The LAS VEGAS TGA
RYAN WHITE PART A

HIV/AIDS NEEDS ASSESSMENT
2009

Acknowledgments

Conducting a Comprehensive Needs Assessment involves numerous people within a community lending their time and talents to fight for one common cause. This needs assessment was no exception, it came together in just six months as a result of hard work from the diverse and dedicated individuals throughout the Las Vegas TGA. These include:

Members of the Planning Councils Needs Assessment/Care Strategies Committee

- Leaha Crawford, Chair
- Gina Byrge
- Karyn Smith
- Heather Lazarakis
- Clayton McLean

Ryan White and Non-Ryan White Funded Service Providers

- Aid for AIDS of Nevada, AFAN
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- Community Counseling Center
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- Nevada Association of Latin Americans (NALA)
- The GLBT Center of Southern Nevada

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- Jeff Vollman
- Alisha Campbell

The Ryan White Part A Planning Council Coordinator

- Shayla Streiff

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- Rick Reich
- Sabrina Hagan-Finks

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Executive Summary

Introduction

The Ryan White Part A Las Vegas TGA's Planning Council is entrusted each year with prioritizing resources and allocating Ryan White dollars by service category, unrelated to who provides these services, to help meet the needs of those living with HIV/AIDS. In order to effectively plan for services and set funding priorities the Planning Council must base decisions on data provided by this needs assessment regarding service utilization, gaps in care, barriers to care, and the needs and availability of services to PLWH/A (persons living with HIV/AIDS).

The Health Resource Services Administration's (HRSA) requirements indicate the importance of brining PLWH/A who know their HIV status and are currently not receiving primary medical care into the care system. Therefore this needs assessment was designed to focus on the following priority populations as they comprise a large portion of the infected population with the lowest number known to be currently accessing services. The goal is to uncover why these populations are not currently receiving care and strategies on how to bring them into the care system.

Men who have Sex with Men (MSM)	Injection Drug Users (IDU)
• MSM of Color • White MSM	• MSM/IDU • Male IDU Population • Female IDU Population

This needs assessment was a team effort. Oversight and management was provided by the Planning Council Coordinator under the supervision of the Planning Council's Needs Assessment/Care Strategies Committee. Several service providers assisted in the recruitment process for client focus groups and consumer surveys. Provider and consumer input was critical and all contributions are recognized and appreciated.

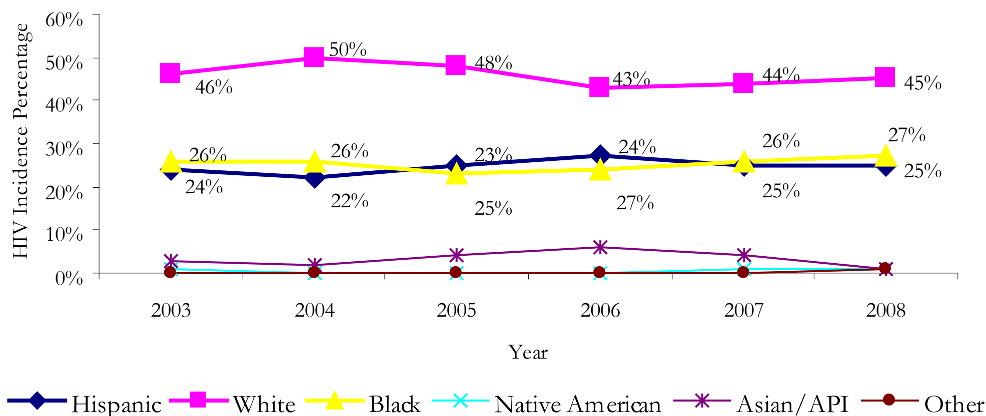
Epidemiological Profile

In 2008 there were 6,867[1] people known to be living with HIV/AIDS in the Las Vegas TGA. That same year 358 new cases of HIV were reported and 247 new cases of AIDS. The majority of new HIV cases occurred in the White population representing 39% with the Black and Hispanic population nearly aligned for second highest at 28% and 29%. The MSM population saw the highest rate of infection representing 68% of newly diagnosed HIV cases followed by the Heterosexual population representing 20%. With Males representing 81% of new HIV cases and the 20-49 year old age group also representing 81% of new HIV cases.

Over time trends have remained relatively stable with no more than a 5% increase or decrease in incidence per year within a single population from 2003 to 2008. The majority of newly diagnosed HIV/AIDS cases and prevalence in the Las Vegas TGA is and has been over the last four years primarily in four categories; MSM, Whites, Males, and the 20-49 age range.

[1] Surveillance data provided by the Nevada State Health Division HIV/AIDS reporting system.

Figure 1.1 Trends in HIV Incidence by Race/Ethnicity in Clark County 2003-2008



Unmet Need

The Grant Year 2008-2009 unmet need estimate[2] found that 36% (1,949)[3] of PLWH (not yet AIDS) in Clark County did not receive HIV Medical Care in the previous 12 months. Those PLWA who did not receive HIV Medical Care during that same time period in Clark County was 59% (1,107). The total estimated unmet need in Clark County as of February 28, 2009 was 47% (3,056).[3]

The rural counties in Arizona had an unmet need estimate of 39% (565) during calendar year 2007. The overall state of Arizona during the same time frame had an unmet need estimate of 40% (5,831) Mohave County specific data is unavailable.

The White population comprises 55% of unmet need in the region while White males comprise 48% of HIV unmet need and 49% of AIDS unmet need. The Black population has the second highest rate at 23% overall unmet need and the Hispanic population at 19%. MSM represent 57% of the out of care population while men alone represent 84%. Females, representing 16% of out of care clients, have 3 times more out of care Black females than Hispanic females with an HIV diagnosis and 2.5 times with an AIDS diagnosis.

Through efforts of the Out of Care Project at the Southern Nevada Health District, 51 PLWH/A were found to already be in care, 36 were located but refused treatment, 14 were brought back into care, and 856 had moved to a new jurisdiction leaving the out of care population in Clark County at 39.6%.

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[2] Unmet Need refers to the approximate number of people in the service area who are HIV positive (HIV+/non-AIDS or AIDS) and know their status, and are not receiving regular HIV related primary medical care (for a period of 12 months or more).

[3] Data was extracted for all patient records in HARS with no reported death and an HIV or AIDS diagnosis before March 1, 2008. Total Out-of-Care was computed from a SAS based program provided by the CDC. The Out-of-Care population was derived from all patients in HARS that received no treatments or blood tests during the period of March 1, 2008 through February 28, 2009.

In collaboration with the SNHD Comprehensive Risk Counseling Services (CRCS) Project, the following are informal responses that were collected for those not accessing CARE services;

- 2,504 "Didn't want to deal with it – in denial"
- 3,461"Didn't feel sick and didn't think care was important"
- 2,674 "Been on meds before – couldn't handle the side effects"
- 2,269 "Substance abuse problems"

Figure 1.2 Out-of-Care Project Demographics and Mode of Transmission

Those Brought Back Into Care	Those Refusing Care or Treatment
36% Hispanic	42% Black
36% Black	28% Hispanic
29% White	28% White
79% Male	69% Male
21% Female	31% Female
71% MSM	53% MSM
7% MSM/IDU	19% Heterosexual
7% IDU	19% NRR (no risk reported)
7% Heterosexuals	
7% NRR (no risk reported)	

Of the out of care PLWH/A their primary care needs were indicated as; access to affordable medication, transportation, and access to support services.

Findings

Consumer Survey

The consumer survey, using a convenience sampling approach, reached 545 participants in the infected or affected TGA community. The respondents profile closely mirrors the regional epidemic and the total Ryan White consumer base in the case system during calendar year 2008.

Barriers to Care

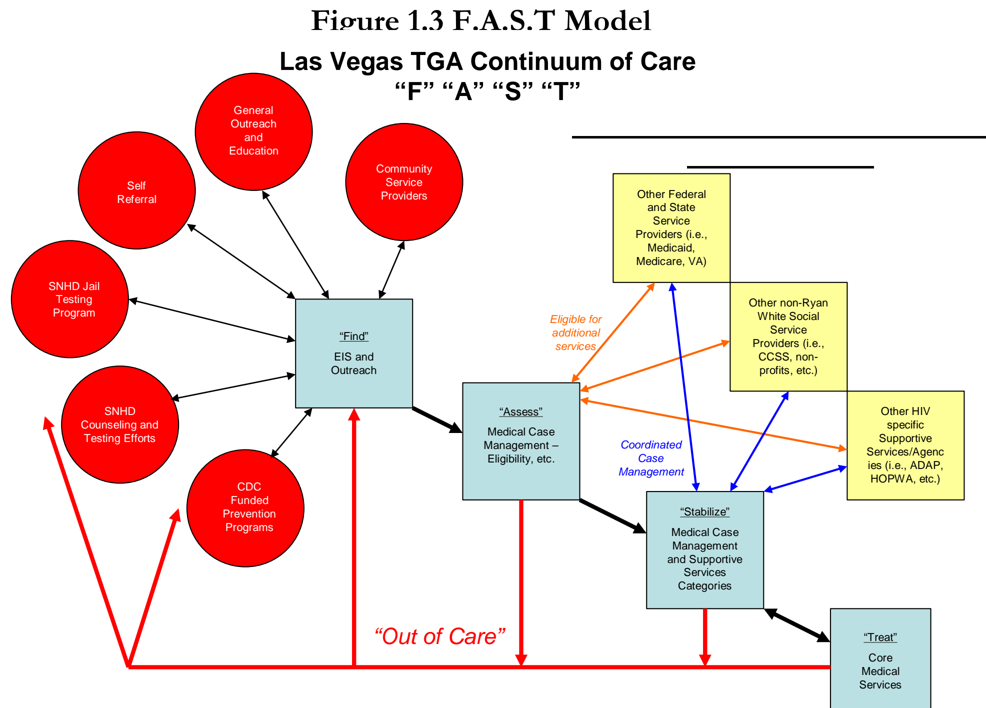
The most widely indicated barrier by survey respondents that prevented consumers from accessing medical or supportive services within the last year was that they didn't know where to access services; on some occasions they didn't even know it was available to them. During each of the three male focus group discussions much of the conversation was concentrated on the difficulties faced while attempting to access the care system in Las Vegas, especially when compared to other TGA's and EMA's. However the female focus group, although the majority of them had been accessing the care system for 5 years or more, said they know where to go for all the services they require.

The following overlapped in all three of the male discussions; the need for a buddy program or volunteer case management system to help navigate newly diagnosed people or those just entering the care system, the need for case managers to be more educated on the services available to clients throughout the community, and the need for better and more referrals from case managers and agencies in general. Additionally the second most indicated barrier providers face while trying to provide services at their agency was tied between; limited community partnerships/linkages with specialized HIV organizations, and my agency doesn't provide all the services a person needs.

The survey responses from consumers and providers as well as the focus groups illustrate one of the greatest challenges we face in the Las Vegas TGA; a disjointed system of care and lack of information in the community regarding free and low cost care through the Ryan White Program and through other funding streams. The number one goal in our TGA's Comprehensive Care Plan is to 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, figure 1.1. This model represents our ideal continuum of care and uses the acronym F.A.S.T. which stands for Find, Assess, Stabilize and Treat. 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. The Stabilization phase of this model is where coordination and collaboration by case managers, clients, and agencies is needed to ensure all physiological needs are provided for so that clients will enter and remain in HIV/AIDS primary medical care.

Figure 1.3 F.A.S.T Model



Similar to other areas across the country, those who are 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 and connect them with the appropriate services and capabilities to navigate the system will allow for case managers to devote more time to high acuity cases. Several objectives and action items have been outlined in the Comprehensive Care Plan to achieve this seamless system of care. They also speak to a streamlined intake and eligibility process, and the process of increasing the capacity of providers to deliver culturally and linguistically appropriate services, barriers that were also discussed with high importance for resolve.

When consumers were asked to indicate the difficulties they face while accessing any medical or supportive service on a regular basis, they indicated;

- lack of transportation 30%
- no issues 27%
- stigma 21%
- depression or other mental health issues 17%
- eligibility process is too long and difficult 13%
- have a hard time keeping appointments 13%

Qualitative comments include;

- financial problems/no money
- the entire process is too long/repetitive

- service providers cancel appointments
- lack of proper guidance/trouble finding locations
- medical issues/symptoms/don't want medical treatment

Barriers Resulting in Out of Care PLWH/A

A total of 23% of survey respondents indicated they had fallen out of care at least once since their diagnosis for 3 months or more. Twenty-nine percent of those PLWH/A indicated their time out of care was for 12 months or more. Of the overall total who had fallen out of care at one time or another 14% indicated it was because they didn't know where to go for care with 18% indicating they moved to a new city, state or location signifying they most likely didn't know where to access care. Using drugs, which made it hard to adhere to care, was sited by 16%, stigma by 13%, inadequate transportation by 23%, and a dislike for the service or the treatment by providers delivering the services was indicated by 31%.

Priority Populations

MSM of Color Population

In the United States HIV infection and AIDS has had a tremendous effect on the MSM population especially in racial and ethnic minority groups. Minority MSM often face poor access to health care because of lack of health insurance and poverty. Additionally, many cope with types of stigma; racial/ethnic minority, MSM, and HIV positive. Therefore, MSM of Color may fear condemnation from their families, communities, and even service providers, preventing them from ever entering the care system.[4]

MSM of Color are often referred to as "hidden" due to a lack of "gay-affirming" venues in their community or a general fear of being "out" in public. House parties are a major social venue and sexual partners are often sought online making prevention, testing, counseling, and care infinitely more challenging. In addition, many minority MSM identify with their racial identity more than their sexual identity; thus, messages encouraging testing and care aimed at the gay community often do not reach them.[5] For MSM of color who date within their race, increased prevalence coupled with a smaller dating community place them at increased risk. Poor self-esteem, loneliness, and internalized homophobia are linked to high-risk behaviors and also increased risk for HIV.[6]

MSM in general represented 64% of HIV/AIDS prevalence in the Las Vegas TGA in 2008. MSM of Color represented 22% of total survey respondents. Stigma is hugely associated with this population, especially with regard to accessing Ambulatory/Outpatient Medical Care in the TGA. This could be attributed to known characteristics of the MSM of Color community and the location of Ryan White HIV/AIDS service providers. Currently Ryan White funded Ambulatory/Outpatient Medical Care services are not specifically located in area's of the TGA with a high population density of Black's. Of the two Ryan White Part A medical providers one is located in the "hospital district" or low income area, the other is located in an area with a large Hispanic population.

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[4] National Alliance of State & Territorial AIDS Directors. *Findings from targeted interviews on HIV prevention activities directed toward Black men who have sex with men.*

[5] National Alliance of State & Territorial AIDS Directors. *Findings from targeted interviews on HIV prevention activities directed toward Black men who have sex with men.*

[6] Populations Served by the Ryan White HIV/AIDS Program: MEN OF COLOR WHO HAVE SEX WITH MEN AND HIV/AIDS www.HAB.HRSA.Gov

Other major barriers to accessing care on a regular basis were indicated by the MSM of Color respondents as;

- 14% "the eligibility process is too long and difficult"
- 13% "didn't know where to find the services"
- 9% "lack of transportation"

During the consumer focus groups the MSM of Color discussion indicated some similarities to survey respondents. 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

This focus group also displayed many of the MSM of Color traits discussed above. Those in attendance discussed their dislike for being labeled "MSM" and "gay" stating that they clearly are not either but did contract HIV/AIDS from male-to-male sexual contact. This outlook from the MSM of Color community could have a profound influence on the out of care population in the TGA. In 2009 MSM represented 57% of overall unmet need while the Black and Hispanic population represented 23% and 19%.[7] This group discussed their major reason for accessing care as their fear of getting sick again (spending time in the hospital), and their friends and support systems encouragement.

HRSA's response to MSM of Color issues; providers must cultivate and then provide high-quality, non-judgmental services that help MSM acknowledge their risk, get tested, and stay in care over time. The usage of peer educators can also be critical.

White MSM Population

Sexual risk factors account for most HIV infections in MSM including unprotected sex and sexually transmitted diseases (STD's). Having unprotected male-to-male sexual contact is a significant threat to the health of MSM and this act with casual partners is an increasing concern. Research points to the following factors for the apparent increase in unprotected sex among MSM; optimism about improved HIV treatment, substance use, complex sexual decision making, seeking sex partners on the internet, and failure to practice safer sex.[8] There is growing recognition that combinations of

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[7] The following data was extracted for all patient records in HARS with no reported death and an HIV or AIDS diagnosis before March 1, 2008. Total Out-of-Care was computed from a SAS based program provided by the CDC. The Out-of-Care population was derived from all patients in HARS that received no treatments or blood tests during the period of March 1, 2008 through February 28, 2009.

[8] Wolitski R. The emergence of barebacking among gay men in the United States: a public health perspective. *Journal of Gay and Lesbian Psychotherapy* 2005;9:13–38.

individual, socio-cultural, and biomedical factors affect HIV risk behavior among MSM.[9] Childhood sexual abuse, substance use, depression, and partner violence have been shown to increase the practice of risky sexual behaviors. Further research has shown that the combined effects of these problems may be greater than their individual effects.[10] Therefore, MSM with more than one of these problems may have additional risk factors for HIV infection.

Survey respondents identifying as White MSM made up 15% of the survey sample. Barriers to accessing care on a regular basis in the Las Vegas TGA were indicated as;

- 30% "lack of transportation"
- 24% "eligibility process is too long and difficult"
- 19% "depression or another mental health issue"
- 15% "stigma"

The focus group discussion for this category yielded similar barriers. These 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

Many of the responses were of an internal nature during the White MSM focus group. Respondents listed reasons for accessing care as; motivation to live for family, friends, their next birthday, their hobbies of bowling, sports, hope and 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.

IDU Population

The spread of HIV/AIDS in the United States is fueled in part by the use of illicit drugs. Injection drug use (IDU) is directly related to HIV transmission because it may involve the sharing of drug equipment which can be contaminated with blood born pathogens. The use of both injected and

[9] Fenton KA, Imrie J. Increasing rates of sexually transmitted diseases in homosexual men in Western Europe and the United States: why? *Infectious Disease Clinics of North America* 2005;19:311–331.

[10] Stall R, Mills TC, Williamson J, et al. Associations of co-occurring psychosocial health problems and increased vulnerability to HIV/AIDS among urban men who have sex with men. *American Journal of Public Health* 2003;93:939–942.

non-injected illicit drugs impairs decision making and increases sexual risk-taking behavior, which in turn, increases the risk for acquiring HIV. [11]

Since the beginning of the epidemic in the U.S. injection drug use has directly and indirectly accounted for more than one-third of AIDS cases. Nationally crystal methamphetamine use among MSM has spiked over recent years, increasing sexual risk-taking behaviors and often interfering with HIV drug regimen adherence. With continued use, crystal methamphetamine can decay teeth, making HIV-positive MSM more susceptible to oral infections which can spread throughout the body, prevent care and even lead to death.

Nevada, with its nightlife and entertainment, has become a Mecca for drug traffickers. Nearly all illicit drugs are available in Nevada, however, methamphetamines, like most of the nation, are most commonly used.[12] Drugs such as cocaine, marijuana, heroine and other "club drugs" also contribute to the spread of the epidemic when users trade sex for drugs or money, or when they engage in risky sexual behaviors that they might not engage in when sober.[12]

In the Las Vegas TGA, HIV/AIDS transmission by injection drug use represented 10% of the overall prevalence and 8% of new cases in 2008. MSM/IDU transmission represented 6% of current prevalence and 4% of new HIV cases in the TGA. The IDU transmission method recently moved to 3rd place in 2007 in overall prevalence behind MSM and heterosexual transmission. From 2004 to 2006 IDU was the second highest mode of transmission for HIV in the TGA. Due widely to recently imposed restrictions regarding pharmacy distribution of known products for making methamphetamines, incidence from 2003 to 2008 involving methamphetamine production in local labs decreased by 90%. However, due to its close proximity to California, Nevada serves as an import and transshipment point for transporting drugs to central and eastern parts of the country. While this drug is now manufactured on a very small scale within the state it remains available to users and suppliers.

Even though substance abuse treatment is crucial for staying in HIV care and adhering to a treatment regimen, it is in short supply. The introduction of buprenorphine, a treatment for opiate addiction that may be given in a primary care setting, offers hope for improved access to treatment for addiction. Special training, however, is required to administer buprenorphine, and the training may not be readily available in all health care environments.[13]

Recent studies have found that trauma, substance abuse, and sexual risk factors are interconnected. For example, women who have experienced sexual abuse, whether as a child or an adult, may be more likely than other women to use drugs as a coping mechanism, have difficulty refusing unwanted sex, or engage in sexual activities with strangers. Women who have experienced trauma also may be less assertive about birth control and have a greater number of lifetime partners,

[11] Populations Served by the Ryan White HIV/AIDS Program www.hab.hrsa.gov

[12] US Drug Enforcement Administration

[13] Substance Abuse and Mental Health Services Administration (SAMHSA). Illicit drug use. In: SAMHSA. Results from the 2006 National Survey on Drug Use and Health: National Findings. Rockville, Md: Author; 2007.

increasing their risk for HIV infection.[14] In addition, research has found that people who suffer from mental illness are more likely to use injection drugs.[15]

Users of illicit substances may receive HIV services through all parts of the Ryan White HIV/AIDS Program. However, the lack of drug treatment services in the United States has placed increased pressure on Ryan White HIV/AIDS Program providers because they must address substance abuse issues often coupled with other more complex issues to sustain individuals in care over time.[16]

Men IDU Population

This category represents 7% of overall survey respondents as indicated by mode of transmission, not current drug usage. These categories were defined as either sharing needles or having sex and sharing needles. Respondents represented four race/ethnicities in this specific mode of transmission;

- White 53%
- Black 26%
- Hispanic 16%
- American Indian or Alaskan Native 5%

Barriers that make it difficult to access care on a regular basis were indicated as;

- "lack of transportation" 42%
- "depression or other mental heath issue" 26%
- "stigma" 21%
- "lack of housing" 16%
- "don't know where to find services" 13%

The focus group discussion yielded a somewhat different scenario with barriers to care indicated as;

- Lack of compassion and understanding by service providers
- The need for 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 and more follow-up by case managers
- More incentives including food vouchers or gift cards
- "Providers need to show more compassionate, and be less prejudiced", incorporate more client input into systems/processes
- Cut down on cumbersome paperwork
- More objective grievance system that doesn't make consumers feel like they are going to lose services
- Provide more recreational activities such as movie tickets or tickets to shows, "we (clients) can't afford recreational activities"

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[14] Simoni JM, Sehgal S, Walters KL. Triangle of risk: urban American Indian women's sexual trauma, injection drug use, and HIV sexual risk behaviors. *AIDS Behav*. 2004;8:33–45.

[15] Weiser SD, Wolfe WR, Bangsberg DR. The HIV epidemic among individuals with mental illness in the United States. *Curr HIV/AIDS Rep*. 2004;1:186-92.

[16] Substance abuse and HIV/AIDS, see the March 2004 issue of *HRSA CAREAction*, available at http://www.hab.hrsa.gov/publications/march04.

- 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"
- Provide better transportation, not just bus passes

Reasons for staying in care included; 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 orders they cited reasons such as; choosing to drink or "party" over taking their meds, disliking the side effects, disliking taking pills, sometimes forgetting to take medication and addictions to a substance consistently interferes with doctor prescribed regimen.

Female IDU Population

The female IDU population represented just over 1% of total survey respondents again indicated by mode of transmission, not current drug use. This, as it did in the Male IDU Population, encompasses either sharing needles or having sex and sharing needles. Respondents fell within the following race/ethnicities;

- White 38%
- Hispanic 25%
- Black 25%
- American Indian or Alaskan Native 12%

Barriers that make it difficult to access care on a regular basis were indicated as;

- "I have a hard time keeping appointments" 25%
- "language or cultural barriers" 13%
- "stigma" 13%
- "don't want to take medication because of the side effects" 13%

Barriers to care discussed within this focus group were identified as;

- Transportation and housing
- Drug abuse (when actively using)

In order to promote access to and retention in care this group indicated that more "lunch and learns" or client centered social activities/events are needed in order to link clients facing similar issues to a support system. Regarding gaps in care this group indicated a need for household and personal supplies such as dishes, new linens, and hygiene products; also cleaning supplies such as laundry soap and bleach. Overall current services were regarded as "excellent" "great" and "better than they have been in the past".

Key Services

Ambulatory/Outpatient Medical Care

The positive health outcomes associated with appropriate medical management of HIV/AIDS have resulted in HRSA's increasing emphasis to utilize Ryan White funding for Ambulatory/Outpatient Medical Care and Supportive Services that will link consumers with and support them in care using a 75%/25% distribution ratio.

Consumer survey respondents recognized the need for HIV/AIDS medical care, ranking it as the number one priority among all services, with an indicated service gap of 8%. In care consumers

identified lack of transportation, lack of knowledge on the availability of the service and where to access it, and the feeling of being treated poorly by the service provider as major barriers. Therefore enhance HIV/AIDS medical care by:

- Ensuring adequate transportation is available especially in rural areas.
- Provide a service directory at all points of entry in the care system indicating services provided, location(s), and contact information.
- Ensure service providers adhere to standards of care while providing services in a manner that supports consumers' cultures, value systems and beliefs.

Additional factors in need of consideration in the Las Vegas TGA system of care include;

- The extremely high rate of HIV/AIDS in the Black population in the Las Vegas TGA, 975 per 100,000.
- The unusually high rate of stigma to accessing HIV/AIDS medical care among the Black population.
- Populations under-utilizing HIV/AIDS medical care; MSM, White's, and Males.

AIDS Pharmaceutical Assistance

Assistance with obtaining HIV/AIDS life sustaining medication was ranked as the second priority among PLWH/A survey respondents in the Las Vegas TGA, with a 12% current service gap. Due largely to the advancements in HIV/AIDS medication the fatality rate in the TGA dropped 59% between 2005 and 2008.

In care consumers indicated they didn't know where to access this service, the process of obtaining medication is too cumbersome and lengthy, and the inability to take medication due to; drug use, dislike of side effects from medication, inability to swallow pills, ect. Therefore, enhance adherence and access to medication by:

- Connect with the local Ryan White Part B Grantee to discuss the need for more pharmacies (more than one location) to dispense medication to Ryan White consumers in the TGA.
- Emphasize the importance and magnitude of consequences regarding HIV/AIDS medication. Additionally, discontinue providing medication to clients adhering to physician prescribed medication regimens less than 50% of the time, instilling a waiting period to be placed back on medication assistance.

Additional factors in need of consideration in the Las Vegas TGA include;

- Hispanic population utilizing 60% of AIDS Pharmaceutical Assistance during GY 07-08.

Dental/Oral Health Care

While dentists recommend that all people seek routine care to prevent oral health problems from developing, it is particularly imperative for those living with HIV/AIDS. Individuals with a compromised immune system need to avoid bacterial infections, and the two major oral health conditions, dental caries and periodontal disease, both caused by bacteria and may be intensified by other factors. While preventative and procedural care are both needed for PLWH/A, preventative care is much less costly, healthier and less invasive than treatment.

Dental/Oral Health Care was ranked as the 3rd highest priority for consumer survey respondents, also indicating a 36% gap in care. Enhancing access to oral health care is crucial for PLWH/A throughout the region and providing education regarding the importance of dental hygiene for

PLWH/A could prevent bacterial infections in the mouth from spreading to other areas in the body resulting in higher overall treatment costs.

Early Intervention Services

Moving newly diagnosed PLWH/A into medical care immediately after diagnosis is the critical first step to maintaining PLWH/A in the care system. Effective post-test counseling, referrals to HIV/AIDS medical care and needed support services is essential.

Consumer survey respondents ranked EIS the 4th highest priority in the care system. Therefore enhance Early Intervention Services by:

- Fully implementing and familiarizing consumers, providers, and all points of entry with the Las Vegas TGA Continuum of Care F.A.S.T Model ensuring all participants involved follow through with outlined tasks to establish a seamless transition into the care system for all newly diagnosed and those re-locating to the TGA.

Health Insurance Premium and Cost Sharing Assistance

This cost containment program is vital to the overall care system with the intention of saving Ryan White funding by purchasing cost effective employment-related medical insurance for PLWH/A. This allows for a portion of Ryan White clients to utilize medical care not funded directly by Ryan White, while alleviating the burden of the uninsured on the care system and allowing more funding to provide for more and/or higher acuity cases.

Survey respondents ranked this as the 5th priority overall among Ryan White funded services. Keeping clients in the care system is critical and utilizing this program promotes usage of medical services, allows participating clients to enjoy more independence when selecting a physician, and allows for more funding to be utilized by PLWH/A in need of Ryan White funded medical services. It is critical that this service is promoted as an option for PLWH/A as the most indicated barrier to accessing this service was the client didn't know about it or where to access it.

Linkages with Non-Ryan White Funded Agencies

The Las Vegas TGA is strongly dedicated and strives to meet the many needs of people living with HIV/AIDS in the region. This needs assessment will allow determination of funding priorities, but the growing epidemic and the many needs identified can only be fulfilled with the help and support of organizations throughout the community and additional funding streams. In order to maintain the continuum of care and effectively adapt to new and growing demands the Planning Council, Grantee, and Service Providers need to leverage available Ryan White funding to best meet the needs of the clients and coordinate with other funding streams ensuring clients are adequately provided for.

Providers in the community indicated the top two things needed in order to increase capacity to serve PLWH/A at their agency as more funding to expand current capacity, and increased partnerships with HIV/AIDS specialty organizations. While attempting to provide services to PLWH/A providers indicated three major barriers; 1) clients lack payment source, 2) limited community partnerships/linkages with specialized HIV organizations, and 3) our agency doesn't provide all the services clients need. Similar trends can been seen in focus group comments regarding the lack of resource stability throughout agencies and the lack of knowledge case managers have regarding available services throughout the community. Again client surveys collectively

indicated the major barrier to care was simply not knowing the service was available and where to access it. Linkages within the community are vital, especially during the current recession, open lines of communication between case managers throughout the region will help ensure clients receive HIV/AIDS medical care and all necessary supportive services to stabilize and keep them in care.

Current State of the Las Vegas TGA

By the end of 2008 Las Vegas had its smallest annual population gain in nearly 20 years. With only 14,000 domestic migrants relocating to the Valley in 2008, two years ago the valley saw three times that many[17]. Home prices in the valley have fallen 50.6% from the market's peak in June 2006 at $315,000 to $155,603 in February 2009.[18] Las Vegas, with the third highest foreclosure rate in the nation, has approximately 30,000 vacant housing units with no one to fill them. The unemployment rate in Las Vegas was 10.4% as of March 2009, statewide was at 10.6%, and Nye County 13%.[19]

The recent economic recession, housing downturn and financial meltdown has left much of the U.S. population in disarray. The rippling effects of job layoffs, mortgage foreclosures, and frozen lines of credit can bee seen throughout every industry, impacting some beyond repair. Major industries in Nevada are leisure and hospitality (26.2%), construction (10.4%), and trade and transportation (18%). While these industries flourished 5% to 6% above the national average from 2002 to 2006, regional job growth in 2007 was at 1% and shortly after moved into the negative where it remains in 2009. [20]

All of these factors have attributed to patterns of increase client demand for service (56.3%), increase in the number of clients seeking services (68.8%), and a decrease in the amount of funding received from any funding stream (59.4%) that Ryan White and non-Ryan White providers have reported occurring at their agency over the last year.[21] While these Community Based Organizations and AIDS Service 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. The numbers of new clients accessing care are skyrocketing, unfortunately available funds are not. While an increase in the capacity of the care system is ideal, at this time budget cuts and shortfalls are inevitable. Thus making the identification of gaps in care and increasing the coordination of funding streams to fill those gaps is vital.

