

A large red ribbon symbol is positioned on the left side of the page, partially overlapping the text. The ribbon is a vibrant red color and is tied in a loop at the top, with two long tails hanging down.

Las Vegas

Transitional Grant Area (TGA)

Ryan White Part A

Comprehensive HIV/AIDS

Services Care Plan

2008 – 2011

**There are over 40 million people worldwide living with
HIV/AIDS and there is still no cure.**



Show you Care...Wear the Red Ribbon

*This Comprehensive HIV/AIDS Services Care Plan is dedicated to those who have
lost the battle to HIV/AIDS and to those who are still fighting to abolish it.*

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Letter of Concurrence

December 10, 2008

Dear Friends,

It is with great pleasure that we present to you the Las Vegas Transitional Grant Area (TGA) Three-Year Comprehensive HIV/AIDS Care Plan.

This plan was developed in accordance to HRSA rules and regulations and is a collaborative document developed in conjunction with Clark County, the planning council support staff and the Needs Assessment Committee all of whom we thank for their time and commitment to this project.

We welcome all interested parties to assist in ensuring the successful implementation of this plan over the next three years. This Three-Year Comprehensive Plan is a working document that will be monitored and evaluated on a regular basis.

Thank you for joining us in working to improve our system of HIV/AIDS Care and support services for those living with HIV/AIDS in the Las Vegas area.

Sincerely,

A handwritten signature in black ink, appearing to read "David Bond".

David Bond
Co-Chair

A handwritten signature in black ink, appearing to read "Jim St. Marie".

Jim St. Marie
Co-Chair

CONTRIBUTORS

This document is the product of countless hours and contributions from several individuals including; persons living with HIV/AIDS (PLWH/A), affected community members, Ryan White and non-Ryan White HIV/AIDS service providers, members of the Las Vegas TGA Ryan White Part A Planning Council, Planning Council Support Staff, and the Las Vegas TGA Ryan White Part A Grantee Staff, all of whom are dedicated to creating and coordinating the ideal health care system for people living with HIV/AIDS in the Las Vegas TGA.

The diversity of the Las Vegas TGA is reflected within this list of contributors. All contributors should be acknowledged for their diligence in this rewarding and inspiring process.

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INTRODUCTION

Our Planning Council

Members of the Las Vegas TGA Planning Council (Planning Council) are appointed by the Clark County Board of County Commissioners (BCC). Membership consists of 31 volunteer citizens, covering a three county geographical area of Southern Nevada and North-Western Arizona. The duties of the Planning Council, as specified by Federal law and grant requirements, include identifying service needs and gaps in service, prioritizing those service needs and allocating dollars to meet those needs. Additionally, the Planning Council is responsible for the preparation of a Comprehensive HIV/AIDS Care Plan, also known as a “road map” for improving HIV/AIDS care in the Las Vegas region.

The Planning Council is made up of representatives from various service providers and organizations, including; health care, social service, substance abuse and mental health, public health, health care planning agencies, housing and homeless services and community leaders. Furthermore, this body includes members of the infected and affected HIV/AIDS community, with 38% of council membership being consumers who currently access Ryan White funded services.

Comprehensive HIV/AIDS Care Plan

A Comprehensive Plan answers four distinct questions: 1) “Where are we now?” (What is our current system of care); 2) “Where do we need to go?” (What system of care do we want); 3) “How will we get there?” (What steps can we take to develop this ideal system and what strategies are needed to assure access to the system in order to eliminate disparities); and, 4) “How will we monitor our progress?”

The Comprehensive HIV/AIDS Services Care Plan presents long term goals and objectives to maintain, improve and strengthen the continuum of care that is responsive to the changing epidemic. Comprehensive planning development activities conducted include: examination and analysis of needs assessment data, existing resources (either Ryan White or non-Ryan White) funded to meet those needs, service gaps, barriers to care, and ensuring that the planning process is consistent with the Statewide Coordinated Statement of Need (SCSN). Through this process we will incorporate strategies that produce tangible benefits that will help enhance program implementation and maximize the use of existing funding streams, resulting in increased efficiency in service delivery.

The Las Vegas Transitional Grant Area (TGA) developed a Comprehensive Care Plan for fiscal years 2002 – 2008, which was updated in 2005. The original plan has been rewritten to encompass the current continuum of care, future plans for the TGA, new methodology for meeting goals, and innovative techniques for evaluating and monitoring the progress of the TGA.

Process for Development of the 2009-2012 Comprehensive HIV Services Care Plan

The process of updating the Comprehensive Plan is one that extended over several months and involved multiple meetings, trainings and discussions.

The Planning Council and Grantee received training on the HIV Continuum of Care, where members discussed the existing Comprehensive Services Plan's strengths and weaknesses. The training entitled "Strengthening the HIV Continuum of HIV Care" was provided to the Planning Council, Grantee Staff, Members of the Community, and all Ryan White and Non-Ryan White service providers. This provided a friendly atmosphere for fostering positive discussion between all parties, allowing various view-points to be heard, bridging many service gaps and communication barriers that once prevailed.

These sessions were held in early June 2008. New members of the Planning Council were trained on roles and responsibilities and encouraged to participate in the comprehensive planning process as a way to learn more about the overall system of care.

In late October the Needs Assessment Committee, in conjunction with the Grantee, held a two-day meeting to develop goals and objectives designed to enhance the overall system of medical care and support services. In addition, methods for evaluating the plan were also discussed.

The plan was developed in conjunction with the 2009 Nevada Statewide Coordinated Statement of Need (SCSN). The HIV/AIDS Comprehensive Care Services Plan was approved by the Las Vegas Planning Council on December 23, 2008.

The Planning Council is aware of and takes into account the numerous aspects affecting access to services and barriers in care relating to PLWH/A. Great strides have been taken with our community partners to identify the specific needs and barriers in the TGA with a variety of methods, including; a Nevada Statewide HIV/AIDS Services Assessment in 2007, an Out-of-Care Project (conducted by the Southern Nevada Health Districts Early Intervention Services team (EIS)), an annual Summit for clients and providers, and a targeted needs assessment that is currently in progress which incorporates a focus group(s) component for PLWH/A to divulge relevant unidentified issues.

Included in this plan is a thorough assessment of the data, methodology, forums, and community input that has influenced the development of service improvement goals for the Las Vegas TGA.

EXECUTIVE SUMMARY

The Ryan White HIV Treatment and Modernization Act (RWHTMA) is Federal legislation that was developed to address the unmet health needs of persons living with HIV/AIDS (PLWHA). It does this by funding primary health care and support services that enhance access to and retention in care. It was first enacted by Congress in 1990 as the Ryan White Comprehensive AIDS Resources Emergency Act. It was amended and reauthorized in 1996 and 2000. In 2006, it was renamed as the RWHTMA. Federal funding for these critical services has been granted to Clark County since 1998. The Act provides for significant local and State control of HIV/AIDS health care planning and service delivery, which has led to many inventive and practical approaches to the delivery of care.

The Las Vegas Transitional Grant Area (TGA) consists of Clark County, Nevada, Nye County, Nevada and Mohave County, Arizona. One of the fastest growing communities in the southwest, this region has an estimated population of 2,231,657.¹ This represents an increase in population of 43% since the 2000 Census.² Nye County represents the smallest population of the TGA counties at an estimated 2007 population of 45,737, and is located an hour and a half drive from Las Vegas. Mohave County is a minimum of a two hour drive to Las Vegas and represents 204,122 of the overall TGA population. Clark County (aka Las Vegas) has an estimated 2007 population of 1,981,798.³

The Incidence and Prevalence of HIV/AIDS in the Las Vegas TGA for the period of January 1, 2006 to December 31, 2007, as submitted by the Nevada State HIV Surveillance Program is fifty-seven (57%) of the 4,976 living AIDS cases are White, twenty-four (24%) are Black and sixteen (16%) are in the Hispanic community. The prevalence of HIV cases in 2007 reflects a similar pattern, with fifty-five percent (55%) of the HIV cases being in the White community, twenty-four percent (24%) in the Black community and seventeen percent (17%) represented in the Hispanic community. Of note is the percentage increase in the Hispanic community of both HIV and AIDS prevalence. Over the period of 2006 to 2007 the prevalence of HIV cases in the Hispanic population increased by 10%, and by 8% in the AIDS prevalence category.

HIV and AIDS prevalence in the TGA can be characterized as being primarily in the MSM, IDU and MSM/IDU categories (53%, 10%, 5% of HIV prevalence respectively in 2007 and 62%, 15%, 8% of AIDS prevalence respectively in 2007). In addition to the transmission mode most represented in the prevalence cases in the TGA, we also see that the HIV/AIDS prevalence is an increasingly aging population. Fifty-eight percent of the HIV prevalence in the TGA in 2007 was found in the age categories between 30 to 50 years old. AIDS prevalence followed a similar trend with 69% of the cases being in the 30-49 age grouping. Calendar year 2007 saw 82% of the HIV prevalence in the male population with 86% of the 2007 AIDS cases represented in the male category.

While the TGA's prevalence numbers present a picture of the cumulative cases in the TGA, incidence numbers present a peek into the future of the epidemic in the TGA. Over the course of

¹ State of Nevada and State of Arizona Demographers

² US Census Bureau

³ State of Nevada Demographer

the 2006 and 2007 calendar years, the TGA saw emerging trends related to transmission mode and race/ethnicity. In 2007 Whites represented 48% of new AIDS cases. Blacks and Hispanics represented 26% and 20% of new AIDS cases in 2007. Of significant note is the increase in these categories from 2006 to 2007, with an increase in new HIV cases of 11% in the White community and 19% in the Black community. New AIDS cases saw an increase of 19% in the White community and 26% in the Black community. The Hispanic community saw a decrease in both HIV and AIDS cases, 3% in new HIV cases and 2% in new AIDS cases.

The demographic make up of the out of care population (n=1,259) reinforces the needs of the emerging populations in the TGA. Of the 1,259, Whites represented 49% and Blacks accounted for 26% of the cases. Hispanic out of care cases were at 23%. More alarming is the transmission mode of the out of care cases. Men who have Sex with Men accounted for more than half of the out of care cases (57%; n=719). Injecting Drug Users and MSM/IDU accounted for 20% of the cases (n=257). Taken as a whole seventy-seven percent (77%) of all out of care cases fall in the MSM, IDU, and MSM/IDU cases.

This year the TGA participated in the Statewide Coordinated Statement of Need process in which the following needs were discussed:

Core Service Needs:

- Additional medical and nursing providers.
- Increased Mental Health and Substance Abuse services.
- Consumer friendly hours of operation.
- More locations of providers and core services with emphasis on rural areas.
- Creation of a stable infrastructure for core services.
- Early Intervention Services including testing sites and private physicians offering HIV testing as a part of routine care.

Support Service Needs:

- Increased number of support service providers, non medical case managers and educators.
- Education to reduce the stigma of HIV and knowledge of early intervention services.
- Transportation services particularly for rural areas of the state.
- Creation of a stable infrastructure between providers and funding organizations to provide support services.
- Access to services for the homeless population.
- Consumer friendly hours of operation.

The process also revealed several issues that affect both maintenance and access to care for those who know their status and are not in the system. These issues include:

- a fragmented service system,
- lack of access to care (which included issues from basic transportation, to service hours that did not go beyond 8AM - 5PM Monday through Friday), and
- lack of knowledge about HIV/AIDS medical services.

A review of TGA-specific care and treatment needs discusses the results of the Planning Council's consumer needs assessment surveys, which indicate the top Service Gaps to include: 1) A system of HIV/AIDS care that is difficult to navigate; 2) transportation; 3) housing; and 4) a lack of compassion among service providers.

The Planning Council has identified an ideal continuum of care for the Las Vegas TGA. In conjunction with the Clark County Part A Grantee, the ideal continuum of care works on a model of disease management that focuses on making services accessible to clients who need a variety of support and medical services in order to manage their HIV disease through all stages of the illness. This comprehensive plan is client focused and designed to create a seamless continuum of care that meets needs and facilitates entry and maintenance in HIV treatment services. The ideal continuum of care includes Part A services and other funders of HIV/AIDS services such as Medicaid, Medicare, the Veterans Administration, and Housing Opportunities for Persons living With AIDS (HOPWA), Substance Abuse and Mental Health Services Agency (SAMHSA), and other Ryan White Programs including Parts B, C, D and F. In order to effectively meet the diverse and complex medical and psychosocial needs of those living with the virus in the Las Vegas TGA, the ideal continuum of care also includes additional sources of support such as faith-based and other for and not-for-profit agencies.

The major goals of the 2009-2012 Comprehensive HIV/AIDS Services Care Plan are:

GOAL 1: To Ensure a seamless system of HIV/AIDS care that is available and accessible for PLWHA in the Las Vegas TGA based on the disease management model.

GOAL 2: To ensure a high quality client centered service system designed to address barriers to access and adherence to care.

GOAL 3: To reduce disparities in the access and availability of services for special and emerging populations.

GOAL 4: To ensure continuity and quality of core medical and support services that meets or exceeds Public Health Standards (PHS) and other industry standards.

GOAL 5: To understand and address unmet need.

GOAL 6: To ensure that Las Vegas TGA's Planning Council conducts its activities efficiently and effectively and that it fulfills all mandated roles and responsibilities.

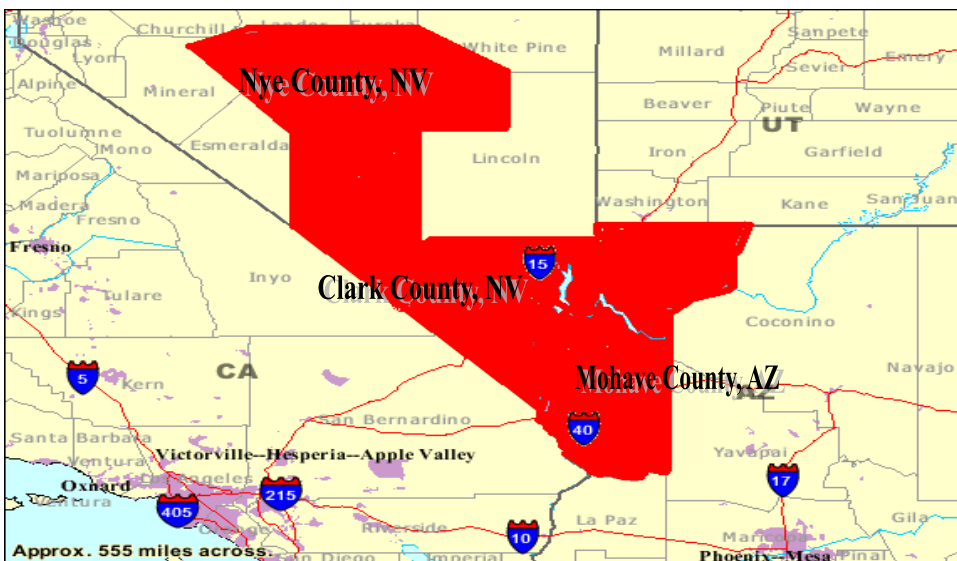
The Planning Council intends to use this document as a roadmap for HIV/AIDS planning and service delivery in the TGA for the next three years. Part of the process to make this a living document includes periodic assessments by the Executive Committee of the Planning Council to review progress in achieving the goals of the plan semi-annually. This process is designed to demonstrate the council's commitment to implement, monitor and evaluate a plan to create a better system of care for people living with HIV and their families within the next three years.

SECTION I: WHERE ARE WE NOW?

DESCRIPTION OF THE LAS VEGAS TGA

The Las Vegas TGA is comprised of three counties; Clark and Nye Counties in Nevada, and Mohave County, Arizona, covering a vast area of 39,368 square miles that crosses state borders.

