statutes (NRS) 441A-** Limitation of the release of personal health information (PHI) for HIV. In this era of electronic health records (EHR), it is becoming increasingly challenging to "carve-out" any HIV / STI information from the record if a patient doesn't specifically consent to release. This makes it more difficult to encourage continuity of care across various systems and clinics to ensure patients stay in care for their HIV. This idea of carving out STI/HIV/mental health because of stigma makes it increasingly difficult to ensure that STI/HIV/mental health is addressed across the spectrum of care. Much of the current work in STI/HIV/Mental healthcare revolves around removing barriers. This legislation in the current format creates a barrier to

care that can be removed, while supporting the stigma associated with HIV, STI, and mental health issues.

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

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

Key Partners: UMC, SNHD, Huntridge Family Clinic, Ryan White Part A, Silver State Equality Institute, Nevada Advisory Task Force on HIV Exposure Modernization
Potential Funding Resources: HRSA Ryan White HIV/AIDS Program (RWHAP) EHE Funding, UMC Wellness Center Part C HRSA funding, Clark County Part A funding
Estimated Funding Allocation: RWPA: $850,000 for Year 1, unknown Years 2-5
Outcomes (reported annually, locally monitored more frequently): PWH continuum of care outcomes, Ryan White Part A number PWH who were reengaged in care and prevention
Monitoring Data Source: State of Nevada surveillance linkage data, RWHAP Careware

PILLAR THREE: PREVENT

The third pillar, Prevent, is not technically part of the HIV care continuum, however, a strong emphasis on HIV prevention will reduce the number of HIV cases and diagnoses, and therefore limit the number of people in the care continuum, which is ultimately the goal of ending the HIV epidemic. The Prevention Pillar focuses on reducing transmission of HIV through increasing evidence-based prevention practices such as condom distribution and use, pre- and post-exposure prophylaxis uptake, and use of syringe services programs. This pillar also includes reducing the transmission of STIs, primarily syphilis, as the presence of STIs increases HIV transmission. These activities will be aimed at high-risk populations, including MSM of color, people who inject drugs (PWID), and transgender women. Providers, pharmacies, and clinics will also be targeted for education and training around sexual history taking, HIV screening, and prescription of both PEP and PrEP. Additionally, SNHD and the NDPBH have developed PEP and PrEP materials for survivors of sexual assault.

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

Key Activities and Strategies:

1) **By 2026, reduce by 10% the rate of new HIV diagnoses (to 17.8 or 403 cases)**
   Baseline: 19.8 per 100,000 or 448 cases.[28] (Note- this goal of 10% takes into consideration the increased testing goals stated in the Diagnose pillar which, in all likelihood, will increase the positivity rate rather than reduce it initially.)
   a. Increase the number of primary care providers (family practice, gynecologists, urgent care providers), providers-in-training, and staff trained on PrEP and PEP. SNHD offers a PrEP/PEP online video series.
   b. Improve collaboration with Clark County School District and the Nevada Department of Education to implement comprehensive sexual health education in schools
   c. Increased community awareness around where to get tested for HIV.
   d. Increased community awareness about how to get condoms in Clark County, including information about SNHD's condom distribution plan and Medicaid support for condom purchase.
   e. Medicaid and Condoms: Created as an ad hoc committee of the Southern Nevada HIV Prevention Planning Group (SoN HPPG), this committee has been meeting to explore opportunities for Medicaid recipients to obtain condoms as part of their benefits. Both internal and external condoms can be acquired by recipients and are listed under "family planning". A prescription from a provider is required. The committee has been researching the products (condoms) that are available as indicated by National Drug Codes (NDCs), and the process by which providers and pharmacies can seek reimbursement through Nevada Medicaid and the most commonly used NDCs in claims. The committee plans on presenting its recommendations to SoN HPPG for SNHD to implement an educational campaign for providers, pharmacists, as well as clients. Additionally,

the ad hoc committee has some recommendation for collaborative practice agreements as well for providers and pharmacies. The scope and direction of these recommendations will be informed by the Condom Distribution Plan as well as the data that was collected for the Condom Distribution Plan (e.g. retail assessment and consumer survey).

f. Implement SNHD Condom Distribution Plan. The Condom Distribution Plan (CDP) is a project that initiated in Fall 2019 and completed in Summer 2020. This plan was developed to aid the NDPBH as well as local health departments with the goal of "ensuring that condoms are available, accessible, and acceptable to all communities in Nevada with a focus on priority populations chosen by Nevada's HIV prevention planning groups (HPPGs)." The elements of the plan are to: provide condoms free of charge, conduct wide-scale distribution, implement a social marketing campaign to promote condom use, conduct promotion and distribution activities at the individual, organizational, and environmental levels, supplement the CDP with more intense risk-reduction interventions and services, integrate distribution program activities within other community-level interventions, establish organizational support for condom distribution and promotion activities and conduct community-wide mobilization efforts. Additionally, the plan discusses the need for tracking and evaluation efforts by the HPPGs for the Local Health Departments (LHD).