Gap Analysis

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 in the TGA, but provider capacity has remained constant while facing fewer funds available for patient care.

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[17] U.S. Census Bureau www.census.gov

[18] The Greater Las Vegas Association of Realtors

[19] Nevada Department of Employment Training and Rehabilitation

[20] Nevada Department of Employment Training and Rehabilitation: Workforce and Economic Briefing

[21] Profile of Provider Capacity and Capability Survey (percentages are reported % of agencies not as percentage increase by year)

The gap analysis was designed to outline gaps in care by service category and is accomplished by projecting the need identified by the consumer survey. It is a generalized summary of the consumer survey in relation to the population of PLWH/A in the TGA. It projects the total need for a service, the extent to which the need is currently being met and estimates the number of PLWH/A not having their need met. These figures are based on the current prevalence of HIV/AIDS in the region (6,867).

This can be calculated by:

1. Calculate the total need by adding those using the service (implying need) with those not using it who stated a need.
2. Project this need to the population of PLWH/A in the Las Vegas TGA which identifies potential need for the service in the region. The calculation divides the total need by the total respondents and multiplying it by the population of PLWH/A in the TGA (6,867).
3. The total consumers who need the service but who are not having their need met is calculated by subtracting the total that are having their need met by the total needing the service. Again, this figure is a projection from consumer survey responses.
4. Capacity required to provide service to all needing but not getting service compares those whose need for the service is being met with those whose need is not being met.[22]

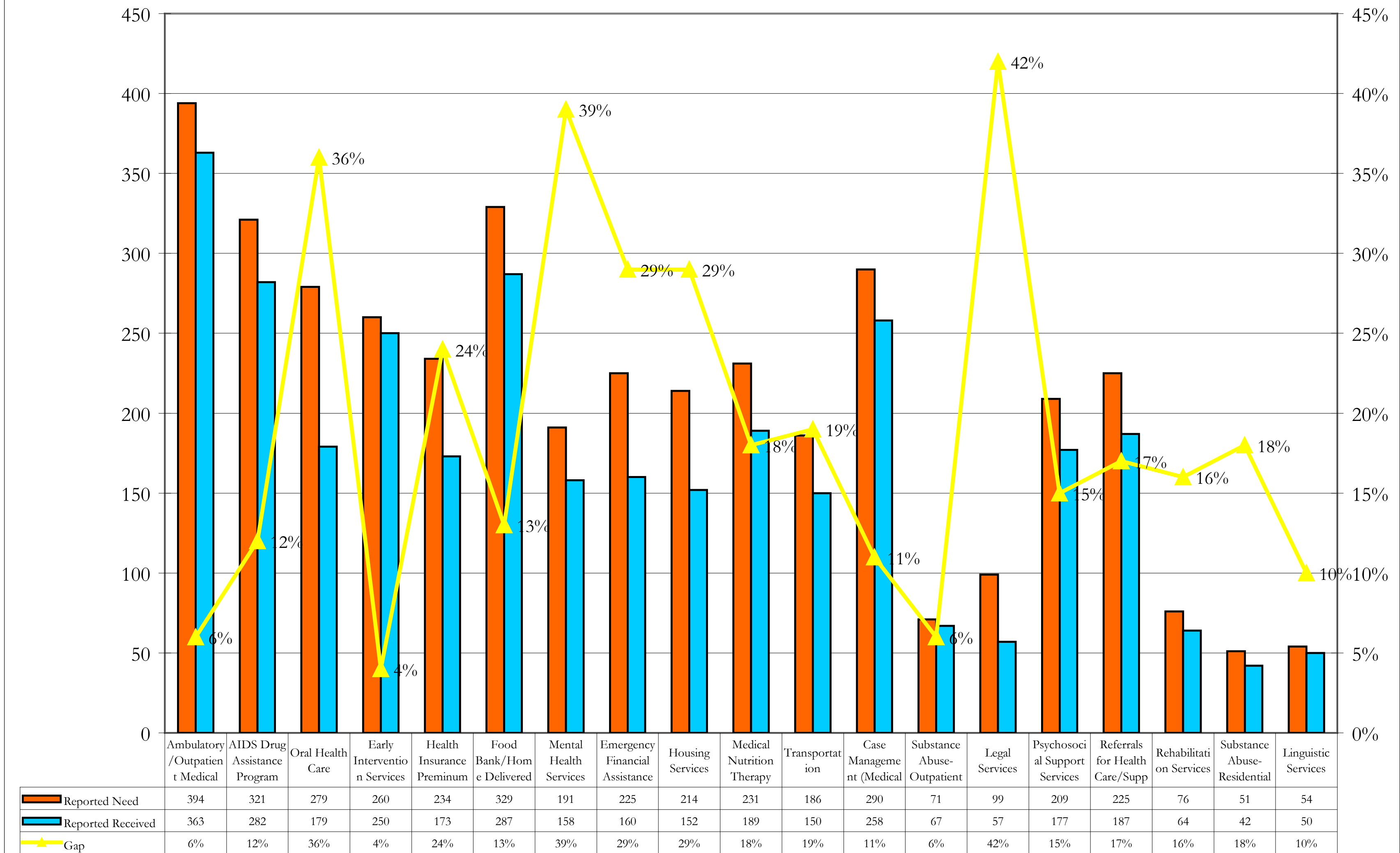
Increasing and expanding capacity, to bring out-of-care consumers into the care system, and providing care to all PLWH/A in need is challenging and will need to occur incrementally by developing targeted strategies and implementing them over time. While the current state of the economy might inhibit immediate expansion, it does not impede a strategic plan to develop the TGA into the ideal health care system for people living with HIV/AIDS.

Figure 1.4 outlines Planning Council priorities and allocations for Grant Year 2009-2010, expenditures by service category for Grant Year 2008-2009, consumer survey response priorities, and a gap analysis by service category. The largest gaps in Core Medical Services fall within Oral Health Care (56%), Health Insurance Premium & Cost Sharing Assistance (54%), and Medical Nutrition Therapy (22%). While the majority of gaps in supportive services fall within physiological needs; food, shelter, emergency financial assistance. Without those basic needs for survival being met clients aren't likely enter or remain in primary medical care and adhere to a medication regimen.

Figure 1.5 outlines by service category, the need, fulfilled need, and service gaps according to the consumer survey. Services are also in order of consumer reported priority, left to right, one through twenty.

[22] Ryan White Planning Council of the Dallas Area

Grant Year 2009-2010 HIV/AIDS Prevalence 6,867 (through December 31, 2008)	Planning Council Priorities & Allocations GY 09-10		Consumer Survey Response 2009 Priorities	Expenditures GY 08-09	Projected Need	Projected Need that is Met	Estimated Number in Need (per 2008 consumer survey results based on 2008 prevalence)	Total Estimated Expansion Required in the TGA's Care System	Total Estimated Expansion Required in the TGA's Care System in Dollar Amount
Ambulatory/Outpatient Medical Care	1	31%	1	$690,612	6,457	5,950	507	9%	$ 286,764.00
AIDS Drugs Assistance Program (ADAP)	3	0%							
AIDS Pharmaceutical Assistance (Local)	10	0.60%	2	$18,000	6,023	5,291	732	14%	$ 133,092.00
Oral Health Care	9	2%	3	$108,171	5,771	3,702	2,069	56%	$1,532,922
Early Intervention Services	4	12.30%	4	$448,996	5,816	5,592	224	4%	$136,416
Health Insurance Premium & Cost Sharing	5	7.70%	5	$422,830	5,618	4,129	1,399	54%	$2,830,331
Home Health Care	12	0%							
Home and Community-based Health Services	11	0%							
Hospice Services	13	0%							
Mental Health Services	6	2.20%	7	$231,089	5,045	4,173	872	12%	$1,044,089
Medical Nutrition Therapy	7	3%	10	$70,271	5,747	4,702	1,045	22%	$203,984
Medical Case Management	2	26.10%	12	$993,206	6,185	5,502	683	12%	$240,416
Substance Abuse Services: Outpatient	8	2.10%	13	$37,612	2,868	2,706	162	6%	$476,051
Total		87.00%		***$3,020,787***					***$6,884,065***
Supportive Services Aggregate	14	13%							
Case Management (non medical)			12	$3,167	6,185	5,502	683	12%	$240,416
Child Care Services			20		N/A	N/A	N/A	N/A	N/A
Emergency Financial Assistance - Housing/Utilities/Transportation/Medication			8	$237,176	5,722	4,069	1,653	41%	
Food Bank/Home Delivered Meals			6		5,618	4,129	1,399	54%	$2,830,331
Health Education/Risk Reduction									
Housing Services			9		5,423	3,852	1,571	41%	
Legal Services			14		3,675	2,116	1,559	74%	
Linguistic Services			19		N/A	N/A	N/A	N/A	N/A
Medical Transportation/Transportation			11	$42,739	5,753	4,640	1,113	24%	$67,370
Outreach Services									
Psychosocial Support Services									
Referrals for Health Care/Support Services			16		5,722	4,756	966	20%	
Rehabilitation Services			17		3,389	2,854	535	19%	
Respite Care for Caregivers									
Substance Abuse - Residential			18		N/A	N/A	N/A	N/A	N/A
Total				***$283,082***					



	Ambulatory/Outpatient Medical	AIDS Drug Assistance Program	Oral Health Care	Early Intervention Services	Health Insurance Preminum	Food Bank/Home Delivered	Mental Health Services	Emergency Financial Assistance	Housing Services	Medical Nutrition Therapy	Transportation	Management (Medical	Substance Abuse-Outpatient	Legal Services	Psychosocial Support Services	Referrals for Health Care/Supp	Rehabilitation Services	Substance Abuse-Residential	Linguistic Services
Reported Need	394	321	279	260	234	329	191	225	214	231	186	290	71	99	209	225	76	51	54
Reported Received	363	282	179	250	173	287	158	160	152	189	150	258	67	57	177	187	64	42	50
Gap	6%	12%	36%	4%	24%	13%	39%	29%	29%	18%	19%	11%	6%	42%	15%	17%	16%	18%	10%

Introduction and Methodology

Introduction

A needs assessment is an interconnected part of the Planning Council's yearly tasks and is completed as a partnership activity between the planning council, the grantee, and the community. The intent of the 2009 Comprehensive HIV/AIDS Needs Assessment is to identify services needs, barriers to care, gaps in care, and the unmet need throughout the Las Vegas TGA. This information is required in order to effectively set priorities and allocate resource by the Ryan White Part A Planning Council. The needs assessment results will not only be reflected in the priority setting and resource allocation process, but in the development of an HIV/AIDS Comprehensive Services Plan, and in crafting strategies to address uncovered needs through the implementation plan. In order to successfully provide this detailed information for decision making specific objectives were outlined. They include:

- ♦ Identifying the HIV/AIDS epidemic within the Las Vegas TGA, emerging trends and/or populations.
- ♦ Identifying services needs and barriers to using services by those currently accessing care.
- ♦ Acquire information regarding PLWH/A that are not currently receiving care, defining their barriers to care, and determining the reasons PLWH/A drop out of care.
- ♦ Identifying utilization patterns, gaps in care, and unfulfilled needs.
- ♦ Evaluating the current system of HIV/AIDS care including the current capacity and potential for expansion of services meet the demands and bridge the gaps in the continuum of care.

In order to complete these objectives information was derived from:

- ❖ Surveillance reporting courtesy of; The Nevada State Health Division HIV/AIDS Reporting System (eHARS) courtesy of the State of Nevada's Office of Epidemiology, Mohave Department of Public Health HIV Epidemiology Program and Sociedemographic Statistics by the U.S. Census Bureau.
- ❖ A detailed survey administered to 454 PLWH/A.
- ❖ Four separate focus group discussions for PLWH/A in populations with the greatest prevalence; MSM, MSM of color, Men IDU, and Women IDU.
- ❖ Ryan White and Non-Ryan White funded service providers through a provider capacity and capability survey including an inventory of community resources.

Definition of Our Service Area

This Needs Assessment focuses on the Las Vegas TGA which is comprised of three areas-Clark County Nevada, Nye County Nevada, and Mohave County Arizona. This TGA is unique in that it covers a vast area of 39,368 square miles that crosses state borders.

Local Support
Several agencies provided recruitment efforts for each of our four focus groups as well assisted in the delivery of the consumer survey, those include; Aid for AIDS of Nevada (AFAN), Community Outreach Medical Center, Community Counseling Center, Mohave County Department of Public Health, Nevada Association of Latin Americans (NALA), Nye County Health and Human Services, and the GLBT Center of Southern Nevada.

Oversight of the Needs Assessment
Direct oversight and management of the needs assessment was provided by the Planning Council Coordinator under the supervision of the Needs Assessment/Care Strategies Committee.

Priority Populations
This needs assessment placed emphasis on several factors, including; unfulfilled needs of out of care PLWH/A and the development of strategies on how best to meet those needs, emerging populations and those disproportionately affected by the epidemic. Those include:

- ***Men who have Sex With Men (MSM)***
  This continues to be the largest population of incidence and prevalence in the TGA especially in the Caucasian/White population and among minority MSM.
- ***Injection Drug Users (IDU)***
  Comprising a large portion of the incidence and prevalence in the TGA is the IDU and MSM/IDU population.
- ***Out of Care Population***
  PLWH/A who know their HIV status and are not accessing medical care for whatever reason. Importance was placed on identifying; 1) who they are, 2) where they are, 3) their primary care needs, and 4) what their barriers to care are.

Methodology

Consumer Survey
A survey of 545 consumers in the infected or affected community was conducted from December 2008 through February 2009. Refer to Appendix A for consumer survey in English and Spanish.

Survey Design
The consumer survey was designed by the Planning Council Coordinator and approved by the Needs Assessment Committee in October 2008. The goal during the design phase was to obtain desired information regarding, demographics, barriers to care, gaps in care, and unmet need using the shortest approach possible as it would be typically conducted in the lobby's of care organizations, in approximately 10 to 20 minutes. The finalized survey supplied sixteen questions, some including more than one section, and contained predominately multiple choice questions. It was intended to be completed independently with a field team member standing by for questions. This survey was geared toward the in care population as out of care information was obtained from the Southern Nevada Health Districts Out of Care Project.

Questions included inquiries in the following areas:

- Age, sex, HIV status, sexual orientation, living arrangement, racial/ethnic background, and transmission mode.

- General barriers to accessing medical and supportive services on a regular basis.
- Reasons for being out of care for three months or more for those who have previously fallen out of care.
- Need and availability for twenty core medical and supportive services within the last twelve months.
- Service needed but not currently offered.
- Overall rating of care received.
- A ranking of core medical and supportive services by numbered priority.

This survey was also translated into Spanish by L. Cisneros an employee of Clark County Social Services where the Grant is overseen.

Survey Sampling Approach

In prior years only a very small sample size was gathered, so the general sampling plan for this needs assessment was to acquire responses from as many PLWH/A accessing the care system as possible. In order to accomplish this task a convenience sample was used, this non-probability method is used to get an estimate without incurring the cost or time required to select a random sample.

Field Team

The field team was comprised of the Planning Council Coordinator, a Graduate student in the field of Health Care Administration, and various highly qualified socials workers, HIV/AIDS educators, outreach workers, counselors, and HIV care and prevention coordinators. One or more employees of the contributing seven agencies brought their expertise to the project and assisted over 250 clients in completing the survey.

Survey Administration

Surveys were conducted at both Ryan and non-Ryan White funded agencies on a one-to-one basis by the field team with the assurance of complete confidentiality. All providers were very helpful in providing specific dates and times that would yield the greatest number of respondents as well as advertising the opportunity to their clients. Most of the respondents interviewed at agencies were there receiving supportive services.

Two approaches were used during the administration process; conducting surveys at agencies to target consumers, and an online method through a web based survey tool, SurveyMonkey. This survey was uploaded as a link on the Las Vegas TGA website so anyone visiting the TGA's home webpage would have the ability to be a respondent. Advertising for the link was distributed in flyers via the lobbies of HIV/AIDS service agencies, a three quarter page ad was published in the Las Vegas Nite Beat magazine during the month of February 2009 (with a distribution of 18,000 per month), and a direct link from the QVegas website homepage during the month of February 2009 was provided (Las Vegas's magazine for the gay, lesbian, bisexual, and transgender community).

Stipends

Upon completion of the survey, all respondents received a $10 al-Mart gift card. This stipend was not offered to online respondents. The field team was paid through their agency or volunteered their time.

Data Analysis
Data was entered manually into the statistical analysis package SPSS containing 131 data fields. It was randomly spot checked to ensure accuracy. Analysis of cross tabulations and frequencies included met and unfulfilled need, barriers to care, and gaps in care by priority population, age, race/ethnicity, and sexual orientation. Excel and SnagIt were used for charts, graphs, and maps.

Survey Respondent Overview
Gender
The respondent overview illustrates that with regard to gender the sample size was closely related to the number of Ryan White Part A clients and the regional epidemic.

- Women were slightly over represented in relation to client population (+3%) and the regional epidemic (+9%).
- Men were slightly under represented in relation to client population (4%) and regional epidemic (11%).
- The overall population of the TGA is almost equal with a 49% to 51% female to male ratio; where as the regional epidemic is a 23% to 76% female to male ratio.

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Race/Ethnicity
Representation was somewhat equal with regard to Race/Ethnicity with the following exception.

- The White population is the largest in all categories comprising 62% of the overall population, 52% of the regional epidemic, 40% of Ryan White clients and 33% of the sample size.
- While representing only 7% of the population the Black's comprise 25% of the regional epidemic signifying a rate of 975 PLWH/A per 100,000 in the TGA.
- Additionally, the Black population is accurately represented in relation to Ryan White Clients and slightly over represented in relation to the epidemic.

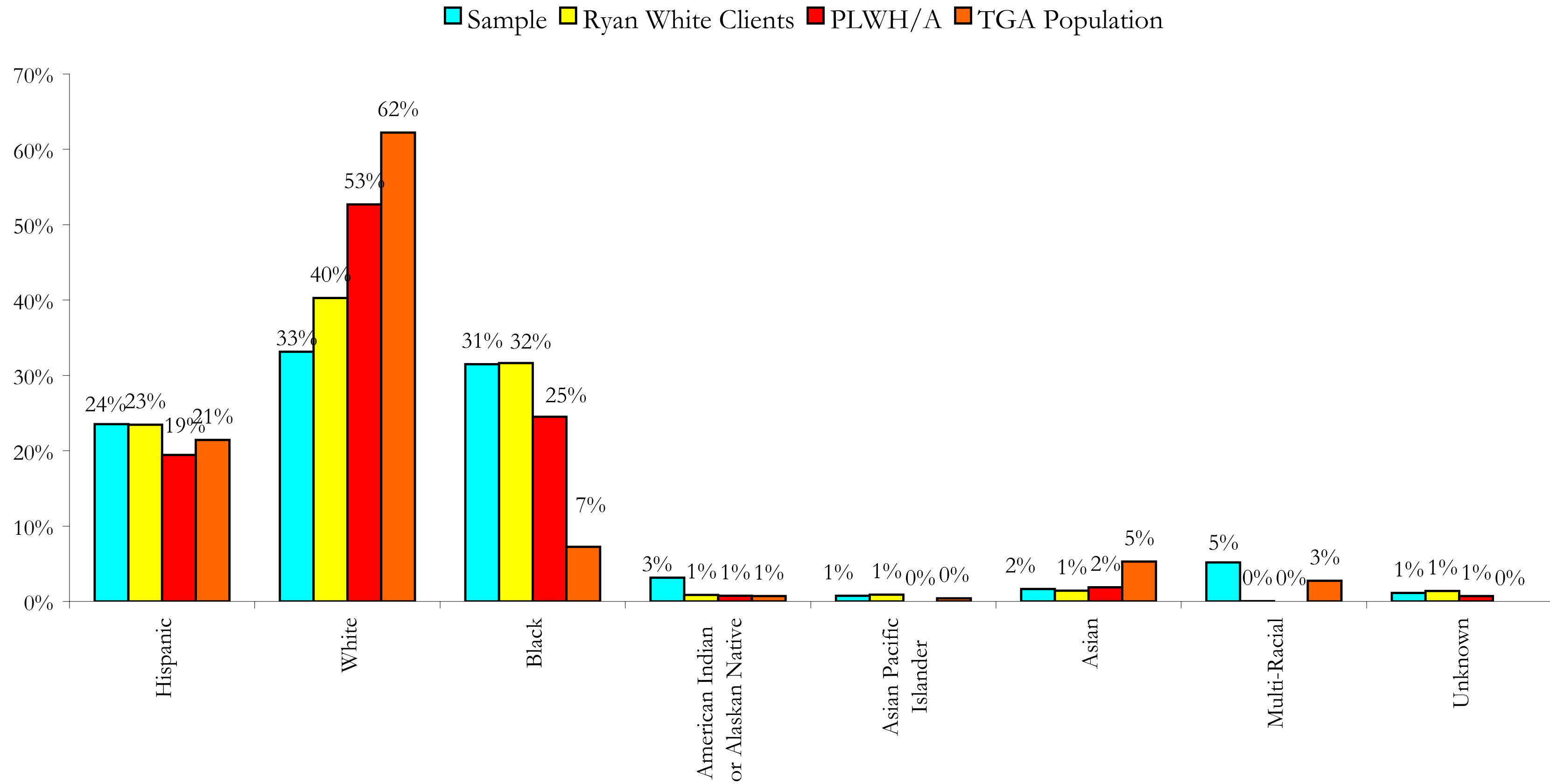


Figure 2.2
Comparison of Consumer Sample Size, Ryan White Part A Clients, Regional Epidemic,
TGA Population, by Race/Ethnicity
Sample
Ryan White Clients
PLWH/A
TGA Population
70%
60%
50%
40%
30%
20%
10%
0%
24%
23%
19%
21%
33%
40%
53%
62%
31%
32%
25%
7%
3%
1%
1%
1%
1%
1%
0%
0%
2%
1%
2%
5%
5%
0%
0%
3%
1%
1%
1%
0%
Hispanic
White
Black
American Indian or Alaskan Native
Asian Pacific Islander
Asian
Multi-Racial
Unknown

Transmission Mode

The Nevada State Health Division HIV/AIDS Reporting System (eHARS), and the survey instrument didn't have corresponding grouping for recording transmission mode. "Prenatal exposure", "Adult NRR" with no risk reported, and "Child NRR" no risk reported, were not options of for the respondents, instead they had the choice of "don't know" or "other". However, respondents could indicate an explanation under the "other" selection where "tattoo needle" was the only explanation indicated by 5 respondents, (2 female, 3 male).

Representation by transmission mode is diverse in nearly every category.

- While MSM is the largest population facing the regional epidemic it is under represented in relation to sample size by 13%. However it is slightly over represented in relation to Ryan White clients.
- Nearly equal in all three categories the IDU sample size almost accurately represents the epidemic and those accessing care.
- The MSM/IDU population is under represented in relation to the regional epidemic yet slightly over represented in comparison to those in the care system.
- Heterosexual contact representing the second highest number of clients in the system is under represented in relation to sample size by 14% yet accurately represented with regard to the epidemic.
- Those having received a transfusion, blood components, a transplant of organ/tissue, or artificial insemination are over represented in the sample.
- The "don't know", "other", and "Adult NRR", can be compared with a large over representation of sample size in relation to clients in the system and the regional epidemic.

Comparison depicted in figure 2.3, please use key below for interpretation of categories.

Key

MSM	Men Having Sex With Men
IDU	Injection Drug Users
MSM/IDU	Men Having Sex With Men/Injection Drug Users
HC	Heterosexual Contact
Hemo/C	Hemophilia/Coagulation Disorder
B/O/T	Having received a transfusion or blood/blood components, transplant of organ/tissue, or artificial insemination.
PE	Perinatal exposure with HIV infection first diagnosed at age 13 years or older
A NRR	Adult No Risk Reported
C NRR	Child No Risk Reported
DK/O	Don't Know/Other

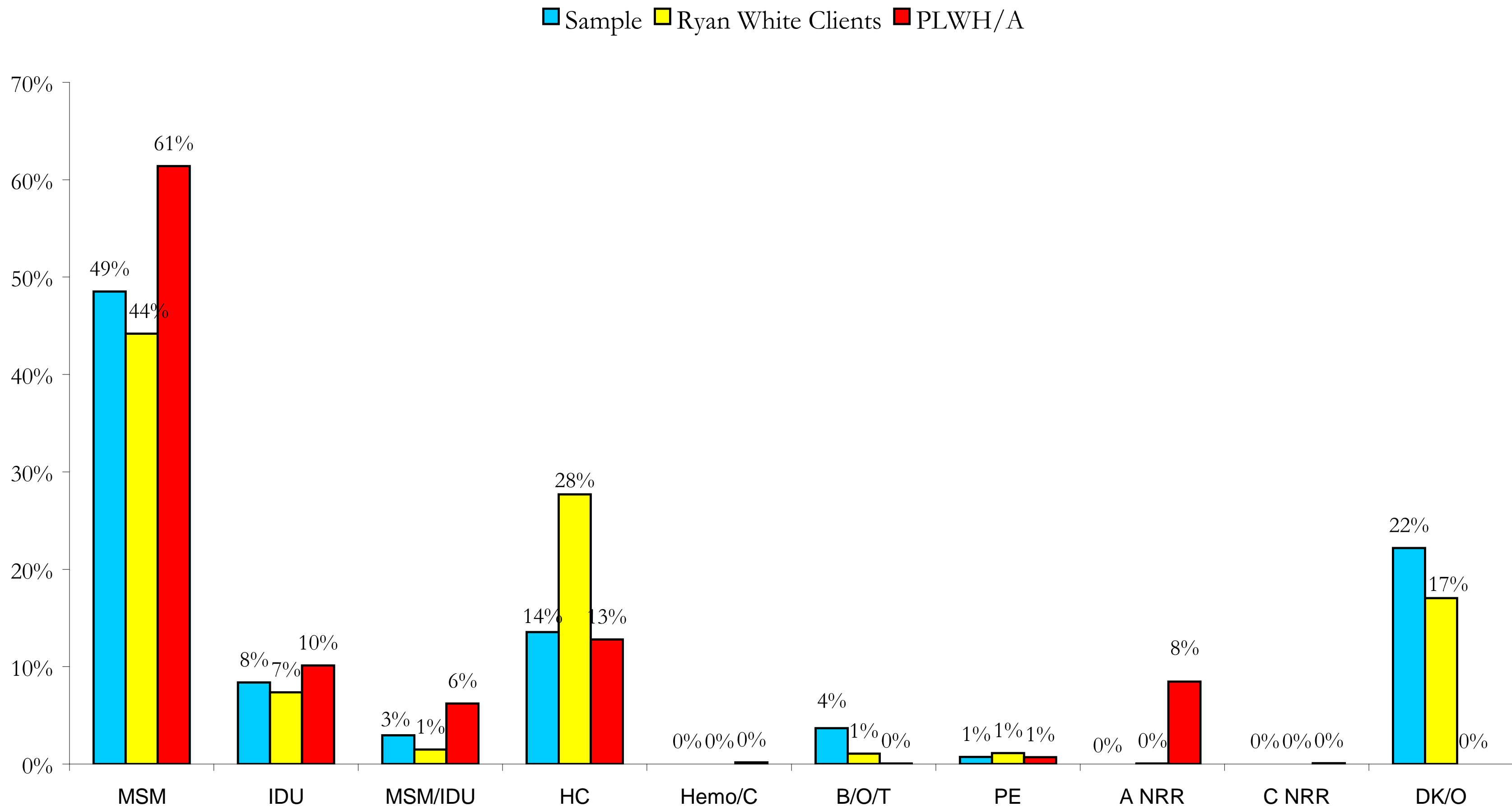


Figure 2.3
Comparison of Consumer Survey Sample, Ryan White Clients, and Regional Epidemic, by Transmission Mode
Sample
Ryan White Clients
PLWH/A
70%
60%
50%
40%
30%
20%
10%
0%
61%
49%
44%
8%
7%
10%
3%
1%
6%
14%
28%
13%
0%
0%
0%
4%
1%
0%
1%
1%
1%
0%
0%
8%
0%
0%
0%
22%
17%
0%
MSM
IDU
MSM/IDU
HC
Hemo/C
B/O/T
PE
A NRR
C NRR
DK/O

Figure 2.4 **Comparison of General Population, Regional Epidemic, RW Clients, and Survey Respondents** Population		TGA, General Population n=2,006,889*	%	TGA PLWH/A n=6,867**	%	Ryan White Clients n=1,875***	%	Survey Respondents n=545	%
Gender									
	Female	988,771	49%	1,157	17%	438	23%	142	26%
	Male	1,018,118	51%	5,710	83%	1,437	76%	390	72%
	Transgender F to M	N/A	N/A	N/A	N/A		N/A	2	0%
	Transgender M to F	N/A	N/A	N/A	N/A	9	N/A	10	2%
	Refused	N/A	N/A	N/A	N/A	N/A	N/A	1	0%
	Total	***2,006,889***	***100%***	***6,867***	***100%***	***1,884***	***100%***	***545***	***100%***
Age at Diagnosis (Incidence)/Current Age (Prevalence)									
	0-12 years	N/A	N/A	57	1%	25	1%	0	0%
	13-19 years	N/A	N/A	112	2%	24	1%	12	2%
	20-49 years	N/A	N/A	6,028	88%	1,380	73%	391	72%
	50+ years	N/A	N/A	670	10%	455	24%	138	25%
	Refused	N/A	N/A	N/A	N/A	-	0%	4	1%
	Total	N/A	N/A	***6,867***	***100%***	***1,884***	***100%***	***545***	***100%***
Race									
Hispanic	Hispanic	508,725	21%	1,335	19%	442	23%	127	23%
Non-Hispanic	White	1,477,941	62%	3,618	53%	759	40%	179	33%
	Black	172,184	7%	1,683	25%	596	32%	170	31%
	American India Alaskan Native	16,559	1%	52	1%	16	1%	17	3%
	Asian	125,583	5%			17	1%	9	2%
	Asian Pacific Islander	9,785	0.4%	129	2%	27	1%	4	1%
	Multi-Racial	64,847	3%	N/A	N/A	1	0	28	5%
	Unknown	N/A	N/A	50	1%	12	1%	6	1%
	Refused	N/A	N/A	N/A	N/A	14	0	5	1%
	Total	***2,375,624***	***100%***	***6,867***	***100%***	***1,884***	***100%***	***545***	***100%***
Transmission Mode									
Adult	MSM	N/A	N/A	4,217	61%	833	44%	204	37%
	IDU	N/A	N/A	695	10%	139	7%	33	6%
	MSM/IDU	N/A	N/A	426	6%	28	1%	14	3%
	Heterosexual	N/A	N/A	878	13%	522	28%	143	26%
	Other	N/A	N/A	585	9%	230	12%	108	20%
	Transfusion/Hemophilia	N/A	N/A	14	0%	20	1%	0	0%
Pediatric	Mother with risk for HIV infection	N/A	N/A	52	1%	21	1%	3	1%
	Refused	N/A	N/A	0	-	91	5%	40	7%
	Total	N/A	N/A	***6,867***	***100%***	***1,884***	***100%***	***545***	***100%***

Survey Limitations

Administering a survey on such a large scale produced data limitations that were somewhat minimized through the field teams one-to-one interaction with the responded. Limitations include:

- The option of selecting contradicting responses.
- Limited choice options lacking the alternatives "refused", "don't know", or "not applicable".
- All but one, with the exception of the online survey option, survey locations were Ryan White Part A funded service providers therefore a larger portion of PLWH/A qualifying for Ryan White funded services are most likely represented.
- Weekly sampling profiles were not in place to ensure adequate representation by emerging or priority populations.
- Age was not specified to age of diagnosis, it was asked as current age.