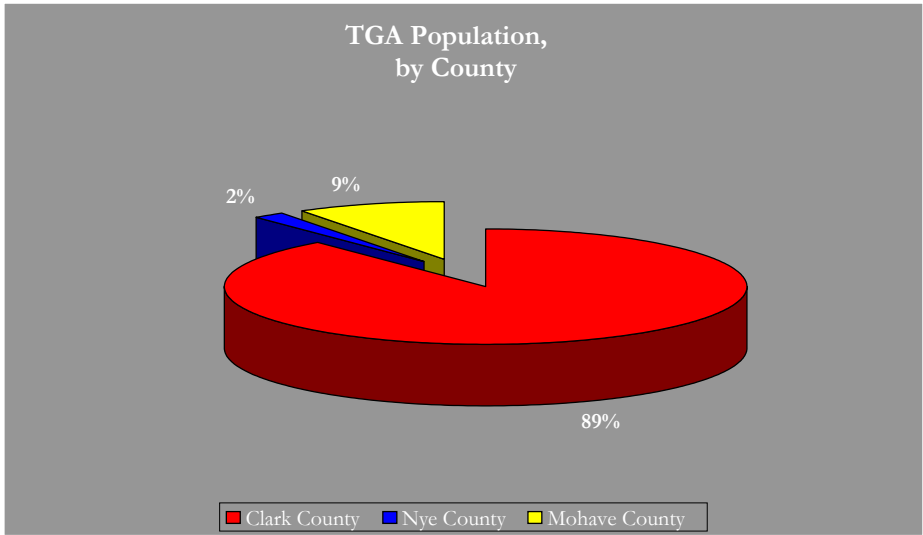
The Area We Serve



The Las Vegas TGA has an estimated population of over 2 million. Nye County, an hour west of Las Vegas, has the smallest population with an estimated 45,737 residents. Mohave County has a population of 204,122 and is located two hours south of Las Vegas. The largest population in the TGA is Clark County with an estimated 1,981,798 residents which represents 89% of the TGA population. Las Vegas, located in Clark County, is the fastest growing metropolitan area in the United States with an increase of almost 5,000 new residents each month and a current population of 1.7 million. Las Vegas was voted American City of the Year in 2007 for its commitment to improving the quality of life of its residents through innovative leadership. Table 1.1 depicts the percentage of total population for each county in the TGA.

Table 1.1 Current Population by County

Comment [t1]:



The State of Nevada and Arizona Demographer population estimates indicate that the population of the TGA in 2007 is almost evenly represented by males (51%) and females (49%). Whites represent 59%, or 1,307,854 of the population; Blacks 8%, American Indian/Alaskan Natives 1%, and Asian/Pacific Islanders 7%. Hispanics represent 25% (565,553) of the TGA's population.

EPIDEMIOLOGICAL PROFILE

Current Local and State Epidemic

The incidence of AIDS and Prevalence of HIV/AIDS in the Las Vegas TGA are high. According to the 2007 State of Nevada Surveillance Data, the TGA had 499 new cases of HIV and 296 new cases of AIDS. Nevada and Arizona State Health Division's HIV/AIDS prevalence as of December 31, 2007 for the TGA is 8,483 cases (3,507 HIV and 4,976 AIDS) documenting a considerable upswing from the total of 7,356 in 2005 and 8,018 in 2006.

Table 1.2 Epidemiological Profile

Demographic Group/ Exposure Category RISKS REDISTRIBUTED	AIDS Incidence in 2007. AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified, data as of 04/05/07		AIDS Prevalence Estimate (excl DOC) through 2007 as of 04/05/07. AIDS prevalence is defined as the number of reported living AIDS cases		HIV (not AIDS) Prevalence Estimate (excl DOC) through 2007, as of 04/05/07. HIV prevalence is defined as the number of reported living HIV (not AIDS) cases	
Race/Ethnicity	#	% of Total	#	% of Total	#	% of Total
White, not Hispanic	141	48%	2,846	57.2%	1,940	55.3%
Black, not Hispanic	78	26%	1,204	24.2%	855	24.4%
Hispanic	60	20%	791	15.9%	579	16.5%
Asian/Pacific Islander	12	4%	30	0.6%	24	0.7%
American Indian/Alaskan Native	3	1%	44	0.9%	34	1.0%
Not Specified/Other	2	1%	61	1.2%	75	2.1%
Total	296	100%	4,976	100.0%	3,507	100.0%
Gender	#	% of Total	#	% of Total	#	% of Total
Male	249	84%	4,258	85.6%	2,878	82.1%
Female	47	31%	718	14.4%	629	17.9%
Total	296	100%	4,976	100.0%	3,507	100.0%
Age at Diagnosis (Incidence) / Current Age (Prevalence)	#	% of Total	#	% of Total	#	% of Total
0-12 years	1	0%	25	0.5%	26	0.7%
13-19 years	5	2%	21	0.4%	66	1.9%
20-49 years	249	84%	4,220	84.8%	3,118	88.9%
50+ years	41	14%	710	14.3%	297	8.5%
Total	296	100%	4,976	100.0%	3,507	100.0%
Adult/Adolescent AIDS Exposure Category	#	% of Total	#	% of Total	#	% of Total
MSM	201	68%	3,085	62%	1,870	54%
IDU	26	9%	757	15%	353	10%
MSM/IDU	14	5%	381	8%	188	5%
Heterosexual	40	14%	483	10%	374	11%
Other	14	5%	245	5%	696	20%
Total	295	100%	4,951	100%	3,481	100%
Pediatric AIDS Exposure Categories (Ages 0-12)	#	% of Total	#	% of Total	#	% of Total
Mother with/at risk for HIV infection	1	100%	25	100%	26	100%
Risk not reported/Other	0	0%	0	0%	0	0%
Total	1	100%	25	100%	26	100%

Source: Nevada and Arizona State Health Divisions 04/05/07

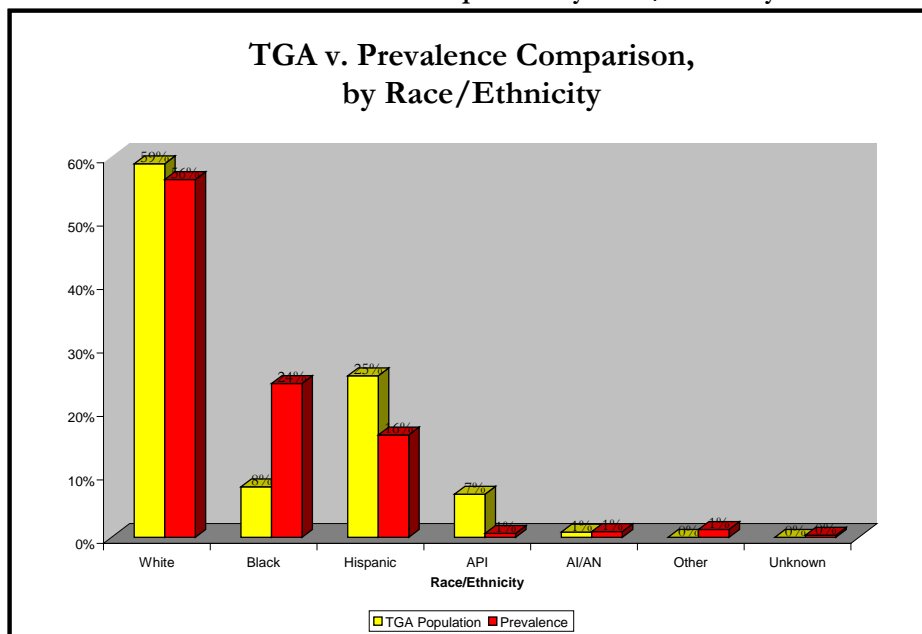
Prevalence

RACE

As identified in table 1.3, 59% of the 4,976 living AIDS cases are White, 24% are Black and 16% are Hispanic. The prevalence of HIV cases in 2007 reflects a similar pattern, with 55% of the HIV cases being in the White community, 24% in the Black community and 17% represented in the Hispanic community.

A comparison of the demographic prevalence of HIV/AIDS to the demographic profile of the general population in the TGA indicates disparity. An analysis, by race, documents that while Blacks account for 24% of the TGA's HIV/AIDS prevalence, they represent only 8% of the TGA's general population. Table 1.2 presents a comparison of the HIV/AIDS demographic prevalence (Nevada State Health Division's HIV Surveillance Program) to the TGA population.

Table 1.3 TGA v. Prevalence 2007 Comparison by Race/Ethnicity

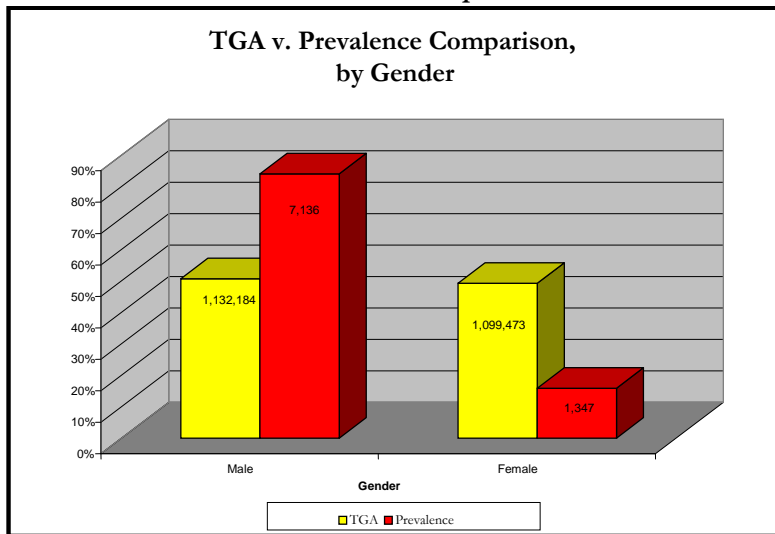


Of note is the percentage increase in the Hispanic community of both HIV and AIDS prevalence. During 2006 and 2007 the prevalence of HIV cases in the Hispanic population increased by 10%, and by 8% in the AIDS prevalence category.

SEX

Men represent 84% (7,136) of HIV/AIDS prevalence, but only 51% (1,132,184) of the entire population of the TGA. Conversely, Women represent 16% (1,347) of HIV/AIDS prevalence and 49% (1,099,473) of the TGA population as seen in table 1.4.

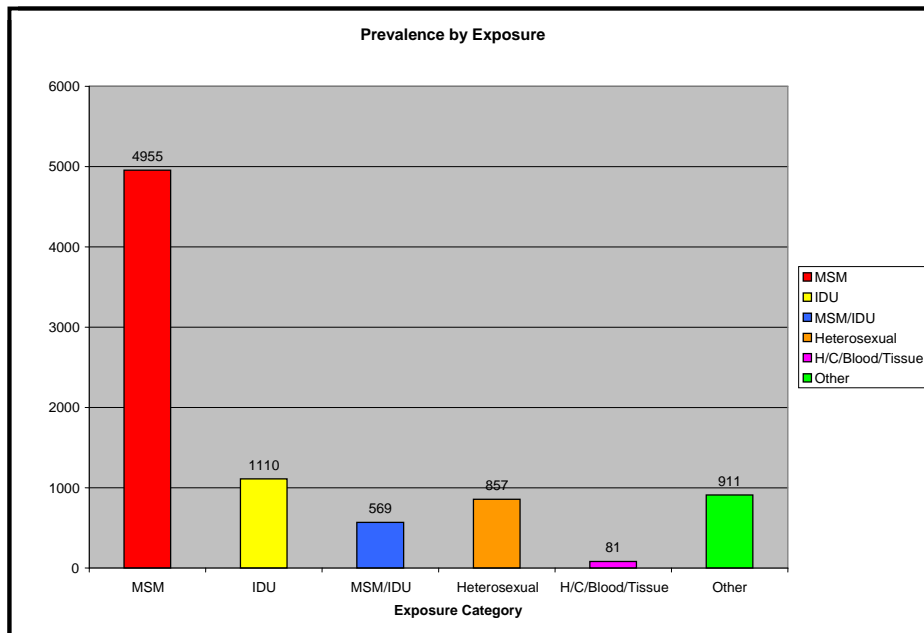
Table 1.4 TGA v. Prevalence 2007 Comparison



EXPOSURE CATEGORY

The exposure categories related to HIV and AIDS prevalence in the TGA can be characterized as being primarily Men who have Sex with Men (MSM) with a current prevalence of 58% (4,955). The second leading exposure category is IDU at 13% (1110) followed by Heterosexual contact at 10% (857). The current MSM/IDU prevalence for 2007 is 6% (569) and the other category at 10% (911).

Table 1.5 2007 HIV Prevalence by Exposure Category



Comment [t2]: Shayla please Rename Graphic "Prevalence by Exposure Category" and change term "Transmission" to Exposure Category at the bottom of the graph

Incidence

Incidence may be defined as the number of new cases diagnosed from January 1, 2007 – December 31, 2007. While the TGA's prevalence numbers present a retrospective picture of the cumulative cases in the TGA, incidence numbers, (as indicated in table 1.6), present an invaluable tool to estimate the future course of the epidemic in the TGA.

Table 1.6 2006 and 2007 HIV/AIDS Incidence

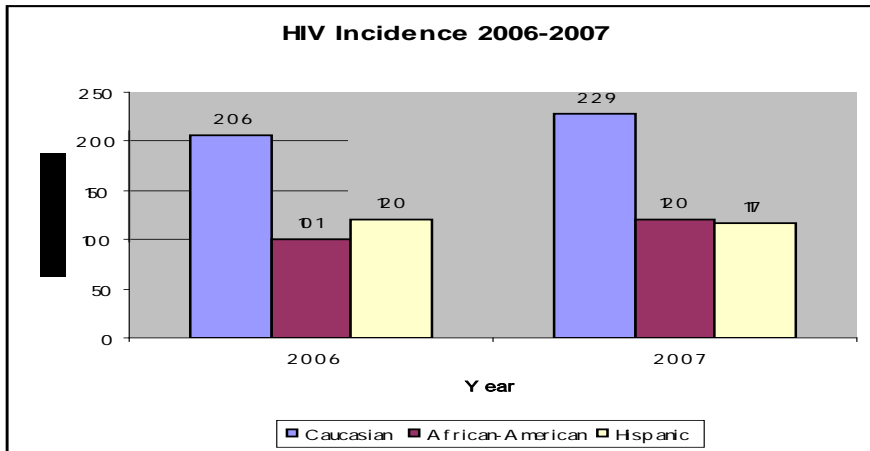
Demographic Group/ Exposure Category RISKS REDISTRIBUTED	AIDS INCIDENCE				HIV INCIDENCE			
	2006		2007		2006		2007	
	#	% of Total	#	% of Total	#	% of Total	#	% of Total
Race/Ethnicity								
White, not Hispanic	118	47%	141	47.6%	206	44.3%	229	45.9%
Black, not Hispanic	60	24%	78	26.4%	101	21.7%	120	24.0%
Hispanic	61	24%	60	20.3%	120	25.8%	117	23.4%
Asian/Pacific Islander	9	4%	12	4.1%	22	4.7%	18	3.6%
American Indian/Alaskan Native	0	0%	3	1.0%	2	0.4%	4	0.8%
Not Specified/Other	1	0%	2	0.7%	14	3.0%	11	2.2%
Total	249	100%	296	100.0%	465	100.0%	499	100.0%
Gender								
Male	211	85%	249	84.1%	405	87.1%	410	82.2%
Female	38	31%	47	15.9%	60	12.9%	89	17.8%
Total	249	100%	296	100.0%	465	100.0%	499	100.0%
Age at Diagnosis (Incidence) / Current Age (Prevalence)								
0-12 years	1	0%	1	0.3%	3	0.6%	3	0.6%
13-19 years	0	0%	5	1.7%	6	1.3%	6	1.2%
20-49 years	214	86%	249	84.1%	396	85.2%	415	83.2%
50+ years	34	14%	41	13.9%	60	12.9%	75	15.0%
Total	249	100%	296	100.0%	465	100.0%	499	100.0%
Adult/Adolescent AIDS Exposure Category								
MSM	157	63%	201	68%	292	63%	323	65%
IDU	31	13%	26	9%	32	7%	34	7%
MSM/IDU	9	4%	14	5%	17	4%	24	5%
Heterosexual	18	7%	40	14%	19	4%	85	17%
Other	33	13%	14	5%	102	22%	30	6%
Total	248	100%	295	100%	462	100%	496	100%
Pediatric AIDS Exposure Categories (Ages 0-12)								
Mother with/at risk for HIV infection	1	100%	1	100%	3	100%	3	100%
Risk not reported/Other	0	0%	0	0%	0	0%	0	0%
Total	1	100%	1	100%	3	100%	3	100%

Source: Nevada and Arizona State Health Divisions 04/05/07

RACE

In 2007 Whites represented 48% of new AIDS cases. Blacks and Hispanics represented 26% and 20% of new AIDS cases in 2007. New HIV cases increased from 2006 to 2007 of significant note is the increase in these categories from 2006 to 2007, with an increase in new HIV cases of 11% in the White community and 19% in the Black community. New AIDS cases saw an increase of 19% in the White community and 26% in the Black community. The Hispanic community saw a decrease in both HIV and AIDS cases, 3% in new HIV cases and 2% in new AIDS cases. The availability of testing and prevention efforts has remained constant during this time. Two theories have been proposed, 1) prevention efforts are working, and 2) historically the Hispanic population in Las Vegas has been especially transient as they are the highest population working in the service sector. With the economic downturn in recent years many service industry jobs have been eliminated which could have resulted in a great number of the Hispanic population relocating to other states.

