Errata to Proposed Regulation of the State Board of Health
LCB File No. R002-22 / Senate Bill 211 (BDR 40-563) Public Workshop
Monday, July 18, 2022 - 10:00 AM

Teams Teleconference

COMMUNITY MEMBERS PRESENT:
Victoria M. Young, Pacific AIDS Education Training Center
Jennifer Bennett, Pacific AIDS Education Training Center
Andre Wade, Silver State Equality
Linda Anderson, Esq., Nevada Public Health Foundation
Dr. Cheryl Radeloff, Southern Nevada Health District
Mona Lisa Paulo, LGBTQIA+ Community Center of Southern Nevada
John (Rob) Phoenix, Huntridge Family Clinic
Octavio Posada, University of California, San Francisco - Clark County Social Service, Office of HIV (Contractor)
Natalie Kuhner, Gilead Sciences
Hazel Gusman, University Medical Center (UMC)

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH STAFF PRESENT:
Tory Johnson, HIV/AIDS Program Manager
Lyell Collins, Health Program Specialist II
Preston Nguyen Tang, Health Program Specialist I
Caress Baltimore, Health Resource Analyst II
Yolanda Littleton, Accounting Assistant III
M. Gabriel Colbaugh, Program Officer I
Marques Thompson, Management Analyst I
Sarah Cowan, Health Program Specialist I

1. **Call to Order, Roll Call (10:03 AM)–** *Preston Nguyen Tang*

2. **Teleconference Etiquettes –** *Preston Nguyen Tang*

3. **Senate Bill 211 Summary and Public Workshop Overview –** *Preston Nguyen Tang*

4. **Written Testimony –** Preston Nguyen Tang
   Read written testimony from Huntridge Family Clinic; support for this legislation; Provide examples of missed opportunities within Clark County. (See Attached).

5. **Public Comment (10:29 AM) –** *Preston Nguyen Tang*
    - Linda Anderson, Esq. – Nevada Public Health Foundation, Foundation thanks the state for proceeding with these regulations. Linda believes the concern express by Board of Health what it means to be "medically indicated" is a concern for medical reimbursement. Suggest the state provide information regarding surveillance/diagnostic testing, what codes to bill, and what reimbursement is provided will assist facilities;
    - John Phoenix – Huntridge Family Clinic, During the initial legislative discussion the Nevada Osteopathic Medical Association provided a statement of opposition, and their statement is flawed in its logic. John quoted opposition statement regarding ER STD results will not be completed before conclusion of visit. This place the ordering physician in a situation where he/she is responsible for the results, even though they have left the facility. Emergency providers are in this relationship with hospital and have the mechanisms for providing results to patient after they are release from a hospital. Example includes patients presents with urinary tract infection - urine analysis culture for reflux doesn't return within 48-72 hours. There are structure and policy in place where hospital staff and/or provider contact the patient to inform patients of diagnostics test results and provide additional treatment options. Blood cultures or wound cultures are another example where results are not known until 48-72 hours. Other concern from the Nevada Osteopathic Medical Association was in regard to referral – Example is pregnancy test coming back positive. Standard of care would be to refer them to a gynecologist, but the argument doesn't relieve provider of the responsibility for following up. This could be applied to HIV/STD testing as well. Just because you are providing a referral, doesn't mean the patient is going to go. This bill talks about plan for referrals. Elevate level of concern. This strategy that can easily be in implemented, will help reduce infections, and engage patients in testing;
    - Andre Wade – Silver State Equality, in support of SB 211 and echo previous comments by attendees;
    - Jennifer Bennett – Pacific Education and Training Center Nevada, one comment in support of Rob Phoenix comment that any ER in opposition to screening in an emergency setting is that there is evidence of ERs across the country are taking this on and successful, even UMC in own state in which program is in place to do screening in ER and have been finding cases that supports finding cases in emergency setting;
    - Hazel Gusman – From University Medical Center (Nurse Navigator) – very successful with offering HIV Testing in all urgent cares, very successfully with opt-in testing in ER since December 2018. Support SB 211;
    - Dr. Cheryl Radeloff – SNHD, reading through meeting minutes for joint HIV prevention planning groups (HPPG) meeting, and identified both HPPG planning groups in support of SB 211 with a letter sent acknowledging support of SB 211.