Consumer Focus Group Discussions

During the period of October and November 2009 four consumer focus groups were conducted with respondents in our priority populations; MSM, MSM of color, IDU Women, and IDU Men. Refer to Appendix B for consumer focus group questions.

Focus Group Design

Focus groups were developed to uncover in-depth qualitative data on the care needs, service use (past and present), barriers to care, accessibility for particular populations or groups, and overall client satisfaction with the TGA's service delivery system for clients currently utilizing services. With 11 questions outlined a 2 hour allotment was permitted per group, this included a small break where lunch was provided.

Focus Group Recruitment

Recruitment and selection was carried out by Aid for AIDS of Nevada's (AFAN) Education Department. The most difficult group to recruit was IDU Women with only one participant in attendance this group was postponed for two weeks during which recruitment efforts were increased substantially.

Focus Group Administration

Neutral meeting locations were provided by the Cambridge Recreation Center and the Clark County Coroners Office. Heather Lazarakis, L.S.W. for Nevada Medicaid and Planning Council member, facilitated each of these groups leading as a knowledgeable but un-bias moderator. Each group discussion was recorded and two note takers were present to capture all information.

Focus Group Participant Overview

Group		Gender		Age					Race/Ethnicity					
	Total #	M	F	20-29	30-39	40-49	50-59	60+	H	AI/AN	A	B	API	W
MSM	5	5				3	2		1					4
MSM/IDU	7	7		1	2	3	1		1	0.5		5.5		
Women IDU	7		7	1	3	3			1.5	5.5				
Men IDU	13	13		1	3	5	4		1			7		5

Focus Group Stipends

Each focus group participant was compensated with a $20 Wal-Mart gift card. The facilitator and note takers were compensated through their employers.

Limitations of Focus Group Data

The focus group discussions were limited by:

- Difficulties recruiting women injection drug users.
- Further recruiting efforts of Women IDU were done by one agency which could have limited options.
- The MSM/IDU group was much larger than expected which limited participation by all members.

Profile of Provider Capacity and Capability

A survey of 211 agency's offering medical and/or supportive services was conducted during February and March 2009. Refer to Appendix C for Profile of Provider Capacity and Capability Survey.

Profile of Provider Capacity and Capability Survey Design

Several goals were outlined in order to successfully design a survey that would capture information regarding existing resources in the community and the provider's perspective for additional development. Goals included developing questions addressing the following; to enhance the understanding of the continuum of care that exists for PLWH/A in the Las Vegas TGA, derive information on capacity development needs of providers targeting historically underserved populations, and to obtain information on supply and demand for HIV/AIDS services to identify the unmet need and service gaps. A variety of multiple choice and open ended questions were assembled in order to encourage full and meaningful answers.

Profile of Provider Capacity and Capability Survey Distribution

In order to successfully compile this data a survey was developed and administered to 206 agencies (including the 14 Ryan White Part A funded agencies) offering medical and supportive services in the Las Vegas TGA. This survey was distributed via regular mail and also accessible online through a SurveyMonkey link on our Planning Council's website, www.LasVegasEMA.org.

Profile of Provider Capacity and Capability Data Analysis

With a 20% response rate 42 completed surveys were returned. Analysis and cross tabulations were performed using SurveyMonkey and Excel. Open-ended questions were analyzed in order to pinpoint similarities and differences among agencies.

Profile of Provider Capacity and Capability Stipends

Each agency that responded was mailed a $60 gift card to Pizza Hut or Papa John's to provide lunch to their entire staff.

Profile of Provider Capacity and Capability Data Limitations

Limitations related to this survey include;

- Expenditures were asked of the entire agency and HIV/AIDS specific, not by service category.
- The survey sample size, 20%, could limit adequate representation of services actually available in the TGA.

Resource Inventory

In order ease the burden of service providers the Resource Inventory survey was incorporated into the Profile of Provider Capacity and Capability survey. Information on current services available will assist case managers and other service personnel by increasing their ability to provide referrals, help all parties involved identify services gaps and needs per population and geographic location, aid the Planning Council in determining which services should be supported with Ryan White Part A funds, and determine capacity development for providers. A complete Resource Inventory is included in this document.

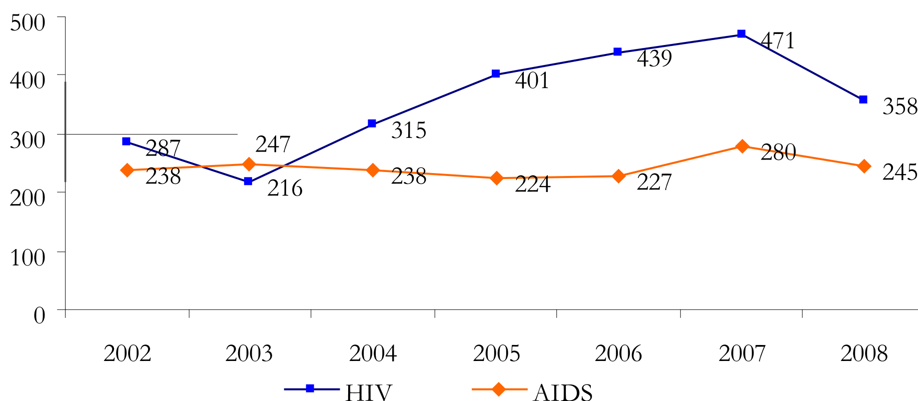
Epidemiologic Profile

Incidence

The Centers for Disease Control and Prevention (CDC) estimates that approximately 1.1 million persons are living with HIV in the United States. Every 9½ seconds someone is infected with HIV in the U.S. alone. These numbers are expected to continue to increase over time, as antiretroviral treatments prolong the lives of those who are infected and more people become infected with HIV than die from the disease each year. As the number of people living with HIV (HIV prevalence) grows, so does the opportunity for HIV transmission to others. It is critical to have a clear understanding of the number of new infections that occur annually (HIV incidence) and the rate of HIV transmission among reported risk factors and demographics to effectively coordinate prevention and care efforts to slow the growing epidemic[23].

Between 2002 and 2008 the Las Vegas TGA saw an increase in new HIV cases by 25% and an increase in the incidence of AIDS by 3%. As shown in figure 3.1, new HIV cases fell 25% from 2002 to 2003 and after a four year steady rise fell again by 24% from 2007 to 2008 all the while new AIDS cases remained relatively stable.[24]

Figure 3.1 HIV/AIDS Incidence by Year in the TGA



MSM

From 2003 to 2008 men have represented in the 80th percentile of HIV incidence, AIDS incidence, and overall prevalence in the TGA. In 2008 Men represented 84% (5,710) of HIV/AIDS prevalence, but only 51% (1,132,184) of the entire population of the TGA. Conversely, Women represented 16% (1,157) of HIV/AIDS prevalence and 49% (1,099,473) of the TGA population.

In the Las Vegas TGA high rates of HIV/AIDS transmission among men lies primarily within the MSM and/or MSM/IDU population, 81%, with just 15% of prevalence in the heterosexual population. Since the onset of the HIV/AIDS epidemic in the United States, incidence has been highest among men who have sex with men (MSM).

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[23] Center for Disease Control and Prevention (CDC) HIV transmission rates in the United States December 2008

[24] Source for Clark and Nye: Nevada Sate Health Division HIV/AIDS Reporting System (eHARS), (March 2009) 2008 HIV/AIDS data is provisional data. Source for Mohave: Arizona Department of Public Health HIV Epidemiology Program. Prevalence by year is estimated, actual number is unavailable.

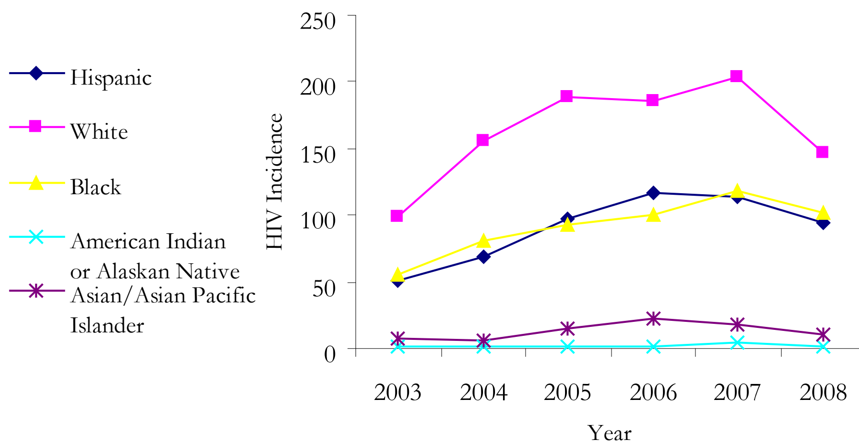
(the number of diagnoses per 100,000 population) in the 33 states was 18.5 per 100,000. The rate for blacks was roughly 8 times the rate for whites (67.7 per 100,000 vs. 8.2 per 100,000)[27].

Representing only 7% of the TGA's population the Black community represents 25% of the regional epidemic signifying a rate of 990 PLWH/A per 100,000. This is nearly 4 times the rate of Hispanics (262 per 100,000), 4 times the rate of Whites (243 per 100,000), 3 times the rate of the American Indian or Alaskan Native population (305 per 100,000) and 10 times the rate of the Asian population (99 per 100,000).

Figure 3.3 Comparison of Clients in the Ryan White Las Vegas TGA Care System, Regional Epidemic, and TGA Population

Race and ethnicity are not, by themselves, risk factors for HIV infection. But studies show that Blacks and Hispanics are more likely than their white counterparts to face multiple challenges associated with risk for HIV infection. These challenges include high rates of sexually transmitted diseases, which can facilitate HIV transmission; substance abuse, which may increase the risk for HIV infection through sexual or drug-related transmission; and socioeconomic factors, such as limited access to high-quality health care. Studies have also suggested that poverty may place Black women at increased risk because of the power imbalance created by financial dependence on men[28].

Figure 3.4 New HIV Cases by Race/Ethnicity in Clark and Nye Counties 2003-2008



Transmission by Race/Ethnicity has remained primarily in the White population over the last five years with new cases among the Hispanic and Black populations remaining roughly equal over time. As depicted in figure 3.4, the Las Vegas region hasn't fluctuated with more than a 5% increase or decrease per any population within a calendar year over the last five years. Peaks in new cases are reflected across the board in their respective categories.

Age at Diagnosis

Much of the nation is seeing the "graying of HIV" or the 50+ age demographic becoming infected at a higher rate than ever before. As seen in figure 3.5, the Las Vegas TGA has seen an upswing in

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[27] National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)

[28] Center for Disease Control, HIV/AIDS in the United States: A Picture of Today's Epidemic

the 50+ age demographic with new HIV cases in the 50-59 age range up 300% from 2003 to 2007 (the highest among all ranges) with new AIDS cases up 72%. The 60+ age range has remained relatively stable regarding new HIV/AIDS infection representing about 2% to 3% of new cases each year.

The two primary causes for this demographics increase in incidence are; many HIV-positive people receiving appropriate care are living into middle and old age, and new infections among this population are driven in part by social and biological factors. Including:

- Many older adults are newly single, widowed, or have grown children and have more time for sexual activity.
- New treatments for erectile dysfunction facilitate sex.
- Older adults may be unfamiliar with condom use or reluctant to use them because birth control after menopause is unnecessary, and condoms can make it difficult to maintain an erection.
- Vaginal dryness is common among menopausal women, making tiny cuts and tears during sex more likely.

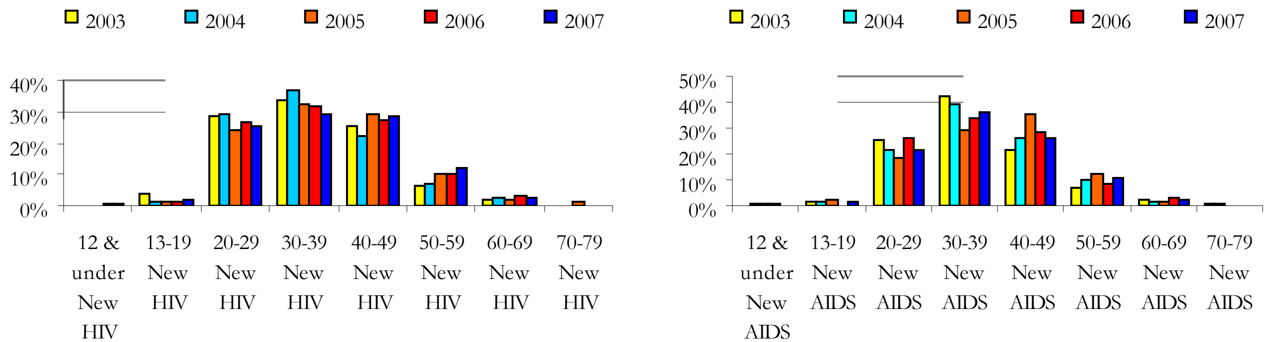
When older adults have insufficient information about HIV transmission, the risks associated with the factors above are intensified.

High rates in this age range could also be attributed to late diagnosis as HIV often goes undiagnosed in older adults for several reasons:

- Clinicians may underestimate the risk for HIV among older adults and not discuss HIV transmission or perform testing.
- Common, nonspecific HIV symptoms, such as fatigue, may be mistaken for signs of aging or other conditions.
- Older patients may not perceive themselves as at risk for HIV because of a lack of information on HIV prevention and transmission.[29]

[29] HRSA CARE ACTION http://hab.hrsa.gov/publications/february2009/default.htm

Figure 3.6
New Cases of HIV/AIDS by Age in Clark and Nye Counties 2003-2007

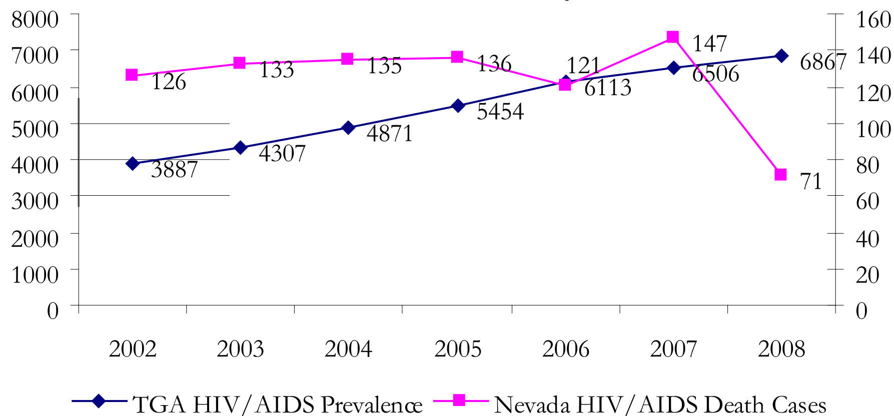


The majority of new cases over the last six years were diagnosed between the ages of 20-49. This range represented 80% of new HIV/AIDS cases in 2008 and 88% of overall prevalence.

Prevalence

HIV/AIDS prevalence has increased 77% over the past 7 years. Deaths related to HIV/AIDS increased 17% from 2002 to 2007 but rapidly dropped 44% from 2007 to 2008. This increase in prevalence and decrease in fatalities can largely be attributed to the improved treatment of HIV and AIDS resulting in fewer fatalities among those infected and many PLWH/A living longer than ever before.[30]

Figure 3.7 PLWH/A Prevalence in Clark and Nye Counties vs. PLWH/A Fatalities by Year 2002-2008



Prevalence in the TGA is high and continues to climb each year. Overall cases reflect incidence trends with the highest rates remaining in the Male, MSM, 20-49 year age range, and the White population. Incidence and prevalence numbers for the Las Vegas TGA through December 31, 2008 are displayed in figure 3.8.

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[30] Nevada State Health Division HIV/AIDS reporting system (eHARS), (March 2009) 2008 HIV/AIDS data is provisional data.

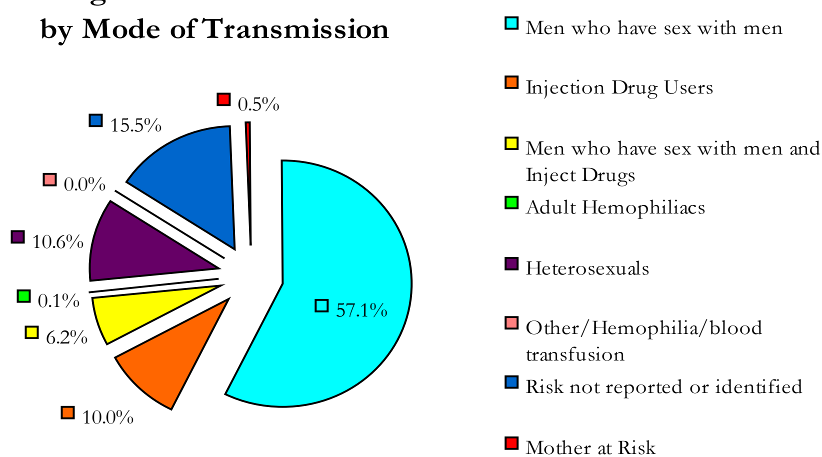
Demographic Group/ Exposure Category RISKS REDISTRIBUTED Figure 3.8	HIV Incidence in 2008 HIV (not yet AIDS) Incidence is defined as the number of new HIV cases diagnosed during the period specified, data as of 2/24/09 (Clark and Nye Counties)		AIDS Incidence in 2008. AIDS incidence defined as the number of new AIDS cases diagnosed during the period specified, data as of 2/24/09 (Clark and Nye Counties)		HIV (not AIDS) Prevalence Estimate through 2008, as of 02/24/09. HIV prevalence is defined as the number of reported living HIV (not AIDS) cases. Las Vegas TGA (including Mohave prevalence through 2006)		AIDS Prevalence Estimate through 2008 as of 2/24/09. AIDS prevalence is defined as the number of reported living AIDS cases. Las Vegas TGA (including Mohave prevalence through 2006)	
Race/Ethnicity	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
White, not Hispanic	146	41%	90	36%	1,765	53.2%	1,853	52.2%
Black, not Hispanic	102	28%	69	28%	834	25.1%	849	23.9%
Hispanic	95	27%	75	30%	611	18.4%	724	20.4%
Asian/Pacific Islander	10	3%	7	3%	61	1.8%	68	1.9%
American Indian/Alaskan Native	1	0%	2	1%	21	0.6%	31	0.9%
Not Specified/Other	4	1%	4	2%	25	0.8%	25	0.7%
Total	**358**	**100%**	**247**	**100%**	**3,317**	**100.0%**	**3,550**	**100.0%**
Gender			**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Male	304	85%	208	84%	2,698	81.3%	3,012	84.8%
Female	54	15%	39	31%	619	18.7%	538	15.2%
Total	**358**	**100%**	**247**	**100%**	**3,317**	**100.0%**	**3,550**	**100.0%**
Age at Diagnosis (Incidence) / Current Age (Prevalence)			**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
0-12 years	0	0%	1	0%	36	1.1%	21	0.6%
13-19 years	11	3%	4	2%	84	2.5%	28	0.8%
20-49 years	290	81%	192	78%	2,948	88.9%	3,080	86.8%
50+ years	57	16%	50	20%	249	7.5%	421	11.9%
Total	**358**	**100%**	**247**	**100%**	**3,317**	**100.0%**	**3,550**	**100.0%**
Adult/Adolescent AIDS Exposure Category			**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
MSM	244	68%	169	69%	1,943	59%	2,274	65%
IDU	25	7%	26	11%	297	9%	398	11%
MSM/IDU	13	4%	6	2%	179	5%	247	7%
Heterosexual	73	20%	44	18%	440	13%	438	12%
Other	3	1%	0	0%	428	13%	168	5%
Total	**358**	**100%**	**245**	**100%**	**3,287**	**100%**	**3,525**	**100%**
Pediatric AIDS Exposure Categories (Ages 0-12)			**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Mother with/at risk for HIV infection	0	0%	2	100%	25	100%	23	100%
Risk not reported/Other	0	0%	0	0%	5	0%	2	0%
Total	**0**	**100%**	**2**	**100%**	**30**	**100%**	**25**	**100%**
Source: Nevada State Health Division HIV/AIDS Reporting System (eHARS), (February 2009) and the Arizona Department of Health Services office of HIV/AIDS								

Unmet Need

The assessment of unmet need[31] is a critical part of the Ryan White programs mission to improve primary health care for PLWH/A. Targeting the out of care population is crucial to better understand who is not in care and why. Information about unmet need assesses PLWH/A not receiving primary health care and their demographics which can be used to craft strategies to overcome service barriers and get individuals into care. This can improve the overall health of the community as those receiving primary medical care are less likely to transmit the disease to others.

The Southern Nevada Health Districts Out-of-Care program is an essential part of locating those who are not in care, identifying why they aren't in care and their demographics, and bringing them back into the care system if they so choose. This program has successfully worked to decrease the out of care population by 16.4% as of February 28, 2009 and continues diligently in their efforts.

Figure 3.9 Out of Care by Mode of Transmission



The total number of PLWH/A in Clark County as of February 28, 2009 was 5,730 (3,059 HIV not yet AIDS, and 2,671 AIDS), which is 83% of the TGA's prevalence. Of those 56% were known to be out of care.[32] As displayed in figure 3.9, the majority (57.1%) of those out of care in Clark County are MSM, with the second highest rates in the Heterosexual community (10.6%) and IDU (10.0%). Women of childbearing age (15-44) comprise 13% of the out of care population with the majority contracting HIV through heterosexual contact (56.5%) and 16.2% through injection drug use. Black women are the most severely affected representing 42.3% followed by White women at 36.5% and Hispanic women, out of care nearly three times less than Black women, at 16.9%.

With regard to Race and Ethnicity, the majority found out of care are White 55.2%, with 23.4% in the Black community and 18.6% in the Hispanic community. Unusually high rates can be found in the Asian population representing only 2% of the TGA's overall prevalence and only 1% of total PLWH/A in the Ryan White care system the Asian community represents 20% of the out of care population. Of those 20% (60 PLWH/A), 84% are male and 16% are female.

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[31] Unmet Need refers to the approximate number of people in the service area who are HIV positive (HIV+/non-AIDS or AIDS) and know their status, and are not receiving regular HIV related primary medical care (for a period of 12 months or more).

[32] The following data was extracted for all patient records in HARS with no reported death and an HIV or AIDS diagnosis before March 1, 2008. Total Out-of-Care was computed from a SAS based program provided by the CDC. The Out-of-Care population was derived from all patients in HARS that received no treatments or blood tests during the period of March 1, 2008 through February 28, 2009.

The Out-of-Care program has successfully worked to decrease the out of care population in Clark County bringing the total adjusted out of care to 39.6%, 2,269. For women of childbearing age, 61% were initially found to be out of care with that number currently at 40.9%. Figure 3.10 depicts the respective area to which those PLWH/A have transitioned into. The majority was found to have moved out of the jurisdiction while 2% refused care, 3% were already in care, and 1% brought back into care. The number of in care clients in Clark County is 2,674 (46.67%) with roughly 787 PLWH/A (13.7%) unable to be found. Rural communities in Arizona have an estimated unmet need of 39%.[33]

Figure 3.10 Out-of-Care Demographics

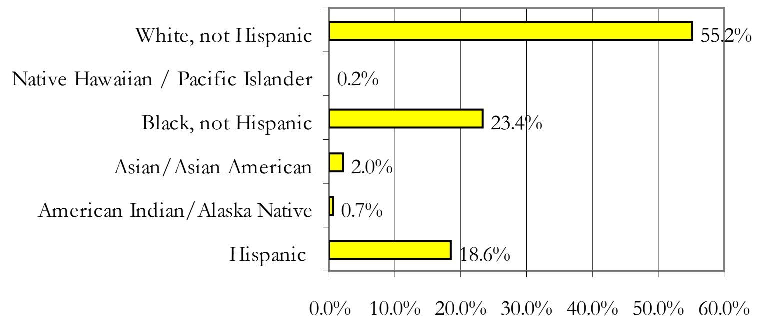
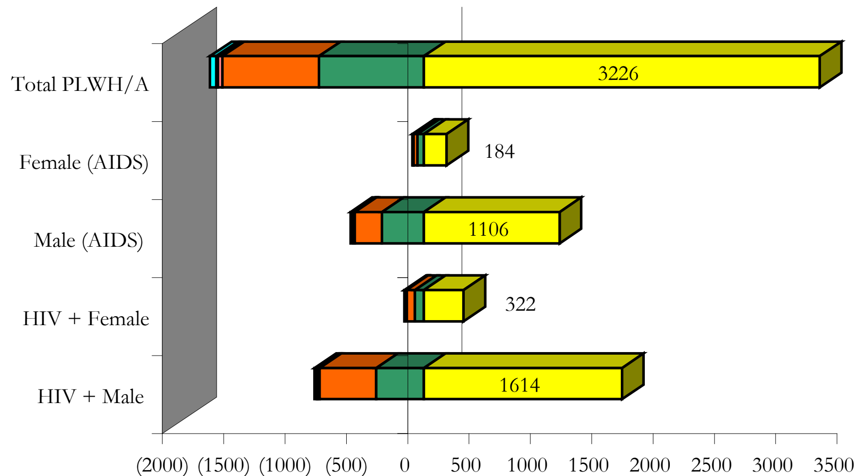


Figure 3.11 Out-of-Care Population



	HIV + Male	HIV + Female	Male (AIDS)	Female (AIDS)	Total PLWH/A
Subtotal Out of Care**	1614	322	1106	184	3226
Already In Care	(17)	(5)	(23)	(6)	(51)
Brought Back Into Care	(8)	(2)	(3)	(1)	(14)
Located but Refused Care / Treatment	(16)	(9)	(9)	(2)	(36)
Unable To Locate within past 6 Months	(462)	(70)	(222)	(33)	(787)
Moved Out of Jurisdiction	(389)	(73)	(342)	(52)	(856)

[33] 39% (565) during calendar year 2007, Arizona 2007 unmet need estimate 40% (5,831) Mohave specific data is unavailable.

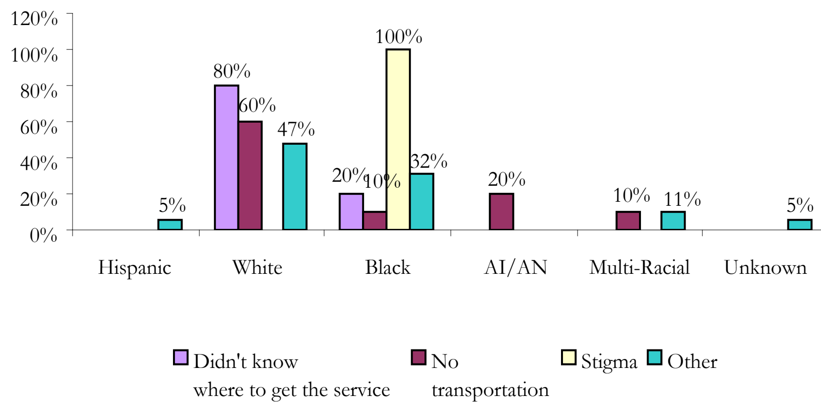
Ambulatory Outpatient Medical Care

HRSA Definition

Provision of professional, diagnostic and therapeutic services rendered by a physician, physician's assistance, clinical nurse specialist, or nurse practitioner in an outpatient, community-based, and/or office based setting. This includes diagnostic testing, early intervention and risk assessment, preventative care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, care of minor injuries, education and counseling on health and nutritional issues, minor surgery and assisting at surgery, well-baby care, continuing care and management of chronic conditions, and referral to and provisional of specialty care.

Consumer Survey Results

HIV/AIDS outpatient medical care was the top ranked priority for consumer respondents at 19%. When examining barriers to Ambulatory Outpatient Medical Care 7% of respondents indicated that they encounter one of the following barriers when attempting to access medical care; 26% have no transportation, 13% don't know where to find medical care, 8% don't want to deal with the stigma of their status, and 49% indicated encountering other barriers when attempting to access medical care. As depicted in figure 4.1 the Black population indicated the highest level of stigma while the white population indicated the highest number of PLWH/A that don't know where to get services. A lack of transportation can be seen across the board with the White population representing the majority at 60%.



Out of Care Questions

Respondents were asked, "Have you ever stopped seeing your doctor or taking your meds?" Of the 494 responses to the question 28% indicated "Yes". In response to how long, 38% indicated 3 to 6 months, 17% said 6 to 9 months, 16% chose 9 to 12 months, and 28% responded with 12 months or more.

HRSA defines "out of care" as someone who has not accessed medical care for their HIV/AIDS status for 266 consecutive days or more. With 28% of our sample falling into this category a closer look reveals that in relation to our sample size American Indian or Alaskan Native Men and Women

had the highest rate, 41%, of falling out of care for 12 months or more. Second is the White population at 27% and Black's at 25%.

Respondents were asked, "What was your motivation for accessing care again?" The most frequently indicated reason at 47%, "I was encouraged by my friends and family". The second most frequently indicated reason at 31%, "I got very sick", 18% selected "I found out where to go for care and supportive services", and 12% indicated "I stopped using drugs". Of the remaining 16% who chose "Other" several qualitative responses were listed;

- "I felt like it was time to get my life back together"
- Unexpected pregnancy
- God
- A new doctor in Kingman, Arizona

The survey offered 8 options in response to why there was a lapse in medical care, supportive services, or medication adherence, and an "Other" box including a comment section. The majority, 22%, indicated a lack of transportation, the second major factors tied at 19%, "I didn't like the way I was treated by service providers" and "I didn't know where to go for care", with 17% signifying they moved to a new city, state or location, followed by 15% who chose "I was using drugs and it made it difficult to get care", and 13% indicating stigma with 11% who didn't like the services they were offered.

Qualitative comments included;

- No insurance
- No money
- Anxiety about accessing services and taking medication
- Don't like the side effects of the medication
- In denial and angry
- Didn't have required documentation
- Couldn't afford medication, "So I skipped days here and there to make it last longer"
- Didn't like the doctor
- Addicted to methamphetamines
- No stable housing
- "Forget"
- Have reactions to medication

Focus Groups

The client focus group discussions focused mainly on the past and present usage of Ambulatory Outpatient Medical Care. As four focus groups took place they are broken down by priority population.

White MSM

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, and their next birthday
- Their hobbies of bowling and other sports
- Hope and 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. Many listed a secondary medical condition such as diabetes, allergies, and high cholesterol.

Participants were asked if there had been a period of 12 months or more when they went without medical care, positive responses included:

- Frustration with medication
- Drug use
- The choice of facing death or accessing care

MSM of Color

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 also responded that they don't want to get really sick again or have another long hospital visit. Others 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.

While several men stated that they had quit taking their medication at one time or another none had left the care of a physician. Those who began taking medication again concluded it was due to the positive effects they saw from it.

Women IDU

Women noted a much higher utilization of medical and supportive services, accessing medical care every two, three, or six months. Many of these visits are also attributed to a secondary medical condition such as; osteoporosis, emphysema, thrush, and frequent nose bleeds.

Two of our participants acknowledged being out of care for 12 months or more at one time, both attributed it to drug use. One woman indicated that because of her drug use she planned to die before she ever put her life back together.

Men IDU

This group was roughly 50/50 with regard to accessing medical care and following the guidance of a physician.
Indicated reasons for not following doctors orders include:

- "I go with how my body feels, not always what my doctor says"
- Medication has too many side effects
- Drug addiction
- Forgetting to take meds
- Dislike taking pills
- "Would rather party and drink than take meds"

Indicated reasons for following doctor's order include:

- "Life is my motivation"
- The feeling of having a second chance at life
- Family and friends

Four respondents indicated going without care for a period of 6 months or more attributing it to; moving to a new location, becoming severely ill, or started receiving Medicaid enabling him to access care.

This priority population expressed signs of violence and verbal abuse toward one another often discussing their inappropriate behavior toward particular staff members at agencies.