2) By 2026, reduce to 20% the incidence of infectious syphilis among PWH in Clark County

Baseline: 36% of infectious syphilis cases are among PWH

a. Develop ability to track this metric through NDPBH
b. Provide STI trainings to primary care and HIV providers, encouraging routine sexual history evaluation and STI testing to determine PWH at risk
c. Develop resource guide for providers to use as referrals for STI specialists
d. Increase risk reduction and health education for patients to include STIs and the importance of screening and testing

3) By 2026, increase the percentage PrEP coverage in Clark County to 30%

Baseline: 14.1%[27]

a. Increased screening for PrEP indications among HIV-negative clients
b. Improve support to clinics who offer PrEP
c. Increased referral and rapid linkage of persons with indications for PrEP
d. Increased PrEP prescriptions among persons with indications for PrEP. Investigate programs such as California where pharmacies are PrEP providers.
e. Development of public awareness campaign focused on increasing PrEP uptake among high-risk populations including MSM of color, PWID, and transgender women.

4) By 2026, increase the number of access points to syringe services programs (SSPs) in Clark County to 10

Baseline: 7

a. Increased knowledge about the services and evidence-base of SSPs in communities through traditional and non-traditional educational venues
b. Increased access to SSPs through non-traditional methods of service delivery including mobile outreach, vending machines, secondary exchange, and others.

5) Policy changes and their impact on Pillar Three-

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

b. **Proposed change in City of Las Vegas policy-** In 2019, the Las Vegas City Council passed an ordinance which criminalizes homelessness. This policy punishes people who are homeless or underhoused by imposing a $1,000 fine or up to six months in jail. Many community advocacy groups oppose this policy as it creates yet another barrier for this marginalized population and does nothing to provide opportunities or resources to assist this group. As noted above, people who are homeless experience higher rates of HIV, mental health, and substance abuse issues.

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

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

Key Partners: Southern Nevada Health District, Nevada Division of Public and Behavioral Health, Trac-B Syringe Services Program, Clark County School District, Silver State Equality Institute, Nevada Advisory Task Force on HIV Exposure Modernization, Immunize Nevada, Clark County Medical Association, UNLV, Nevada State College, College of Southern Nevada, UMC Wellness, HRSA, Ryan White, healthcare providers
Potential Funding Resources: SNHD, NDPBH, CDC
Estimated Funding Allocation: TBD
Outcomes (reported annually, locally monitored more frequently): Number of new HIV diagnoses, number of new infectious syphilis among PWH, percent of PrEP coverage, and number of access points for SSP
Monitoring Data Source: State of Nevada HIV Surveillance data, SNHD surveillance data, CDC EHE indicators data, SAPTA

PILLAR FOUR: RESPOND

The last pillar, Respond, incorporates epidemiological surveillance into the Clark County Plan. Surveillance is essential in ending the epidemic through data management and contact tracing, particularly for outbreak response. In Clark County, the Southern Nevada Health District works closely with the Nevada Division of Public and Behavioral Health to manage HIV surveillance and response.

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

Key Activities and Strategies:

3) **Increase the capacity to identify and investigate active HIV transmission clusters and respond to HIV outbreaks by 2026.**
   Baseline: Data currently unavailable
   Note: The Enhanced HIV/AIDS Reporting System, eHARS, cannot consume molecular sequencing data; therefore, capacity building for these new technologies is currently at a standstill. Until this is resolved, progress cannot be made. The Nevada Division of Public and Behavioral Health is working to address this issue to be able to enhance surveillance technology in Clark County.
   a. Increased health department/community engagement for cluster detection and response. Clark County HIV Outbreak Response Plan is in process through SNHD, with updates occurring annually.
   b. Increased funding for EHARS staff to maintain SAS code.
   c. Improved surveillance data for real-time cluster detection and response. RWPA, NDPBH, and SNHD are developing a partnership with UCSD to support molecular surveillance. This process is extremely expensive and is dependent on future funding.
   d. Improved policies and funding mechanisms to respond to and contain HIV clusters/outbreaks
   e. Improved response to HIV transmission clusters and outbreaks
   f. Investigate programs and initiatives of other jurisdictions for ideas and lessons learned in surveillance
   g. Propose development of a statewide task force to explore development and use of molecular surveillance in other jurisdictions and its impact on the community, including mistrust, hesitations in testing, and fear of criminal implications.