6. **Adjournment –** *Preston Nguyen Tang*
   Meeting adjourned at 10:40 AM

Public Comment

ERRATA to LCB file# R002-22

I am writing this workshop committee to express my support of this legislative initiative. I also want the committee to be aware of my interest in helping to put this legislation into effect through participation in workshops and committees and possibly as a committee member on this issue.

I also have some questions/concerns about the workshop as posted.

1. The 3rd paragraph of page 2 starts with "current regulations do not outline…." I ask that the committee refer to the USPTF recommendations for HIV and Hepatitis C testing, level A recommendations for when these tests should be offered, and the population impacted under those recommendations.
2. At the end of that same paragraph, the statement "medically indicated" will create a barrier to patient access. Specifically, emergency department providers are not offering access to HIV, even when it is "medically indicated." Here are real-world examples of missed opportunities from the Clark County medical system.
    a. Your symptoms indicate that you have HIV, but we don't test for that at this hospital ED (newly diagnosed HIV patient when he presented for care at an Emergency Department in Las Vegas, NV, in 2021). This young man is living with HIV and thriving, despite being offered "medically indicated" testing and referral for treatment.
    b. You have "COVID" despite having negative COVID testing. This patient presented with all the symptoms of the acute viral syndrome, including rash, body aches, diarrhea, and weight loss, but was not offered HIV testing in a Las Vegas emergency department. This patient had two visits to the ED with different providers for the same complaint and was never offered HIV testing.
    c. A 23-year-old Black MSM who presented to 2 urgent care and had 2 ED visits for symptoms suggestive of HIV infection for over one month was only offered and tested for COVID. He presented to the Gay and Lesbian Center Sexual Health Clinic for HIV testing. His point of care testing was reactive for HIV. On his subsequent initial labs, his CD4 count is 41.
    d. A female patient presented to local urgent care two times for viral illness symptoms and sore throat. They were tested for strep throat with an office-based rapid strep, negative,

and treated with steroids and an injection for gonorrhea. They returned for a follow-up with continuing symptoms and were offered more steroids, but no offering of an HIV test or conversation about sexual health, despite being "medically indicated." She presented to the clinic for follow-up and had a positive HIV antigen/antibody by laboratory analysis.

e. Black bi-sexual males with over 25 visits to local medical clinics, urgent care, and ER use the same EMR for sexual health concerns (burning with urination, penile discharge, pharyngitis). Evaluated and treated for sexually transmitted infections such as gonorrhea and chlamydia by multiple providers in those 26 visits and NEVER tested for HIV. Further, in a review of his records, no documentation about a sexual health history was present. Fortunately, when he tested for HIV, it was negative. Therefore, BMSM has a 1:2 lifetime risk of HIV acquisition.
f. A 52-year-old Black man presented to a local emergency department multiple times over four months for abdominal pain, weight loss, and diarrhea but was never offered an HIV test. He regularly visited his primary care provider monthly for medication management for chronic pain and hypertension for several years. He had multiple orthopedic surgeries over the past three years while living in Las Vegas. When tested in the emergency department, that test identified that he was living with HIV. His initial response was, "so now I'm gay" because I HIV? He also insisted that he had been tested every time he had orthopedic surgery. On review of his past laboratory results, operative reports, pre-procedural history, and physical, there was no evidence of any testing for HIV. He was angry with the surgeons but failed to recognize that his PCP had also failed to test him as part of the USPTF guidelines recommending that everyone 15-64 should be tested at least once in their life for HIV.
g. Our clinic has six patients who are all newly diagnosed with HIV that had at least one visit to a local ED or Urgent Care and were told they had COVID but never offered an HIV test. All 6 had a positive point of care testing in our office during their initial clinic visit.
h. A 48 year Latino female presented to the ED with fever and body aches post a colposcopy at her GYN office. The colposcopy was performed due to the presence of High-Grade CIN on her annual PAP smear. Despite living most of her life in an area with a high prevalence of HIV among women, there was no conversation about the risk for HIV along with no offer of HIV testing. In the ED, her laboratory-based HIV test was reactive. She is thriving with HIV, undetectable, and her cervical cancer concerns are being adequately addressed following evidence-based guidelines for cervical cancer screening in women living with HIV.