Service Utilization

The two Ryan White Part A Ambulatory/Outpatient Medical Care service providers in the Las Vegas TGA served 1,221 clients during Grant Year 2008-2009 (GY 08-09) providing 40,967 units of care and expending $690,612 of Ryan White Part A funding. Client utilization by Mode of Transmission, Race/Ethnicity, and Gender are depicted in the following figures.

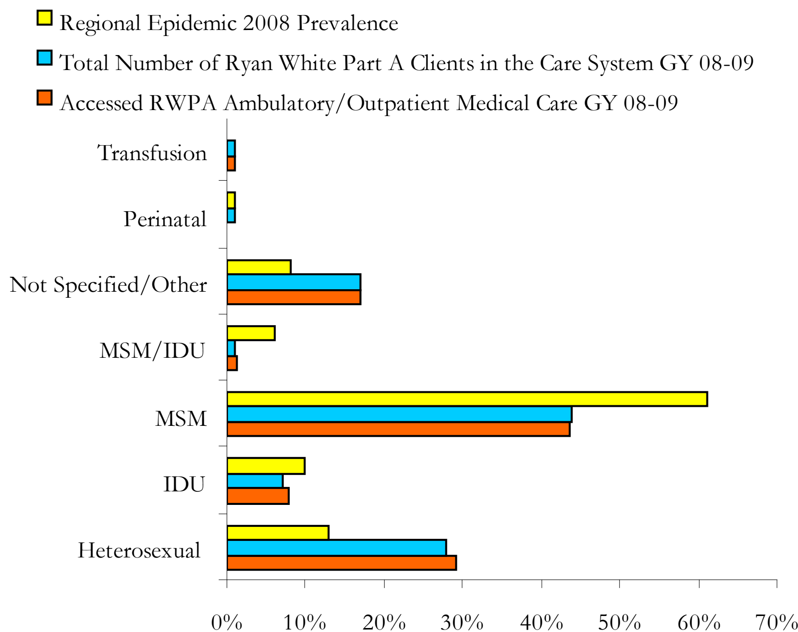
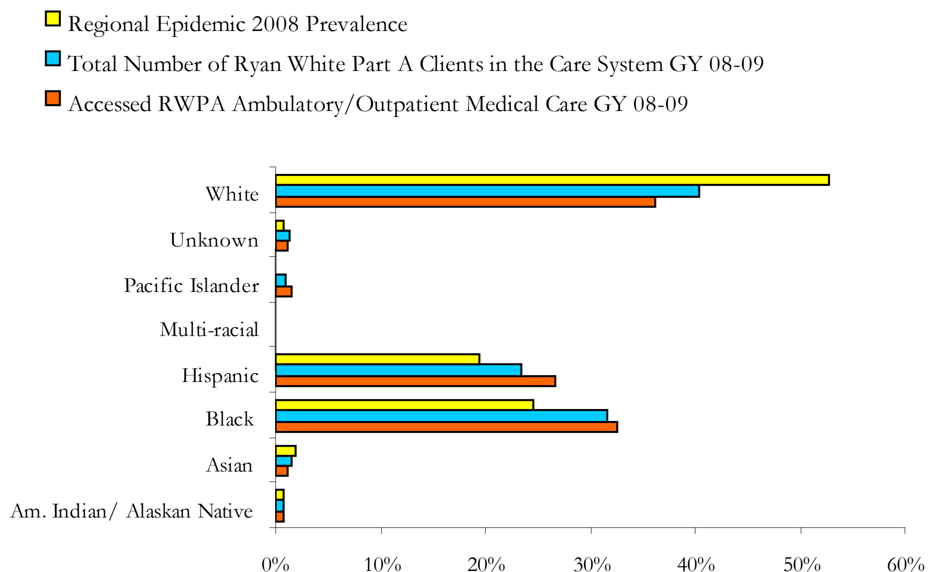


Figure 4.2
Comparison of Grant Year 2008-2009 RWPA Clients Accessing Ambulatory/Outpatient Medical Care, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Mode of Transmission

Figure 4.3
Comparison of Grant Year 2008-2009 RWPA Clients Accessing Ambulatory/Outpatient Medical Care, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Race/Ethnicity



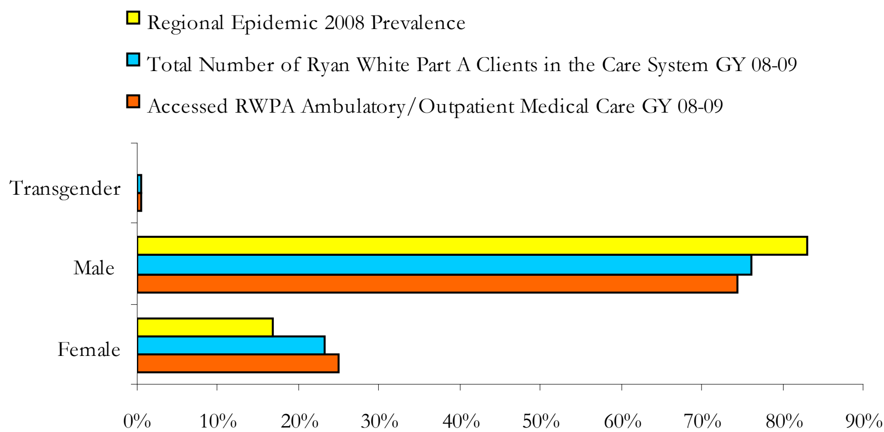


Figure 4.4
Comparison of Grant Year 2008-2009 RWPA Clients Accessing Ambulatory/Outpatient Medical Care, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Gender

From these figures we can see that Ambulatory/Outpatient Medical Care is utilized fairly consistently with regard to those enrolled in Ryan White Part A during GY 08-09. Those underutilizing this service are the White population, Men, and MSM which also carry the highest prevalence in the TGA and the highest populations out of care.

Figure 4.5
Frequency of Usage Relative to Clients in the Care System and Regional Epidemic

Those Populations Utilizing Ambulatory/Outpatient Medical Care Most Frequently GY 08-09	Those Populations Utilizing Ambulatory/Outpatient Medical Care Less Frequently GY 08-09	Consumer Survey Respondent Service Gap for Ambulatory Outpatient Medical Care
Heterosexuals	MSM	Heterosexual Black Women
Blacks	Whites	Heterosexual Black Men
Hispanics	Men	White MSM
Women		Black MSM

Currently in the TGA there is not a HIV/AIDS Ambulatory/Outpatient Medical Care Center that specifically targets or is located in an area with a large population density of Blacks. This could be a factor impeding the desire for that specific population to enter and/or maintain HIV/AIDS specific care. The consumer reported gaps, with regard to the Black population, don't specifically correspond to the number utilizing this service. However the Black population did indicate the highest level of stigma as a barrier when accessing this service in comparison to other Race/Ethnicities.

Gap Analysis

Of our total survey respondents 72% indicated a need for Ambulatory Outpatient Medical Care within the last year. Ninety-four percent of that need was met leaving a service gap of 8% or 31 respondents without access to medical care.

The gap analysis reveals that approximately 507 PLWH/A in the TGA have an unfulfilled need for Ambulatory/Outpatient Medical Care. In order to meet this need completely an approximate expansion of 9% is required in the care system. Based on GY 08-09 costs, an estimated $286,764 in additional funding is needed to ensure treatment for PLWH/A in the TGA.

Ambulatory/Outpatient Medical Care Gap Analysis

Gap Analysis	
a. Total Projected Need in the TGA Applies total need from the consumer survey to the 6,867 Las Vegas TGA PLWH/A [(Total-No Need)*6867/Total]	6,457
b. Total Projected Need that is Met Applies need met from consumer survey to the 6,661 Las Vegas TGA PLWH/A [(Need Met)*6,867/Total]	5,950
c. Potential Additional Clients whose need is not Being Met Difference between total projected need and total projected need that is met (row a-row b)	507
d. Additional System Capacity Required to Provide Service to all Needing but Not Receiving Service Current provider expansion required to completely meet need (row c/row b)	9%

Profile of Provider Capacity and Capability

Services

Eight Ambulatory/Outpatient Medical Service Providers responded to our survey, three of which do not provide services to PLWH/A. Of the remaining five, two only accept insurance reimbursement or full payment for services, one offers OB/GYN services to uninsured and underinsured people and the remaining two are Ryan White funded medical service providers.

Language Assistance

Of these agencies 90% have bi-lingual staff on hand and all indicated Spanish as the primarily requested language, next to English. Chinese, Filipino languages and Tagala were also indicated as frequently requested.

Services Area and Hours

All agencies provide services to Clark County with only one agency providing services to Mohave and Nye counties in addition to Clark County. Two agencies provide services above and beyond 8am to 5pm Monday through Friday, including weekend and evening hours. Ninety percent indicated that public transportation is readily available near their facility.

Service Demand and Funding

Providers indicated the following occurrences within their agency in the past year: (Note: respondents had the option to choose more than one.)

- 57% indicated seeing an increase in the number of clients seeking services.
- 42.9 indicated seeing an increase in demand from clients.
- 28% indicated a decrease in the amount of funding provided from private donations.
- 42% indicated a decrease in the amount of funding received from any funding stream.

The average wait time for medical care at one Ryan White funded agency is 1 to 6 days and the other is to 2 to 4 weeks up to > 2 months. For a private pay medical visit the wait is 1 to 6 days to 2 to 4 weeks and an OB/GYN visit has a 1 to 6 day wait time on average.

Capacity and Need
Responses to needs required in order to develop capacity include. (Note: respondents had the option to choose more than one.)

- 55% indicated funding to expand current capacity.
- 44% indicated increased partnerships with HIV/AIDS specialty agencies and organizations.
- 33% indicated training in HIV/AIDS for staff members.
- 22% indicated funding to develop new capacity.

Barriers to Providing Services
When providing services to clients, providers indicated facing the following barriers: (Note: respondents had the option to choose more than one.)

- 60% indicated that clients have no payment source.
- 30% indicated there are not enough resources at the agency to fulfill the need.
- 20% indicated limited partnerships/linkages with specialized HIV organizations.
- 20% indicated staff training in HIV/AIDS is limited at their agency.
- 10% indicated that clients routinely miss appointments.

Recommendations
1) Evaluate options for expanding the medical care system over a period of time by introducing more HIV/AIDS specialists, Nurse Practitioners (APRN), and Physician Assistants (P.A.) to the opportunity for growth and career development in the Las Vegas Region. This, in-turn, will increase capacity to accommodate the growing prevalence of HIV/AIDS in the TGA.

2) Reduce paper work requirements and outline the eligibility process including timeline requirements for ease of understanding, Doing so will ease barriers to care and encourage a continuous smooth process for clients accessing care.

3) Educate consumers on the importance of accessing medical care even when not feeling well and educate women on the importance of OB/Gyn care. This will reduce the incidence of Emergency treatment, promote constant continuance in the care system, and encourage healthy lifestyles for PLWH/A.

4) Consider innovative models to reduce barriers to care for newly diagnosed PLWH/A, those re-entering the system, or priority populations.

AIDS Pharmaceutical Assistance

HRSA Definition

AIDS Drug Assistance Program (ADAP Treatments) is a State-administered program authorized under Part B of the Ryan White Program that provides FDA-approved medication to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid or Medicare.

AIDS Pharmaceutical Assistance (Local) includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients, this

assistance can be funded with Part A grant funds and/or Part B award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding.

Consumer Survey Results

Pharmaceutical Assistance was the 2nd ranked priority by survey respondents at 14%. Of the 366 responses to this question, 88% indicated a need for this service. Of those in need 88% were able to access it when in need, leaving a gap of 12%. The most widely indicated barrier to receiving AIDS Pharmaceutical Assistance, the client didn't know where to receive it. Those in need include:

- White Men 41%
- Hispanic Women 21%
- Black Men 18%
- Black Women 13%
- Hispanic Men 7%

Consumer Focus Group Responses

White MSM

White MSM indicated a high level of dependence on HIV/AIDS drug assistance programs. Several men spoke of the complications they endured while trying to find a combination of medication that worked with their body while becoming resistance to several HIV/AIDS medications. Many emphasized the importance of adherence to their prescribed medications.

MSM of Color

MSM of color focus group respondents stressed the importance of adhering to medication regimens with the supervision of an RN and Nutritionist to keep medication and diet in line. They also stressed the importance of Ryan White funding to pay for their HIV/AIDS medications. Additionally, they indicted that the 4 day span when filling their prescription medications is "cutting it way too close" and said that sometimes they have gone without meds over long weekends or holidays because of the refill limitations.

Women IDU

Women IDU indicated more difficulties when physically taking the medication from the inability to swallow pills to the crippling side effects.

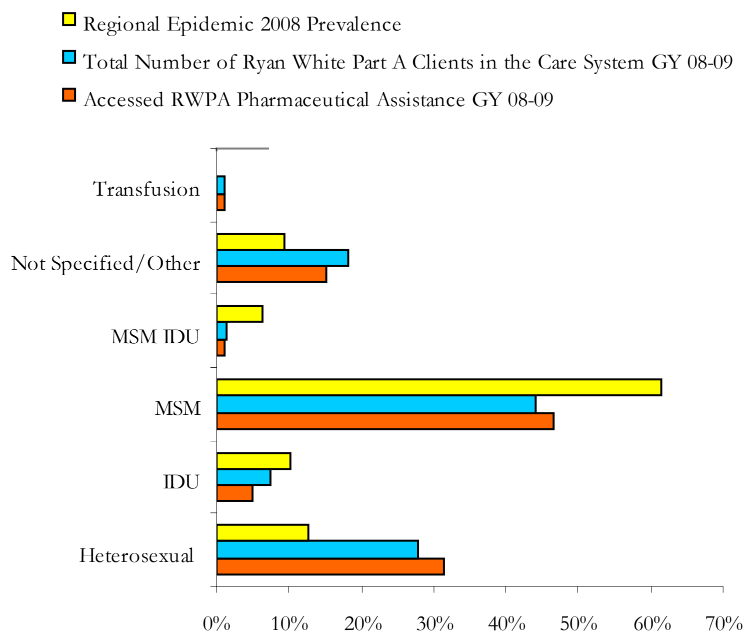
Men IDU

Men IDU were 50/50 with medication adherence. Some said their medication works and they take it faithfully, some take it sparingly or "forget when I'm on a drug binge", and one Black male in his twenties indicated that he "doesn't want to pop pills for the rest of his life" and would rather drink and enjoy partying than take medication.

Service Utilization

During GY 08-09, a total of 99 unduplicated clients were seen by Ryan White Part A funded service providers for pharmaceutical assistance utilizing 1,187 service units and expending $18,000. The figures below depict utilization of Pharmaceutical Assistance by Mode of Transmission, Race/Ethnicity, and Gender.

Figure 4.6
Comparison of Grant Year 2008-2009 RWPA Clients Accessing AIDS Pharmaceutical Assistance, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Mode of Transmission



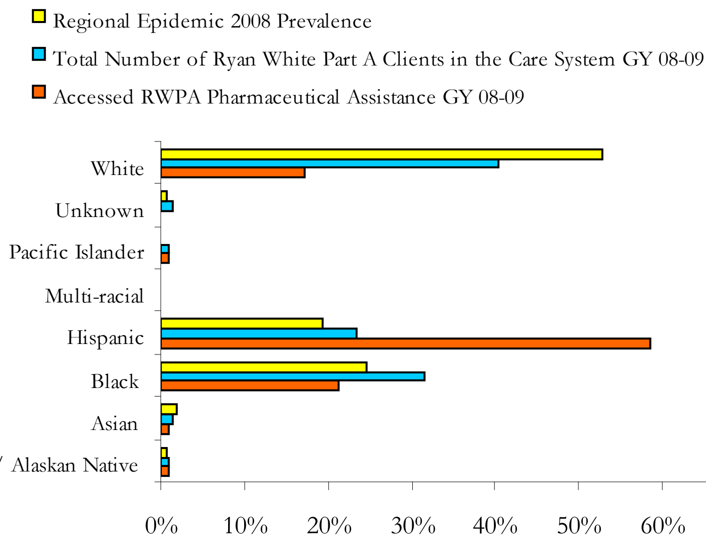
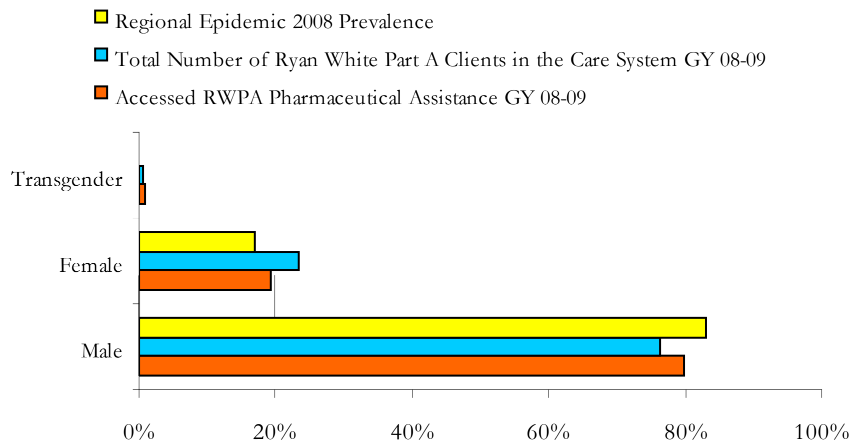


Figure 4.7
Comparison of Grant Year 2008-2009 RWPA Clients Accessing AIDS Pharmaceutical Assistance, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Race/Ethnicity

Figure 4.8
Comparison of Grant Year 2008-2009 RWPA Clients Accessing AIDS Pharmaceutical Assistance, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Gender



Hispanics utilized nearly 60% of AIDS Pharmaceutical Assistance during GY 08-09 with the Black and White populations making up nearly all of the remaining 40%. This could be attributed funding as the greater part of funding was dispersed in a location that primarily serves the Hispanic community. Men utilized roughly 80% while MSM utilized 45% and Heterosexual Men and Women just over 30%. Those three populations also comprise the majority of current TGA prevalence.

Figure 4.9

Frequency of Usage Relative to Clients in the Care System and Regional Epidemic

Those Populations Utilizing AIDS Pharmaceutical Assistance Most Frequently GY 08-09	Those Populations Utilizing AIDS Pharmaceutical Assistance Less Frequently GY 08-09	Consumer Survey Respondent Service Gap for AIDS Pharmaceutical Assistance
Heterosexuals	IDU	White Men
MSM	Blacks	Hispanic Women
Hispanics	Whites	Black Men
Men	Females	Black Women

Gap Analysis

A gap analysis reveals that roughly 732 PLWH/A are in need of pharmaceutical assistance. An estimated 14% increase in capacity is required to sufficiently meet the pharmaceutical needs in the Las Vegas TGA. Based on GY 08-09 expenditures, this equates to approximately $133,092.

Pharmaceutical Assistance Gap Analysis

Gap Analysis	
a. Total Projected Need in the TGA Applies total need from the consumer survey to the 6,867 Las Vegas TGA PLWH/A [(Total-No Need)*6,867/Total]	6,023
b. Total Projected Need that is Met Applies need met from consumer survey to the 6,661 Las Vegas TGA PLWH/A [(Need Met)*6,867/Total]	5,291
c. Potential Additional Clients whose need is not Being Met Difference between total projected need and total projected need that is met (row a-row b)	732
d. Additional System Capacity Required to Provide Service to all Needing but Not Receiving Service Current provider expansion required to completely meet need (row c/row b)	14%

Resource Inventory and Profile of Provider Capacity and Capability

In addition to AIDS Pharmaceutical Assistance and the AIDS Drug Assistance Program (ADAP) which is provided by Part B, one organization in the heart of Las Vegas provides AIDS drug assistance. In 2008 the organization expended $69,325 in donated funds to PLWH/A in need of pharmaceutical assistance serving 20 to 25 clients per month at about $267.00 per person. Many clients fall in a gray area of not meeting the minimum requirements to receive pharmaceutical assistance through Ryan White but lacking the ability to pay for them out-of-pocket. This community based organization bridges the gap for many such PLWH/A in the TGA. The ability for this organization to expand capacity is dependent upon funding levels.

Recommendations

1) Explore various strategies in order to expand prescription refill timeframe availability.

2) Reduce barriers to refilling medication and wait times by delivering medication via mail or another acceptable route.

3) Ensure medical case managers are adequately trained on the cost of medications, limitations of insurance coverage on HIV/AIDS pharmaceuticals, and know where to access alternative funding sources to ensure treatment regimens are sufficiently met.

Dental/Oral Health Care

HRSA Definition

Dental Care/Oral Health Care includes diagnostic, preventative, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Consumer Survey Results

Dental Care is the 3rd highest ranked priority among survey respondents at 6.8%. Of the survey respondents, 51% indicated a need for Dental/Oral Health Care. Of those in need, 64% responded that their need was met while 36% indicated their need was not met. The most widely indicated barrier to care, the client not knowing where to receive this service, with the second highest indication as "other reasons". Those in need and their barriers include:

- 20% White Men-"other reasons"
- 12% White Men-"didn't know where to get the service"
- 5% Black Women-"other reasons"
- 5% Hispanic Women-"other reasons"
- 5% Hispanic Women-"didn't know where to get the service"
- 4% Black Women-"didn't know where to get the service"
- 4% Black Men-"other reasons"
- 4% Black Men-"didn't know where to get the service"

Consumer Focus Group Results

Each consumer focus group indicated a very high level of satisfaction with all aspects of Dental/Oral Health Care from the respectful way they are treated, to brief wait times, to the services that are provided to them. Some patients indicated that appointment times are long, approximately 3 hours, but understand that their care comes from students overseen by faculty which makes the process slightly longer than at a regular facility. This was not indicated as a barrier to care, just an inconvenience during the care process.

Service Utilization and

During GY 08-09, 138 unduplicated clients were served by Ryan White Part A funded agencies for Dental/Oral Health Care expending $108,171 and providing 5,909 units of service. As addressed in the following figures the MSM, IDU, White and Pacific Islander populations access at a much higher rate than Heterosexuals, and the Black and Hispanic populations. Additionally of those who accessed Dental/Oral Health Care during GY 08-09 Men represent over 80%.

Figure 4.10
Comparison of Grant Year 2008-2009 RWPA Clients Accessing Dental/Oral Health Care, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Mode of Transmission

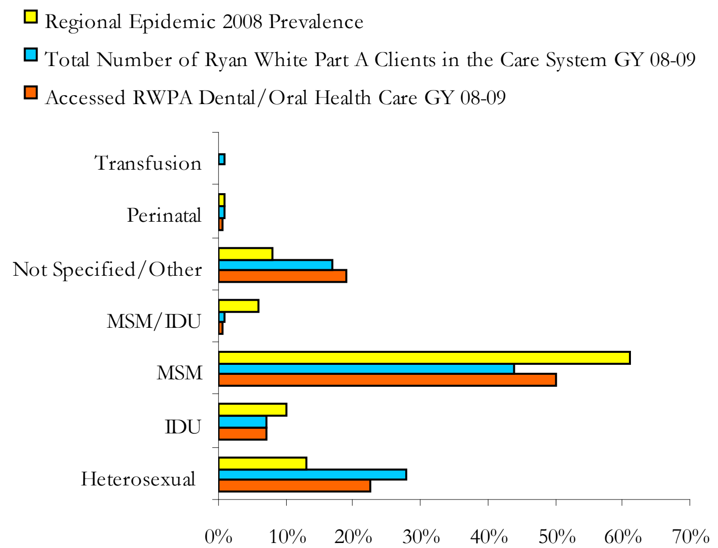


Figure 4.11
Comparison of Grant Year 2008-2009 RWPA Clients Accessing Dental/Oral Health Care, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Race/Ethnicity

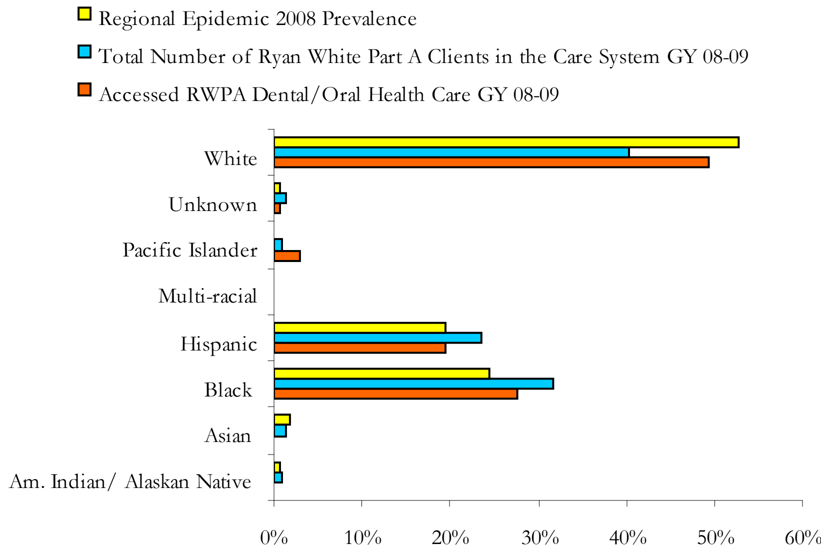


Figure 4.12
Comparison of Grant Year 2008-2009 RWPA Clients Accessing Dental/Oral Health Care, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Gender

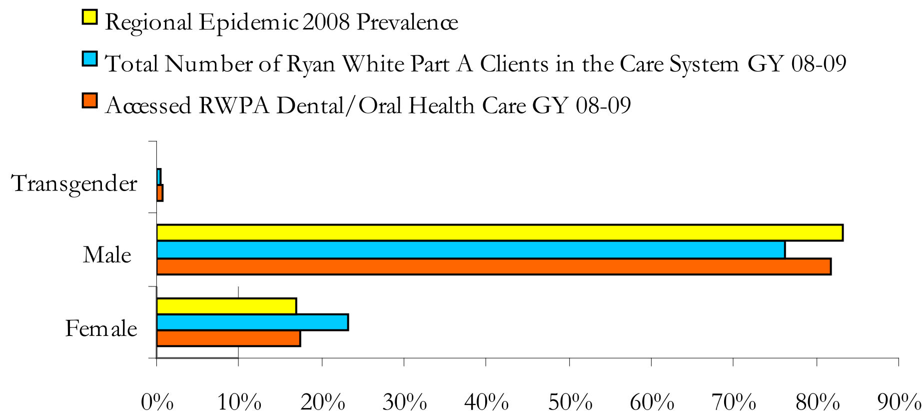


Figure 4.13

Frequency of Usage Relative to Clients in the Care System and Regional Epidemic

Those Populations Utilizing Dental/Oral Health Care Most Frequently GY 08-09	Those Populations Utilizing Dental/Oral Health Care Less Frequently GY 08-09	Consumer Survey Respondent Service Gap for Dental/Oral Health Care
MSM	Heterosexual	MSM White and Black
IDU	Hispanic	Heterosexual Men and Women
White	Black	
Pacific Islander	Women	
Men		

Gap Analysis

Based on a gap analysis, 2,069 PLWH/A in the TGA have an unmet need for Dental/Oral Health Care. In order to completely meet this need the care system will need to expand by 56%. Based on 08-09 GY expenditures approximately $1,532,922 is needed to completely meet this need.

Dental/Oral Health Care Gap Analysis

Gap Analysis	
a. Total Projected Need in the TGA Applies total need from the consumer survey to the 6,867 Las Vegas TGA PLWH/A [(Total-No Need)*6,867/Total]	5,771
b. Total Projected Need that is Met Applies need met from consumer survey to the 6,661 Las Vegas TGA PLWH/A [(Need Met)*6,867/Total]	3,702
c. Potential Additional Clients whose need is not Being Met Difference between total projected need and total projected need that is met (row a-row b)	2,069
d. Additional System Capacity Required to Provide Service to all Needing but Not Receiving Service Current provider expansion required to completely meet need (row c/row b)	56%

Resource Inventory

Two agencies indicted offering Dental/Oral Health Care, one is Ryan White Part A funded and offers translation services, the other is located in rural Nevada and provides this service through another funding stream but currently does not have translation services. Both indicated providing this service to the general public and PLWH/A. Both also indicated an increase in the number of clients seeking services within the past 12 months, a decrease in the amount of funding the agency receives from any source within the past 12 months, and one indicated an increase in demand for services from clients. One agency indicated no wait time for services while the other agency has a 1 to 6 day waiting period.

In order to increase capacity both agencies indicated a requirement for the following:

- Training in HIV/AIDS
- Increased partnerships with HIV/AIDS specialty organizations
- Funding to expand current capacity

The most widely indicated barrier to serving clients, "clients have trouble getting to our offices", followed by:

- Not enough resources at the agency
- Clients don't have a payment source
- Staff training in HIV/AIDS is limited
- Clients routinely miss appointments
- Client distrust and suspicion
- Limited community partnerships with HIV/AIDS organizations
- Agency doesn't provide all the services the client needs

Two other agencies were located in the community providing Dental/Oral Health Care for the uninsured and underinsured population. One caters to only teen's ages 12 to 18 through a pool of 35 volunteer dentists, while the other has no limitations on the population it serves. Both provide restorative and preventative dental care, exams, fillings, cleanings, extractions, and oral health education.

Recommendations

1) Take the opportunity to educate PLWH/A on the importance on dental hygiene, teaching skills to prevent the need for fillings, dentures, ect. Provide dental hygiene kits to those PLWH/A in need.

2) Educate consumers and case managers on available dental resource both Ryan White and non-Ryan White funded throughout the region to reduce the unfulfilled need for this service.

3) Expand access to all parts of the region by expanding providers to ensure service delivery in more than one location to increase accessibility.

Early Intervention Services (EIS)-HIV/AIDS Testing Services

HRSA Definition

Early Intervention Services include counseling individuals with respect to HIV/AIDS; testing; referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

Consumer Survey Results

It was unclear as to what extent survey respondents would recognize Early Intervention Services and all the aspects in encompasses, therefore, the survey listed HIV/AIDS testing services in its place. HIV/AIDS testing services was the 4th highest ranked priority among consumer respondents. Of survey responses 48% indicated a need for testing services within the last year, 96% of those in need received testing services leaving a gap of only 4%.

Consumer Focus Group Responses

The MSM of color consumer focus group indicated a need for free HIV/AIDS testing services. This particular group expressed their fury that no free testing was available in Las Vegas. They argued that the cost of $25.00 for an HIV test is unrealistic and people who need to get tested can't afford it, thus perpetuating the spread of disease.

In actuality testing is provided at a minimal fee of $25.00 however no one is denied service for the inability to pay. Testing is also offered throughout the Las Vegas region at several agencies on a regular basis free of charge with many other opportunities for free testing at several varying locations monthly. By educating this group on the availability of free testing we were able to neutralize an argumentative situation and hopefully spread the word that testing is free in certain locations.