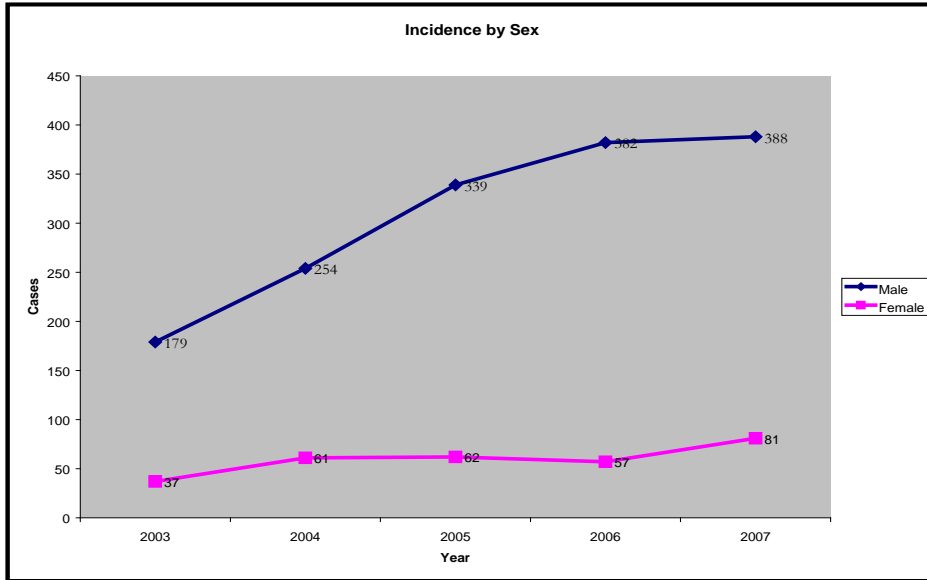
Table 1.7 HIV Incidence 2006-2007 by Race/Ethnicity



SEX

Comparable to trends in HIV/AIDS Prevalence Men are infected at a much higher rate than Women. In 2007, 83% (659) of HIV/AIDS incidence in the TGA were Men while 17% (136) were Women. As depicted in table 1.8 it is evident that men are infected at a much more rapid rate than women in the TGA.

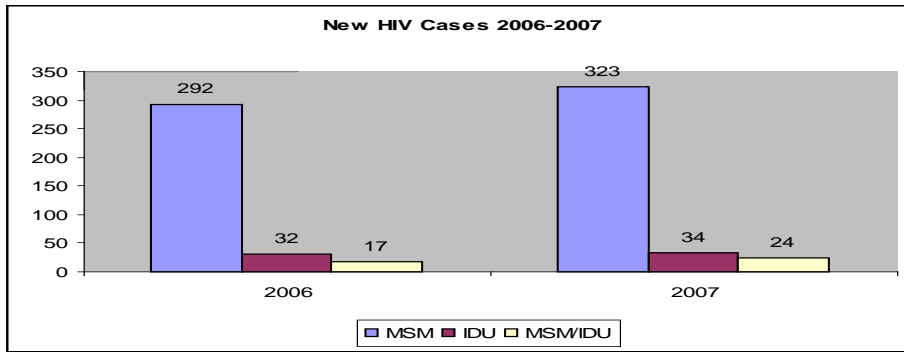
Table 1.8 Incidences 2003-2007 by Sex



EXPOSURE CATEGORY

New HIV and AIDS cases by transmission mode provide another picture that requires significant analysis. In 2007 the MSM population represented 65% of the new HIV infections in the TGA. This was an increase of 11% over 2006 rates. New AIDS cases in 2007 indicated that 68% of new cases were in the MSM population. This represented an increase in the number of new AIDS cases in the MSM population of 28%. The IDU population saw historical patterns of representation in the new HIV and AIDS cases. The MSM/IDU population saw the greatest increases among new HIV and AIDS cases. In 2007 the MSM/IDU population represented 5% of new HIV cases. While small in general number, the percentage of MSM/IDU cases increased by 41% from 2006 to 2007. New AIDS cases for this population over the same period of time represented an increase of 56%.

Table 1.9 New HIV Cases 2006-2007 by Exposure Category



Heterosexual transmission also saw huge jumps in the representation of new HIV and AIDS cases. Over the course of 2006 and 2007 the number of new HIV cases in this population increased by 347%, with the number of new AIDS cases jumping by 122%. While the overall representation of this transmission grouping is at 17% for new HIV cases in 2007 and 14% of new AIDS cases in the same period, the jump in new infections represents a significant trend in the TGA.

AGE

The TGA saw an increase of 34% in the 40 and over age categories within new HIV cases. New AIDS cases increased by 35% from 2006 to 2007. The age representation of the newly infected population indicates that individuals in the TGA are becoming aware of their status at a later age. The number of new HIV cases during 2006 and 2007 for individuals age 49 and over increased by 25%. New AIDS cases in the same time frame increased by 21% in this age group.

Transmission Mode and Age Group

HIV/AIDS incidence is an increasingly aging population. Fifty-eight percent of the HIV prevalence in the TGA in 2007 was found in the age categories between 30 to 50 years old. AIDS prevalence followed a similar trend with 69% of the cases being in the 30-49 age grouping. Calendar year 2007 saw 82% of the HIV prevalence in the male population with 86% of the 2007 AIDS cases represented in the male category.

As denoted in table 1.9, new HIV and AIDS cases by transmission mode provide another picture that requires significant analysis. In 2007 the MSM population represented 65% of the new HIV infections in the TGA. This was an increase of 11% over 2006 rates. New AIDS cases in 2007 indicated that 68% of new cases were in the MSM population. This represented an increase in the number of new AIDS cases in the MSM population of 28%. The IDU population saw historical patterns of representation regarding new HIV and AIDS cases. The MSM/IDU population saw the greatest increases among new HIV and AIDS cases. In 2007, the MSM/IDU population represented

5% of new HIV cases. While small in general number, the percentage of MSM/IDU cases increased by 41% from 2006 to 2007. New AIDS cases for this population over the same period of time also represented and increase, of 56%.

CO-MORBID FACTORS

The Impact of Sexually Transmitted Infections and Co-morbidities

PLWH/A have a compromised immune system leaving them more susceptible to co-infections with other diseases. Co-infections in PLWH/A can lead to resistance, limited and slow response to medications and treatment for HIV and co-infections.

Chlamydia and Gonorrhea

According to data provided by the Southern Nevada Health District (SNHD) the number of Chlamydia cases in Clark County increased by 784 from CY 2006 to CY 2007. This rise from 6,580 to 7,364 represents a 10.6% increase. Gonorrhea cases in Clark County decreased slightly from CY 2006 (2,472) to CY 2007 (2,118).

Tuberculosis (TB)

The Nevada State Health Division Tuberculosis (TB) Program indicates the co-morbidity of Tuberculosis and HIV, in the State of Nevada, was 4 in 2006 and 6 in 2007. The State of Nevada saw 101 new cases in 2006 and 102 cases in 2007. The majority of these cases, 90.2%, were in Clark County. The Hispanic community represented 36.6% of the TB infections and the Asian population ranked second highest at 31.4%.

Syphilis

According to the Nevada State Health Division Communicable Disease Program, in 2006, Nevada ranked 4th nationally for the rate per 100,000 of new primary and secondary syphilis cases, and 1st for the rate per 100,000 of new congenital syphilis cases. Clark County ranked 18th nationally among counties for the rate per 100,000 of new primary and secondary syphilis in 2006. The Syphilis outbreak in Southern Nevada appears to be two parallel epidemics, one among heterosexual Black, non-Hispanic persons and another among White, non-Hispanic men who engage in male to male sexual contact (MSM). In 2007, Nevada had an HIV and primary/secondary syphilis co-infection rate of 41.4 % among men and 0.0 % among women, 97% of co-infected men reported being MSM. Over 70% of the persons co-infected with HIV and primary/secondary syphilis in 2007 were non-Hispanic, while Blacks, though only accounting for roughly 7% of the population in Nevada, represented 27% of the new co-infections. Whites accounted for 51% of the new co-infections, the largest percentage of the cases based on race.

Hepatitis

In January 2008 the Southern Nevada Health District (SNHD) reported three new Hepatitis C cases to the Center for Disease Control (CDC) which caused great concern because they typically report four or fewer cases in an entire year. Further investigation found that all 3 persons underwent procedures at the same endoscopy clinic within 35-90 days of illness onset. A laboratory investigation revealed the Hepatitis C virus (HCV) transmission likely resulted from reuse of syringes on individual patients and use of single-use medication vials on multiple patients at the clinic. At that time approximately 40,000 patients of the clinic were notified of their possible exposure to any blood-borne pathogen. Currently six new infections of HCV in Clark County have

been linked to that endoscopy clinic and the investigation is ongoing. SNHD reported that Clark County saw 42 incidents of Hepatitis in 2006 and 45 incidents in 2007.

COST AND COMPLEXITY OF TREATMENT

The cost and complexity of the co-morbid infections facing the TGA and the social-economic factors that contribute to their transmission present significant challenges to the identification and treatment of co-infected individuals.

Impact of STD's and Co-morbid Factors on Cost and Complexity of Treatment

The Henry J. Kaiser Family Foundation's Women's Health Policy Program conducted an extensive research project entitled; "The Direct Medical Costs of STDs in the United States". It is estimated that in 2007 the direct cost for treating STDs and their complications in the United States was \$8.4 billion. This number does not include; non-medical indirect costs, lost wages and productivity due to STD-related illness, out-of-pocket expenses, costs incurred when transmitted to infants (which could include life long expenditures), nor does it include STD prevention or screening. The economic impact of STDs results in a high level of cost in terms of pain, suffering and grief. If left untreated, many can lead to chronic pain, infertility and tubule pregnancies which can affect a woman's health and well-being throughout her lifetime. Despite advances in treatment and prevention at least one in three Americans will get an STD in their lifetime and the United States continues to have the highest STD rates of any country in the industrialized world.

The State of Nevada has approximately 84,200 new cases of STDs annually resulting in a direct medical cost of approximately \$46.2 million. The cost of treating bacterial and viral STDs is looked at separately due to the fact that treatment of bacterial STDs most often results in a cure and is relatively inexpensive. The average cost of treating a bacterial STD, per case, ranges from \$75 for trichomoniasis, to \$80 for Chlamydia or gonorrhea, and up to \$1,386 for syphilis during primary or early latent stages. The treatment of viral STDs, per case, is more expensive and varies greatly. An episode of genital warts costs approximately \$446, the average cost for treating Hepatitis B is \$668 but can range anywhere from \$210 up to \$25,400 depending upon the severity of liver damage, and the cost of treating a person with HIV/AIDS, if they visit their health care provider at least once every six months, is approximately \$20,000 on average. A survey included in the study also revealed that only 28% of men and 34% of women in the United States disclose their STD status to their current or most recent partner.

Substance Abuse Prevalence in Nevada and the Cost of Treatment

According to the Nevada's Division of Mental Health and Developmental Services' Substance Abuse Prevention and Treatment Agency, Nevada had the 15th highest rate of "any illicit drug" use in the United States in 2004, with 8.68% of the population dealing with substance abuse issues. In 2004, Nevada's youth (12-17) ranked 23rd in the country for illicit drug use (11.27%).

According to the State of Nevada's HIV Surveillance Program, self identified injection drug users accounted for 15% of all prevalent HIV cases in Nevada, while they represented 23% of all prevalent AIDS cases. IDU cases represented 12% of all new HIV cases in 2007. Of the new AIDS cases in Nevada for 2007, 14% were self identified injection drug users. These rates of co-morbid conditions exceed the overall rates of substance abuse in Nevada.

Drug use among the HIV/AIDS population in the TGA, and in the TGA as a whole, is an increasing problem when available substance abuse treatment resources are reviewed in Nevada. According to The Substance Abuse Prevention and Treatment Agency, there were 112,034 individuals seeking treatment who could not receive services in 2006.

In 2006 the average wait for admission to a substance abuse treatment agency was 24 days. This required wait for services poses the problems of relapse, the continuation of risky behaviors in order to feed a person's drug habit and rejection of the notion of treatment altogether. These possibilities increase the likelihood of infection with HIV and/or the continued failure of the individual to treat and manage their HIV disease.

The Nevada Substance Abuse Prevention and Treatment Agency (SAPTA) estimates the cost for outpatient substance abuse treatment services ranges between \$10,000 and \$15,000 per client, per year. Estimates are between \$35,000 to \$50,000 for inpatient substance abuse services. Using the estimates for outpatient services costs, to fully fund the 20% of the individuals with a self-identified IDU transmission mode (1,679), over 25 million dollars would need to be allocated to the substance abuse treatment category alone. Based on 2007 service utilization data and resource allocation determinations by the Planning Council, only \$76,755 in Ryan White Part A funds are allocated to substance abuse treatment, and only 7.5% of the active clients in the TGA access these services. For just the 7.5% of the cases that are accessing substance abuse services through Ryan White providers, an accurate funding level would be \$1,875,000.

Mental Illness in Nevada and the Cost of Treatment

According to the Nevada State Division of Mental Health and Developmental Services, 2004 saw total spending for mental health treatment in Nevada at \$126,626,590. This equates to a per capita spending level of \$56.73 per person. The same report indicates that a total of 30,086 individuals received treatment in 2004, with a rate of 12.46 people per 1,000. Using these figures, a total of 24,693 individuals in the Las Vegas region received treatment for mental health issues. Of the total number of people in treatment in Nevada in 2004, 66% received services funded with Division of Mental Health and Developmental Services, 20% received services through Medicaid, and 13.9% received services funded through a combination of Medicaid and other sources.

Applying these figures to the HIV/AIDS prevalence figures for 2007 in the TGA, 680 individuals living with HIV/AIDS in the TGA suffer from mental illness. Utilization data from the TGA's client level data management system indicates a client population for mental health services at 239 in 2007. In total, 441 individuals infected with HIV/AIDS went without needed mental health services. This fact takes on a more important nature when one realizes that the number of clients accessing mental health services declined 25% from 320 clients in 2005 to 239 in 2007.

Homelessness

The impact homelessness has on the system of care in any jurisdiction is colossal because it taxes every sector of public services, from law enforcement to public healthcare systems. Homeless individuals present the public health care system with a multitude of challenges, ranging from being able to provide basic healthcare, mental health and substance abuse services to assistance as simple and straightforward as nail care. The 2007 Southern Nevada Homeless Census and Survey estimated that 11,417 individuals were homeless in Clark County. Of these, 27% reported having been homeless for a year or more. The African American population has a high prevalence of homelessness, accounting for 33% of the homeless population.

Specific to the TGA funded healthcare system, homelessness takes on a more hidden nature. Roughly 9% of the clients registered in the TGA's client level data management system, WebCIM (client level data tracking system), list no address. These individuals are often episodically homeless, having no physical address they can call home. These clients often live with friends, or at times perfect strangers. These situations can lead to having to trade sex for shelter, the sharing of IV drugs and paraphernalia, and prostitution in order to generate income for food and medical care. These activities greatly increase the potential spread of HIV/AIDS in the community. The TGA's system of care is designed to assist these at risk individuals through the provision of housing assistance, food bank assistance and access to education regarding the nature and management of their disease.

Unemployment Rate

Lack of sustainable income and the inability to provide for themselves accounts for a significant number of new Ryan White eligible clients entering the system. According to the Nevada Department of Employment, Training and Rehabilitation, Nevada's unemployment rate has hit a 23-year high, registering at 7.1% in August of 2008 leaving roughly 90,000 people out of work. This figure has risen significantly from the 6.6 % it rose to in July of 2008.

Industrial employment in Nevada grew by 2,000 jobs in August of 2008 from the preceding month, however, employment remained 8,500 jobs lower than the employment level from August 2007. The population growth in Nevada, particularly Clark County, is still strong which leads to a continual increase of the labor pool without a corresponding increase in jobs, this lethal combination ensures unemployment rates will continue to rise.