4) **Policy changes and their impact on Pillar Four**
   a. **Proposed change in legislation in support of Pillar Four** –State laws that target people living with HIV for prosecution as a way to address public health concerns need to be modernized. Research has demonstrated that laws criminalizing HIV infection can undermine public health efforts and state plans to address HIV. These laws stigmatize those living with HIV and deter people from getting tested and knowing their status, measures which can thwart the transmission of HIV. Also, pertinent to this surveillance pillar, these antiquated laws may impact the

development of molecular surveillance practices in Clark County; thus, reducing the jurisdiction's potential surveillance capacity.

b. **Proposed change in testing policy in support of Pillar Four**- the World Health Organization is now recommending focusing HIV testing efforts on simpler, rapid point of care tests in lieu of traditional western blot and line immunoassay testing. These rapid diagnostic tests (RDTs) are less expensive, faster, and can be conducted by many different provider types, making facilitation of them easier as well.

Key Partners: SNHD and the Nevada Division of Public and Behavioral Health (NDPBH) Office of Public Health Investigations and Epidemiology (OPHIE)
Potential Funding Resources: NDPBH, SNHD
Estimated Funding Allocation: TBD
Outcomes (reported annually, locally monitored more frequently): Establishment of protocols for cluster detection and response procedures.
Monitoring Data Source: SNHD and OPHIE

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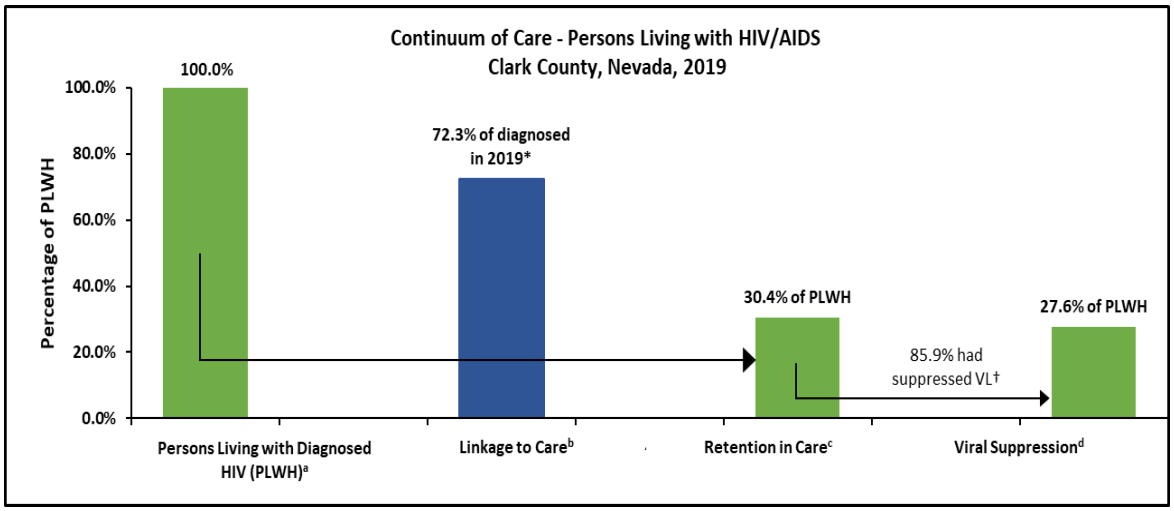
Appendix A:

2019 Clark County Continuum of Care



Data from Division of Public and Behavioral Health, HIV/AIDS Reporting System (eHARS), data as of March 2020.
‡Persons Living with HIV indicate any person regardless of HIV staging, including HIV stage 3 (AIDS).
aDefined as persons diagnosed with HIV infection (regardless of stage of disease) through year-end 2018, who were alive at year-end 2019.
bCalculated as the number of persons linked to care within one month after HIV diagnosis during 2019, divided by the total number of persons diagnosed with HIV infection in 2019. Linkage to care is based on the number of persons diagnosed during 2019, and is therefore shown in a different color than the other bars with a different denominator.