Service Utilization

During GY 08-09, Early Intervention Services served 609 clients in the Las Vegas TGA utilizing $448,996 in Part A funding delivering 36,941units of care. Approximately 48% percent of survey respondents indicated a need for HIV/AIDS testing services in the past 12 months. Of those indicating a need, 96% had their need met while 4% claimed testing was unavailable when needed. The largest populations served include:

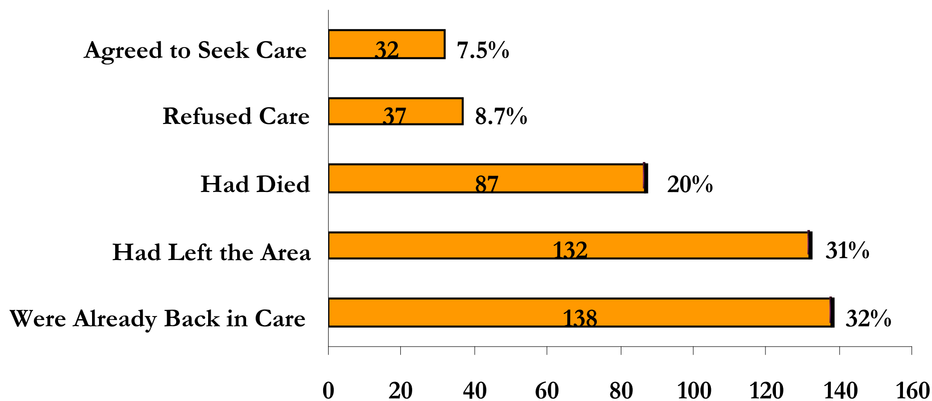
- Men 70.9%
- Black Men and Women 36%
- White Men 27%
- Hispanic Men 20%

Out of Care Project

Early Intervention Services (EIS) in the Las Vegas region are unique to those in the rest of the nation whereas employees become detectives in their mission to promote care. Because PLWH/A who are out of care are more likely to infect other people, getting and keeping people in care lowers the viral load in the community and decreases overall infectiousness. Also, keeping people in care keeps costs down as emergency treatment is far more costly than preventative medicine. Therefore EIS communicable disease workers in Southern Nevada mine databases, check lists of the recently deceased who had been receiving Social Security benefits, search voter registration lists, state prison inmate registers, local lab reports and other data to locate those people who have fallen out of care and link them back into the care system.

In October of 2007 EIS compiled a list of 1,259 infected individuals that had fallen out of care, 833 were never found. Of the remaining 426, the majority was already back in care.

Figure 4.14 EIS Out-of-Care Project



As of June 2008, the Out of Care Project cost about $800,000 in federal funding, however the goal is to transition into making this part of the staff's regular duties.

Gap Analysis

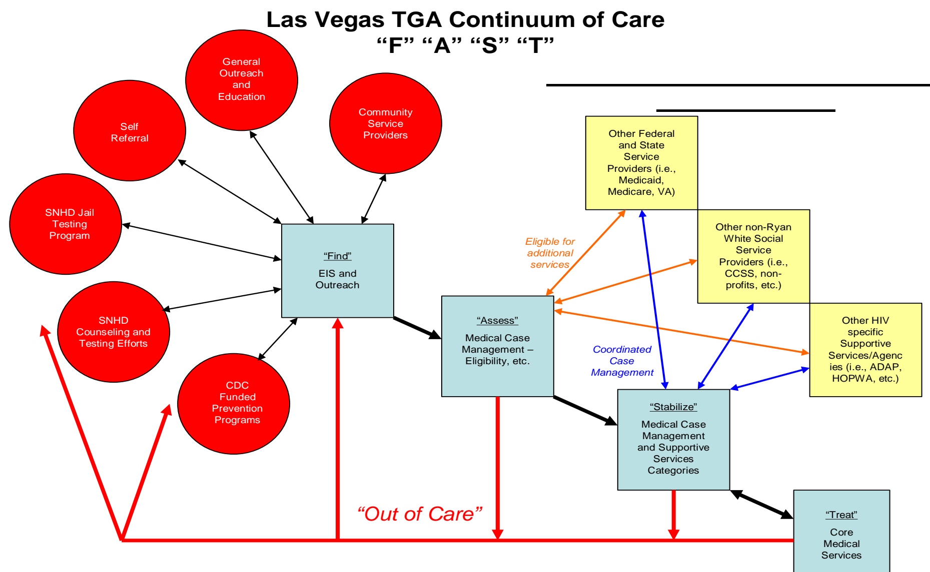
A gap analysis reveals that in order to completely meet this need in the TGA the care system will need to expand by 4%. Based on GY 08-09 expenditures roughly $136, 416 is needed.

Early Intervention Services Gap Analysis

Gap Analysis	
a. Total Projected Need in the TGA Applies total need from the consumer survey to the 6,867 Las Vegas TGA PLWH/A [(Total-No Need)*6,867/Total]	5,816
b. Total Projected Need that is Met Applies need met from consumer survey to the 6,661 Las Vegas TGA PLWH/A [(Need Met)*6,867/Total]	5,592
c. Potential Additional Clients whose need is not Being Met Difference between total projected need and total projected need that is met (row a-row b)	224
d. Additional System Capacity Required to Provide Service to all Needing but Not Receiving Service Current provider expansion required to completely meet need (row c/row b)	4%

Recommendation

1) Educate the public including all points of entry that the first step to entering care begins with Early Intervention Services and provide all necessary contact information including the Las Vegas Continuum of Care "F" "A" "S" "T" model.



Health Insurance Premium and Cost Sharing Assistance

HRSA Definition
Health Insurance Premium (HIP) and Cost Sharing Assistance is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Health Insurance Coverage in America
America is continually moving from a manufacturing based economy to a service economy, employee patterns are constantly changing, and consequently health insurance coverage has become less stable. The service sector offers less access to health insurance and employers and employees alike are relying on part-time and contracted work, which doesn't qualify for health care benefits.

Simultaneously, health insurance premiums are increasing so rapidly that many employers cannot afford to offer these benefits nor can employees pay such large contributions toward their coverage. This has resulted in fewer Americans taking advantage of health care benefits because they simply can't afford it. According to the latest government data available by the U.S. Census Bureau 18% of the population under the age of 65 were without health insurance coverage in 2007 with 18.4% rate for Nevada specifically.

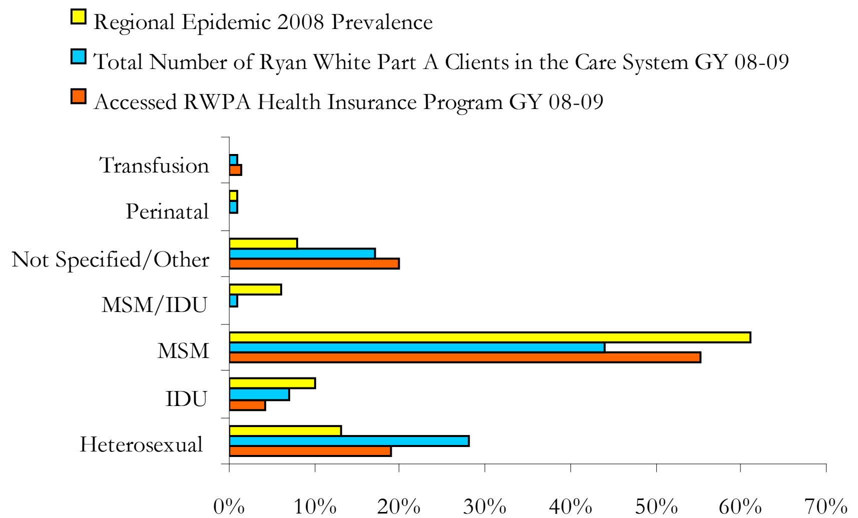
Consumer Survey Results
Health Insurance Premium and Cost Sharing Assistance was ranked 5th among consumer survey respondents at 5.5%. Of those in need of this service the most indicated reason for not accessing it was that the client didn't know where to receive this service. The largest populations indicating unavailability were:

- White population 52%
  - White MSM 27%
- Black population 34%
  - Black Heterosexual Women 7%
  - Black MSM 7%

Consumer Focus Groups
The MSM of Color Consumer Focus Group was the only group that discussed the current utilization and need for this service as a priority.

Service Utilization
During GY 08-09 the Health Insurance Program served 210 Ryan White Part A clients expending $422,830 while delivering 10,504 units of care. The following figures depict service utilization indicating that MSM consumed 55% with regard to mode of transmission followed by the Not Specified/Other category at 20%. The White population represents 40% of Ryan White clients however they utilized 60% of Health Insurance Program resources, with Men utilizing over 80% of HIP resources.

Figure 4.15
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing the Health Insurance Program, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Mode of Transmission



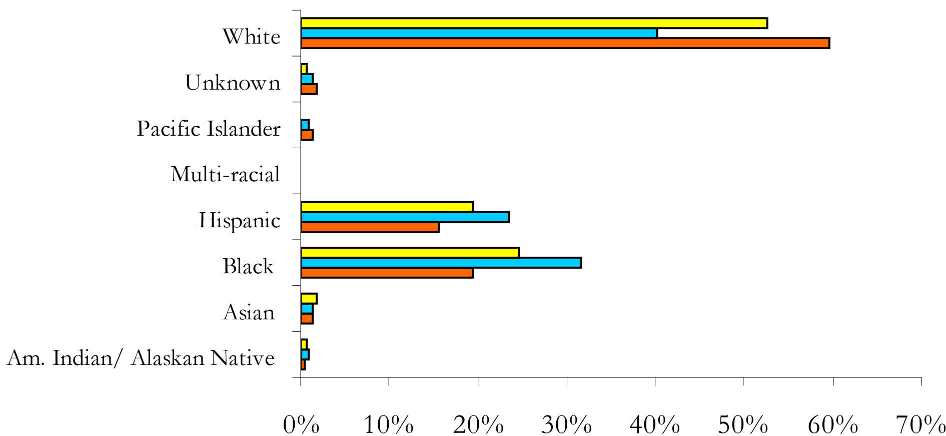
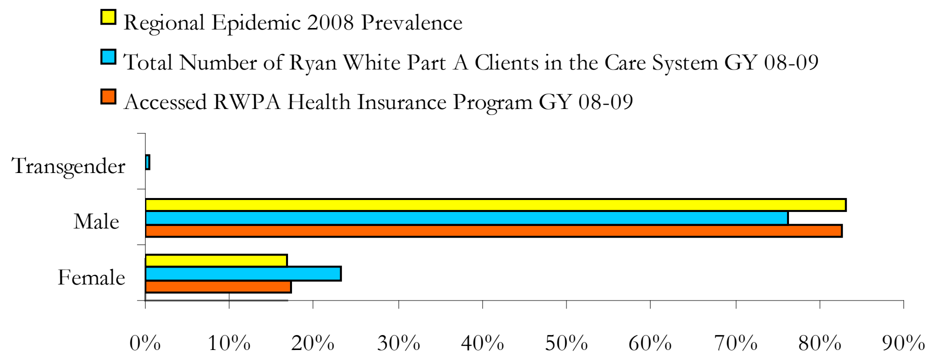


Figure 4.16
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing the Health Insurance Program, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Race/Ethnicity

Figure 4.17
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing the Health Insurance Program, RWPA Clients in the Care System during
Grant Year 2008-2009, and the Regional Epidemic by Gender



Historically in the TGA the Hispanic population has primarily worked in the service industry which often times doesn't offer health insurance benefits to its employees. This could explain the low utilization of this service among that population.

Figure 4.18

Frequency of Usage Relative to Clients in the Care System and Regional Epidemic

Those Populations Utilizing the Health Insurance Program Most Frequently GY 08-09	Those Populations Utilizing the Health Insurance Program Less Frequently GY 08-09	Consumer Survey Respondent Service Gap the Health Insurance Program
MSM	Heterosexual	White MSM
Not Specified/Other	IDU	Black MSM
White	Hispanic	Black Heterosexual Female
Pacific Islander	Black	
	Female	

Gap Analysis

During GY 08-09 Ryan White Part A service providers assisted 209 PLWH/A using the Health Insurance Program which utilized $422,830. A gap analysis reveals that approximately 1,399 PLWH/A have an unfulfilled need for health insurance continuation. In order to completely meet this need the current care system will need to expand by 34% requiring roughly $2,830,331

Health Insurance Premium and Cost Sharing Assistance Gap Analysis

Gap Analysis	
a. Total Projected Need in the TGA Applies total need from the consumer survey to the 6,867 Las Vegas TGA PLWH/A [(Total-No Need)*6,867/Total]	5,618
b. Total Projected Need that is Met Applies need met from consumer survey to the 6,661 Las Vegas TGA PLWH/A [(Need Met)*6,867/Total]	4,129
c. Potential Additional Clients whose need is not Being Met Difference between total projected need and total projected need that is met (row a-row b)	1,399
d. Additional System Capacity Required to Provide Service to all Needing but Not Receiving Service Current provider expansion required to completely meet need (row c/row b)	34%

Recommendations

1) Continue to provide funding for health insurance program to maintain consumers in the care system and reduce the burden of the uninsured on Ryan White funding streams.

2) Provide detailed information to consumers about Health Insurance Program requirements, necessary documentation, and location for service.

Food Bank/Food Vouchers

HRSA Definition

Food Bank/Home delivered meals involves the provision of actual food, meals, or nutritional supplements. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item.

Consumer Survey Results

Food bank/food voucher assistance ranked 6th among consumer survey respondents, 60% of which indicated a need for this service within the past 12 months. Of those in need 87% indicated receiving this service leaving an unfulfilled need of 13%. The most widely indicated barrier to receiving this service is the client didn't know where to get this service followed by "other" reasons. The largest populations indicating unavailability were:

Mode of Transmission and Gender

- MSM 36%
- Heterosexual Males and Females 26%

Race/Ethnicity and Gender

- White Men 36%
- Black Men 26%

Respondents were asked; "are there any services you need but are not offered", 19.8% indicated a need for a hot meals program. Those populations most frequently indicating this need were:

- White MSM 10%
- Black Heterosexual Women 6%
- Black MSM 6%
- White Heterosexual Women 6%
- Multi-racial MSM 5%

Consumer Focus Groups

Women IDU

The Women IDU focus group indicated a great need for household cleaning products and linens. Many of them also discussed the need for pots, pans and kitchen utensils. One participant stated, "I ain't got no dishes so I can't cook nothing". This group also indicated a need for more lunch and learn activities sponsored by agencies, not only for the food they provide but for social interaction as well.

Other Focus Group Comments

In the MSM/IDU Focus Group a participant stated with regard to the $20 Wal-Mart stipend; "If they give me $50 I would be on time but $20 isn't really worth my time, it only buys a few packs of cigarettes". Another participant commented that, "food is outdated at the food banks, get non-outdated food".

During the MSM of color focus group discussion a respondent commented, "With food vouchers, sometimes you don't want to spend $20 at a time so if there could be a rechargeable debit card so you could spend as you need". One participant commented that clients need, "More food vouchers,

more than 1 up to 6," another along the same lines stated, "more food vouchers at least 4 or 5 just more instead of just 1".

Following the MSM Focus Group a participant discussed the need for better regulation of Food Vouchers as he has witnessed these vouchers being traded for drugs and used to buy alcohol and tobacco products.

Service Utilization

During GY 08-09 Ryan White Part A funding assisted 959 clients with food vouchers/food assistance providing 16,658 units of care. The figures below correspond with focus group comments regarding the high priority and utilization of this service by Black Women both Heterosexual and IDU. The MSM population has the highest service gap at 8% while men overall are second at 5%.

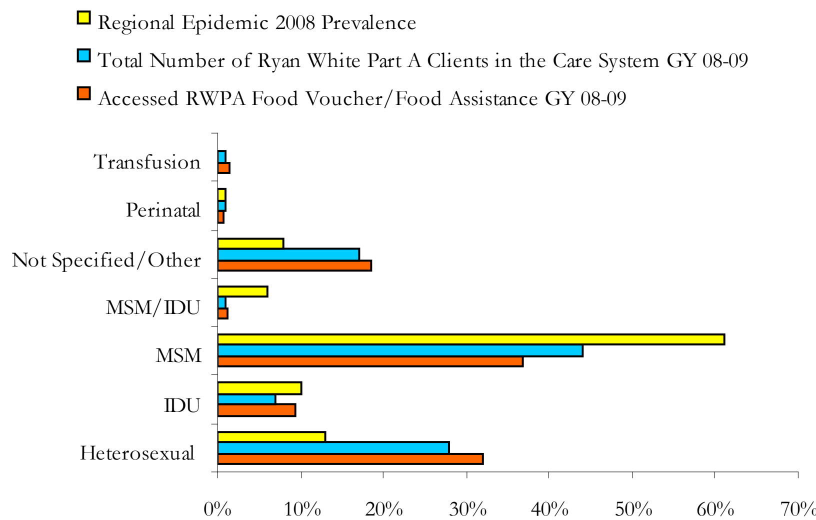


Figure 4.19
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Food Voucher/Food Assistance, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Mode of Transmission

Figure 4.20
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Food Voucher/Food Assistance, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Race/Ethnicity

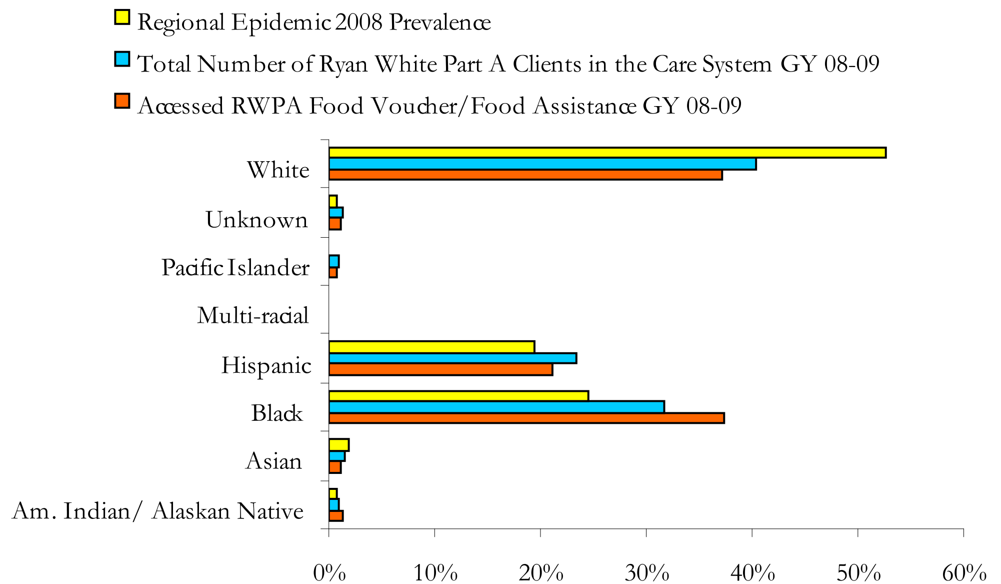


Figure 4.21
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Food Voucher/Food Assistance, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Gender

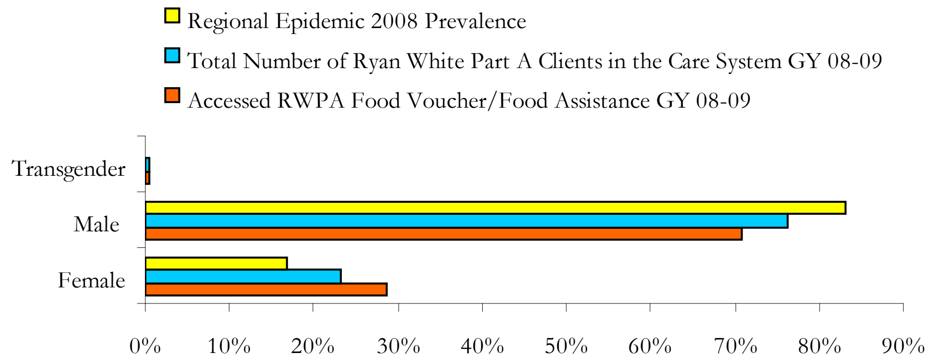


Figure 4.22
Frequency of Usage Relative to Clients in the Care System and Regional Epidemic

Those Populations Utilizing Food Voucher/Food Assistance Most Frequently GY 08-09	Those Populations Utilizing Food Voucher/Food Assistance Less Frequently GY 08-09	Consumer Survey Respondent Service Gap Food Voucher/Food Assistance
Heterosexual	MSM	MSM 36%
IDU	White	Heterosexual Males and Females 26%
MSM/IDU	Hispanic	White Males 36%
Black	Males	Black Males 26%
Females		

Gap Analysis

A gap analysis reveals that approximately 824 PLWH/A in the TGA were without this service in the past 12 months. With such an extensive resource inventory there is little need for capacity expansion in this area by way of Ryan White funding. However, reported barriers have indicated that clients simply don't know where to access this service. This indicates that it is imperative to distribute a food assistance resource directory.

Food Bank/Food Voucher Gap Analysis

Gap Analysis	
a. Total Projected Need in the TGA Applies total need from the consumer survey to the 6,867 Las Vegas TGA PLWH/A [(Total-No Need)*6,867/Total]	6,455
b. Total Projected Need that is Met Applies need met from consumer survey to the 6,661 Las Vegas TGA PLWH/A [(Need Met)*6,867/Total]	5,631
c. Potential Additional Clients whose need is not Being Met Difference between total projected need and total projected need that is met (row a-row b)	824
d. Additional System Capacity Required to Provide Service to all Needing but Not Receiving Service Current provider expansion required to completely meet need (row c/row b)	15%

Resource Inventory
In the Las Vegas region 57 food assistance locations were identified, many of these provided by faith based organizations and community agencies. Some of the programs have requirements such as; photo ID, proof of residence, social security card, birth certificate, proof of HIV status, or age limitations. Available food assistance programs are as follows:

- Food Pantry-39
- Hot Meal-7
- Food Bank-3
- Food Assistance/Food Shelf/Food Distribution-3
- Sack Lunch-2
- Soup Line-1
- Bread Program-1
- Baby Formula/Baby Food-1

Recommendations
1) Evaluate the ability of the food assistance programs to connect consumers to the care system, specifically HIV/AIDS Medical Care. Also connect with food assistance programs for opportunities to connect those who have fallen out of care back into care.

2) Distribute the already developed food assistance directory to all agencies servicing PLWH/A. Encourage utilization of community resource first as the intent of Ryan White is to be the payer of last resort.

Mental Health Services

HRSA Definition
Mental Health Service are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

Consumer Survey Results
Mental Health Services ranked 7th among consumer survey respondents. Of survey respondents 48% indicated a need for this service, of those in need 61% received this service leaving an unfulfilled need of 39%. The most widely indicated barrier to accessing this service was the client didn't know where to receive it. The largest populations claiming unavailability were:

Mode of Transmission and Gender

- MSM 39%
- Heterosexual Females 21%

Race/Ethnicity and Gender

- White Males 30%
- Black Females 12%
- Black Males 12%

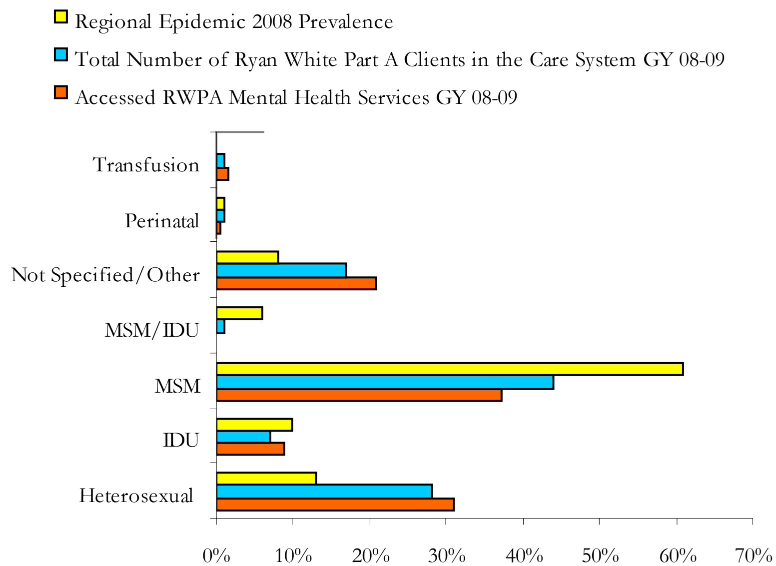
Consumer Focus Groups

Participants from each focus group commented on the utilization of counseling, group sessions, or psychiatric help on a frequent basis without strong negative or positive comments on service delivery or access. During the MSM focus group one participant stated that wait times for Mental Health Services are too long. During the MSM/IDU Focus Group a participant stated; "Services are good, but delivery is poor, focus should be on Mental Health and Housing". One client in the MSM of color focus group commented that clients need, "More mental health services and easier access to mental health services".

Service Utilization

During GY 08-09 Ryan White Part A funding provided Mental Health Services to 193 clients expending $231,089 and supplying 13,422 units of care.

Figure 4.23
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Mental Health Services, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Mode of Transmission



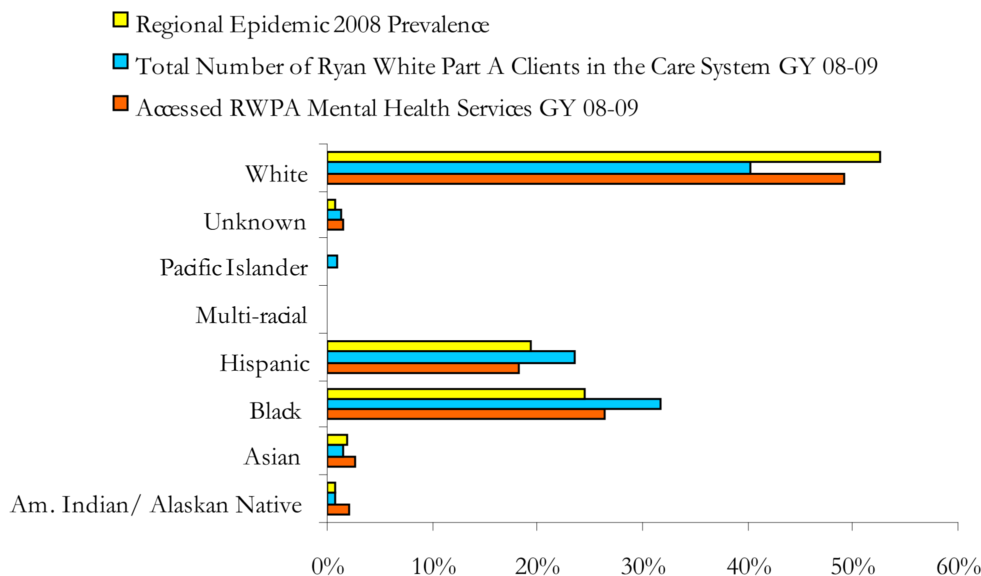


Figure 4.24
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Mental Health Services, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Race/Ethnicity

Figure 4.25

Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Mental Health Services, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Gender

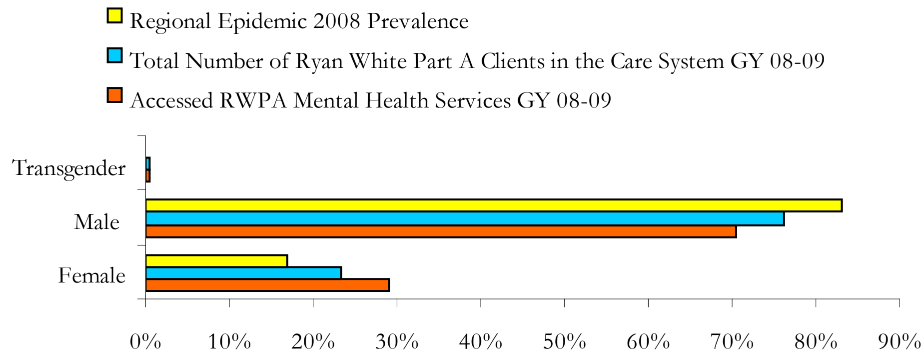


Figure 4.26

Frequency of Usage Relative to Clients in the Care System and Regional Epidemic

Those Populations Utilizing Mental Health Services Most Frequently GY 08-09	Those Populations Utilizing Mental Health Services Less Frequently GY 08-09	Consumer Survey Respondent Service Gap Mental Health Services
Heterosexuals	MSM	MSM 39%
IDU	Hispanics	Heterosexual Females 21%
Whites	Blacks	White Males 30%
American Indian/Alaskan Native	Males	Black Females 12%
Females		Black Males 12%

Gap Analysis

A gap analysis reveals 872 PLWH/A in the region had an unfulfilled need for Mental Health Services. In order to completely meet this need the care system will need to expand by 21% and approximate $1,044,089 will be required to treat these patients.

Mental Health Services Gap Analysis

Gap Analysis	
a. Total Projected Need in the TGA Applies total need from the consumer survey to the 6,867 Las Vegas TGA PLWH/A [(Total-No Need)*6,867/Total]	5,045
b. Total Projected Need that is Met Applies need met from consumer survey to the 6,661 Las Vegas TGA PLWH/A [(Need Met)*6,867/Total]	4,173
c. Potential Additional Clients whose need is not Being Met Difference between total projected need and total projected need that is met (row a-row b)	872
d. Additional System Capacity Required to Provide Service to all Needing but Not Receiving Service Current provider expansion required to completely meet need (row c/row b)	21%

Resource Inventory

Four agencies were identified as providing Mental Health Services, of which all provide services to PLWH/A and two also provide this service to the general public. The funding for these agencies is provided by; Ryan White Part A and C Programs, Federal Programs, Revenue, Foundations, and contributions.

One agency indicated serving primarily adults, women, and offenders. Another indicated servicing primarily the homeless, women and children. While the other two agencies serve all populations. All agencies provide translation assistance, the only indicated language sought was Spanish. All but one agency serves PLWH/A throughout the entire TGA.

Regarding funding streams, 50% have seen an increase in the number of clients seeking services, 50% have seen an increased demand from clients, and 25% has seen a decrease in the amount of funding provided to their agency from any funding stream. Two agencies provided their HIV/AIDS program expenditures for the prior year;

- $1,651,234
- $37,255

Three agencies listed their total number of PLWH/A served for the prior year;

- 1707
- 70
- 10

Regarding an increase in capacity, 75% of respondents indicated they need more funding to increase current capacity for PLWH/A, 50% need an increase in partnerships with HIV/AIDS specialty organizations, and 25% need funding to develop new capacity.

When asked what are the most pressing needs your agency sees for PLWH/A that your agency could provide:

- Obtaining HIV medication, vision & dental care, psychiatric care, housing and transportation
- Counseling Services Coordination

The most widely indicated barriers for Mental Health Service Providers when providing care:

- Not enough resources at my agency 50%
- Insufficient staff to provide services 25%
- Clients don't have payment source 25%
- Our hours limit clients access to our services 25%

For Mental Health Services, 2 agencies indicated a 1 to 6 day wait while a third agency indicated the wait to be less than a month. All agencies indicated supportive counseling wait times to be 1 to 6 days.

Emergency Financial Assistance

HRSA Definition

Emergency Financial Assistance is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps) and medication when other resources are not available. Part A and Part B programs must allocate, track and report these funds under specific categories.

Consumer Survey Response

Emergency financial assistance was ranked as the 8th priority for survey respondents. Nearly 41% of respondents indicated a need for this service within the last 12 months. Of those indicating a need 71% had their need met leaving a 29% unfulfilled need. The most widely indicated barrier to accessing emergency financial assistance, 69% didn't know where to receive the service. The largest populations claiming unavailability were:

Mode of Transmission and Gender

- MSM 43%
- Heterosexual Females 15%
- Heterosexual Males 9%
- Other/Unknown Males 8%

Race/Ethnicity and Gender

- White Males 38%
- Black Males 20%
- Hispanic Males 11%
- Black Females 9%

Focus Group Discussion

MSM

Several people commented during this discussion that they don't qualify for some services but they still need assistance with them. One man commented, "I want to access Services but I don't qualify, and I need help with electricity bills and food". Other comments from this group included needing gas vouchers for those clients that have cars and money management/training classes.

Other Focus Group Discussions

The other focus groups didn't comment specifically on utilizing this service however the MSM of color group discussed the need for more incentives such as McDonald's gift cards. The MSM/IDU group discussed the need for money in general to buy, "food, clothes, whatever we want" and money set aside to pay for clients, "recreational activities like going to shows or the movies, we can't afford to do fun stuff like that".