Persons without Health Insurance Coverage

Nevada and Arizona have low health insurance coverage rates for their residents. For 2005, Nevada was 44th in the nation with about 19% of the residents being uninsured. For 2005, Arizona ranked 40th overall in the U.S. in lack of health insurance with 17% having no health insurance. For Nye County, the total number of uninsured was almost 15%. Being uninsured is more common in certain population groups in the Las Vegas TGA, as indicated below:

- **Persons of Hispanic Origin:** The number of Hispanics who are uninsured is 33% of the total Hispanic population of Clark County. This represents an increase from 32% of Clark County residents of Hispanic origin in 2003. According to the 2004 US Census, Hispanics are three times less likely to have health insurance coverage.
- **The Working Poor:** The working poor are defined as 100% to 200% of the Federal Poverty Level (FPL), and are the fastest growing uninsured group, making up 127,000 of the almost 400,000 uninsured Nevadans.
- **Women of Childbearing Age:** While there are more uninsured men than women, uninsured women are a faster growing group than men. This takes special consideration, since Nevada has the highest pregnancy rate in the country. Women of reproductive age pay 68 percent more in out-of-pocket medical expenses than men, largely due to their reproductive health-care needs. Pregnant women need prenatal care to ensure they and their babies remain healthy, but without insurance, most are not getting the care they need.

PLWH/A at or below 300 percent of the 2006 Federal Poverty Level

The number of clients registered in WebCIM that are at or below 300 percent of the FPL is 1,325. This number represents 88% of clients registered in the database who are registered to receive Part A funded services. The proportion of all known/reported PLWH/A in Arizona who are at or below 300% of the FPL is 97%. All of the PLWH/A receiving Part A funded services from the Mohave County Department of Public Health are living on less than 300% of the FPL in Mohave County.

Nevada State Medicaid and Medicare Impacts

Medicaid is limited to those who can meet the program's definition of disability and other program rules. Not everyone who has a disability is eligible for Medicaid. Many people with disabilities are not disabled or poor enough to qualify for Medicaid. Nationally, of the 25 million people under age 65 who have specific, chronic disabilities, 20% or less are covered by Medicaid. In Nevada, less than 10% are covered by Medicaid per State of Nevada Medicaid. Nevada is 51st in the nation for per capita expenditures over the last decade on Medicaid. Less is spent on Medicaid in Nevada than any other state in the country, yet it has one of the highest uninsured rates. The following is an overview of the Medicaid/Medicare coverage in Nevada (Nevada Medicaid Office):

- Medicaid covered 14% of the U.S. population; but only 8% of Nevada residents;
- Medicare covered 12% of the U.S. population; but only 11% of Nevadans;
- 10% of U.S. ADAP clients have Medicaid coverage; 0% of Nevada ADAP clients do;
- 18% of U.S. ADAP clients have private coverage; only 11% of Nevada ADAP clients do;
- and
- 73% of U.S. ADAP clients are uninsured while 89% of Nevada ADAP clients are uninsured.

The Complexity and Cost of the Recently Released Incarcerated Population

The Status of HIV and AIDS in Nevada Correctional Facilities 2006 report, developed and published by the Nevada Department of Corrections (NDOC), placed the number of individuals with HIV and AIDS in the state's correctional system at 139. Of these cases, 107 cases were in the male population, with 32 cases being female inmates. Fifty-two of male cases are White, 45 were Black with the remaining 10 males cases being representative of the Asian and Hispanic populations. The female population of HIV and AIDS stood at 19 White and 14 Black, with no other race/ethnicities being represented in 2004.

The majority of the male cases are housed in Northern Nevada, where they receive care services at the system's Regional Medical Facility (RMF). All of the infected female inmates are housed in southern Nevada, at Southern Nevada Women's Correctional Center. Upon release, inmates are asked where they would like to be returned i.e., northern Nevada or Southern Nevada. The vast majority of the inmates return to the jurisdiction of arrest. According to the NDOC report, 67% of the inmates have an official county of arrest as Clark County Nevada.

The issues surrounding the treatment and support of these newly released clients in the TGA care system is complex. Newly released clients have multiple barriers to access and adherence to treatment regimes. Mental health diagnoses, substance abuse issues, higher than average rates of co-morbid STI's are just a few of the barriers. Homelessness upon release, unemployment and a lower than average educational level amplifies the barriers to accessing care. When a released client is able to access care services, treatment regimes and courses of treatment differ greatly than what was available inside the correctional medical system. Medication adherence is no longer a matter of

timely visits to the RMF, but is left up to the individual client to remember to take their medications at appropriate times. Similar to the homeless population, the cost of care for recently released clients is very time and cost intensive.

A review of the TGA data management system indicates that the average newly released client accesses a higher number of services on a more frequent basis. Costs are estimated to be four times more than the average TGA client.

EMERGING POPULATIONS

Emerging Populations as Noted by Service Providers

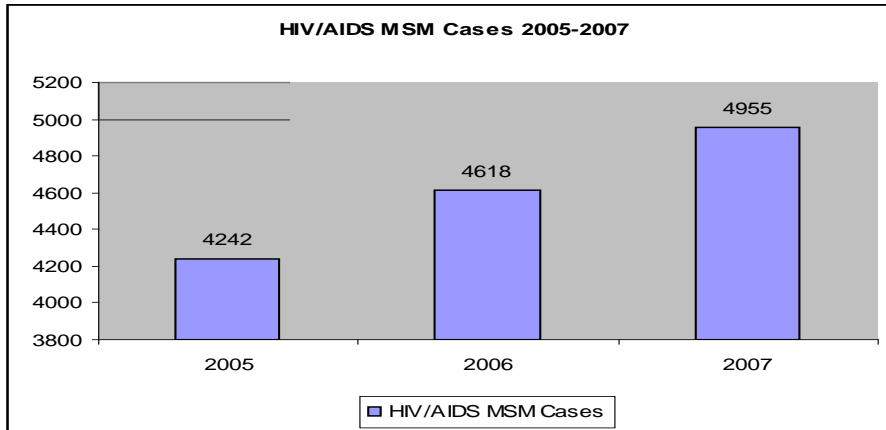
In addition to the populations identified in the discussion of incidence, of the fourteen currently funded Ryan White Part A service providers we asked, in a confidential online survey, "What new emerging issues or trends have you identified in your client population?" An overwhelming number of providers responded that they have seen an increase in the HIV positive female IDU client population, the underinsured and uninsured client population, and the number of clients who have no support system or encouragement outside of the provider. The report of these new and emerging trends was reported in November of 2008 so more research, focus groups and surveys will be conducted in these populations to uncover the underlying reasons for these trends.

Providers also revealed that they are seeing an increase in the number of people who need assistance with food, including vouchers and food pantries. There is an increase in demand for co-pays for medical visits, requests for rental assistance and mortgages, and power bills. These emerging needs can be attributed to the economic state of America. With the unemployment rate at 7.1% in Nevada, more people are losing stable employment and are unable to find replacement jobs. Without an income to provide for the basic necessities of life, clients are turning to providers for assistance but even they have hit economical hardships.

Men Who Have Sex With Men (MSM)

The number of men who have sex with men that are HIV/AIDS infected in the Las Vegas TGA is continuing to rise at a faster rate than any other sub-population. According to the HIV/AIDS surveillance data reported by the Nevada State HIV Surveillance Program for 2007, MSM infected with HIV represented 65% of all new cases in 2007. MSM represented 68% of all new AIDS cases in the same year. In 2007, MSM represented 53% of all cases of HIV infection reported to be in the TGA. MSM AIDS cases represented 62% of all prevalent AIDS cases in 2007.

Table 1.10 MSM HIV/AIDS Cases from 2005 to 2007



Over the same period, the Las Vegas client data management system, WebCIM, indicated that MSM receiving services in the TGA's system of care decreased by 47%. This decrease in service utilization is in direct opposition to the increased demand in the TGA's top three service categories; Ambulatory Outpatient health services, Early Intervention Services and Medical Case Management. The decrease in MSM utilizing the services of the TGA system of care, and the increased infection rates can be explained by several factors.

Apathy in the MSM population

Considerable literature has pointed to an increased feeling of apathy in the MSM community. Beliefs that HIV is no longer a "death sentence" because of the availability of HIV/AIDS medications has been cited as one reason for increasing infection rates in this population. The fear of contracting HIV no longer serves as a deterrent to participating in risky sexual practices. The literature indicates that this feeling of apathy is particularly strong in the younger MSM population, who has grown up in a world characterized by multi-drug cocktails, and the lack of visual reminders of the effects of HIV on a person's health status. When combined with the natural feeling of invincibility a younger person has, the results are deadly.

Lack of Knowledge regarding the Availability of HIV related Services

The results of a client forum conducted by the Planning Council and the TGA Grantee staff in January 2007 provided valuable insight into the client population's view of the HIV services system in the TGA. Over half of the respondents to the client survey indicated an overall lack of knowledge of services provided in the system of care. Thirty-five percent indicated that they first accessed services by looking in the phone book or by word of mouth. This data indicates that services available to individuals infected with HIV/AIDS are not well known in the community. Many clients never access the system of care, even if diagnosed in the TGA, due to a lack of understanding of what is available to them in support of managing their disease.

Injection Drug Users (IDU)

Individuals self identifying as Injection Drug Users (IDU) represented 15% of the HIV prevalence in the TGA for 2007. (This figure is reflective of both the IDU and the MSM/IDU populations.) Individuals self identifying as IDU represented 23% of the AIDS prevalence in 2007. Of the new HIV cases in the TGA for 2007, 12% were IDU, while 14% of the new AIDS cases were IDU. As a percentage of new cases, IDU and MSM/IDU experienced an increase of 14% in new HIV infections from 2005 to 2007. IDU and MSM/IDU saw an increase of 8% in new AIDS cases over the same period of time.

IDU related HIV/AIDS cases present the TGA with significant barriers related to access of care services, and the adherence to services once enrolled in the system. These individuals face multiple barriers, including substance abuse issues and co-morbidities stemming from risky behaviors that lead to multiple sexually transmitted disease infections. These barriers increase the likelihood that clients will fall out of care, fail in their attempts to maintain adherence to treatment regimes, and cost the system of health care more than average due to the poor health status.

As a percentage of the clients actively seeking care in the TGA, IDU and MSM/IDU are underrepresented in relation to prevalence and incidence rates. The active client population consists of 10% IDU and MSM/IDU. The Nevada State HIV Surveillance program reported to the CDC that in 2007 IDU and MSM/IDU represented 20% of the HIV/AIDS prevalence and 12% of the new HIV/AIDS cases.

According to the TGA client data management system, only 134 clients accessed outpatient substance abuse services. The prevalence of IDU and MSS/IDU in the TGA for 2007 was 1,679. In essence, only 8% of the individuals living in the TGA with HIV/AIDS in the IDU and MSM/IDU population are currently seeking substance abuse treatment services.

Unmet Need Estimate

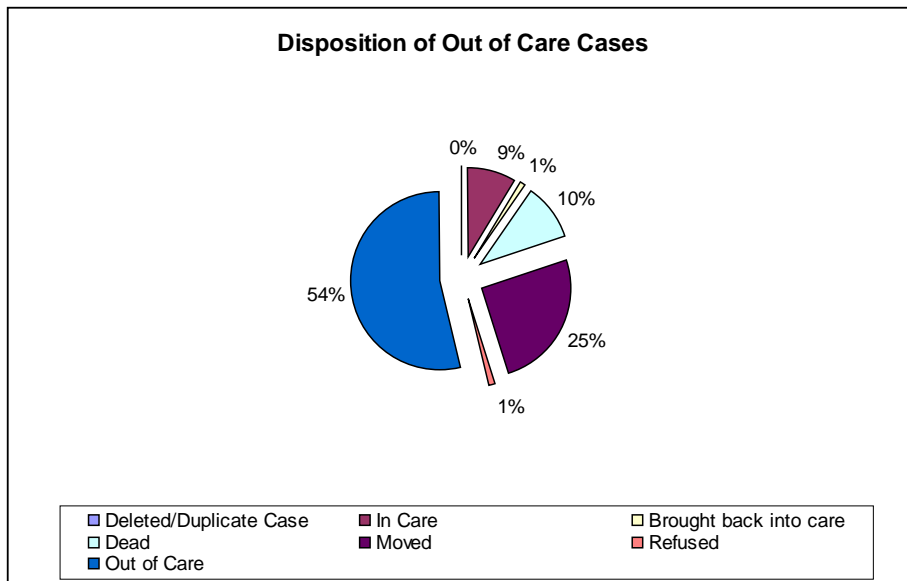
The total number of HIV not yet AIDS and AIDS cases reported by the Nevada State Health Division serve as the basis for the estimation. The next step involves the identifying all cases receiving services through the TGA's system of care (via data in WebCIM), identifying all cases of individuals receiving a positive viral load or T-cell lab report (Nevada requires mandatory reporting of all positive viral load and T-cell counts), and AIDS Drug Assistance registry. After culling out these cases, the remainder is considered out of care, having not received an HIV related service or HIV related lab test for more than 12 months.

The cases identified as out of care are then cross-matched against numerous publicly available databases in Nevada. These include: the WebIZ program, the Health District's Health Card database, the Health District's Sexually Transmitted Disease registry, the Nevada Department of Corrections Inmate registries, the Nevada Department of Motor Vehicle database, the Health District's Birth and Death Registries, and the Physician/Institution of Last Report index.

After the cases identified through the cross matching with the above databases are completed, the cases that are still unable to be located are run through a personal information tracking program, Lexis-Nexis. This program allows appropriately certified users (a very limited number of Health District staff only) to use personal identification information to identify the individual's location based on publicly available information (i.e., registered for a license in another state, signed a lease agreement in another state, etc.).

The results of this process of data analysis indicated that of the 8,483 HIV and AIDS cases reported as being in the Las Vegas TGA, 59% (n=5,021) received some type of HIV related care service in calendar year 2007. Forty-one percent (3,462) had no record of receiving and HIV related service in calendar year 2007. Of the 3,462 defined as out of care, 2 cases were identified as duplicate cases in the HARS program, 9% (n=301) were identified as receiving care in a non-Ryan White funded system, and 32 cases were identified and brought back into the TGA system of care. Three hundred and sixty-two cases (10%) were identified as deceased, 857 cases (25%) were identified as having moved out of the jurisdiction and 38 cases were identified but refused care services. A total 1,870 (54%) cases were unable to be located. This is considered to be the TGA's unmet need as it related to HIV/AIDS cases not receiving services.

Table 1.11: Disposition of Out of Care Cases



Of the original 3,462 cases defined as out of care, 18% (n=616) were Hispanic, 24% (n=816) were Black and 56% (n=1,924) were White. Not surprisingly, 85% (n=2,927) of the out of care cases were male. Fifty-six percent (n=1,953) of the out of care cases were Men who have Sex with Men, 11% (n=391) were IDU, and 6% (n=224) were MSM/IDU. Sixteen percent (n=546) were reported as having no risk. Traditionally, those cases that report no risk do so to conceal their sexual preference or drug using histories. Taken as a whole, the MSM and IDU populations accounted for 73% (n=2,568) of the out of care cases.

As part of the unmet need project, the Southern Nevada Health District continued to refine their process for identifying the clients that are out of care. To test this phase of the project, the health district selected a group of out of care clients identified by the health district's counseling and testing

program (i.e., no cases that were identified by a private physician were included in this cohort). The base for this phase of the project was 1,259 out of care cases. The use of cross matching against the public database identified the disposition of 426 of the cases. The remaining 833 cases were researched through searches by the Lexis-Nexis system, time and personnel intensive searching by Disease Investigators on the ground and contracting local known hangouts, past residences and acquaintances. Of the 833 cases, 20 were identified and brought back into the TGA care system, 2 cases were identified as duplicates in the HARS system, and 23 were identified as deceased. Forty-four percent (n=363) were identified as having moved out of the jurisdiction, 16% were identified as having a new residence in the jurisdiction and 43 cases had insufficient personal information to be tracked. The remaining 246 cases (30%) retained the out of care definition.