When "medically indicated" statements are listed, evidence shows that the patient and the community fail to achieve the intended outcomes.

3. There is no mention in these workshop documents about testing for Hepatitis C or HPV, sexually transmitted infections that are increasing in prevalence throughout the US and especially in Clark County. Through our collaborative testing partnerships with local substance treatment facilities, we identified 46 Hepatitis C-positive patients during May. These numbers continue to increase as we expand access to testing.
4. In the fourth section of this document, you list the high rates of the different STIs in Nevada. While these numbers are alarming, their actual impact is understated and under-recognized in the medical community in Nevada. Here are examples of missed opportunities to test for syphilis, specifically in Clark County.
    a. 36-year-old male presents to a local Urgent Care on two separate occasions for a rash that started on his back, covers his chest and arms, and is on his palms and soles of feet. On visit one, he has prescribed steroids for an "allergic reaction." On visit two, which occurred one week later as a follow-up since the rash had not resolved, he was told it might be a fungal infection and had a very extensive physical exam of the rash using ultraviolet light. He also reported that the provider was not affirming his sexual health history, which caused the patient to disengage from the conversation. He presented to the clinic for follow-up. His initial test for syphilis was positive, and his initial titer was 1:16. He had tested in 2020 and was negative.
    b. The patient presents to a local ED for a rash on the palms of their hands, arms, and upper body. They were treated for an allergic reaction with steroid cream. A sexual health history and testing for HIV or syphilis were not performed. However, his initial syphilis test at our office confirmed a new secondary syphilis infection.
5. In item 1, anticipated effects on business and the general public, item A, this legislation can potentially decrease the stigma associated with STI testing and impact, in an affirming way, public access to testing for STI.
6. While not the original intent of this legislation, there is no mention in this workshop about HIV prevention education and access to condoms, biomedical interventions for HIV prevention, or counseling for person-centered counseling around opportunities to maintain their HIV-negative status.
7. In the May 2022 MCAC meeting, Preston Tang presented this legislation. As a committee member, my comments are on record about the provider and hospital's concern over testing costs and the perceived lack of reimbursement for testing in the ED. This concern is based mainly on the "bundled payments" that hospitals receive from insurance companies based on DRGs. Although Lyle Collins pointed out in the initial meeting conducted on SB211 earlier this year, no comments were raised about this; these are legitimate concerns expressed by providers and hospitals.
8. While not necessarily the workshop's intent, this legislation lacks real enforcement possibilities. In addition, although the bill addresses the respective professional boards responsible for

developing a response around non-compliance, there is nothing legislation supporting provider compliance.

9. While not necessarily the intent of this workshop, there is no mention of any educational component or requirement related to Sexual health history taking, gender-affirming, and culturally competent care provision around this sensitive topic. There is also no requirement for provider education, so providers provide the most current evidence-based education, testing, and treatment guidelines. Providers are still not following, in many cases, the revised STI testing guidelines released by the CDC in July 2021. For example, providers are consistently not administering the increased doses of ceftriaxone for gonorrhea and not prescribing doxycycline for chlamydia instead of the older recommendation of azithromycin. Providers are not offering three sites, or extragenital testing, for STIs. Providers are still collecting "clean catch" urine samples for STI testing, invalidating the results. STI testing that is urine based has to be collected as a first void or "dirty catch" sampling technique.

In closing, the items I am addressing in this letter to the committee highlight the missed opportunities this legislative initiative needs to address. Education to providers surrounding this critical and sensitive topic must be included if we are to make any meaningful impact in improving access to STI testing, which is a goal of this legislation. This legislation is an excellent first step toward the concept of STI. Enhancements in the future need to include conversations around strategies such as"getting to zero" for new HIV infections, "ending the HIV epidemic," preventing congenital syphilis, and stemming the tide of our STI epidemic in Nevada and across the globe.

Respectfully;

John Phoenix, MSN, APRN, FNP-C

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