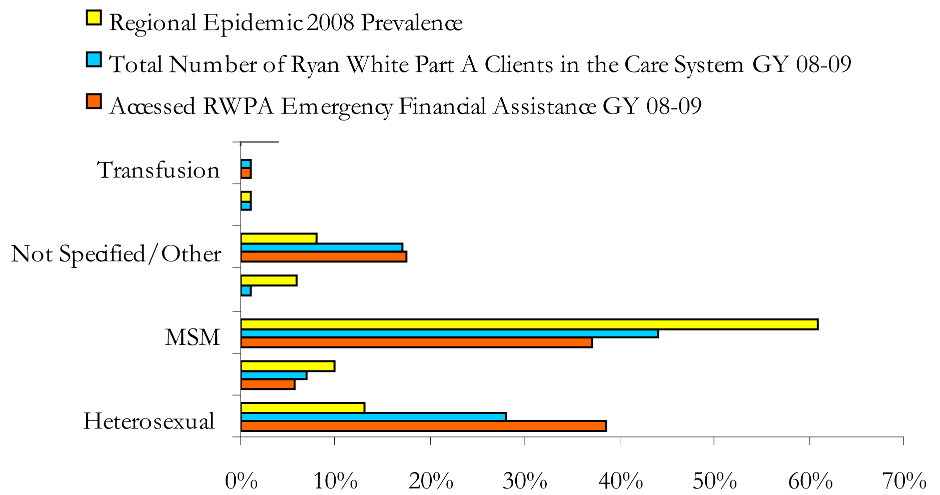
Service Utilization

During GY 08-09 Emergency Financial Assistance was utilized by 194 clients. Part A funded service providers delivered 2,245 units of this service expending $237,176. Broken down in 4 specific categories with their utilized dollar amount:

- EFA-Housing/Utilities $102,452
- EFA-Food $90,190

- EFA-Transportation $44,145
- EFA-Medication $389

Figure 4.27
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Emergency Financial Assistance, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Mode of Transmission



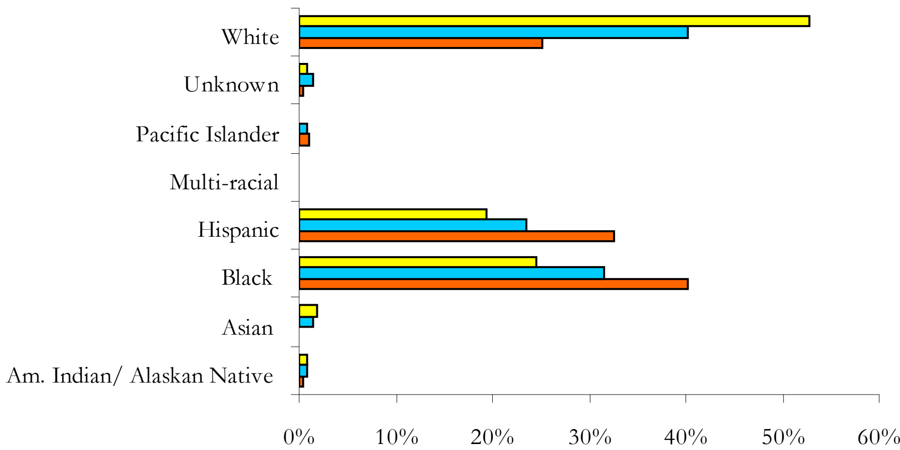
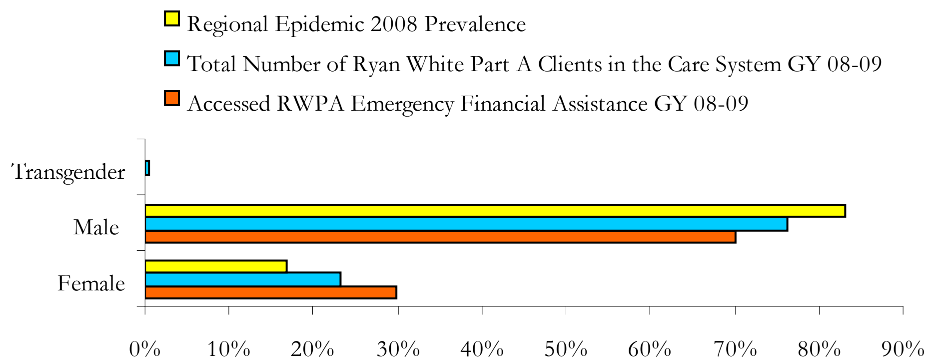


Figure 4.28
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Emergency Financial Assistance, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Race/Ethnicity

Figure 4.29
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Emergency Financial Assistance, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Gender



While representing less than 30% of Ryan White Part A clients in the TGA, Heterosexuals utilized nearly 40% of all Emergency Financial Assistance during GY 08-09. Additionally the Black and Hispanic populations utilized 72% while representing only 32% and 23% of clients in the TGA. Whites utilizing only 25% comprise 40% of clients in the TGA and 53% of the epidemic.

Figure 4.30

Frequency of Usage Relative to Clients in the Care System and Regional Epidemic

Those Populations Utilizing Emergency Financial Assistance Most Frequently GY 08-09	Those Populations Utilizing Emergency Financial Assistance Less Frequently GY 08-09	Consumer Survey Respondent Service Gap Emergency Financial Assistance
Heterosexuals	MSM	MSM 43%
Blacks	MSM/IDU	White Males 38%
Hispanics	Whites	Black Males 20%
Females	Males	Heterosexual Females 15%

Gap Analysis

A gap analysis reveals that approximately 1,653 PLWH/A in the TGA had and unfulfilled need and the care system will need to expand by 41% to completely meet this need. However, stabilizing clients in other aspects of care will cut down on the need for this service.

Emergency Financial Assistance Gap Analysis

Gap Analysis	
a. Total Projected Need in the TGA Applies total need from the consumer survey to the 6,867 Las Vegas TGA PLWH/A [(Total-No Need)*6,867/Total]	5,722
b. Total Projected Need that is Met Applies need met from consumer survey to the 6,661 Las Vegas TGA PLWH/A [(Need Met)*6,867/Total]	4,069
c. Potential Additional Clients whose need is not Being Met Difference between total projected need and total projected need that is met (row a-row b)	1,653
d. Additional System Capacity Required to Provide Service to all Needing but Not Receiving Service Current provider expansion required to completely meet need (row c/row b)	41%

Resource Inventory

Three agencies were identified as providing Emergency Financial Assistance. One agency provides this service to all 3 counties in the TGA while the other 2 support Clark County. Spanish is the most requested language at all facilities, each offering translation services to their clients. Public Transportation is readily available near all 3 agencies and 1 offers early morning and evening hours. All agencies indicated that services are free, 100% of agencies indicated a need for funding to expand their current capacity.

Within the last year;

- 100% of agencies have seen an increase in the number of clients seeking services,

- 100% have seen an increase in demand from clients seeking services,
- 66.7% have seen a decrease in the amount of funding received from private donations, and
- 66.7% have seen a decrease in the amount of funding received from any funding source.

Two agencies indicated services that they could provide that they feel are the most important to PLWH/A in the TGA, they are;
- Food, Transportation, Housing, Hygiene Products
- Case management, Drug assistance, Housing, Food

Barriers that these providers face when attempting to provide care to clients include;
- 66.7% agency doesn't provide all the services a client needs,
- 66.7% limited community partnerships/linkages with specialized HIV organizations,
- 33.3% client distrust and suspicion,
- 33.3% clients routinely miss appointments, and
- 33.3% staff training in HIV/AIDS is limited.

Two agencies indicated a 1 to 6 day wait time for Emergency Financial Assistance while 1 indicated no wait time.

Recommendations
Emergency Financial Assistance is a top unfulfilled need.

1) Develop strategies to facilitate access to and linkage with other community resources.

Housing Services

HRSA Definition
Housing Services are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

Consumer Survey Response
Housing Assistance ranked as the 9th priority by consumer survey respondents. Of total respondents 39% indicated a need for this service, 71% reported having their need met leaving a 29% unfulfilled need. Regarding barriers to accessing this service 70% of those with an unfulfilled need indicated they didn't know where to access this service. The largest populations claiming unavailability were:

Transmission Mode and Gender
- MSM 47%
- Heterosexual Females 13%
- Heterosexual Males 11%

Race/Ethnicity and Gender
- White Males 37%
- Black Males 19%

- Hispanic Males 19%

Respondents were also asked to indicate any services they need of but aren't offered, 43% said more housing assistance. Regarding housing arrangements;

- 75% Rent or own a house or apartment
- 13% Live with family
- 6% Are staying with friends
- 1% Reside in a halfway house or drug treatment program
- 1% Live in a shelter
- 1% Are homeless or live on the street
- 1% Indicated other

Of those living in a halfway house or drug treatment program;

- 50% Black
- 50% White

Of those living in a shelter;

- 66% Black
- 33% Unknown

Of those indicating they are homeless;

- 71% White
- 14% American Indian or Alaskan Native
- 14% Black

Focus Group Discussions

MSM

This group discussed frustration with the inability to access services because they don't qualify. Other comments included their dissatisfaction with the quality of housing available to them and the need for better housing assistance.

MSM of Color

This group placed great emphasis on the need for more housing and specifically discussed their desire for specialty housing for PLWH/A only. One participant said, "For housing $500 to $600 every month isn't enough" another stated, "I want stable housing, not for just 6 months at a time". Another participant discussed the need for HIV housing throughout the city in various locations.

Women IDU/Substance Abusers

This group discussed the utilization of section 8 housing as well as free housing through other avenues. When asked if there are any services that are needed but aren't offered, 2 participants indicated more housing assistance.

Men IDU/Substance Abusers

One participant discussed his frustration with Clark County Social Services as they could only help him with rent for 1 month. Another participant commented, "We need stable housing (for) more than 6 months, and transitional housing, stable transitional housing for PLWH/A".

Southern Nevada Homeless Census and Survey Study

A study done by Applied Survey Research reveals that the total number of people in shelters has risen over 80% from 2007 to 2009 totaling 13,338.

The majority of the total homeless population are chronic substance abusers, followed by those with sever mental illness. Regarding race/ethnicity, the White population comprises 52% of the total homeless population followed by the Black population at 31%, and Hispanics at 9%.

Figure 4.31
Homeless Census

	2007	2009	07-09 Net Change	07-09 Percent Change
Total Sheltered People	3,844	7,004	3,160	82.2%
Total Unsheltered People	3,747	3,027	-720	-19.2%
Total Hidden Homeless	3,826	3,307	-519	-13.6%
TOTAL	**11,417**	**13,338**	**1,921**	**16.8%**

Seventy-six percent of the homeless population is not chronically homeless. The primary reason for homelessness in 2009, 67% lost their job, 27% have a substance abuse problem, and 12% have a gambling problem. When 222 participants were asked to identify the top five services they utilize the most; free meals 65%, emergency shelter 44%, shelter day services 20%, health services 15%, food pantry 9%, and bus passes 16%. Regarding foreclosures, 2.1% of respondents stated they lost the home they owned through foreclosure and 2.1% indicated they lost the home they rented due to a landlords foreclosure.

Gap Analysis

A gap analysis reveals that 1,571 PLWH/A in the TGA are in need of some variety of housing assistance. In order to completely meet this need the care system will need to expand by 41%.

Housing Services Gap Analysis

Gap Analysis	
a. Total Projected Need in the TGA Applies total need from the consumer survey to the 6,867 Las Vegas TGA PLWH/A [(Total-No Need)*6,867/Total]	5,423
b. Total Projected Need that is Met Applies need met from consumer survey to the 6,661 Las Vegas TGA PLWH/A [(Need Met)*6,867/Total]	3,852
c. Potential Additional Clients whose need is not Being Met Difference between total projected need and total projected need that is met (row a-row b)	1,571
d. Additional System Capacity Required to Provide Service to all Needing but Not Receiving Service Current provider expansion required to completely meet need (row c/row b)	41%

Resource Inventory

Emergency Housing Assistance

Five organizations were identified as providing Emergency Housing Assistance. Of those agencies 80% receive Part A funding, 80% receive Foundation funding, 80% receive contributions and private donations, 60% receive federal/state funding, 40% utilize revenue, and 20% receive Part B funding. Sixty percent only serve PLWH/A while the other 40% serve a larger population including those PLWH/A.

All agencies provide language assistance through bi-lingual staff, a language line, or outside translation service with the most requested language as Spanish. All clients in the TGA have access to this service as four providers primarily serve Clark County, three serve Nye County and two serve in Mohave County, public transportation is readily accessible near all agencies except one.

All agencies provide this service free of charge with the following occurrences having taken place within the last year;

- 83% have seen an increase in the amount of clients seeking services,
- 83% have seen an increase in demand from clients,
- 66% have seen a decrease in the amount of funding from any funding source, and
- 50% have seen a decrease in the amount of private funding.

Agencies indicated that in order to increase their capacity and ability to serve more PLWH/A they need;

- 80% an increase in partnerships with HIV/AIDS specialty organizations
- 80% funding to expand current capacity
- 20% training in HIV/AIDS
- 20% funding to develop new capacity

When attempting to provide services, the majority indicated the most common barrier as the agency doesn't provide all the needed services, followed by limited partnerships and linkages with HIV/AIDS specialty organizations, staff training in HIV/AIDS is limited, and clients lack payment source. Three agencies indicated no wait times, while the other two have a 1 to 6 day wait for this service.

Transitional Housing Services

Transitional Housing Services are available at five agencies in the TGA funded primarily through; Foundations, Federal/State funding, private donations, revenue, and Ryan White Part A. One agency only offers service to PLWH/A while the rest serve a wide variety including PLWH/A. Four agencies have bi-lingual staff on hand and the other agency uses a language line or an outside translation service, Spanish is the primary language requested.

When asked what obstacles their agency has faced within the last 12 months;

- 80% indicated an increased number in clients seeking services
- 80% indicated an increase in demand from clients seeking services
- 60% indicated a decrease in the amount of private donation to their organization
- 60% indicated a decrease in the amount of funding received from any funding stream

When asked what their agency would require in order to increase capacity and serve more PLWH/A;

- 60% indicated an increase in partnership with HIV/AIDS specialty organizations
- 60% indicated funding to increase current capacity
- 20% indicated more training in HIV/AIDS

The wait times for Emergency Housing Assistance was 1 to 6 days for two agencies and no wait time for the other three agencies.

Housing Payment Services
Housing Payment Services is provided by four agencies primarily funded by; Foundations, Federal/State funding, contributions and private donations, revenue, and two are funded by Ryan White Part A. One agency only serves PLWH/A while the other agencies provide this service to all including PLWH/A, two agencies focus on domestic violence victims, women and children. All offer service primarily in Clark County, with public transportation nearby all, and translation services offered by 50%.

When asked about the obstacles their agency has faced within the past 12 months;

- 100% indicated an increase in the number of clients seeking services
- 75% indicated an increase in the demand for services from clients
- 50% indicated a decrease in the amount of funding from private donations
- 50% indicated a decrease in the amount of funding received from any funding stream

In order to increase capacity and the ability to provide for more PLWH/A 75% of agencies indicated they need funding to expand current capacity, and increase partnerships with HIV/AIDS specialty organizations, with 25% indicating a need for more training in HIV/AIDS. Half of these agencies indicated a 1 to 6 day wait time for this service while the other half has no wait time.

Recommendations
Housing options continue to be difficult for PLWH/A without jobs or other forms of income. The current housing crisis has put an additional burden on non-Ryan White funded agencies decreasing the supply with an ever increasing demand.

1) Develop more job assistance programs and community payback programs in exchange for housing assistance. This will help clients develop a skill, take ownership and pride in the payment of their residence, and develop into a self sufficient person.

2) Impose time limits and/or restrictions on the number of service units and assist clients in devising a plan to gradually become more independent.

Medical Nutrition Therapy

HRSA Definition

Medical Nutrition Therapy is provided by a licensed registered dietitian outside of a primary care visit and includes nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

Consumer Survey Results

This service was referred to as "Nutritional Services" on the consumer survey. Of survey respondents 42% indicated a need for this service, 82% had their needs met leaving an 18% unfulfilled need. The most widely indicated barrier to not receiving this service, 66% said they didn't know where to access it. The largest populations claiming unavailability were:

Transmission Mode and Gender

- MSM 57%
- Heterosexual Females 10%
- Heterosexual Males 10%
- IDU 7%

Race/Ethnicity and Gender

- White Males 31%
- Black Males 21%
- Hispanic Males 19%

Focus Group Discussion

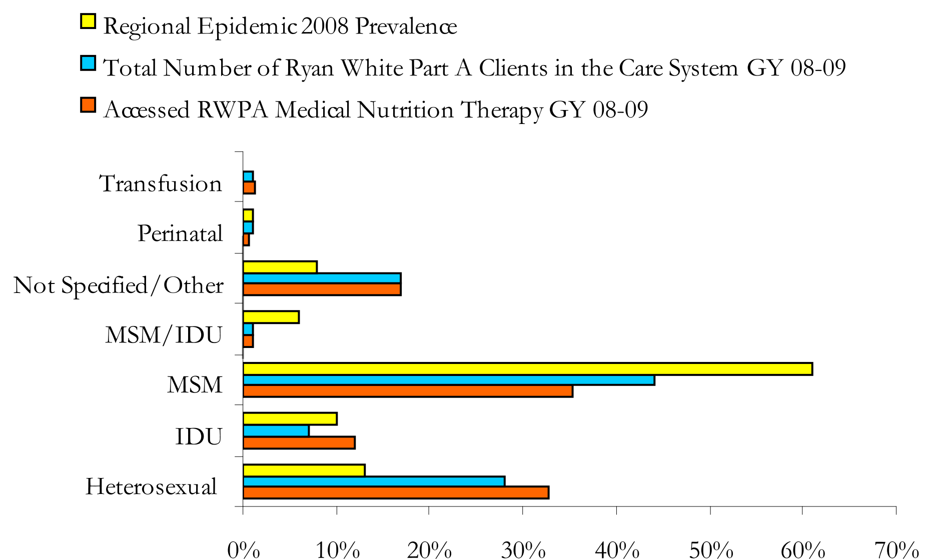
Each focus group discussed the utilization of this service, none in great detail. The MSM focus group discussed the need for more supplements and vitamins.

Service Utilization

During GY 08-09 Ryan White service providers served 360 individuals utilizing 6,734 units of care, expending $70,271. The following figures depict usage relative to clients in the care system and the regional epidemic.

The Heterosexual population, while representing 28% of Ryan White Part A clients utilized 32% of Medical Nutrition Therapy during GY 08-09. Additionally the Black populations utilized 40% of this service while only representing 32% of clients in the TGA.

Figure 4.32 Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Medical Nutrition Therapy, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Mode of Transmission



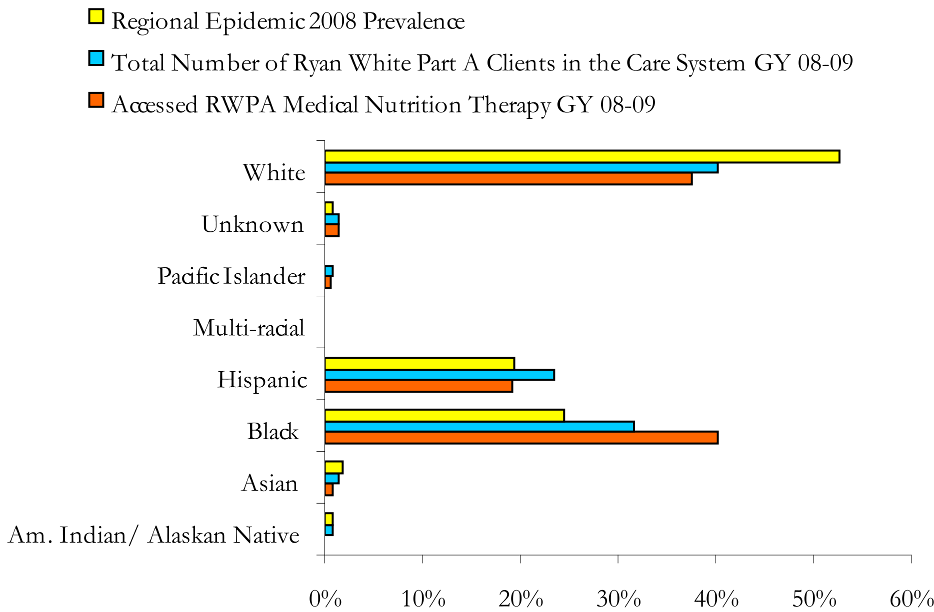


Figure 4.33
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Medical Nutrition Therapy, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Race/Ethnicity

Figure 4.34
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Medical Nutrition Therapy, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Gender

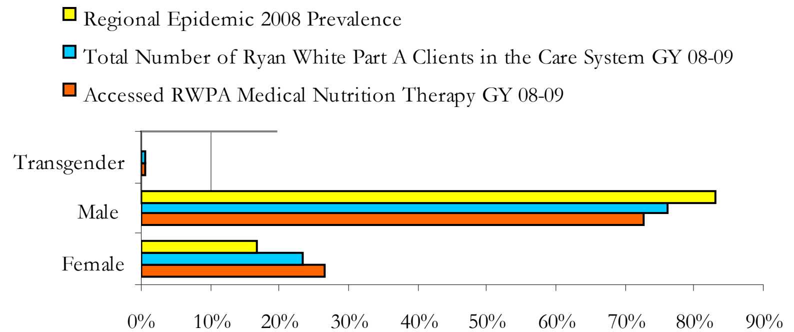


Figure 4.35
Frequency of Usage Relative to Clients in the Care System and Regional Epidemic

Those Populations Utilizing Medical Nutrition Therapy Most Frequently GY 08-09	Those Populations Utilizing Medical Nutrition Therapy Less Frequently GY 08-09	Consumer Survey Respondent Service Gap Medical Nutrition Therapy
Heterosexuals	MSM	MSM 57%
IDU	Hispanics	White Males 31%
Blacks	Whites	Black Males 21%
	Males	Heterosexual Males 10%
		Heterosexual Females 10%

Gap Analysis

A gap analysis reveals that approximately 1,045 PLWH/A in the TGA are in need of Medical Nutritional Therapy. To completely meet this need the care system will need to expand by 22% and roughly $203,984.

Medical Nutrition Therapy Gap Analysis

Gap Analysis	
a. Total Projected Need in the TGA Applies total need from the consumer survey to the 6,867 Las Vegas TGA PLWH/A [(Total-No Need)*6,867/Total]	5,747
b. Total Projected Need that is Met Applies need met from consumer survey to the 6,661 Las Vegas TGA PLWH/A [(Need Met)*6,867/Total]	4,702
c. Potential Additional Clients whose need is not Being Met Difference between total projected need and total projected need that is met (row a-row b)	1,045
d. Additional System Capacity Required to Provide Service to all Needing but Not Receiving Service Current provider expansion required to completely meet need (row c/row b)	22%

Resource Inventory

Two agencies reported providing Medical Nutrition Therapy to PLWH/A. One agency is located in Clark County and the other in Mohave County, both receive Ryan White Part A funding. The agency in Clark County recently faced drastic Part B funding cuts forcing them to close their Nutrition Therapy program. Currently there is no other Medical Nutrition Therapy program for PLWH/A in Clark County.

Recommendations

1) In light of recent Part B funding cuts it is imperative to develop positive working relationships with Part B administrators and develop a strategic plan to achieve parity between Northern and Southern Nevada throughout the years to come.

2) Develop a funding plan for the current year to incorporate this service while strategically planning with other available funding streams to take over when stability is established.

Transportation

HRSA Definition

Transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care or support services.

Consumer Survey Response

Transportation was ranked as the 11th priority among consumer survey respondents. Of respondents 34% indicated a need for this service, 81% had their need met leaving an unfulfilled need of 19%. The most widely indicated barrier to accessing this service, 41% didn't know where to access it. Those populations most widely indicating an unmet need:

Mode of Transmission and Gender

- MSM 36%
- Heterosexual Females 14%
- Heterosexual Males 8.3%

Race/Ethnicity and Gender

- White Males 36%
- Black Males 19%
- Black Females 14%
- Hispanic Males 11%

Respondents were asked to indicate if there are any services they need but aren't currently offered to them, 44% indicated a need for more transportation options/gas vouchers.

Focus Group Discussions

MSM

The MSM focus group discussed the need for gas vouchers for clients that have cars. They also discussed the need for better transportation assistance meaning more variety in their options besides the bus. This group also discussed the difficulties they face while trying to go grocery shopping on the bus because there isn't enough room to put things and they can only carry so much.

MSM of Color

In the MSM of Color discussion one participant commented that, "We need more selection because sometimes buses aren't enough". Another respondent said, "It's too hard to catch the bus in the heat of summer".

Women IDU/Substance Abuser's

The Women IDU/Substance Abuser's focus group discussed only the utilization of bus passes given to them by Ryan White funded agencies.

Men IDU/Substance Abuser's

The Men IDU/Substance Abuser's focus group discussed the inconvenience of utilizing public transportation, switching busses to get to the desired location, and the extent of time to which it takes.

None of the focus groups discussed the utilization of medical transportation.

Service Utilization

During GY 08-09 Ryan White agencies provided 24,245 units of medical transportation serving 706 clients while expending $42,739. Non-Medical Transportation services were also utilized under Emergency Financial Assistance in the amount of $44,145.

The Black population utilized nearly 50% of this service while representing only 32% of clients in the care system. Heterosexuals and IDU together used utilized half while comprising a third of those in care.

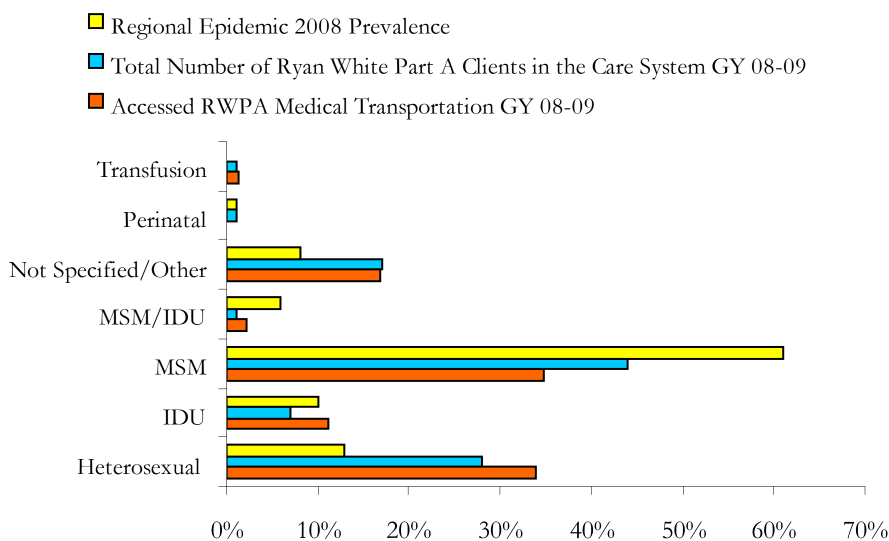


Figure 4.36
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Medical Transportation, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Mode of Transmission

Figure 4.37
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Medical Transportation, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Race/Ethnicity

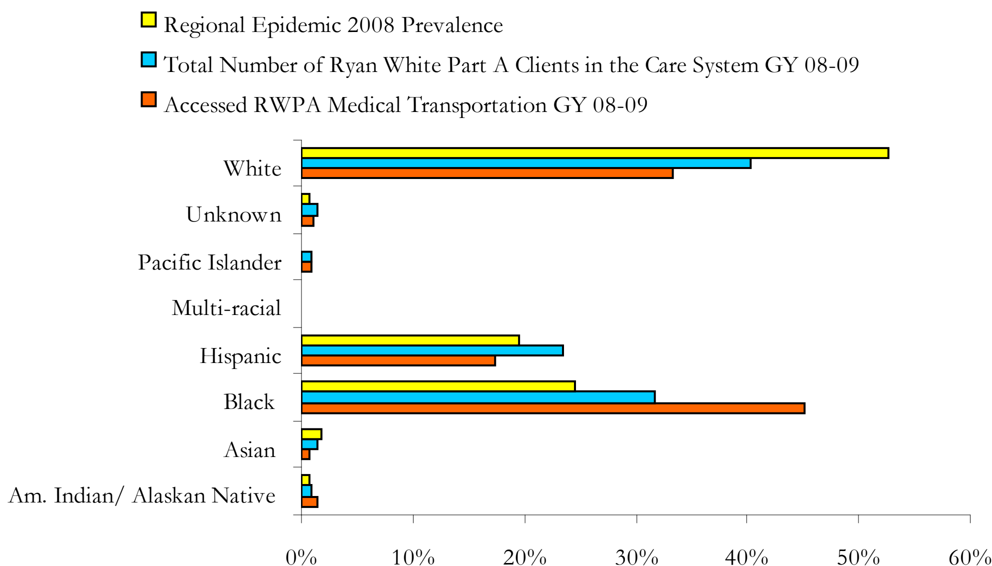


Figure 4.38
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Medical Transportation, RWPA Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Gender

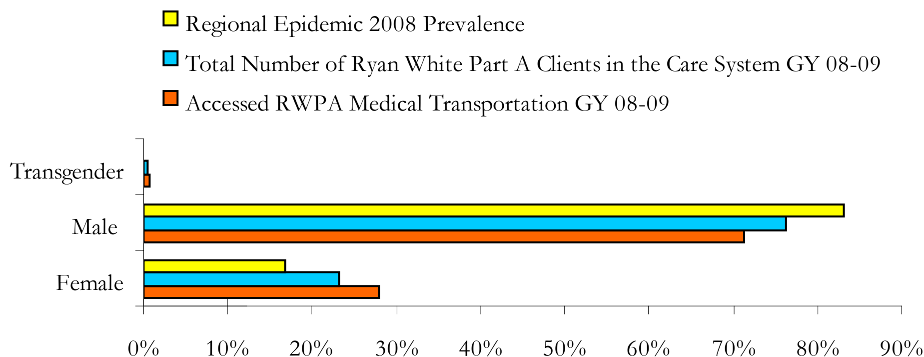


Figure 4.39

Frequency of Usage Relative to Clients in the Care System and Regional Epidemic

Those Populations Utilizing Medical Nutrition Therapy Most Frequently GY 08-09	Those Populations Utilizing Medical Nutrition Therapy Less Frequently GY 08-09	Consumer Survey Respondent Service Gap Medical Nutrition Therapy
Heterosexuals	MSM	MSM 57%
IDU	Hispanics	White Males 31%
Blacks	Whites	Black Males 21%
	Males	Heterosexual Males 10%
		Heterosexual Females 10%

Gap Analysis

According to a Gap Analysis 1,113 PLWH/A are in need of Medical Transportation Services. In order to completely meet this need the care system will need to expand by 24% and approximately $67,370.

Medical Transportation Gap Analysis

Gap Analysis	
a. Total Projected Need in the TGA Applies total need from the consumer survey to the 6,867 Las Vegas TGA PLWH/A [(Total-No Need)*6,867/Total]	5,753
b. Total Projected Need that is Met Applies need met from consumer survey to the 6,661 Las Vegas TGA PLWH/A [(Need Met)*6,867/Total]	4,640
c. Potential Additional Clients whose need is not Being Met Difference between total projected need and total projected need that is met (row a-row b)	1,113
d. Additional System Capacity Required to Provide Service to all Needing but Not Receiving Service Current provider expansion required to completely meet need (row c/row b)	24%

Resource Inventory

Medical Transportation

Six agencies were identified as providing Medical Transportation two only serving those in the HIV/AIDS community while the other four see clients regardless of their HIV status. Eighty percent of these agencies are Ryan White Part A funded, many also received federal funding, contributions and private funding. The most indicated language requested by all agencies is Spanish with 80% maintaining bi-lingual staff the other 20% utilize a language line and/or provide language assistance through an outside organization. This service is provided by 66.7% of agencies in Clark County, 16.7% in Nye County, and 16.7% in Mohave, with public transportation readily available near 83.3% of agencies.