It should be noted that these are only the SNHD initiated cases. Applying this percentage to the privately initiated cases would increase the true number of out of care clients by an additional 311 clients. The final phase of the out of care project is to physically find the out of care clients still residing in the TGA. This is a time consuming and sensitive activity that can address the TGA goal of ensuring all clients that are in need of services access services. It is estimated that a minimum of four full time Disease Investigators would be needed to seek out, contact and assist the out of care population back into the care system. This represents an additional \$250,000 that would need to be allocated to the project. While the Planning Council is supportive of the project, funding is not currently adequate to fund these activities and the rest of the TGA's priority services.

Another population of concern is clients who have for one reason or another fallen out of care. Of equal importance are those individuals that are HIV+ but who are unaware of their status. To address these issues, the Part A grantee, the State Part B program and the Southern Nevada Health District created a comprehensive program designed to identify out of care clients and those individuals that are infected but are unaware of their status.

The EIS program serves as the "out of care" phase of the services system. This program serves to identify those individuals who are out of care with a definition of not having received an identifiable HIV related service for 13 months or more. The first step in this part of the program is to use computer software matching programs to identify the location and status of each and every HIV/AIDS case listed as residing in the TGA by the State of Nevada. A full description of the Out of Care process is included in the Unmet Need section of the application. Related to emerging populations with special needs, the outcomes of the out of care process are particularly important.

The out of care data project began with a cohort of SNHD initiated cases. By using these cases, issues of confidentiality with private physicians could be by-passed for the initial test of the system. The cohort was cross referenced against current reports of lab work in the HIV/AIDS Reporting System (HARS) and services entered in the TGA's client data system. This process identified 1,259 cases that were defined as out of care for at least 13 months. The 1,259 cases were then cross referenced with publicly available data bases such as the Nevada State Prison inmate registry, the Nevada Department of Motor Vehicles database, the Social Security death index, etc. This data matching process yielded the following results:

- 138 were found to be in care in a private system of care (non-Ryan White funded),
- 32 were identified, contacted and brought back into the care system,

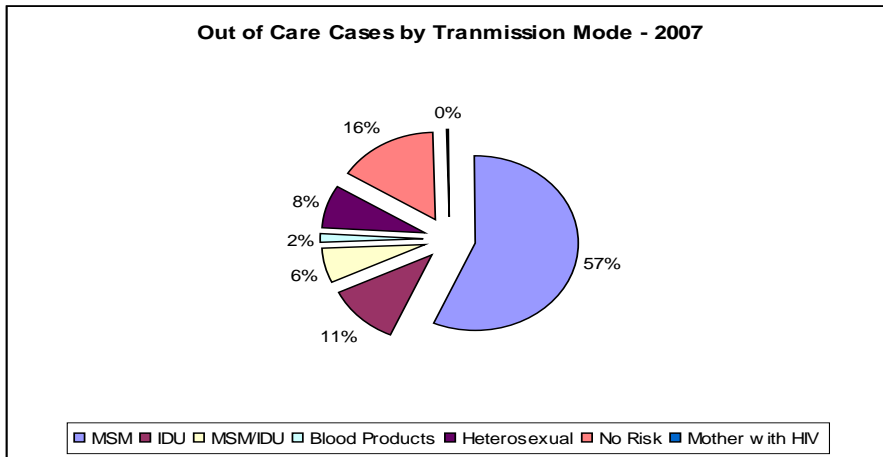
- 87 were identified as deceased,
- 132 were identified as having moved out of the jurisdiction,
- 37 were identified and refused any assistance of care services, and
- 833 remained out of care and “missing.”

The 833 cases remaining out of care were further investigated by using available Lexis/Nexis software which yielded the following results:

- 20 were located and brought back into the care system,
- 2 were identified as duplicate cases in HARS,
- 23 were identified as deceased,
- 363 were identified as having moved out of the jurisdiction,
- 43 had insufficient data points with which to track,
- 136 were identified as having a new address in the jurisdiction, and
- 246 remained out of care.

The demographic make up of the out of care population (n=1,259) reinforces the needs of the emerging populations in the TGA. Of the 1,259, Whites represented 49% and Blacks accounted for 26% of the cases. Hispanic out of care cases were at 23%. More alarming is the transmission mode of the out of care cases. Men who have Sex with Men accounted for more than half of the out of care cases (57%; n=719). Injecting Drug Users and MSM/IDU accounted for 20% of the cases (n=257).

Table 1.13 Out of Care Cases by Risk Factor for 2007



Taken as a whole 77% of all out of care cases fall in the MSM, IDU, and MSM/IDU categories. When this information is linked together with the trends in service utilization and infection rates the following picture becomes clear:

- The TGA is experiencing increased numbers of MSM, IDU and MSM/IDU infections, a lack of access for the MSM, IDU, and MSM/IDU clients, and the highest percentage of clients out of care are MSM, IDU, and MSM/IDU. We need to focus our activities in the TGA as a whole on Men who have Sex with Men and Injecting Drug Users if we are going to ensure equal access and support to the clients in the TGA.

ASSESSMENT OF NEED

Need for Primary Medical Care and other Core Medical Services

Currently Mohave County has two Infections Disease Specialists; one who recently relocated to the area and the other who travels from Prescott Arizona once per month to a new Community Center in Kingman Arizona. However, the vast majority of clients, in Las Vegas and Mohave County, AZ, must receive their HIV/AIDS related medical care at one of two medical facilities. The majority of clients receive services at the Las Vegas Part C clinic, UMC Wellness Center. Wellness Center is a specialty clinic that receives Part A and Part C funding, and is part of Clark County's indigent county hospital system. As part of the University Medical Center bureaucracy, hiring new positions is a time consuming and rarely approved process. This fact has contributed to a level staffing level for the past three years, which has resulted in increased wait times for clients seeking medical care. The other Part A medical provider is the Community Outreach Medical Center (COMC), which provides comprehensive medical services to the indigent minority population. Over the past two years they have worked in a focused nature to increase retention of clients, HIV clients and non-HIV clients, in the community that have accessed medical services. COMC is a small clinic and the capacity of that clinic is limited by funding, space and political factors. The TGA Planning Council has increased the funding for the Ambulatory Outpatient Medical Care services category in response to the increased number of clients entering the TGA's service system.

Gaps in Care

The delivery of services and coordination of care present an ongoing challenge to the Las Vegas TGA. In the system of care, service gaps make addressing increasing trends in subpopulations much more difficult. The number of clients demanding services continues to climb year to year in the TGA, but provider capacity has remained constant while facing fewer funds available for patient care.

In August 2008, grantee staff began developing an ongoing report of service demand and utilization in the TGA. The purpose of this report is to track the demand of services for use in comparing service demand in relation to Needs Assessment data, client input through open discussion forums and focus groups, and for up to date reporting to the planning council. Upon which it became evident that service demand in the TGA centered on three primary services which serve as the core of the TGA's system of care; Early Intervention Services, Medical and Non-medical case management and Ambulatory Outpatient Health Services.

A review of the demand for service for these three categories identifies a major gap in services for individuals infected and affected with HIV/AIDS in the TGA. Over the period of 2005 to 2007 the number of clients receiving medical case management services increased 339%, from 76 unduplicated clients in 2005 to 334 unduplicated clients in 2007. Non-medical case management

clients increased 81% over the period of 2005 to 2006, increasing from 1703 clients in 2005 to 3,087 in 2006.

Ambulatory Outpatient Health Services saw significant increases in the demand for services while facing frozen staffing levels. Over the period of 2005 to 2007 client visits with a physician increased from 664 in 2005 to 1,007 in 2007. This represents an increase of 52%. This fact is startling as there was no increase in provider capacity over the same period of time. Client visits with a nurse over the same period increased 60%, from 559 to 894. Again, this occurred in the face of no increase in the number of nurses available to see clients in the TGA. Other TGA services followed these trends in service demand; clients receiving dental services increased by 546% from 30 in 2005 to 194 in 2007; emergency financial assistance clients increased by 48%; health insurance continuation assistance clients increased by 24%; and outpatient substance abuse treatment clients increased by 41%.

The service utilization data supported the intuitive belief that client demand for services was exceeding the ability of the agencies to provide the needed services. The data also confirmed the needs assessment data available to the TGA over the past few years. In the Nevada Statewide HIV/AIDS Services Assessment for 2007 report, clients were asked to rank service categories by their importance to the individual client, by how easily accessible the services were, and by their satisfaction with the services they received. The responses were ranked on a seven point Likert Scale with 1 being the lowest possible score and 7 being the best possible score.

The 2007 Services Assessment indicated that clients felt the most important services available in the TGA were medical care from a doctor (6.32), CD4 and Viral Load testing (6.31) and case management services (6.05). Client satisfaction with these services in the TGA suffered from lower scores, with medical care from a doctor at 5.13, CD4 and Viral Load testing at 5.44 and case management at 4.89.

Identified Service Gaps in the MSM Community

The TGA has developed a coordinated approach to finding individuals infected with HIV into the beginning phases of the care system. Retention in the system of care after initial diagnosis remains an issue in the TGA. During the January 2008 client forum, 60% of the clients responded that access to medical and supportive services was a barrier to receiving care. Long wait times for medical appointments, overloaded case managers and a lack of wrap around services were cited as reasons clients had exited the care system. Over the last two years, client demand for ambulatory outpatient, early intervention services and case management services has increased. The provider capacity to meet these demands has remained level and in some cases has actually decreased. Supportive services, federally required to receive no more than 25% of Ryan White funding, has lead many clients to have to access these services through traditional, non-HIV related agencies. These agencies have seen a dramatic increase in service demand from the community as a whole, leaving many individuals to go without adequate services, if they receive services at all.

The increase in HIV related service demand, the loss of funding in many HIV related supportive service categories and level provider capacity has led to increased wait times, shortened visits with case managers and the elimination of services once funded by Ryan White. These trends in HIV/AIDS infection and service utilization are indicative of the many needs and challenges facing the MSM population.

Barriers to Care

The Planning Council and the Grantee consistently monitor barriers that impact service access and availability, both through the comprehensive needs assessment process and through ongoing data collection, program monitoring, and client satisfaction surveys.

Barriers to care can be identified as internal or external forces that prevent those who know their HIV/AIDS status but are not accessing care. During the process of identifying barriers to care three sources were solicited for explanation and interpretation; all staff members at the 14 Ryan White Part A Service Agencies through an online confidential survey, clients accessing the Ryan White care system through four separate focus groups, and the Needs Assessment/Care Strategies Committee on the Las Vegas Part A Planning Council, through an open forum, who is assigned the tasks of updating and writing the Comprehensive Care Plan through the Bylaws and Policies and Procedure that govern the Planning Council.

Barriers to Care-Service Provider Responses

Ryan White Part A service providers were asked to participate in a confidential survey regarding the gaps in care and barriers to care in the Las Vegas TGA. A total of sixteen individuals responded from the fourteen Ryan White Part A service providing agencies.

Within their Specific Agency

When attempting to provide services at their agency the top four barriers to care for clients that were indicated by providers were identified as;

1. Medical transportation (including to and from rural areas in the TGA) and the geographical distance between providers
2. A cumbersome and time intensive eligibility and recertification process
3. Language barriers (focusing on the Spanish speaking population) and the relationship of trust between different cultures
4. Receiving specialty care needs through the current system

Also, cited in the responses was the process of obtaining prescriptions through the ADAP system. Currently ADAP medication can only be obtained through the UMC Lied Pharmacy. Therefore clients sometimes have to travel a great distance and wait a considerable amount of time for their prescriptions which discourages patients who, as a result, fail to pick up their meds at all. Another barrier with the ADAP system is the small window of opportunity for refilling medication which is four days prior to the last dosage. When the end of the medication falls on a Monday patients scramble to get refills during the end of the prior week due to the Pharmacy not being open during the weekend. It is especially intensified when the Pharmacy is closed over a holiday, clients may have to go without medication for a few days before prescriptions can be refilled causing reactions and illness during the lag time.

Another key response was the lack, among providers, of coordination between key contacts at the Welfare office, Clark County Social Services offices, and within other important agencies for referrals and information.

When providers were asked to identify the programs/services within their agency that they identified as effective in meeting client demand they responded with the following top three;

1. Medical and non-Medical Case Management
2. Ambulatory Outpatient Medical Care
3. Housing

Other effective programs were named as;

- An effective collaborative relationship with Ryan White and non-Ryan White services providers, Southern Nevada Health District, and Clark County Social Services
- Provider attendance with medical appointments and assisting clients in understanding the content and communication of the visit
- Medical transportation
- Nutrition counseling, and
- Education

Within the Las Vegas TGA

To broaden the scope, providers were asked to identify what they feel is and what is not working well within the Transitional Grant Area's system of HIV/AIDS care.

Providers identified those things that ARE working well in the TGA's HIV/AIDS service system as;

1. Networking with other providers throughout the TGA
2. Supportive Grantee Staff

Providers identified those things that ARE NOT working well in the TGA's system of HIV/AIDS care as;

1. The ineffectiveness and inefficiency of the Ryan White Part A Planning Council
2. Case management (not following up)
3. A system for clients that is hard to navigate
4. Coordination of the eligibility process

Barriers to Care-Client Responses

During each of our four focus groups participants were asked a series of question regarding service barriers, service needs, and gaps in care related to the HIV/AIDS service system in the Las Vegas TGA. Because each population responded with such varying answers they are divided under the population sub-heading. Before each group started a questionnaire of demographics was completed by each respondent. Each client received a \$20 Wal-Mart gift card as compensation for their participation.

Focus Group #1) MSM living with HIV/AIDS

Barriers to care within this group were identified as;

- Difficulty navigating the system
- Self-consciousness from body changes and stigmas
- Inconsistencies within agencies regarding availability of services

- Transportation
- Housing

When asked what service providers could do to encourage enrollment in services and active participation respondents said;

- Ensure providers are people with likeable personalities and positive attitudes
- Show a willingness to refer more
- Stop treating PLWH/A like second class citizens
- Have the people behind the desk be nicer and more compassionate
- Employ dedicated case managers
- Train the case managers better
- Be more client centered and less agency centered

When asked, “what is your motivation for adhering to medical orders and seeking medical care?” all responses were of an internal nature. Respondents listed reasons such as; motivation to live for family, friends, their next birthday, their hobbies of bowling, sports, hope a sense of belonging. A large consensus was motivated by finding a regimen of medication that works with their bodies and makes them feel somewhat healthy again.

Focus Group #2) MSM of Color living with HIV/AIDS

Barriers to care within this group were identified as;

- Transportation
- Housing
- Geographical distances between service providers
- Navigation within the system

When asked what service providers could do to encourage enrollment in services and active participation respondents said;

- Send out reminders for eligibility requirements every six months
- Don't treat PLWH/A like a statistic
- Promote participation more
- Offer more education on HIV/AIDS and available services
- Recruit success stories of PLWH/A to speak and mentor

When asked, “what is your motivation for adhering to medical orders and seeking medical care?” the responses were similar to those of the previous group. Many responded that they don't want to get really sick again or make another long hospital visit, other said that friends and networking systems keep them on their medication. One man commented that because there is no cure, he relies on friends and survivors to encourage him.

Focus Group #3) Women IDU's living with HIV/AIDS

Barriers to care within this group were identified as;

- Transportation
- Drug abuse (when actively using)

No emphasis or elaboration was placed on any specific category. Within this focus group services were regarded as “excellent” “great” and “better than they have been in the past”.

Focus Group #4) Men IDU’s living with HIV/AIDS

Barriers to care within this group were identified as;

- Lack of compassion and understanding by service providers
- A system that is easier to navigate including better and more referrals for services
- Stable housing

When asked what service providers could do to encourage enrollment in services and active participation respondents said;

- Provide more referrals for services
- More incentives
- More food vouchers or gift cards
- More follow-up by case managers
- Be more compassionate, less prejudiced
- Cut down on cumbersome paperwork
- More objective grievance system that doesn’t make you feel like you are going to lose services
- Providers should ask for clients opinions more often
- Provide more recreational activities such as movie tickets or tickets to shows, “we (clients) can’t afford recreational activities”
- More than a \$20 gift card for coming to a focus group, “\$20 only buys a few packs of cigarettes but \$50 would be more worth my time”
- Provider better transportation, not just bus passes

When asked “what is your motivation for following your doctor’s orders and staying in care?” respondents gave similar answers to those in the other focus groups; a chance at life, not wanting to die, and not wanting to get really sick. For those participants that don’t currently follow their doctors order they cited reasons such as; choosing to drink or “party” over taking their meds, doesn’t like the side effects, doesn’t like to take pills, sometimes forgets and addictions to a substance interferes with his regimen.