cCalculated as the percentage of persons who had ≥2 CD4 or viral load test results at least 3 months apart during 2019 among those diagnosed with HIV through year-end 2018 and alive at year-end 2019.
dCalculated as the percentage of persons who had suppressed VL (<=200 copies/mL) at most recent test during 2019, among those diagnosed with HIV through year-end 2018 and alive at year-end 2019.
†Calculated as number of persons who had suppressed VL (<=200 copies/mL) at most recent test during 2019, among those who were retained in care during

Appendix B:

Transmission Category of Persons Living with HIV/AIDS, 2019

Among the transmission categories of all persons living with HIV, MSM had the highest rate at 292.5 per 100,000, and comprised 65.6% of the total persons living with HIV. Among males only, the MSM rate increased to 585.2 and comprised 78% of males living with HIV in Clark County. Heterosexual contact of all persons living with HIV had a rate of 52.6 and comprised 11.8% of the persons living with HIV. Heterosexual contact among females living with HIV had a rate of 80.8 and comprised 57% of the females living with HIV. See Table 4 for more details.

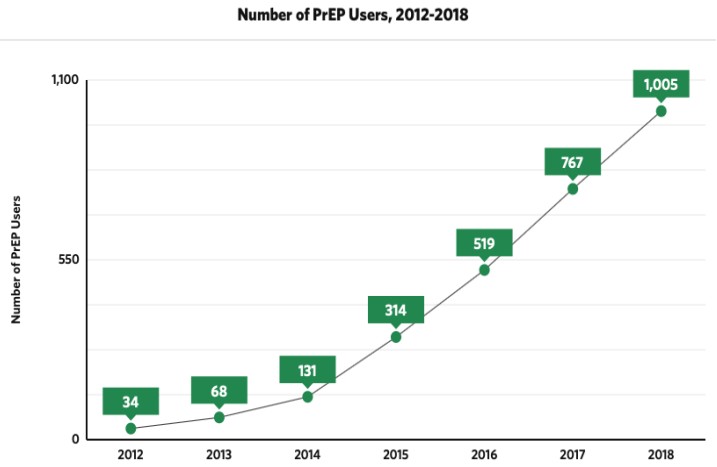
Transmission Category of Persons Living with HIV/AIDS, 2019

Transmission Category of Persons Living with HIV§ by Sex, 2019[a]									
Transmission Category	Total			Male			Female		
	N	Column %	Rate*	N	Column %	Rate*	N	Column %	Rate*
Male-to-male sexual contact (MSM)	6,631	65.6	292.5	6,631	78.0	585.2	-	-	
Injection drug use (IDU)	574	5.7	25.3	363	4.3	32.0	211	13.1	18.6
MSM+IDU	560	5.5	24.7	560	6.6	49.4	-	-	
Heterosexual contact	1,192	11.8	52.6	276	3.2	24.4	916	57.0	80.8
Perinatal exposure	68	0.7	3.0	30	0.4	2.6	38	2.4	3.4
Transfusion/Hemophilia	6	0.1	0.3	4	0.0	0.4	2	0.1	0.2
No identified risk (NIR)	1,079	10.7	47.6	639	7.5	56.4	440	27.4	38.8
Total	**10,110**	**100.0**	**446.0**	**8,503**	**100.0**	**750.4**	**1,607**	**100.0**	**141.8**

§Persons Living with HIV indicates any person regardless of HIV staging, including HIV stage 3 (AIDS), living in Nevada in 2019.
a Nevada Department of Health and Human Services, Office of Analytics, on behalf of the Division of Public and Behavioral Health [17]
*Rate per 100,000

Appendix C:

Number of PrEP users, 2012-2018[a]



[a] AIDSVu, Local Data: Clark County, NV[1]

In 2018, PrEP was being used by 1,005 people, and the rate of PrEP use was 57 per 100,000 population.[1] PrEP use in Clark County has seen a steady increase since 2012. See Figure 12 for more details. The majority of PrEP users, 94.3%, were male, and 5.4% of the users were female.[1] Eleven percent of PrEP users were between the ages of 13-24, 37.7% were 25-34, 28.6% were 35-44, 19.2% were 45-54, and 5.3% were 55+.[1] See figure 12 for details.

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