Agencies indicated experiencing the following within the last year;

- 83% an increase number in clients seeking services
- 83% an increase in demand for services from clients

- 40% a decrease in the amount of funding provided from private donations
- 60% a decrease in the amount of funding provided from any funding stream

In order for these agencies to expand capacity and serve more PLWH/A in the TGA the following is required;

- 80% funding to expand current capacity
- 60% training in HIV/AIDS
- 40% increased partnership with HIV/AIDS specialty organizations

Non-Medical Transportation

Three agencies indicated providing non-medical transportation, one is Ryan White Part A funded. Two agencies provide this service in Clark County, one in Mohave County with extended hours in the morning and evening provided by 66%.

Agencies indicated experiencing the following within the last year;

- 66% an increase number in clients seeking services
- 100% an increase in demand for services from clients
- 100% a decrease in the amount of funding provided from private donations
- 100% a decrease in the amount of funding provided from any funding stream

In order to expand current capacity all agencies indicated a need for more funding. Wait times are currently low with a 1 to 6 day wait at one agency and no wait time indicated at the other two.

Recommendations

1) Maintain a current bus pass policy.

2) Identify additional options for those living in rural or suburban areas with limited public transportation.

Medical and Non-Medical Case Management

HRSA Definition

Medical Case Management

Medical Care Management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of client's and other key family members' needs and personal support systems. Medical Case Management includes the provision and treatment of adherence counseling to ensure readiness for, and adherence to, HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of

utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Non-Medical Case Management

Non-Medical Case Management includes the provision of advice and assistance in obtaining medical, social, community, legal, financial and other needed services. Non-Medical Case Management does not involve coordination and follow-up of medical treatments, as Medical Case Management does.

Consumer Survey Response

For the purpose of this survey medical and non-medical case management were referred to as simply Case Management. This service ranked as the 12th priority for consumer survey respondents. Of total survey respondents 53% indicated a need for case management services within the past 12 months. Of those in need, 89% indicated having their need met, leaving a service gap of 11%. The most widely indicated barrier to receiving this service; 44% didn't know where to access it. Those populations claiming the highest unavailability:

Mode of Transmission and Gender

- MSM 56%
- Heterosexual Females 13%

Race/Ethnicity and Gender

- White Males 34%
- Black Males 13%
- White Females 6%
- Black Females 6%

Focus Group Discussions

MSM

The MSM focus group placed a lot of emphasis on case workers and discussed the enormous stress that is put on clients when they are first diagnosed and introduced into the care system. This led to the consensus that more case workers need to be HIV positive so they understand first hand the issues clients face. They also discussed attributes that case workers should have, which include; "have a likeable personality and a positive attitude", "smile at clients, acknowledge our difficulties", ("have a) willingness to refer more and go the extra step", and "be dedicated, hire case workers they are dedicated to the field".

Furthermore this group discussed the need for case workers to be better trained so they can learn how to, "take stress issues away from the client, providers need to walk out of the office when they are too stressed out to address the clients issues". They also discussed that agencies are not client centered and they feel as if they aren't treated like real people when accessing services. To remedy this issue one participant suggested a volunteer case worker program which would help newly diagnosed people navigate the system better.

MSM of Color

The MSM of Color focus group didn't specifically mention case management as a utilized service or a need. However, they did discuss that the system of care in Las Vegas is hard to navigate and there should be a buddy program in place for newly diagnosed PLWH/A or those just entering the care system.

Women IDU/Substance Abusers
Much of the focus during the Women IDU/Substance Abuse discussion was the improvement in the care system over the years. One client stated; "Previously clients were treated badly, now staff is getting much better and are much nicer". Another less satisfied participant said that her case manager had the nerve to ask her where she spent her money when she asked for more assistance. Overall there was a positive light placed on improvements over the years.

Men IDU/Substance Abusers
The Men IDU/Substance Abuser focus group made very derogatory comments with regard to case managers and providers in general. One man stated with regard to providers and case managers; "Be more compassionate because not everyone asked for HIV. It is hard when service providers "pimp slap" you. Most people at agencies are not HIV positive and are prejudice against us".

One participant commented that he has never faced a problem but hears from friends that case managers have no compassion. He suggested that case managers be required to sit in of focus groups so they can hear what clients needs really are.

Another participant stated; "Providers need to ask clients what they need, the criteria for eligibility is too complex-too many things to bring, some providers are ignorant and pompous, there needs to be more HIV positive people working at agencies-because they are less critical, don't make it so hard to get services, lower criteria for receiving services, and don't be so cold hearted".

Furthermore clients said that case managers need to follow up more because "clients forget things," and they need to give "better referrals because if you don't ask they won't tell you". Another participant stated with regard to case managers; "stop being assholes and give us the help we need, they are there to give us what we need".

Service Utilization
During GY 08-09 Ryan White Part A Service Providers delivered 70,187 units of Medical Case Management to 1,421 clients in the Las Vegas TGA expending $993,206. They also delivered 34,856 units of non-Medical Case Management to 610 clients in the Las Vegas TGA expending $3,167.

Figure 4.40
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Medical and Non-Medical Case Management, Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Mode of Transmission

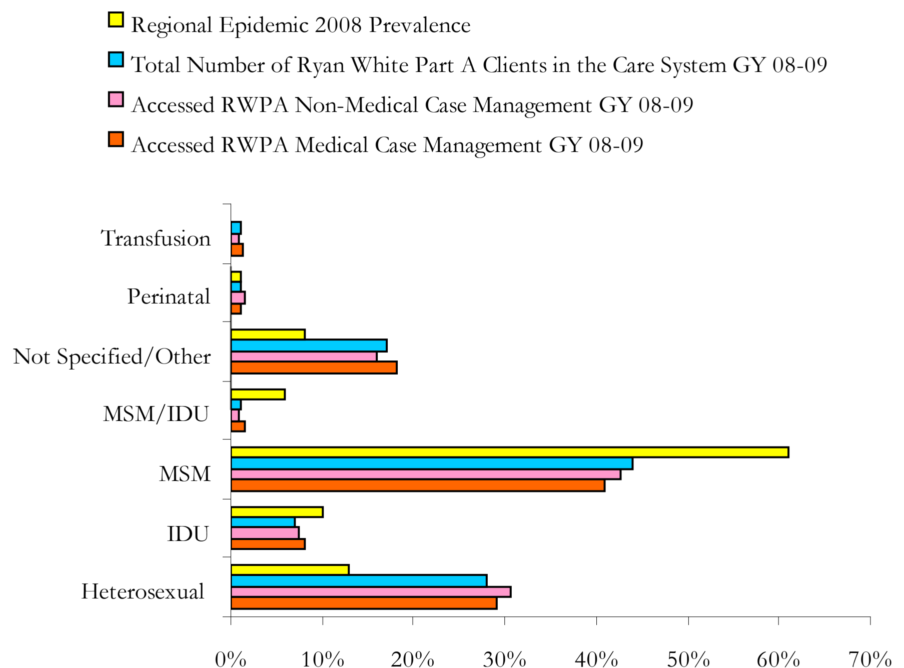


Figure 4.41
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Medical and Non-Medical Case Management, Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Race/Ethnicity

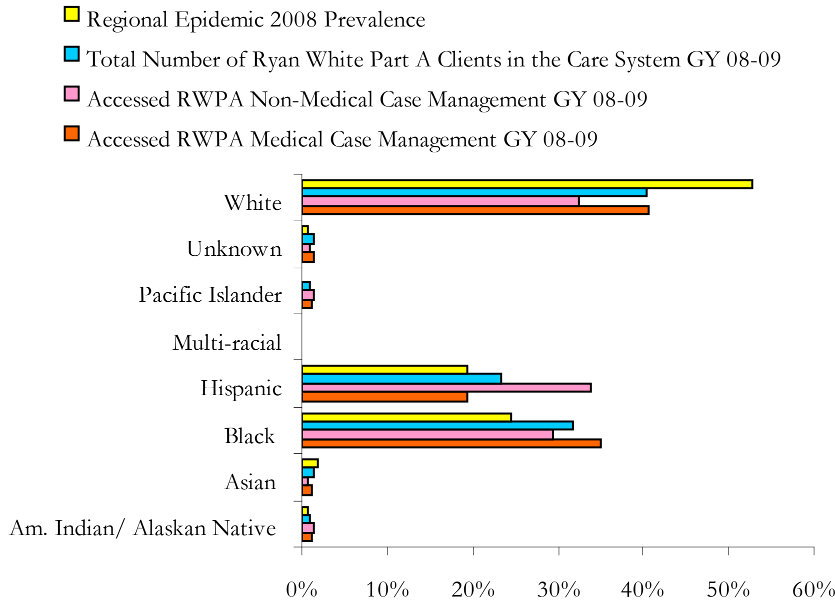
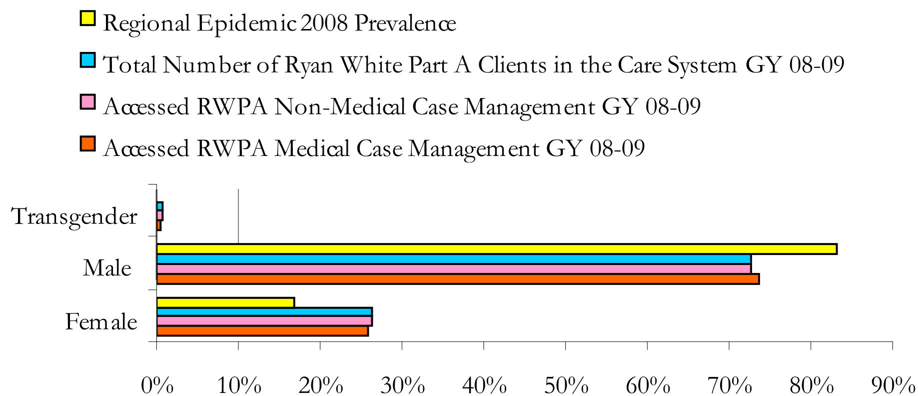


Figure 4.42
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Medical and Non-Medical Case Management, Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Gender



Medical Case Management was utilized fairly equally with regard to clients in the care system. MSM comprise 44% of clients in the care system while utilizing 41% of Medical Case Management services and 43% of Non-Medical Case Management services. The Black population represents 32% of clients in the care system and utilized 35% of Medical Case Management services and 29% of Non-Medical Case Management services.

Utilization in the Hispanic community is the most obscure. While representing 23% of clients in the care system they utilized the largest amount of Non-Medical Case Management services at 34% and only 19% of Medical Case Management services.

Figure 4.43
Frequency of Usage Relative to Clients in the Care System and Regional Epidemic

Those Populations Utilizing Case Management Services Most Frequently GY 08-09	Those Populations Utilizing Case Management Services Frequently GY 08-09	Consumer Survey Respondent Service Gap Case Management Services
Heterosexuals	MSM	MSM 56%
Not Specified/Other	IDU	Heterosexual Females 13%
Hispanics	Whites	White Males 12%
Blacks	Males	Black Males 12%
Females		White and Black Females 12%

Gap Analysis
A Gap Analysis reveals that approximately 683 PLWH/A in the TGA are in need of Medical and/or Non-Medical Case Management services. To completely meet this need the care system will need to expand by 12% and approximately $240,416.

Medical and Non-Medical Case Management Gap Analysis

Gap Analysis	
a. Total Projected Need in the TGA Applies total need from the consumer survey to the 6,867 Las Vegas TGA PLWH/A [(Total-No Need)*6,867/Total]	6,185
b. Total Projected Need that is Met Applies need met from consumer survey to the 6,661 Las Vegas TGA PLWH/A [(Need Met)*6,867/Total]	5,502
c. Potential Additional Clients whose need is not Being Met Difference between total projected need and total projected need that is met (row a-row b)	683
d. Additional System Capacity Required to Provide Service to all Needing but Not Receiving Service Current provider expansion required to completely meet need (row c/row b)	12%

Resource Inventory
Eleven providers indicated they currently provide Case Management Services six of which are Ryan White Part A funded. Two agencies provide services strictly to PLWH/A while the rest serve a greater population including those PLWH/A.

Public transportation is readily accessible near all agencies, 82% provide services primarily in Clark County, 9% in Nye County, and 27% in Mohave County Arizona. Additional evening and weekend hours are provided by 45%.

Agencies indicated experiencing the following within the last year;

- 70% an increase number in clients seeking services
- 80% an increase in demand for services from clients
- 50% a decrease in the amount of funding provided from private donations

- 70% a decrease in the amount of funding provided from any funding stream

In order for these agencies to expand capacity and serve more PLWH/A in the TGA the following is required;

- 55% funding to expand current capacity
- 27% training in HIV/AIDS
- 46% increased partnership with HIV/AIDS specialty organizations

The most widely indicated barriers encountered while attempting to provide services include;

- 36% Staff training in HIV/AIDS is limited
- 27% Agency doesn't provide all the services clients need
- 18% Clients routinely miss appointments
- 18% Limited community partnerships/linkages with HIV/AIDS specialty organizations

The majority 67% of agencies have no wait time for this service, 22% have a 1 to 6 day wait, while 11% have a 1 week wait.

Recommendations

1) Present the possibility of a volunteer case worker position to Ryan White Part A Providers so that case managers can focus on high acuity cases.

2) Educate consumers on the difference between Medical and Non-Medical Case Management services and the appropriate use of each while promoting self sufficiency and navigation in the care system.

3) Promote networking between case managers throughout the region as a means of educating them on the availability of Ryan White and non-Ryan White funded resources.

Substance Abuse Services-Outpatient

HRSA Definition

Substance Abuse Services-Outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting rendered by a physician or under the supervision of a physician, or by other qualified personnel.

Consumer Survey Response

Consumers ranked Substance Abuse Services-Outpatient priority 13 overall. Of survey respondents 13% indicated a need for this service within the last 12 months, 94% of those had their need met leaving a 6% unmet need. Those populations indicating the highest unmet need;

Mode of Transmission and Gender

- MSM 33%
- Heterosexual Males 16%
- Male IDU 16%

Race/Ethnicity and Gender

- White Males 50%

- Hispanic Males 16%

For those who had fallen out of care at one time or another, 3% indicated it was a result of drug use. When asked what motivated them to access care again, 2% indicated "I stopped using drugs".

Focus Group Discussions

No particular group focused on the issue of Substance Abuse. One comment came from the Men IDU/Substance Abuser focus group; "More concentration around issues of using, try to help people who use manage, better services to get into rehab, find our what other communities do and adopt it to make services better here".

Service Utilization

During GY 08-09 Ryan White Part A Providers served 54 clients providing 4,660 units of Substance Abuse Outpatient care to PLWH/A expending $37,612.

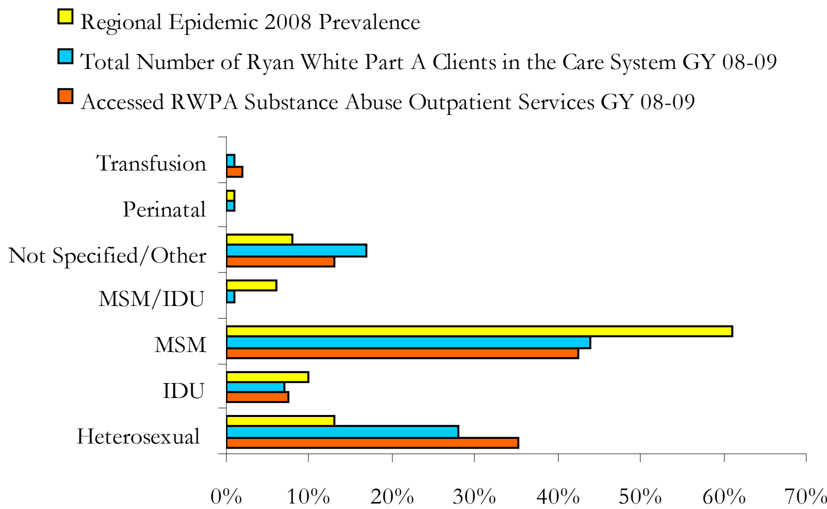


Figure 4.44
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Substance Abuse-Outpatient Services, Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Mode of Transmission

Figure 4.45
Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Substance Abuse-Outpatient Services, Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Race/Ethnicity

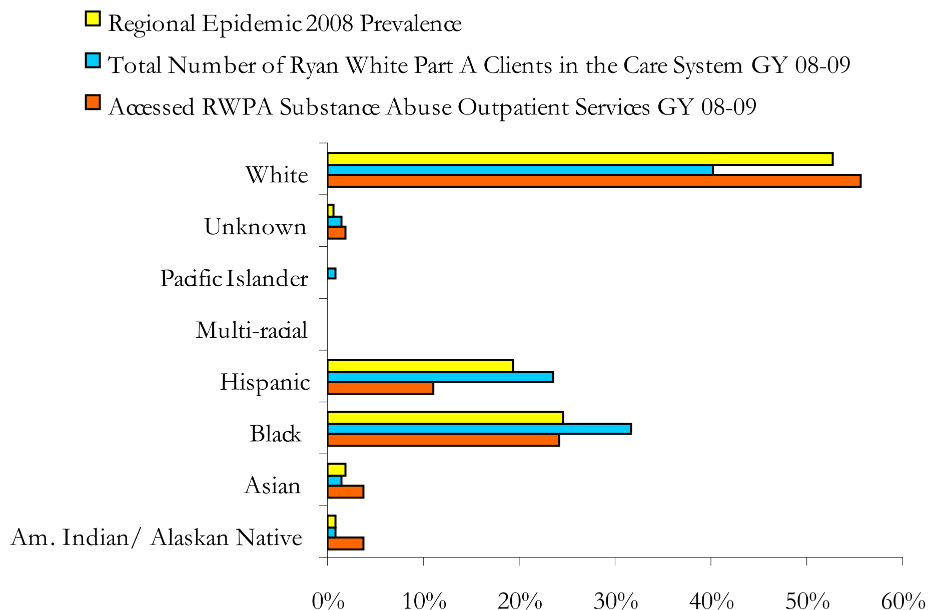
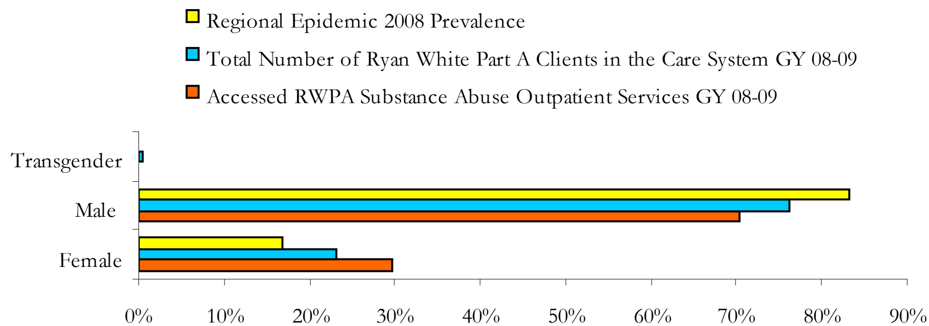


Figure 4.46

Comparison of Grant Year 2008-2009 RWPA Clients Utilizing Substance Abuse-Outpatient Services, Clients in the Care System during Grant Year 2008-2009, and the Regional Epidemic by Gender



Heterosexuals utilized the majority of this service at 35% in relation to their total population in the care system 28%. The IDU population, while representing 7% of clients in the care system, also represented 7% of those accessing Substance Abuse Outpatient Services. The White population utilized 56% of this service while representing 40% of those in care. However, the Hispanic and Black populations utilized 11% and 24% of this service while comprising 23% and 32% of those in care.

Figure 4.47

Frequency of Usage Relative to Clients in the Care System and Regional Epidemic

Those Populations Utilizing Substance Abuse Outpatient Services Most Frequently GY 08-09	Those Populations Utilizing Substance Abuse Outpatient Services Less Frequently GY 08-09	Consumer Survey Respondent Service Gap Substance Abuse Outpatient Services
Heterosexuals	MSM/IDU	MSM
IDU	Not Specified/Other	Heterosexual Males 16%
Whites	Hispanics	Male IDU 16%
Asians	Blacks	White Males 50%
American Indian/Alaskan Natives	Males	Hispanic Males 16%

Gap Analysis

A Gap Analysis reveals that approximately 162 PLWH/A are in need of Substance Abuse Outpatient Services. In order to completely meet this need the care system would need to expand by 6% and roughly $476,051.

Substance Abuse Services-Outpatient

Gap Analysis	
a. Total Projected Need in the TGA Applies total need from the consumer survey to the 6,867 Las Vegas TGA PLWH/A [(Total-No Need)*6,867/Total]	2,868
b. Total Projected Need that is Met Applies need met from consumer survey to the 6,661 Las Vegas TGA PLWH/A [(Need Met)*6,867/Total]	2,706
c. Potential Additional Clients whose need is not Being Met Difference between total projected need and total projected need that is met (row a-row b)	162

d. **Additional System Capacity Required to Provide Service to all Needing but Not Receiving Service** Current provider expansion required to completely meet need (row c/row b)	6%

Resource Inventory
A total of 7 agencies indicated providing Substance Abuse Outpatient Services, 3 of which are funded by Ryan White Part A. While 29% are Aids Service Organizations specifically, the other 71% serve a larger population including those infected or affected by HIV/AIDS.

All agencies indicated having bi-lingual staff on hand with Spanish as the most request language followed by multiple Asian dialects. All agencies provide services to the residence in Clark County, with one providing services in Nye County and Mohave County. All agencies indicated that public transportation is readily accessible near their agency.

Agencies indicated experiencing the following within the last year;
- 57% an increase number in clients seeking services
- 71% an increase in demand for services from clients
- 29% a decrease in the amount of funding provided from private donations
- 71% a decrease in the amount of funding provided from any funding stream

In order for these agencies to expand capacity and serve more PLWH/A in the TGA the following is required;
- 57% funding to expand current capacity
- 43% increased partnership with HIV/AIDS specialty organizations

The most widely indicated barriers encountered while attempting to provide services include;
- 29% Clients routinely miss appointments
- 14% Staff training in HIV/AIDS is limited
- 14% Agency doesn't provide all the services clients need

Recommendations
1) In light of recent Ryan White Part B funding cuts continue to fund this service and partner with organizations and other funding streams to develop a future source of stable funding.

Legal Services

HRSA Definition
Legal Services are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program. It does not include any legal services that arrange for guardianship or adoption of children after the deal of their normal caregiver.

Consumer Survey Response

Legal Services ranked as the 14th priority among consumer survey respondents. Of total respondents 18% indicated a need for this service, 58% had their need met leaving an unmet need of 42%. The most widely indicated barrier to not receiving this services, 70% didn't know where to access it. Those populations claiming unavailability were;

Mode of Transmission and Gender

- MSM 45%
- Heterosexual Males 17%
- Heterosexual Females 12%

Race/Ethnicity and Gender

- White Males 50%
- Black Males 17%
- Black Females 10%
- Hispanic Males 7%

Focus Group Discussion

None on this topic

Utilization Data and Gap Analysis

Legal Service were not provided through Ryan White Part A funding during GY 08-09. A gap analysis reveals that approximately 1,559 are in need of legal services. In order to completely meet this need the care system would need to expand by 74%

Legal Services Gap Analysis

Gap Analysis	
a. Total Projected Need in the TGA Applies total need from the consumer survey to the 6,867 Las Vegas TGA PLWH/A [(Total-No Need)*6,867/Total]	3,675
b. Total Projected Need that is Met Applies need met from consumer survey to the 6,661 Las Vegas TGA PLWH/A [(Need Met)*6,867/Total]	2,116
c. Potential Additional Clients whose need is not Being Met Difference between total projected need and total projected need that is met (row a-row b)	1,559
d. Additional System Capacity Required to Provide Service to all Needing but Not Receiving Service Current provider expansion required to completely meet need (row c/row b)	74%

Resource Inventory

Three providers indicated providing Legal Support in the TGA, two in Clark County, one in Nye County, and one in Mohave County. Funding for these agencies is primarily provided by; Federal/State Government, Contributions/Private Donations, and Foundations. One agency provides services strictly to those clients with HIV/AIDS while the other two agencies provide services to anyone.

All agencies have bi-lingual staff on hand and stated the most requested languages as; Spanish, Russian, and Mandarin. Public transportation is readily accessible near all agencies and service are provided free of charge.

Agencies indicated experiencing the following within the last year;

- 67% an increase number in clients seeking services
- 100% an increase in demand for services from clients
- 100% a decrease in the amount of funding provided from private donations
- 100% a decrease in the amount of funding provided from any funding stream

In order for these agencies to expand capacity and serve more PLWH/A in the TGA the following is required;

- 67% funding to expand current capacity
- 33% increased partnership with HIV/AIDS specialty organizations
- 33% training in HIV/AIDS

One agency expressed no wait time for Legal Services while another agency expressed a 1 to 6 day wait.

Recommendations

Promote utilization of non-Ryan White funded agencies that provide Legal Services to those PLWH/A in need of this service. Ensure all case managers in the Ryan White system of care are aware of where to refer for these services.

Psychosocial Support Services

HRSA Definition

Psychosocial support services are the provision of support and counseling activities, child abuse and neglect counseling, HIV Support Groups, pastoral care, and bereavement counseling, Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

Consumer Survey Response

For the purpose of the survey Psychosocial Support Services was referred to as "support groups". Consumer survey respondents ranked this service as the 15th overall priority. Of total respondents 38% indicated needing this service within the last 12 months, with 85% indicating their need was met leaving a 15% unmet need. The most widely indicated barrier to accessing this service, 60% indicated they don't know where to access it. Those populations most widely indicating an unmet need;

Mode of Transmission and Gender

- MSM 45%
- Heterosexual Males 10%

Race/Ethnicity and Gender

- White Males 48%
- Hispanic Males 19%

- Black Males 13%

Focus Group Discussion

MSM

The MSM focus group discussed support groups in the sense of a buddy program or support group to get to know what and where services are.

MSM of Color

The MSM of Color focus group discussed support groups in terms of informal lunches for PLWH/A where speakers could be flown in from around the nation to give motivational speeches. Additionally, they discussed the need for more "success stories" to be shared proving that PLWH/A can live a normal life and be successful.

Women IDU/Substance Abusers

Women discussed support groups with regard to more social activities. Women in this discussion indicated a need for more; lunch and learns, events, one on one social interaction, and exercise classes.

Men IDU/Substance Abusers

No discussion on this topic.

Service Utilization and Gap Analysis

Psychosocial Support Services were not provided through Ryan White Part A funds during GY 08-09. A gap analysis reveals that approximately 852 PLWH/A in the Las Vegas TGA are in need of Psychosocial Support Services. In order to completely meet this need the care system will need to expand by approximately 18%.

Psychosocial Services Gap Analysis

Gap Analysis	
a. Total Projected Need in the TGA Applies total need from the consumer survey to the 6,867 Las Vegas TGA PLWH/A [(Total-No Need)*6,867/Total]	5,563
b. Total Projected Need that is Met Applies need met from consumer survey to the 6,661 Las Vegas TGA PLWH/A [(Need Met)*6,867/Total]	4,711
c. Potential Additional Clients whose need is not Being Met Difference between total projected need and total projected need that is met (row a-row b)	852
d. Additional System Capacity Required to Provide Service to all Needing but Not Receiving Service Current provider expansion required to completely meet need (row c/row b)	18%

Resource Inventory

Eleven agencies indicated providing supportive counseling services. Agencies receive funding from; Federal/State Government, 73%, Contributions/Private donations, 73%, Foundation funding, 55%, and 36% also receive Ryan White Part A funding. The majority of these agencies serve a larger

populations including people with HIV/AIDS however 18% indicated only serving the HIV/AIDS community.

Spanish was the most widely indicated language requested at all agencies with 81% providing bi-lingual staff on hand and the other 19% utilize a language line or translation service. Public transportation is located near all agencies with 91% providing services in Clark County, 36% in Nye County, and 46% in Mohave County. Service are provided free of charge at 81% of these agencies and 45% indicate operating hours outside the normal working hours of 8am to 5pm.

Agencies indicated experiencing the following within the last year;

- 73% an increase number in clients seeking services
- 73% an increase in demand for services from clients
- 55% a decrease in the amount of funding provided from private donations
- 64% a decrease in the amount of funding provided from any funding stream

In order for these agencies to expand capacity and serve more PLWH/A in the TGA the following is required;

- 55% funding to expand current capacity
- 73% increased partnership with HIV/AIDS specialty organizations
- 18% training in HIV/AIDS

The majority of agencies, 67%, indicated no wait time for this service with 24% indicating a 1 to 6 day wait time and 8% indicated a 2 to 4 week wait time.

Recommendations

With such a wide variety of providers, promote utilization of non-Ryan White funded agencies that provide Psychosocial Support Services to those PLWH/A in need of this service. Ensure all case managers in the Ryan White system of care are aware of where to refer for these services.

Referrals for Health Care/Supportive Services

HRSA Definition

Referrals for health care/supportive services is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.

Consumer Survey Response

For the purpose of the survey this service was referred to as "referrals". This service was ranked as the 16th priority among survey respondents. Overall 41% indicated a need for this service within the last year, 83% had their need met, leaving an unmet need of 17%. The most widely indicated barrier to receiving this service, 65% indicated they didn't know where to receive it. Those populations most widely indicating an unmet need;

Mode of Transmission and Gender

- MSM 47%
- Heterosexual Females 13%

- Tattoo Needle Males 5%

Race/Ethnicity and Gender

- White Males 39%
- Black Males 24%
- Black Females 11%

Focus Group Discussion

MSM

The MSM group discussed the difficulties they face while navigating the care system. They indicated that services are rarely stable at different agencies and sometimes unavailable. They discussed the need for case managers to be better trained on where services are available and how they are obtained.

MSM of Color

The MSM of Color focus group discussed the need for a buddy program to help everyone navigate the system until they can do it on their own. They also suggested placing all services in one convenient location so they don't have to travel so far by bus to make all their appointments.

Women IDU/Substance Abusers

The Women focus group said they know where to get all services that are available to them.

Men IDU/Substance Abusers

The Men IDU/Substance Abuser focus group discussed the need for job referrals and job training as they feel it is difficult to find a job when you are HIV positive. One participant stated; "more job referrals because now self research is required when looking for a job".

Another participant stated that a "(one) stop shop reference system that is current and accessible with medication, (a) buddy program, (and) services to help with body image" is needed in the TGA. Other participants that have been in the care system for a long period of time discussed the old "Central Services Office" and that they liked having everything together.

Several members commented that case managers need to be more willing to tell them about available services. Indicating, "most counselors suck, they need to refer more and better services". Another participant stated with regard to case managers, "if you don't ask them they wont help you" discussing the need for service providers to "be more helpful" and "tell us more".

Service Utilization and Gap Analysis

The Ryan White Part A program did not specifically fund this category during GY 08-09. However the recently implemented client level data system CAREWare does have a specific tracking system whereas the type of referral and client demographics will be tracked for future reporting.

A gap analysis reveals that approximately 966 PLWH/A are in need of referral services. An estimated 20% is required to completely meet this need.

Referrals for Health Care/Supportive Services Gap Analysis

Gap Analysis	
a. Total Projected Need in the TGA Applies total need from the consumer survey to the 6,867 Las Vegas TGA PLWH/A [(Total-No Need)*6,867/Total]	5,722
b. Total Projected Need that is Met Applies need met from consumer survey to the 6,661 Las Vegas TGA PLWH/A [(Need Met)*6,867/Total]	4,756
c. Potential Additional Clients whose need is not Being Met Difference between total projected need and total projected need that is met (row a-row b)	966
d. Additional System Capacity Required to Provide Service to all Needing but Not Receiving Service Current provider expansion required to completely meet need (row c/row b)	20%

Resource Inventory

Referrals were divided into two categories for the purpose of the provider survey, 1) Referrals and 2) Employment Assistance/Referrals.