Barriers to Care-Needs Assessment/Care Strategies Responses (NA/CS)

During the design of the Comprehensive Needs Assessment 2008 for the Las Vegas TGA, HRSA Technical Assistance Coordinator Harold Phillips facilitated a discussion and planning session to assist in the development of the Comprehensive Care Plan. The Grantee Staff, Planning Council Support Staff, one client, and five members of the Planning Council’s NA/CS Committee attended, two of which are Ryan White clients currently accessing services.

This body agreed upon three top barriers that clients have trying to get into the HIV/AIDS care system in the Las Vegas TGA;

1. A lack of knowledge of the system
2. A fear and stigma

3. Apathy (not attending to their HIV status until a serious illness or Emergency Room visit occurs)

The discussion also concluded that fear and stigma are heightened in rural areas and within different ethnic groups. It was also discussed that the fear and stigma decrease in younger generations but is replaced with apathy.

A separate list of barriers were exposed for clients accessing the system once they are already in care;

1. Navigation of a fragmented system
2. Lack of information coordination by Ryan White and non-Ryan White funded service providers resulting in inconsistent messages to clients
3. Poor case management
4. Transportation

This body then identified what they feel is working well within the entire HIV/AIDS care system in the Las Vegas TGA;

1. The relationship between the Grantee and the Planning Council
2. Ambulatory/Outpatient Medical services work great but should be expanded
3. Dental Services
4. Relationships between the Grantee and Providers
5. Centralization of Ryan White Service Providers (UMC Wellness, AFAN, Lied Pharmacy, UNLV Dental School)
6. Service are very accessible for those living in the urban area
7. Mental Health and Substance Abuse Services

Through the eyes of the Planning Council the core service in the TGA function effectively including the development of positive relationships between the Grantee and the Planning Council and the Grantee and Providers.

Throughout each of the focus groups, provider survey responses and the assumption of the Planning Council the primary barriers to care in the Las Vegas TGA can be concluded as;

- A system of HIV/AIDS care that is difficult to navigate
- Transportation
- Housing
- Lack of respect and positive relationships between all stakeholders involved
- A meager case management system; and
- A cumbersome eligibility process

Many of the issues expressed in the focus groups relate to the concerns of the grantee and planning council regarding the need to better coordinate services over the geographic area. Work to streamline intake and assessment is greatly needed and underway. In addition, the need to close the gaps between service coordinators to facilitate maintenance in the care system has also been recognized as an issue in past needs assessments.

In addition to a fractured system of care, there is also a need to increase awareness of the system of care and the key points of entry. The rapid growth in the Las Vegas area and the lack of information on where and how to access HIV services continues to hamper efforts to get more people in care.

Another huge barrier to care for many clients is the lack of adequate transportation in the area. While the majority of the service providers are located in central Las Vegas, clients are scattered across a wide geographic area. The ability to access reliable transportation is an important factor that affects care seeking and maintenance behavior. The Las Vegas Area lacks sufficient bus and rail systems which are prevalent in other urban areas. This issue is compounded in Nye in Mohave Counties which are more rural. Clients in these areas often face numerous transportation challenges.

DESCRIPTION OF THE CURRENT CONTINUUM OF CARE

The TGA's economy is best described as predominately serviced-based. The United States Bureau of Economic Analysis reported that 44% of all jobs in the Las Vegas region are in the hospitality, retail and construction sectors. Unfortunately, the current state of the economy has hit these industries particularly hard, which has contributed to the Las Vegas regions 7.1% unemployment rate.

Even with all the economic turmoil, McCarran International Airport remains the 8th busiest airport in the world receiving 851 flights each day that deliver over 2.4 million Las Vegas visitors each month. Tourism slogans such as "Sin City," "What Happens Here, Stays Here" and more recently, "Your Vegas is Showing" seem to endorse if not promote risky behaviors and/or dangerous conduct to tourists and residents. Marketing campaigns like these have had a severe impact on the efforts of local public health agencies to promote healthy lifestyles, although some progress has been made in the TGA in this area.

RYAN WHITE TREATMENT MODERNIZATION ACT of 2006

Congress first authorized the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990 and re-authorized the legislation in 1996 and again in 2000. The CARE Act represents the largest dollar investment made by the Federal government specifically for the provision of services for people living with HIV disease.

The purpose of the Ryan White CARE Act is to improve the quality and availability of care for people with HIV disease. The Act is also intended to reduce the burden on the local health system to absorb the high cost of treating this illness by reimbursing providers for delivering services free of charge to the uninsured.

Part A of the Act provides grant funding directly to Eligible Metropolitan Areas/Transitional Grant Areas with the largest number of reported cases of AIDS, to meet emergency needs of people living with HIV disease. Las Vegas is the only Part A funded area in Nevada.

Part B of the Act provides funding directly to the fifty states to administer additional services in all communities across each state. The state of Nevada funds a number of core medical and support services throughout the state including the Las Vegas area in an attempt to fill gaps in care.

Part C of the Act provides funding directly to various service providers throughout the country for special programs and/or additional services.

PART A PROGRAM ORGANIZATION

The Clark County Department of Social Services is the officially designated Grantee for all Part A funds in the Las Vegas TGA. The Part A Grantee is housed within the Department of Social Service and is organized as an independent sub-unit within the Department's Administrative Services Section. As an independent sub-unit, the Part A Grantee program consists of five full time employees which include; 1) a Grants Administrator, 2) one administrative Management Analyst, 3) an Administrative Specialist, 4) a Financial Office Specialist, 5) a dedicated Planning Council Management Analyst. Together, this team of dedicated staff addresses all the requirements of the Ryan White Part A funding requirements in a team oriented manner that fosters cooperation, innovative and effective problem identification and resolution.

In addition to the dedicated Grantee staff, the Part A Team benefits from the support of the Department of Social Services staff in numerous ways. The Department's Quality Management Program provides all Technical Assistance to Grantee and provider staff in the area of Quality Management concepts and activities. The Quality Management Program staff has participated in the development of overall and provider specific Quality Management plans, accompanied Grantee staff when conducting provider site visits, and will be a consistent Quality Management presence in all Ryan White Part A Quality Management activities in the coming grant years.

Beginning in 2008, the Grantee staff and Planning Council for the TGA benefited from consistent staff support. In response to historical issues of reliable Planning Council administrative support, and based on HRSA's guidance regarding Grantee provided PC support staff a full time dedicated support position is in place. This position, while paid from the grantee administration funds, reports and works at the direction of the Planning Council.

Despite all the adversity the Las Vegas TGA faces, the Grantee Staff, 14 direct service providers, and the Planning Council continually strive toward meeting HRSA's long range strategies to improve access to care by; reducing barriers to care, improving retention in care by providing an effective system of support services, addressing unmet needs to reduce stigma, and reducing health disparities among special populations.

While a great deal is being accomplished in these areas, an extensive amount of outreach, education, early identification, risk reduction and care are needed to effectively address the HIV/AIDS epidemic in the Las Vegas TGA.

The Las Vegas TGA's Continuum of HIV/AIDS Care is designed to facilitate three primary activities for clients; 1) to find those clients not in the system that are in need of HIV/AIDS care, 2) to identify, assess and develop a care plan to address the client's medical and social support needs, and 3) to link the client into the needed social support and medical care providers to stabilize their medical and social needs, and to increase continued adherence to these needed services.

Finding Clients Who Are Positive and Are not in Care

Known as the “Early Intervention Services” Program (EIS), this program coordinates the activities of HIV prevention counseling and testing, an early intervention services clinic, intensive medical case management and intensive referral and client navigation staff to provide assistance to some of the hardest clients to identify and link into care. A summary review of the program identifies a multi-stage process that begins with HIV counseling and testing staff out-stationed in areas of the community that have a high probability of finding HIV+ individuals. Prevention staff are located inside the local jails and detention centers, high risk youth facilities and in the local minority agencies. Prevention staff is also on-site providing testing at the local gay and lesbian center and other gay oriented agencies. Counseling and testing is provided by these staff to anyone who is interested in getting a test. If a test comes back positive, that individual is immediately linked to the early intervention evaluation clinic.

The clinic provides free viral load and CD4 testing to establish the client’s disease level and progression. The client is seen by physicians from the local HIV specialty clinic, so a measure of trust and a relationship is established even before the client becomes part of the mainstream system of care in the TGA. Over the course of the six month evaluation clinic, the client receives assessment and assistance from the health district’s nurse case managers. A plan to address the client’s medical needs is developed, and a referral plan for all social support needs is developed prior to the end of the six month evaluation process. Once the client’s care plan has been developed, their disease status identified and stabilized the client is linked to a case manager with the largest local case management provider. At this stage the nurse case manager and the HIV specific case manager work together to ensure the transition to the TGA’s system of care is seamless and effective.

Determining Client Need and Stabilizing with a Comprehensive Treatment Plan

The second phase of the continuum of care in the TGA is the identification and assessment of the clients overall medical and supportive service needs. Regardless if a client enters the system of care through the EIS program, through a medical appointment, or from word of mouth referral, every client entering the TGA system of care receives a comprehensive assessment of need and an individualized treatment plan.

The first step in this phase of the continuum of care, is eligibility determination. In-take into the system of care occurs at one of four eligibility programs. These eligibility programs are trained to conduct eligibility assessment for all Ryan White funding streams serving the TGA, i.e., Part A, Part B, Part C and ADAP. Clients are also screened for eligibility for other non-Ryan White programs such as Clark County Social Service, Veteran’s Administration, Medicaid and Medicare, and numerous community based assistance organizations. Information gathered on the client’s eligibility for other program in addition to Ryan White programs is recorded and serves as a basis for the development of the client’s treatment plan.

Each client receives a comprehensive assessment of need, which identifies the clients medical and social support needs. Clients often present with multiple issues, all of which can provide a barrier to the accessing and adherence to medical care. Issues surrounding child care, immigration status, hunger and access to food assistance, lack of adequate or safe housing, and transportation all present the client with barriers that serve to destabilize their emotional and physical health, and their ability to understand and manage their HIV disease. The treatment plan and accompanying referral plan serves as a road map by which the client and the case manager can work to address and eliminate the

barriers to self sufficiency and management of the HIV disease. The treatment plan identified all needed services, frequencies at which assistance needs to be provided, and all wrap around service providers that will assist the client in their treatment. The case manager and the client develop this plan together, which ensure the plan is able to be understood and managed over the course of time. As needs change, or additional needs are identified, the treatment plan is adjusted accordingly, and new strategies are developed.

Case Management has historically been seen as imperative to the success of the treatment plan. As such, the Planning Council has consistently funded case management (now termed medical case management) and other supportive services as a way for agencies to assist the client in taking control of their situation in order to increase their ability to manage their disease.

Staff in the TGA's case management agencies is able to link clients into the comprehensive system of HIV/AIDS care depending on their needs. Case managers provide referral and follow up services on behalf of clients to the Ryan White funded wrap around service providers, which include oral health care, medically based nutritional therapy and education, substance abuse treatment services, mental health treatment programs, transportation assistance, food assistance, and emergency financial assistance for medications and rent and utilities. Case managers also assist the client in navigating non-Ryan White funded agencies, such as the VA, Southern Nevada Adult Mental Health, pastoral services, companion services, life skills training and employment services. By working as a coordinated system, clients are linked into programs and receive the services they need to remove the barriers they face to maintaining adherent to medical care and medications regimes.

In the FY07-08 grant year, WebCIM identified over 32,500 units of case management were provided to clients in the HIV/AIDS system of care. Over 23,000 units of out patient substance abuse counseling services were provided to individuals working to address issues surrounding substance abuse. Individuals suffering from mental health issues received over 15,000 units of service from the TGA's Part A funded mental health providers.

Ensuring Access to Life Saving Medical Care and AIDS Medications

The third phase of the continuum of care is the provision of needed medical care, and related medically based services, to assist clients in the management of their disease. In the TGA, there are two primary outpatient/ambulatory medical care providers, University Medical Center's (UMC) Wellness Center and the Community Outreach Medical Center (COMC). The TGA relies on these two agencies to ensure a high level of care is provided to individuals infected with the HIV virus and all of the resulting HIV related medical needs. TGA clients with insurance that are receiving assistance through the Health Insurance Continuation Programs are able to access not only these two clinics, but also a handful of "private" doctors in the community that treat HIV/AIDS. The services available through these two clinic range from basic primary health care to HIV specific health care to highly specialized medical services, such as cancer treatments, treatment for Hepatitis infection and intensive psychiatry.

Over the course of the FY07-08 grant year, UMC provided outpatient/ambulatory medical care to 821 unduplicated clients. The COMC provided services to 42 unduplicated clients over the course of the last grant year. In total, these two agencies provided over 290,000 units of outpatient/ambulatory medical care to clients receiving services in the TGA.

RESOURCE INVENTORY

The chart below provides a comprehensive listing of agencies in the Las Vegas TGA that provide direct care and support services for persons in our region who are infected and affected by HIV/AIDS. Together these agencies compose the high quality continuum of care that is designed to provide the most effective and sensitive levels of support, treatment, and prevention services, while consistently providing a high level of cost-efficiency and coordination.

**Table 1.14 Current
Ryan White Funded
Community Resources**

	Ambulatory Outpatient Medical Care	Food Bank/Voucher Assistance	Housing Services	Mental Health	Oral Health	Substance Abuse	State Part B AIDS Drug Assistance	Outreach
Aid for AIDS of Nevada (AFAN)			X				X	
Caminar, Inc.			X	X				X
Community Counseling Center				X		X		
Community Outreach Medical Center (COMC)	X							
Golden Rainbow			X					
Mohave County Department of Public Health		X						
Nevada Association of Latin Americans (NALA)								X
Nye County Health and Human Services								
Southern Nevada Adult Mental Health Services (SNAMHS)				X		X		
University Medical Center Wellness Clinic (UMC Wellness)	X							
UNLV School of Dental Medicine					X			
WestCare, Inc.						X		

PROFILE OF THE RYAN WHITE PROGRAM FUNDED PROVIDERS BY SERVICE CATEGORY

Ryan White Part A currently funds 14 Service Providers within the Las Vegas TGA. All of the core services are located in Las Vegas and clients residing in rural areas must be transported in for medical care. While most of the support services are also located in Las Vegas, Nye County and Mohave County provide only limited resources.

Core Medical Services	
<p>UMC-Wellness Clinic 701 Shadow Lane Suite 200, Las Vegas, NV 89106 Phone: 702-383-2691 <i>Ambulatory/ Outpatient Health Services</i></p>	<p>Community Outreach Medical Center (COMC) 1400 N. Eastern Avenue, Las Vegas, NV 89101 Phone: 702-657-3873 <i>Ambulatory/ Outpatient Health Services</i></p>
<p>West Care, Inc. 900 Grier Dr. Las Vegas, NV 89119 Phone: 702-385-2090 <i>Substance Abuse Services</i></p>	<p>Southern Nevada Adult Mental Health (SNAMH) 6161 W. Charleston Blvd, Las Vegas, NV 89146 Phone: 702-486-4552 <i>Substance Abuse Services; Mental Health Services</i></p>
<p>Community Counseling Center 1120 Almond Tree Lane, Las Vegas, NV 89104 Phone: 702-369-8700 <i>Substance Abuse Services Mental Health Services</i></p>	<p>University of Nevada Las Vegas School of Dental Medicine 1001 Shadow Lane, Las Vegas, NV 89106 Phone: 702-774-2498 <i>Oral Health Care</i></p>
<p>Caminar, Inc 2140 Vegas Dr. Las Vegas, NV 89106 Phone: 702-471-6360 <i>Mental Health</i></p>	
Support Services	
<p>Aid for AIDS of Nevada 701 Shadow Lane, Las Vegas, NV 89106 Phone: 702-382-2326 <i>Housing Assistance; Case Management; AIDS Drug Assistance Program; Food bank/ food voucher assistance Transportation Assistance</i></p>	<p>Caminar, Inc 2140 Vegas Dr. Las Vegas, NV 89106 Phone: 702-471-6360 <i>Housing Services Outreach</i></p>
<p>Golden Rainbow 3233 W. Charleston, Suite 108, Las Vegas, NV 89102 Phone: 702-384-2899 <i>Housing Assistance</i></p>	<p>Mohave County Department of Public Health 700 West Beale, Kingman, AZ 86401 Phone: 928-753-0748 <i>Food bank/ food voucher assistance</i></p>
<p>Nevada Association of Latin Americans (NALA) 323 N. Maryland Parkway, Las Vegas, NV 89101 Phone: 382-6252 <i>Outreach</i></p>	<p>Nye County Health and Human Services 250 Highway 160, Suite 4 Pahrump, NV 89060 Phone: 775-751-7094 <i>Transportation Assistance</i></p>

Services Provided by Other Modernization Act Programs

The HIV/AIDS clients in the Las Vegas TGA benefit from most major Ryan White funding streams. Parts A, B, C, Minority AIDS Initiative (MAI) and AIDS Education and Training Center (AETC) funding works together to support a coordinated system of HIV/AIDS care for the TGA's clients. Ryan White Part D program funding is not represented in the TGA.

In FY 2008-2009, the Ryan White funds in the TGA are coordinated to ensure the most important needs of the client are met. Part A funds serve as the primary funding source for the top three core service categories identified by the Planning Council; 1) Ambulatory Outpatient Health Services, (2) Medical Case Management, and (3) Early Intervention Services. The remainder of the Part A funds support vitally needed wrap around services, such as oral health care, nutritional services, mental health and substance abuse treatment services and a wide range of supportive services, such as food assistance, transportation assistance and housing assistance.

Part B funds serve to compliment and enhance the TGA service system. Part B ADAP funds are the primary source of assistance for clients in need for HIV/AIDS medications. Eligibility for ADAP is conducted by the same AIDS service organization that provides the eligibility services for Part A funds. This reduces the need for clients to access multiple agencies in order to receive the full range of Ryan White funding. ADAP services are coordinated by the TGA primary ambulatory outpatient medical care provider. Wrap around services that compliment the direct medical care provided by this agency, such as adherence counseling, education and counseling on the management of the clients disease, are provided on site in a one stop shopping environment. The TGA's largest case management agency and its largest ambulatory outpatient medical clinic are located in the same building for ease of access for the client.

Part B, non ADAP funding, is contracted to many of the same Part A funded agencies in the TGA. The services funded through Part B serve to streamline the process of client intake and enrollment, and service delivery. Part B funds support the eligibility process in the TGA, provide additional medical services in the minority populations and serve to coordinate access to specialty services not funded by Part A or C. Part B funding also serves to enhance the level of substance abuse and supportive services in the TGA.

Fortunately for the TGA's clients, the Part C provider in the TGA is also the major Part A funded ambulatory outpatient health services provider. Part C funds are coordinated with Part A funds, insurance payments by clients with insurance, indigent care funds and ADAP funds to ensure clients in the TGA have access to a multi million dollars system of HIV/AIDS care second to none in Nevada. Part C funds are also used to ensure clients needing specialty services, such as psychiatry, intensive oral health care and specialty medical services are accessible.

AIDS Education Training Center funding serves as the primary support for medical provider education and retention. The AETC in southern Nevada provides on-going educational opportunities for doctors, nurses and case managers working in the TGA's system of care. Special programs designed for the HIV positive client are also provided annually. Through these programs, clients learn how to engage and participate in their own medical care plans, how to advocate for themselves in Ryan White and non-Ryan White service systems, and how to manage their disease through healthy living strategies.

Of significant impact in the TGA is the services supported with Minority AIDS Initiative funds. After careful analysis by the Planning Council, the grantee staff and the provider community, it was determined that a system within a system of care targeted to minority populations needed to be developed. Through the application of MAI funding to the TGA two minority service providers, that system was built. MAI funds support access to medical and social support services primarily in the Black and Hispanic populations. COMC and the Nevada Association of Latin Americans (NALA) created a coordinated system of case management and medical care for infected minority populations. The system has a network of linkages to the traditional system of care in the TGA and has helped to increase the number of minorities accessing services to exceed the infection prevalence in the TGA. The continued use of these funds, with enhanced funding from the Part A grant, will allow the linkages between minority service providers and all other Ryan White funded providers to remain strong in the years to come.

Services Provided by Other Funding Streams

In the Las Vegas TGA, Parts B and C, housing grants (CDBG), Substance Abuse and Mental Health Services funding (SAMHSA), including State, City, and County funding are other financial support sources currently available to PLWH/A. Prior to the determination of proposed funding for each service category, the Planning Council reviews other potential sources of funding in that specific category. As depicted in table 1.15, an inventory of community resources including sources used prior to or in conjunction with Part A to best utilize funding streams concurrently within the community.

Table 1.15 Services Funded by Other Sources

Service Category	Other Sources of Funding/Other Available Service Providers
Ambulatory Outpatient Medical Care	Clark County Medical Assistance, Medicaid, Health Insurance Continuation, Arizona Health Care Cost Containment System (AHCCCS) in Mohave County, Medicare, Veteran’s Administration
Oral Health	Part C, Veteran’s Administration, Medicaid, Medicare Risk – HMO’s
State Part B AIDS Drug Assistance	Part B, State funding
Transportation	CAT Para Transit, Medicaid LogisticCare, AHCCCS (Mohave County)
Mental Health	Part C, SAMHSA, Southern Nevada Adult Mental Health (general State services), Medicaid, AHCCCS (Mohave County), NARBHA (Northern Arizona Regional Behavioral Health Authority)
Substance Abuse	SAMHSA, AHCCCS (Mohave County)
Housing Services	HOPWA, Clark County Assistance, Section 8
Food Bank	St. Therese, Help of Southern Nevada, Food Stamp Program, Catholic Charities, fundraising efforts

Outreach	Prevention grants, CDBG
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Coordination of Services and Funding Streams

The process of coordinating services and funding streams is based on a systems approach. The TGA identifies its service system as composed of three primary functions; 1) Finding individuals infected that are out of care or do not know they are infected, 2) Assessing and stabilizing the client as soon as they enter the system of care, and 3) ensuring access to medical care services to manage their disease.

One of the many ways we address coordination of services at the front line of service delivery is by ensuring that Ryan White Part A dollars are utilized as a last resort. This occurs when clients are determined eligible for Part A services. The TGA requires that Eligibility Specialists exhaust all other avenues for assistance before approving Part A services. Determining eligibility and the review of prior resources are outlined in the Part A Eligibility Policies and Procedures manual.

Clients new to the system of care in the TGA, and those already receiving Ryan White services, are provided with an eligibility assessment and a comprehensive assessment of their medical and social support needs. Based on the client’s individual treatment plan, a referral plan is developed that incorporates Ryan White funded and non-Ryan White funded service providers. The TGA’s case management agencies serve as the hub for the coordination of all of these services. Clients are linked into service agencies that address their specific needs. For example, Veteran’s Administration (VA) clients are linked to VA services that compliment the Ryan White funded services in the area of mental health, substance abuse, and medical assistance, with the Ryan White case manager following the client through those systems to ensure appropriate services are provided to address the client’s needs. The TGA’s housing and homelessness service community serves as a resource case manager’s access to ensure client’s with unstable or histories of homelessness have access to adequate housing. Case managers in the Ryan White funded case management agencies have established and maintain strong working relationships with the case workers and case managers in these outside service agencies. Together, the respective case managers, and the client work to address the client’s needs through cooperative, coordinated service provision.

The care system ensures a coordination of medical care for clients, not only for HIV services, but for non-HIV specialty services as well. The system of coordinated medical care in the TGA reflects this interconnected approach to client care. Ryan White funded medical providers see the majority of clients with HIV/AIDS in the TGA. To address the unique medical needs of the client, a network of specialty medical providers exist to ensure services such as psychiatry, ophthalmology and physical rehabilitation are available to TGA clients. These services are coordinated through a medically based system of case management, with the nursing case managers in Ryan White funded clinics serving as the primary linkage point.

In addition to the wrap around services identified above, the TGA case management providers maintain effective working relationships with other governmental and non-profit service providers. This linkage ensures that Ryan White services serve to compliment the services of other providers. Included in the network of partner agencies is Nevada State Medicare and Medicaid offices, Nevada State Welfare, the Veteran’s Administration, the Southern Nevada Health District, Clark County Social Services, Catholic Charities of Southern Nevada, Nevada Partners (work related skills

training), Section 8 providers, Help of Southern Nevada, Southern Nevada Adult Mental Health, West Care Treatment Corporation, Bridge Counseling and AHCCCS in Mohave county Arizona.

All of these service providers, Ryan White and non-Ryan White, are coordinated by the case managers in conjunction with the client to ensure all identified barriers to accessing care services, all barriers to remaining compliant with care services and all social support issues hindering the effective management of the clients disease are addressed.

Ways in which Services Funded by Other Sources are Taken into Planning Consideration

The Planning Council, which is charged with priorities and allocations, includes representatives from various HIV/AIDS service provider areas including: Medicaid/Medicare, the State of Nevada Part B program, Office of AIDS (HIV Prevention and Surveillance) and AIDS Drug Assistance Program (ADAP). These members actively participate on the Resource Allocation/Evaluation and the Needs Assessment/Priority Setting Committees. Additionally, the Planning Council has members from community-based organizations that provide information on local fund raising efforts and other non-monetary resources in the community which affect funding allocations within the Part A program. Also, all contractors are required to submit a summary of all funding sources.

DESCRIPTION OF THE CURRENT LOCAL, STATE AND REGIONAL RESPONSE TO THE EPIDEMIC

The response to the AIDS epidemic within the Las Vegas EMA has been one of a grassroots effort. With the first case of AIDS in Clark County reported in 1985, the community responded with the formation of Community Based Organizations providing social services, support groups and housing assistance throughout.

Currently our local and state economy has suffered severely from the housing crisis that hit the Las Vegas Valley especially hard. The economic recession of 2008 has caused a ripple effect throughout America and leaves no exceptions affecting all Americans including those suffering with HIV/AIDS. While Community Based Organizations continually press forward providing services for those in need more and more people are finding themselves requiring services, such as food assistance, from programs they once donated to. Meanwhile PLWH/A that depend on the consistency of those community services are finding that now there is not enough to go around.

While the numbers of new clients accessing care is skyrocketing, unfortunately available funds are not. Budget cuts and shortfalls in a recession are inevitable.

The emerging populations in most of medical and supportive services are the MSM and IDU populations and the out of care population. This presents a significant challenge to the TGA in that these populations require time and personnel intensive activities in order to have their needs meet adequately. Over the course of the 2007 calendar year, the TGA say the incidence of HIV/AIDS infection increase in the MSM and IDU populations, at the same time that these populations decrease their representation in the system of care. The challenge to the TGA system of care is how to maintain these populations in the system of care. The answer will be to increase the availability of substance abuse treatment services in the care system. Table 1.7 shows the increase in the number of HIV/AIDS MSM in the TGA from 2005 to 2007.

The emerging out of care population presents many challenges to the TGA and its clients. First and foremost, these clients are not receiving any type of care services. Their disease status is not being monitored, checked or addressed. This leaves the client highly vulnerable to opportunistic infections, deteriorating health status due to non-adherence to medical/medication regimens, and on-going mental health and substance abuse issues. A second challenge is the impact these clients have on the population as a whole. Without access to medical, educational and preventive services, these clients are at high risk for spreading the disease to uninfected individuals. Transmission through risky sexual behaviors and through the sharing of infected needles puts the MSM and IDU population at a higher risk of increased HIV incidence. This issues becomes more serious when one factors in the co-morbidities of other STI's being spread by this out of care population.

To address these challenges, time and personnel intensive activities must be conducted. The very nature of their out of care status means that someone has to find them in order to get them back into care. Hoping they come across an intake point in the system is not enough. It is estimated that a minimum of three full time disease investigators need to be dedicated to finding the out of care clients. This represents an additional \$250,000 in EIS funds to find out of care cases.

The challenges continue once the out of care client is located and brought back into the care system. Because of the lower health status of these clients, the increased prevalence of co-morbidities and the concurrent mental health and substance abuse issues, these newly found clients will place a financial drain on the TGA's system of care. More intensive medical services to treat the client's disease will be needed. Treatment and education for co-morbid conditions will be needed, and service to address the mental health and substance abuse issues will become imperative in order to assist the client to remain in care. It is estimated that an additional \$800,000 would be needed to find the 249 identified out of care cases and to provide the intensive medical and social support services needed to keep them in care.

SECTION II: WHERE DO WE NEED TO GO: WHAT SYSTEM OF CARE DO WE WANT?

VISION

The comprehensive planning process has been used as an opportunity in our Transitional Grant Area to study the epidemic and re-examine our response to the changing and diverse needs of those with HIV/AIDS in our community. The Needs Assessment Committee; based on data and the early findings for the focus groups is interested in looking at what is being called “the hidden epidemic”. This phrase relates to the HIV/AIDS epidemic among IDU, rural residents, MSM, and MSM of color. These subpopulations comprise the majority of those infected with HIV/AIDS in the TGA and face numerous challenges and barriers that affect their abilities to access and remain in core medical and support services.

Recent focus groups indicate differences in the needs of MSM and MSM of color. Much of our future needs assessment work will include further study of subpopulations to determine further variations in needs and how this should be used in priority setting and resource allocations.

Services in the Las Vegas TGA are often described as fragmented. They can be difficult to access due to the administration requirements and a lack of coordination between the programs and funding streams. By looking at “the hidden epidemic”, the planning council hopes to create a diverse and flexible system of care designed to meet a variety of client needs.

MISSION

The Planning Council will develop a comprehensive plan for organizing and delivery of HIV health and support services, establish priorities for the allocation of Ryan White Care Act funds and assess the efficiency of the administrative mechanism. These services will be coordinated with other funding agencies, particularly other Ryan White CARE Act Titles.

VALUES

The Las Vegas TGA has a long history of activism, where individuals have banded together with or without federal, state and local funding in response to community need. This approach to being client-centered is reflected in the planning council today and among many of the service providers in the area. As one of the core values reflected in this comprehensive plan, it will allow the system to change in order to keep pace with changes in the Treatment Modernization Act, the shifting demographics of the clients, medical advances in the treatment of HIV/AIDS and the changing needs of the clients both in and out of care. A client-focused system of care is one which works to stabilize clients who are often in crisis situations and meet the critical needs of those living with HIV/AIDS.

In meetings with the Needs Assessment Committee and the Clark County Grantee, the important value of having an available, accessible and appropriate system of care was discussed. A system that is easily accessible in that needs and barriers are reduced or diminished. It is open to those who need it with ease of access from various points of entry and is culturally and linguistically relevant and comfortable for those of different genders, sexual orientations, races and ethnicities. These are

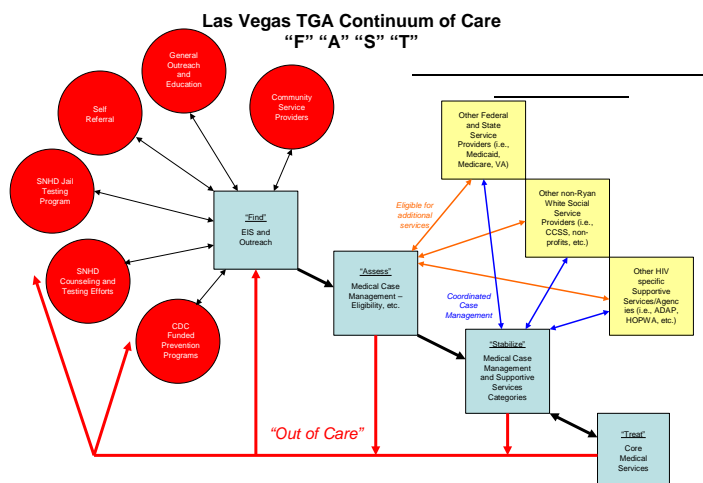
the values that will help guide the council and the grantee as it designs the ideal continuum of care over the next three years.

IDEAL CONTINUUM OF CARE

The Needs Assessment Committee adopted a disease management model for its vision of the ideal HIV/AIDS Continuum of Care. The disease management model incorporates the values of the committee and encapsulates the desired changes needed to create a system that allows providers and clients to access assistance in managing their HIV disease through all stages of the illness from diagnosis to stabilization to maintenance.

As stated in Section 1 of this Comprehensive Plan, Las Vegas is one of the fastest growing areas in the Country. Coupled with a large geographic and fragmented system of medical and support services often located in Central Las Vegas, the Grantee and the Council devised goals and objectives designed to bring the disease management model to fruition by taking steps to maximize the effectiveness of Ryan White services and to ensure that Ryan White services work in collaboration with other federal, state and local programs serving PLWH/A.

The diagram below represents the vision of the Ideal Continuum of Care for 2009-2012



This model uses the acronym F.A.S.T. which stands for Find, Assess, Stabilize and Treat. Find which requires work with points of entry especially work with providers of Prevention, testing and counseling services including STDs, prisons, community based substance abuse and homeless service providers. This is to be accomplished through the use of Early Intervention Services (EIS)

and outreach services. This model is applicable for use in illustrating the work to be done with those who have knowledge of their HIV status and are ready to begin care and the model also works with those who know their status and are not in care.

One of the greatest challenges faced by the County and the Planning Council is the lack of information in the community regarding free and low costs care through the Ryan White Program. Similar to other areas across the country, those who are often late to care or not in care often choose this path because of HIV stigma or a lack of knowledge about the availability of Ryan White services. Thus the ability to find those who need care is an important aspect of this model.

Assessment under this model takes place using medical case managers who are strategically placed throughout the continuum of care enabling them to conduct eligibility and intake for Ryan White services. At this stage, medical case managers also use evaluation tools to assess the need for and determine the eligibility for other services designed to reduce barriers to care. In many cases this entails making referrals for additional services.

Las Vegas, similar to other Part A programs across the country are moving toward medical case management as the predominant model of case management. IN our continuing effort to make this transition, medical case management will play an important role in our disease management model.

Stabilizing clients is done through the provision of other core and support services. It is the completion of successful referrals. The entire service network plays a role in helping to ensure that fewer clients are lost to care and that administrative, structural and personal barriers are reduced.

Treating clients is done through the provision of core medical services. All services lead to this point with the eventual goal of improving the client's clinical outcomes. To do this high quality core medical service provided using generally accepted standards of care including the Public Health Service Standards for Primary Medical Care for the Treatment of Adults with HIV/AIDS.

As presented, the FAST Model for the Ideal Continuum of Care looks linear, but as it is a disease management model and thus some of the steps may occur simultaneously in an effort to assist clients manage their disease. Assessment, stabilization and treatment may occur at the same time dependent upon the needs found during the assessment and the severity of the situation.

SECTION III: HOW WILL WE GET THERE: HOW DOES OUR SYSTEM NEED TO CHANGE?

All goals and objectives will be addressed consistently on a continual basis throughout the next three-year period. The following goals and objectives listed below are intended to assist the Las Vegas TGA achieve 100% access, 0% disparity in HIV/AIDS services through on-going systems improvements, timely and responsive planning and client-level evaluation.

Table 3.1 Goals, Objectives and Actions

Goals, Objectives and Actions	Responsible Party	Target Date
GOAL 1: Ensure a seamless system of HIV/AIDS care that is available and accessible for PLWH/A in the Las Vegas TGA based on the disease management model.		
Objective 1.1: Coordinate funding streams ensuring Ryan White funds are the payer of last resort.	Grantee, All Care Act Programs	2009/Ongoing
<i>Action 1.1.1:</i> Increase communication and collaboration between all Modernization Act programs and Community Service Providers by invitation to planning meetings, and capacity building retreats.	Council, Staff, HRSA TA	2009/Ongoing
<i>Action 1.1.2:</i> Maintain representation of Care Act grantees and Community Service Providers on the Planning Council.	Membership Committee, Staff	2009/Ongoing
<i>Action 1.1.3:</i> Ensure representation at each yearly All-Titles conference.	Grantee	2009/Ongoing
<i>Action 1.1.4:</i> Provide education to HIV providers regarding appropriate benefits counseling, legal support, and other client advocacy referral services.	Grantee, HRSA TA	2009/Ongoing
Objective 1.2: Develop and implement a Ryan White single eligibility and intake process.	Grantee	2009/Ongoing
<i>Action 1.2.1:</i> Development and implementation of a TGA wide multi-Ryan White eligibility intake process.	Grantee	2009/Ongoing
Objective 1.3: Increase the capacity of Community Service Providers to deliver culturally and linguistically appropriate services.	Council, Staff, HRSA TA	2009/Ongoing
<i>Action 1.3.1:</i> Provide technical assistance, when identified, to providers to enhance their ability to serve disproportionately affected sub-populations and historically underserved communities.	Council, Staff, HRSA TA	2009/Ongoing
GOAL 2: Ensure a high quality client centered service system designed to address barriers to access and adherence to care.		
Objective 2.1: Increase knowledge, awareness and availability of Ryan White services and how to access them.	Planning Council, Staff, Grantee	2008/Ongoing
<i>Action 2.2.1:</i> Track the number of Public Service Announcements and advertisements of Ryan White services.	Planning Council Staff	March 2009 (quarterly basis thereafter)

<i>Action 2.2.2:</i> Update, reprint, and disperse Ryan White service directories to service providers and key points of entry tracking how many are distributed.	Planning Council Staff	March 2009 (quarterly basis thereafter)
<i>Action 2.2.3:</i> Survey clients receiving services at each agency to see how they found out about that agency.	Planning Council Staff	March 2009 (annual basis thereafter)
<i>Action 2.2.4:</i> Review HIV quality management indicators to ensure effectiveness.	Grantee	March 2009 (semi-annual basis thereafter)
Objective 2.2: Revision of the Medical Case Management system.	Service Providers, Grantee, Council	March 2009
<i>Action 2.2.1:</i> Identify the needs and service gaps in Medical Case Management.	Council, Staff	March 2009 (annual basis thereafter)
<i>Action 2.2.2:</i> Collaborate with primary care sites to insure linkage and retention in HIV medical care.	Grantee	monthly and annual basis
Objective 2.3: Create Standards of Care designed to address and assess barriers to care.	Council, Staff	July 2009
<i>Action 2.3.1:</i> Update standards of care base on HIV Quality Management indicators.	Staff	March 2009 (annually thereafter)
Objective 2.4: Decrease the impact of stigma as a barrier.	All Stakeholders	Ongoing
<i>Action 2.4.1:</i> Develop and disseminate informative flyers to counter stigma with assistance from the AIDS AETC.	Staff, AETC	annual basis
GOAL 3: To reduce disparities in the access and availability of services for special and emerging populations.		
Objective 3.1: Ensure 50 new African American and 25 new Hispanic HIV clients will receive HIV specialty care.	All Stakeholders	July 2009
<i>Action 3.1.1:</i> Provide Outreach, Early Intervention Services and Medical Case Management to hard to reach minority clients through the Minority AIDS Initiative.	All Stakeholders	August 2009/ Ongoing
Objective 3.2: All new clients, detailed above, will receive a minimum of 2 CD4 and Viral Load counts based on PHS guidelines.	All Stakeholders	July 2009
<i>Action 3.2.1:</i> Deliver HIV services according to PHS Guidelines to minority populations described above.	All Stakeholders	July 2009/ Ongoing
Objective 3.3: All new clients, detailed above will receive necessary and appropriate medical care to address their HIV disease.	Service Providers	July 2009
<i>Action 3.3.1:</i> Deliver HIV services according to PHS Guidelines to minority populations described above.	Service Providers	July 2009
GOAL 4: To ensure continuity and quality of core medical and support services that meets or exceeds PHS and other industry standards.		
Objective 4.1: Implement a client level data system.	Grantee	March 2009

<i>Action 4.1.1:</i> Implement Careware.	Grantee	July 2009
Objective 4.2: Incorporate the use of quality management data into the planning and priority setting process.	Council, Grantee, Staff	June 2009 June 2010 June 2011
<i>Action 4.2.1:</i> Review and report on a systematic basis to ensure quality care.	Grantee	Ongoing
GOAL 5: To understand and address unmet need.		
Objective 5.1: Develop a system based on qualitative and quantitative data that identifies the unmet need population.	Grantee, SNHD	2009/Ongoing
<i>Action 5.1.1:</i> Develop in conjunction with the CQM contractor, a set of easily identified and collection data points that describe the unmet need population in the TGA.	Grantee, SNHD	2009/Ongoing
Objective 5.2: Develop and implement an effective targeted outreach evaluation system to reach the unmet need population.	All Stakeholders	2009/Ongoing
<i>Action 5.2.1:</i> In conjunction with the CQM contractor, develop a methodology by which the data on unmet need is crafted into an evaluation program covering data quality, testing and counseling activity quality, and effective client descriptions related to unmet need.	Grantee, SNHD	2009/Ongoing
Objective 5.3: Create a mechanism to bring individuals who have fallen out of care back into the care system.	Grantee, SNHD	2009/Ongoing
<i>Action 5.3.1:</i> In conjunction with the CQM contractor, develop a methodology by which the data on unmet need is crafted into an evaluation program covering data quality, testing and counseling activity quality, and effective client descriptions related to unmet need.	Grantee, SNHD	2009/Ongoing
Objective 5.4: Bring 5 % of those who have fallen out of care back into care.	Grantee, SNHD	2009/Ongoing
<i>Action 5.4.1:</i> Utilize motivational counseling, barrier identification and trust developing techniques to encourage individuals to re-enter the care system once identified in the community.	Grantee, SNHD	2009/Ongoing
GOAL 6: Ensure that Las Vegas TGA's Planning Council conducts its activities efficiently and effectively and that it fulfills all mandated roles and responsibilities.		
Objective 6.1: Prioritize services and allocate funds through an efficient and well-informed annual process while ensuring that people living with HIV/AIDS and community service providers are central to the planning and allocation of services and resources in the Las Vegas TGA.	Council, Staff, Grantee	June 2009 June 2010 June 2011
<i>Action 6.1.1:</i> Conduct a comprehensive needs assessment.	Council, Staff, Outside Consultant	2009 (every 3 years thereafter)
<i>Action 6.1.2:</i> Conduct a targeted needs assessment.	Council, Staff	2010 2011
<i>Action 6.1.2:</i> Utilize comprehensive services and resource data to inform the prioritization and allocation process, including epidemiological, unmet need, resource, and service utilization data	Council	June 2009 June 2010 June 2011

presented by Grantee and Staff.		
<i>Action 6.1.3:</i> Conduct a facilitated prioritization and allocation process involving and soliciting input from both people living with HIV/AIDS and Community Service Providers.	Council, HRSA TA, Grantee	June 2009 June 2010 June 2011
<i>Action 6.1.4:</i> Conduct a survey of prioritization and allocation processes, using the outcome to plan for a more effective and efficient process for the following year.	Staff	July 2009 July 2010 July 2011
Objective 6.2: Monitor the Planning Councils progress toward legislative requirements and expectations as defined by both HRSA and the local Planning Council itself.	Executive Committee, Staff	2008/Ongoing
<i>Action 6.2.1:</i> Collaboratively design and adhere to a calendar of events, meetings and mandated tasks.	Executive Committee, Staff	March 2009 (quarterly thereafter)
Objective 6.2.2: Increase Planning Council member's knowledge regarding the Modernization Act, its requirements and their role in implementing those requirements.	Membership Committee, Staff	March 2009 Ongoing
<i>Action 6.2.1:</i> Establish a training program for all new and existing Planning Council members including committee specific information.	Membership Committee, Staff	March 2009 Ongoing

SECTION IV: MONITORING OUR PROGRESS

MEASURING CLINICAL OUTCOMES

Overall Quality Management Program: The TGA has implemented a Clinical Quality Management (QM) Program designed to meet or exceed all HAB quality management expectations. The purpose of the QM program is to enable the grantee and Planning Council to monitor the fiscal performance, compliance with programmatic standards, quality of clinical care and health outcomes of care interventions for all funded Care Act services. The goal of the QM program is to provide information to the Planning Council for use in prioritizing services and allocating resources, and by the grantee and service providers to improve access to care, service delivery, quality of care and health outcomes.

Quality Management Oversight: The Quality Management Program is administered by the grantee with oversight from the Project Director and day-to-day management by the Program Manager. An external consultant is contracted to assist in development of an annual Quality Assurance Plan, update and revise the Quality Assurance Manual (including updating standards of care), conduct on-site provider audits monitoring compliance with standards of care, and work with the grantee to collect and analyze outcome data and convene the Quality Assurance Team.

Internal Assessment of the QM Program: As noted above one of the functions of the QM consultant is to review standards of care annually to assure compliance with the most current USPHS clinical standards of care.

Assessing Quality of Services: All Part A providers are required to deliver services according to the minimum PHS standards and generally accepted standards of practice for each specific service. This requirement is spelled out in language in the RFP to which providers respond, and again in any subsequent service contracts. In order to monitor compliance with this requirement, the grantee requires verification of appropriate staff licensure and/or organizational accreditation or certification applicable to each clinical service area. The grantee also requires that providers maintain their own internal QM systems; those protocols must be submitted as part of their proposal. The grantee also requests the results of providers' outcome studies and client satisfaction surveys regarding HIV care.

QM Indicators for Core Medical Services: The following indicators are included in the current QM Plan, spelled out in the RFP and service contracts and are reviewed during on site audits:

Primary Care:

Verification of Medical Licensure
Annual ID Physician visit
Semi annual RN care contact
Indicated sub-specialty referrals completed
Semi annual viral load, CD4
CD<350, VL >55,000 – ART
Annual Dental Referral
Annual TB screen
Women – annual PAP
Pregnant women, ART after 1st trimester

Medications:

CD<350 & VL >55,000 - ART
Pregnant women – ART after 1st Trimester
Additional meds as indicated

Medical Lab Tests:

Verification of Lab certification
Semi annual viral load, CD4
Lab values dictate treatment

Dental/Oral Care:

Verification of Dental Licensure
Semi annual dental visit

Preventive exam and cleaning
Procedures and appliances as indicated

Case Management:

Verification of LSW and supervision
Annual psychosocial assessment
Annual ISP, Interventions to ISP goals
Progress notes documenting interventions

Substance Abuse Treatment

Verification of staff licensure
Verification of certification through the Nevada Department of Alcohol and Drug Addiction Services (NDADAS)
Adherence to NDADAS treatment guideline
Verification of Medicaid Certification
Verification of medical, dental, lab visits

Mental Health Counseling

Verification of staff licensure
Verification of certification through the Nevada Department of Mental Health (NDMH)
Verification of Medicaid Certification
Adherence to NDMH treatment guidelines

Data Collection: Data required to implement the QM plan are collected from a number of sources. Structural indicators such as agency licensures, accreditations, policies and procedures regarding client rights, confidentiality and HIPAA, and service protocols are submitted to the grantee prior to any service contracting in service proposals.

The verification of such licenses and accreditations and of the practice of written policies is done during the provider site visits through chart reviews and employee interviews. Compliance with process indicators including PHS standards and other locally established program and service guidelines is also verified during provider site visits. Client demographic data, service usage patterns and spending patterns utilization are provided by the grantee from their own data base.

Data for reporting outcomes comes from a number of sources. Data relating to specific service usage patterns comes from the grantee's database.

Planning Council's plan for semi-annual evaluation of their progress in implementing the comp plan for June and December for the next 3-year period.

ACRONYMS

ADAP-AIDS Drug Assistance Program
AETC-AIDS Education and Training Center
AFAN-Aid for AIDS in Nevada
AIDS-Acquired Immunodeficiency Syndrome
ASO-AIDS Service Organization
CBO-Community Based Organization
CDC-Centers for Disease Control and Prevention
COMC-Community Outreach Medical Center
CY-Calendar Year
EMA-Eligible Metropolitan Area
FY-Fiscal Year
HAART-Highly Active Antiretroviral Therapy
HCV-Hepatitis C Virus
HIV-Human Immunodeficiency Virus
HOPWA-Housing Opportunities for People With AIDS
HRSA-Health Resources and Services Administration
IDU-Injection Drug User
MAI-Minority AIDS Initiative
MSM-Men who have Sex with Men
NALA-Nevada Association of Latin Americans
PHS-Public Health Standards
PLWA-People Living with AIDS
PLWH-People Living with HIV
PLWHA-People Living with HIV/AIDS
RFP-Request for Proposals
RWHTMA-Ryan White HIV Treatment Modernization Act
SAPTA-Substance Abuse Prevention and Treatment Agency
SAMHSA – Substance Abuse and Mental Health Services Agency
SCSN-Statewide Coordinated Statement of Need
SNAMHS-Southern Nevada Adult Mental Health Services
SNHD-Southern Nevada Health District
STI-Sexually Transmitted Infections
TGA-Transitional Grant Area
UMC Wellness- University Medical Center Wellness Clinic
UNLV-University of Nevada Las Vegas
VA-Veterans Administration