Three agencies indicated providing Employment Assistance/Referral services. All indicated providing this service in Clark County, one also provides in Nye and Mohave County as well. All indicated providing this service to the larger population including those with HIV/AIDS, have public transportation readily accessible near their agency, and have bilingual staff on hand, Spanish was listed as the most requested language.

Agencies indicated experiencing the following within the last year;

- 67% an increase number in clients seeking services
- 100% an increase in demand for services from clients
- 33% a decrease in the amount of funding provided from private donations
- 67% a decrease in the amount of funding provided from any funding stream

In order for these agencies to expand capacity and serve more PLWH/A in the TGA the following is required;

- 67% funding to expand current capacity
- 100% increased partnership with HIV/AIDS specialty organizations
- 33% funding to develop new capacity

All agencies reported no wait time for this service.

Recommendations

1. Continue to provide an updated resource directory to all agencies and points of entry into the care system to assist clients in finding needed services. This is also a helpful tool for case managers and an online version could keep all services and locations up to day by the hour.

2. In our current economic state unemployment is prevalent and the availability of work is very low. However, providing quarterly classes to assist with resume building techniques, job searching

locations, and interview skills could empower and motivate clients to become more self sufficient. This would fulfill some of the needs discussed during focus group sessions regarding some clients need to find motivation to overcome the disease and succeed in following through with their goals.

Rehabilitation Services

HRSA Definition

Rehabilitation services are services provided by a license or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

Consumer Survey Response

Rehabilitation services ranked as the 17th priority among survey respondents. Overall 14% of respondents indicated a need for this service within the last 12 months, 84% reported receiving this service leaving a 16% unmet need. Barriers to accessing this service were indicated as 50% other reasons and 20% didn't know where to access it. Those populations most widely indicating an unmet need;

Mode of Transmission and Gender

- MSM 25%
- Heterosexual Females 16%
- Heterosexual Males 16%

Race/Ethnicity and Gender

- Black Males 42%
- Black Females 25%
- White Males 16%

Focus Group Discussion

None of the focus groups discussed this service.

Service Utilization and Gap Analysis

The Ryan White Part A program did not specifically fund this category during GY 08-09. Approximately 535 PLWH/A are in need of this services. In order to completely meet this need the care system will need to expand by 19%.

Rehabilitation Services Gap Analysis

Gap Analysis	
a. Total Projected Need in the TGA Applies total need from the consumer survey to the 6,867 Las Vegas TGA PLWH/A [(Total-No Need)*6,867/Total]	3,389
b. Total Projected Need that is Met Applies need met from consumer survey to the 6,661 Las Vegas TGA PLWH/A [(Need Met)*6,867/Total]	2,854

c. Potential Additional Clients whose need is not Being Met Difference between total projected need and total projected need that is met (row a-row b)	535
d. Additional System Capacity Required to Provide Service to all Needing but Not Receiving Service Current provider expansion required to completely meet need (row c/row b)	19%

Resource Inventory and Recommendations
No agencies specifically indicated offering Rehabilitation Services. Coordinate with case managers to locate funding streams and/or agencies that currently provide this service to publish in the resource directory.

Substance Abuse Services-Residential

HRSA Definition
Substance Abuse Residential Services is the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health services setting (short-term).

Consumer Survey Response
Consumer survey respondents ranked Substance Abuse-Residential services as the 18th priority. Overall 9% of respondents indicated a need for this service within the last 12 months, 82% indicated having their need met leaving an unmet need of 18%. Only one respondent indicated a barrier to accessing this service, they didn't know where to access it. Those populations most widely indicating an unmet need:

Mode of Transmission and Gender
- Heterosexual Females 33%
- MSM 11%
- IDU Males 11%
- Heterosexual Males 11%
- Unknown Females 11%

Race/Ethnicity and Gender
- Black Females 33%
- White Males 33%
- White Females 11%
- Black Males 11%

Service Utilization and Resource Inventory
As a support service this Substance Abuse-Residential services are included under the Support Services Aggregate category however it wasn't specifically funded under Ryan White Part A during GY 08-09.

Two agencies responded as providing this service, one providing assistance to access the program, the other providing the actual service. Both are funded by Ryan White Part A among other funding streams. Both agencies have bilingual staff on hand, have public transportation located near their

facility, and provide services in Clark County while one provides services in Mohave and Nye counties as well.

Currently there is a 1 to 6 day wait to access this service. In order to expand current capacity, both agencies indicated a need for more funding.

Linguistics Services

HRSA Definition

Linguistics services include the provision of interpretation and translation services.

Consumer Survey Response

For the purpose of this survey Linguistics Services were referred to as "translation services". This service was tanked as the 19th priority among respondents. The survey was administered in Spanish with 15% of overall respondents utilizing the Spanish version, 90% of those respondents were Hispanic and 37% were MSM.

Overall 10% of respondents indicated a need for this service within the last 12 months, 93% indicated that their need was met leaving an unmet need of 7%. Only one respondent indicated a barrier to accessing this service, not knowing where to access it. Those populations most widely indicating an unmet need:

Mode of Transmission and Gender

- MSM 50%

Race/Ethnicity and Gender

- Hispanic Males 50%
- White Males 50%

Focus Group Discussion

None of the focus group discussion specifically mentioned a need for this service or the utilization of it. However, a case manager dispersing the client survey's in Spanish said that from his observations and interactions with the Spanish speaking community they respond better to group discussion as opposed to a survey on paper.

Service Utilization and Resource Inventory

This service was not specifically funded through Ryan White Part A during GY 08-09 but was inclusive in the Supportive Services Aggregate category.

A total of 35 service providers in the TGA responded to the Profile of Provider Capacity and Capability survey. Ninety-six percent indicated having bi-lingual staff on hand and 42% translate necessary paperwork and/or information to clients in languages other than English. Language lines are utilized by 31% of providers and 23% ensure translators are provided by an outside company. Spanish was indicated as the most requested language. Additionally Chinese, Russian, Mandarin, Tagala, Fillapino, and multiple Asian and Eastern European dialects were referenced as frequently requested.

Recommendations

1. Ensure contracts with Ryan White Part A providers include provisions to provide bi-lingual staff on hand, a language line, or outside contractor to provide linguistic services to clients. Including written materials translated into Spanish at appropriate reading levels.

2. Future needs assessment should facilitate focus group discussions for the Spanish speaking population.

Child Care

HRSA Definition

Child Care Services are the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointment or Ryan White Program-related meetings, groups, or training.

Consumer Survey Response

Child Care Services were ranked as the 20th and final priority by consumer survey respondents. Overall 4% of respondents indicated a need for this service within the last 12 months, 73% indicated having their need met, leaving an unmet need of 27%. Two respondents indicated barriers to accessing this service, one didn't know where to access it, and the other indicated "other" reasons as barriers. Those populations most widely indicating an unmet need:

Mode of Transmission and Gender

- MSM 50%
- Heterosexual Females 33%
- Unknown Females 17%

Race/Ethnicity and Gender

- White Males 33%
- Black Females 17%
- White Females 17%
- Black Males 17%
- Multi-racial Females 17%

Focus Group Discussion

Our Women IDU/Substance Abuser focus group discussion provided us with only one participant of child bearing age. This woman brought her child to the focus group and provided her with lunch and a toy to occupy the child's time while the mother participated. However neither her nor any other participant in any of the focus groups indicated a utilization or need for child care services.

Service Utilization and Resource Inventory

This service was not specifically funded through Ryan White Part A during GY 08-09 but was inclusive in the Supportive Services Aggregate category.

Two agencies indicated providing Child Care Services, both of which provide to a larger population including those with HIV/AIDS. One agency provides this service in Clark, Nye and Mohave

Counties whereas the other agency provides specifically in Nye County. Services are provided to clients free of charge or on a sliding fee scale, with just one agency staffed with bi-lingual personnel.

Both agencies have seen a decrease in the amount of funding received from any funding source within the past year while also incurring more clients and a greater demand from existing clients. At this point there is no wait time for this service.

Recommendations

1. Women with small children generally bring them to their appointments. This creates difficulty for the patient, the children, and possibly places immuno-compromised patients at the clinic at risk. Providing child care at medical facilities, within a reasonable vicinity of patients, would alleviate and/or minimize these concerns.

2. Given the length of time required for visits to medical providers and the number of women of child-bearing age among the out of care, providing child care at medical care sites may draw women into the medical care system.

Profile of Provider Capacity and Capability

Overview
During Grant Year 2008-2009 the Ryan White Part A program in the Las Vegas TGA funded 14 different service providers in 12 different service categories. Included with those 14 Ryan White funded service providers a total of 35 organizations responded to our survey. These agencies provide a wide variety of services in medical care and support services. A brief overview of those agencies is listed below.

- Over 60% indicated serving a larger population including those who have HIV/AIDS while 11% were AIDS Service Organizations only.
- Nearly all (96.2%) of organizations provide translation services with bi-lingual staff on hand and 42.3% provide information in languages other than English.
- The majority provide services in Clark County, NV (91.4%) with 25.7% in Nye County NV, and 22.9% in Mohave County AZ.
- Public transportation is readily accessible near 94.3%.
- 23.1% offer hours beyond the regular 8am to 5pm business day and 19.2% offer weekend hours.
- The majority indicated that services are free (52.9%) with 26.5% offering a sliding scale fee and 26.5% requiring a minimal fee.

Barriers to Providing Care
With the struggling economy providing care to PLWH/A is becoming increasing difficult. To gauge the impact in the TGA Providers were asked to indicate if any of the following occurrences had taken place at their agency within the past year;

- An increase in the number of clients seeking services-68.8%
- A decrease in the amount of funding your agency receives from any funding stream-59.4%
- An increase in demand for services from clients-56.3%
- A decrease in the amount of funding received from private donations-34.4%

When providing care to PLWH/A the most widely indicated barriers were listed as;

- Clients don't have a payment source-41.2%
- Our agency doesn't provide all the services a person needs-35.3%
- Limited community partnerships/linkages with specialized HIV organizations-35.3%
- Not enough resources at my agency-29.4%
- Clients routinely miss appointments-23.5%
- Insufficient staff to provide services-23.5%
- Staff training in HIV/AIDS is limited-20.6%
- Client distrust/suspicion-14.7%
- Clients may have trouble getting to our offices-14.7%

Needs to Increase Capacity
Providers were asked to indicate what is needed within their agency to increase their capacity to serve more PLWH/A. They were indicated as;

- Funding to expand current capacity-55.9%
- Increased partnerships with HIV/AIDS specialty agencies and organizations-52.9%
- Training in HIV/AIDS-23.5%
- Funding to develop new capacity-20.6%

Summary
Financial challenges and minimal community collaboration amidst an increase in client load and demand from clients are the major barriers facing the provider community in the Las Vegas TGA. As a tremendous increase in funding isn't expected cooperation and partnerships among providers, especially case managers, will allow those areas in which gaps are found to be supplemented with services provided by non-Ryan White funded agencies. Thus ensuring the needs of PLWH/A in the Las Vegas TGA are met.

Resource Inventory

A Resource Inventory provides a comprehensive picture of the continuum of care, the organizations and individuals providing services to PLWH/A in the service area supported by public and private funding. This resource inventory includes the location and contact information for each provider and a description of the types of services provided. Additionally it includes service providers offering primary medical care and supportive services that are available to PLWH/A to help them remain in care, regardless of whether the provider sees itself as an HIV/AIDS service provider or receives Ryan White funding. Figure 5.1 provides all Ryan White Part A funded service providers while figure 5.2 provides non-Ryan White funded service providers.

Figure 5.1 Ryan White Part A Service Providers	
Aid for AIDS of Nevada (AFAN) 701 Shadow Lane, Las Vegas, NV 89106 Phone: 702-382-2326 ***Support Services:*** *Case Management; Referral Services, Medication Assistance- AIDS Drug Assistance Program; Co-Payments for Medical Services, Substance Abuse Outpatient & Residential, Food Bank/Food Voucher Assistance, Nutrition Therapy, Health Insurance Premium Assistance, Utility Payment Services, Housing Payment Services, Medical and non-Medical Transportation Assistance, Eye Glasses/Eye Care, Education on HIV/AIDS, Legal Support, Emergency Financial Assistance, Outreach, Clothing*	**Community Counseling Center** 1120 Almond Tree Lane, Las Vegas, NV 89104 Phone: 702-369-8700 ***Core Medical Services:*** *Substance Abuse Services, Mental Health Services* ***Support Services:*** *HIV/AIDS Support Groups*
	Community Outreach Medical Center (COMC) 1400 N. Eastern Avenue, Las Vegas, NV 89101 Phone: 702-657-3873 ***Core Medical Services:*** *Ambulatory/Outpatient Health Services, Assistance with Medication, OB/GYN Services* ***Support Services:*** *Referrals for Support Services*
F.O.C.U.S Services 1140 Almond Tree Lane Ste 306 Las Vegas, NV 89106 Phone: 702-882-2118 Open: M-Th 9am-5pm F 9am-12pm ***Support Services:*** *Case Management, Emergency Financial Assistance, Food Bank/Food Vouchers, Referrals for Support Services*	**Golden Rainbow** 3233 W. Charleston, Suite 108, Las Vegas, NV 89102 Phone: 702-384-2899 ***Support Services:*** *Housing Assistance, Co-payments for Medical Services, Emergency Housing, Transitional Housing, Utility*

	Assistance, Housing Payment Services, Eye Glasses/Eye Care Assistance, Emergency Financial Assistance, Clothing
Mohave County Department of Public Health 700 West Beale, Kingman, AZ 86401 Phone: 928-753-0748 ***Support Services:*** *Referrals for Services, Co-Payments for Medical Services, Food Bank/Food Voucher Assistance, Nutrition Therapy, Health Insurance Assistance, Medical Transportation, Eye Glasses/Eye Care, Education about HIV/AIDS*	**Nevada Association of Latin Americans (NALA)** 323 N. Maryland Parkway, Las Vegas, NV 89101 Phone: 382-6252 ***Support Services:*** *Case Management, Referrals for Services, Supportive Counseling, Food Bank/Food Voucher Assistance, Utility Payment Services, Housing Payment Services, Education about HIV/AIDS, Employment Assistance/Referrals, Outreach, Childcare*
Nye County Health and Human Services 250 Highway 160, Ste 4 Pahrumph, NV 89060 Phone: 775-751-7094 ***Support Services:*** *Referral Services, Food Baskets/Food Vouchers, Utility Payment Services, Housing Payment Services, Medical Transportation, Child Care*	**Southern Nevada Health District** Ravenholt Public Health Center 625 Shadow Lane, Las Vegas, NV 89106 ***Core Medical Services:*** *Ambulatory/Outpatient Medical Care, Substance Abuse Outpatient Services, HIV/AIDS Testing Services, Case Management* ***Support Services:*** *Referrals for Support Services*
UMC-Wellness Clinic 701 Shadow Lane Suite 200, Las Vegas, NV 89106 Phone: 702-383-2691 ***Core Medical Services:*** *Ambulatory/Outpatient Medical Care, Mental Health Services, OB/GYN Services* ***Support Services:*** *Referrals for Support Services*	***University of Nevada Las Vegas School of Dental Medicine*** 1001 Shadow Lane, Las Vegas, NV 89106 Phone: 702-774-2498 ***Core Medical Services:*** *Oral Health Care*

Figure 5.2 non-Ryan White Funded Service Providers	Ambulatory/Outpatient Medical Care	Assistance with Medication	Dental Care	HIV/AIDS Testing Services	Assistance with Medical Co-pays	Mental Health Services	Nutritional Services	Case Management Medical and/or non-Medical	Substance Abuse Outpatient Services	Child Care Services	Emergency Financial Assistance	Food Bank/Vouchers/Hot Meals	Housing Assistance	Legal Services	Translation Services	Transportation	HIV/Support Groups/Supportive Counseling	Referrals for Support Services	Substance Abuse Residential Services	OB/Gyn Services	Eye Glass/Eye Care	Health Insurance Premium & Cost Sharing	Co-Pays for Medical Services	Employment Assistance	Ombudsman	Clothing/Household Products	Home Health Care/Care Giver Respite
AHEC of Southern Nevada 3014 West Charleston Ste 150 Las Vegas NV, 89102 (Provides Education)																											
Alpha & Omega Ministries 2610 N. Martin Luther King Blvd Las Vegas, NV Phone: 702-385-7801 Open: 9am-12pm M-F (call first)												X															
A Lift Up Org 3310 S. Nellis Blvd Ste 28 Las Vegas, NV 89121 Phone: 702-457-0700 www.ALiftUp.org																										X	
Bridger Health Center 310 S. 9th St. Las Vegas, NV 89101 www.nvrhc.org/bridge Phone: 702-220-9935 Open: 8am-5pm M-F	X											X								X							
Cambridge Family Health Center 3900 Cambridge Ave. Ste 101 Las Vegas, NV 89119 Phone: 702-307-5415 www.nvrhc.org/cambridge	X																										
Catholic Charities 1511 N. Las Vegas Blvd. Phone: 702-387-2291 (food pantry) 1501 N. Las Vegas Blvd. Phone: 702-385-7801 (soup line) www.catholiccharities.linklv.com												X															
Central Christian Church 1001 New Beginnings Dr. Henderson, NV 89011 Phone: 702-735-4004 www.centralchristian.com (food pantry 9am-3pm W, 3pm-7pm S, 9am-1pm Sun)												X															

Figure 5.2 *non-Ryan White Funded* *Service Providers*	Ambulatory/Outpatient Medical Care	Assistance with Medication	Dental Care	HIV/AIDS Testing Services	Assistance with Medical Co-pays	Mental Health Services	Nutritional Services	Case Management Medical and/or non-Medical	Substance Abuse Outpatient Services	Child Care Services	Emergency Financial Assistance	Food Bank/Vouchers/Hot Meals	Housing Assistance	Legal Services	Translation Services	Transportation	HIV/Support Groups/Supportive Counseling	Referrals for Support Services	Substance Abuse Residential Services	OB/Gyn Services	Eye Glass/Eye Care	Health Insurance Premium & Cost Sharing	Co-Pays for Medical Services	Employment Assistance	Ombudsman	Clothing/Household Products	Home Health Care/Care Giver Respite
Christ Church Episcopal 2100 S. Maryland Pkwy. Las Vegas, NV Phone: 702-735-7655 (hot meal Wednesday 5pm-7pm)												X															
Christ the King 4925 S. Torrey Pines Drive Las Vegas, NV www.ctklv.org Phone: 702-871-1904 (food pantry 10am-3pm M-F)												X															
College Park Baptist Church 2101 E. Owens Ave. Las Vegas, NV Phone: 702-642-5921 (food assistance Tuesday 1:30pm-3:30pm) www.mtcharlestonbaptistchurch.com												X															
Colorado River Food Bank 1575 Casino Dr. Laughlin NV Phone 702-298-9220 (food bank 8am-3pm M-F)												X															
Community Grocery Store 1720 N. J Street Las Vegas, NV Phone: 702-647-2627 (food pantry 10am-12pm S-F)												X															
Clark County Social Services 1-Main Office 1600 Pinto Lane Las Vegas, NV 89106 Phone: 702-455-4270 2-Community Resource Center 2432 N. Martin Luther King Blvd. N. Las Vegas, NV Phone: 702-455-7208 3-Cambridge Community Center 3900 Cambridge St. Ste 208 Las Vegas, NV 89119 Phone: 702-455-8687 4-Henderson Office 750 S. Boulder Highway Ste C. Henderson, NV 89015 Phone: 702-455-7918 www.accessclarkcounty.com/depts/social_service	***Provides: Alternative Health Care, Burial and Cremation Counseling, Financial Assistance, Homemaker Home Health Aide, Long Term Care, Medical Assistance, Outreach Services, Senior Citizens Protective Services Transportation Assistance, Volunteer Program (702-455-5719)***																										

Figure 5.2 non-Ryan White Funded Service Providers	Ambulatory/Outpatient Medical Care	Assistance with Medication	Dental Care	HIV/AIDS Testing Services	Assistance with Medical Co-pays	Mental Health Services	Nutritional Services	Case Management Medical and/or non-Medical	Substance Abuse Outpatient Services	Child Care Services	Emergency Financial Assistance	Food Bank/Vouchers/Hot Meals	Housing Assistance	Legal Services	Translation Services	Transportation	HIV/Support Groups/Supportive Counseling	Referrals for Support Services	Substance Abuse Residential Services	OB/Gyn Services	Eye Glass/Eye Care	Health Insurance Premium & Cost Sharing	Co-Pays for Medical Services	Employment Assistance	Ombudsman	Clothing/Household Products	Home Health Care/Care Giver Respite
Downtown Outreach Clinic Healthcare for the Homeless Program 403 W. Wilson Ave. Las Vegas, NV 89106 Phone: 702-380-8511	X																										
Dream Center Church 911 G. Street Las Vegas, NV Phone: 702-636-0023 (food boxes 9am-11am T hot meal Th 5:30pm) www.lasvegasdreamcenter.org												X															
Doyne Medical Clinic 1706 W. Bonanza Rd. Las Vegas, NV 89106 Phone: 702-631-6860	X																			X							
Dwelling Center 1330 S. Third Street Las Vegas, NV Phone: 702-378-3588 (food bank Sunday 12pm-2pm)												X															
Eastern Family Medical and Dental Center 2212 S. Eastern Ave. Las Vegas, NV 89104 Phone: 702-735-9334 www.nvhealthcenters.org/ea	X																			X							
The Embrace Project 1201 Miller Street Las Vegas, NV Phone: 702-994-0585 (food pantry M-Th after 4pm) www.theembracingproject.org												X															

Figure 5.2 ***non-Ryan White Funded Service Providers***	Ambulatory/Outpatient Medical Care	Assistance with Medication	Dental Care	HIV/AIDS Testing Services	Assistance with Medical Co-pays	Mental Health Services	Nutritional Services	Case Management Medical and/or non-Medical	Substance Abuse Outpatient Services	Child Care Services	Emergency Financial Assistance	Food Bank/Vouchers/Hot Meals	Housing Assistance	Legal Services	Translation Services	Transportation	HIV/Support Groups/Supportive Counseling	Referrals for Support Services	Substance Abuse Residential Services	OB/Gyn Services	Eye Glass/Eye Care	Health Insurance Premium & Cost Sharing	Co-Pays for Medical Services	Employment Assistance	Ombudsman	Clothing/Household Products	Home Health Care/Care Giver Respite
Eye Clinic of Las Vegas 2800 N. Tenaya Ste 102 Las Vegas, NV 89128																					X						
First AME Church 2450 Revere Street Las Vegas, NV Phone: 702-649-1774 (food pantry Th 10am-2pm) www.famechurchlasvegas.com												X															
First Baptist Church 440 W. Oakey Blvd. Las Vegas, NV Phone: 702-821-1234(food pantry T&W 10am-2pm)												X															
First Congregational Church 1200 N. Eastern Ave. Las Vegas, NV Phone: 702-642-2220 (food pantry 3rd Friday every month 10am & bread program T&TH mid morning) www.ucclasvegas.org												X															
FISH Emergency Assistance 1600 E. Cartier Ave. Las Vegas, NV Phone: 702-649-6522 (food pantry MWF 11am-1pm)												X															
Frontier Southern Baptist Church 459 E. Cheyenne Ave. Las Vegas, NV Phone: 702-642-8776 (food pantry T&S 9:30am-12:30pm)												X															
Foundation for Positively Kids 3555 W. Reno Ave. Las Vegas, NV 89119 Phone: 702-262-0037 www.positivelykids.org	X							X		X																	X
Giving Life Ministries 416 Perlite St. Henderson, NV Phone: 702-565-4984 (food pantry 9am-12pm T & F)												X															

Figure 5.2 non-Ryan White Funded Service Providers	Ambulatory/Outpatient Medical Care	Assistance with Medication	Dental Care	HIV/AIDS Testing Services	Assistance with Medical Co-pays	Mental Health Services	Nutritional Services	Case Management Medical and/or non-Medical	Substance Abuse Outpatient Services	Child Care Services	Emergency Financial Assistance	Food Bank/Vouchers/Hot Meals	Housing Assistance	Legal Services	Translation Services	Transportation	HIV/Support Groups/Supportive Counseling	Referrals for Support Services	Substance Abuse Residential Services	OB/Gyn Services	Eye Glass/Eye Care	Health Insurance Premium & Cost Sharing	Co-Pays for Medical Services	Employment Assistance	Ombudsman	Clothing/Household Products	Home Health Care/Care Giver Respite
GLBT Center of Southern Nevada 953 E. Sahara Ave., B-31 Las Vegas, NV 89104 Phone: 702-733-9800 www.thecenterlv.com				X													X										
Grapevine Fellowship 4947 E. Cleveland Ave. Las Vegas, NV Phone: 702-431-8463 (food pantry S 10am-12pm & T 1pm-3pm) www.grapevinefellowship.org												X															
Greater New Jerusalem MBC 1100 N. D Street Las Vegas, NV Phone: 702-648-8438 (hot meal W 10am-12pm, food pantry S 7am-11am)												X															
God's Groceries 101 S. Rancho Drive Las Vegas, NV Phone: 702-384-1544 (2nd &4th F of the month 10am-12pm, 3rd Th 4pm-6pm)												X															
HACA 178 Westminister Way Henderson, NV Phone: 702-566-0576 (food pantry by appointment only)												X															
Helping Hands of Vegas Valley 2100 S. Maryland Pkwy. Ste 3 Las Vegas, NV www.hhovv.org Phone:702-633-7264 (food pantry T by appointment)												X				X											
Henderson Senior Center 27 E. Texas St. Henderson, NV Phone: 702-267-4160 (hot meal everyday 11am-1pm)												X															

Figure 5.2 *non-Ryan White Funded Service Providers*	Ambulatory/Outpatient Medical Care	Assistance with Medication	Dental Care	HIV/AIDS Testing Services	Assistance with Medical Co-pays	Mental Health Services	Nutritional Services	Case Management Medical and/or non-Medical	Substance Abuse Outpatient Services	Child Care Services	Emergency Financial Assistance	Food Bank/Vouchers/Hot Meals	Housing Assistance	Legal Services	Translation Services	Transportation	HIV/Support Groups/Supportive Counseling	Referrals for Support Services	Substance Abuse Residential Services	OB/Gyn Services	Eye Glass/Eye Care	Health Insurance Premium & Cost Sharing	Co-Pays for Medical Services	Employment Assistance	Ombudsman	Clothing/Household Products	Home Health Care/Care Giver Respite
Heritage United Methodist Church 2075 N. Lamb Blvd. Las Vegas, NV 89115 Phone: 702-437-8989 (food pantry T-Th 10am-2pm) www.heritageumclv.org												X															
Homeless Helpers of Nevada (food pantry S& Sun. times vary) Phone: 702-400-3155 as for Tony												X															
The House Family Worship Center 2256 Losee Rd. Ste C&A Las Vegas, NV Phone: 702-648-6489 (food pantry M&W call first) www.hbministries.org												X															
Huntridge Teen Clinic 2100 S. Maryland Pkwy. Ste 1 & 5 Las Vegas, NV 89104 Phone: 702-732-8776 www.huntridge.org	X		X	X																							
ICare Ministries (The Sista Project) 3348 Steppe St. N. Las Vegas, NV 89032 Phone: 702-648-0723																	X	X									
Infectious Disease Associates 6088S. Durango #D-100 Las Vegas, NV 89113 Phone: 702- 380-4242 www.infectiousdiseaseassoc.com	X																	X									
Jewish Family Service Agency 4794 S. Eastern Ave. Las Vegas, NV Phone: 702-732-0304 (food assistance 9am-11am M-F)												X															

Figure 5.2 *non-Ryan White Funded Service Providers*	Ambulatory/Outpatient Medical Care	Assistance with Medication	Dental Care	HIV/AIDS Testing Services	Assistance with Medical Co-pays	Mental Health Services	Nutritional Services	Case Management Medical and/or non-Medical	Substance Abuse Outpatient Services	Child Care Services	Emergency Financial Assistance	Food Bank/Vouchers/Hot Meals	Housing Assistance	Legal Services	Translation Services	Transportation	HIV/Support Groups/Supportive Counseling	Referrals for Support Services	Substance Abuse Residential Services	OB/Gyn Services	Eye Glass/Eye Care	Health Insurance Premium & Cost Sharing	Co-Pays for Medical Services	Employment Assistance	Ombudsman	Clothing/Household Products	Home Health Care/Care Giver Respite
Jude 22 Senior Nutrition 300 S. Ninth St. Las Vegas, NV Phone:702-229-1142 (food pantry 10am-2pm M-F)												X															
Kingman Aid to Abused People 2701 E. Andy Devine 103A Kingman, AZ 86401 Phone: 928-753-6222 Crisis Hotline: 928-753-4242								X			X	X		X		X		X						X		X	
Las Vegas Outreach Clinic Healthcare for the Homeless Program 47 W. Owens Ave. Las Vegas, NV 89030 Phone: 702-307-4635	X																										
L.A.C.E 2545 Bruce St. Ste D Las Vegas, NV Phone: 702-362-3387 (food pantry 10am-2pm M-F)												X															
Laughlin Family Resource Center 1975 Arie Ave. Laughlin, NV Phone: 702-298-5292 (food bank 8am-3pm M-F)												X															
Las Vegas Rescue Mission 480 W. Bonanza Rd. Las Vegas, NV Phone: 702-382-1766 (canned goods-odd months only, Daily 8am-12pm) ***Emergency Housing Available www.vegasrescue.org												X														X	
Legacy Vineyard Church 3200 Soaring Gulls Dr. Las Vegas, NV Phone: 702-838-9099 (bbq last Sunday of every month at 1pm)												X															
Lutheran Social Services 51 N. Pecos St. Las Vegas, NV Phone: 702-639-1730 (food pantry 8am-12pm M-F)												X															

Figure 5.2 ***non-Ryan White Funded Service Providers***	Ambulatory/Outpatient Medical Care	Assistance with Medication	Dental Care	HIV/AIDS Testing Services	Assistance with Medical Co-pays	Mental Health Services	Nutritional Services	Case Management Medical and/or non-Medical	Substance Abuse Outpatient Services	Child Care Services	Emergency Financial Assistance	Food Bank/Vouchers/Hot Meals	Housing Assistance	Legal Services	Translation Services	Transportation	HIV/Support Groups/Supportive Counseling	Referrals for Support Services	Substance Abuse Residential Services	OB/Gyn Services	Eye Glass/Eye Care	Health Insurance Premium & Cost Sharing	Co-Pays for Medical Services	Employment Assistance	Ombudsman	Clothing/Household Products	Home Health Care/Care Giver Respite
Martin Luther King Family Health Center 1700 Wheeler Peak Dr. Las Vegas, NV 89106 Phone:702-383-1961	X			X																							
Miles for Smiles Phone:702-220-9908 www.nvrhc.org/m4sdv (call for appointment)			X																								
Nevada AIDS Project 455 S. Grand Central Pkwy. Ste. C-344 Las Vegas, NV 89106 Phone: 702-636-1800 www.nevadaaidsproject.org																	X	X						X			
Nevada Health Centers OB/GYN 400 Shadow Lane, Ste 106 Las Vegas, NV 89106 Phone: 702-253-7802																				X							
Nevada Health Centers, Inc. 2320 McDaniel St. Ste C N. Las Vegas, NV 89030 Phone: 702-220-6096												X															
Nevada State Welfare Phone: 702-486-5000 (call for closest office)												X															
New Hope Las Vegas 3035 Marigold Ln Las Vegas, NV Phone: 702-869-4450 (food pantry: call to fill out an application												X															
Nevada Legal Services 530 S. 6th St. Las Vegas, NV 89101 Phone: 702-386-0404 www.nlslaw.net														X													

Figure 5.2 non-Ryan White Funded Service Providers	Ambulatory/Outpatient Medical Care	Assistance with Medication	Dental Care	HIV/AIDS Testing Services	Assistance with Medical Co-pays	Mental Health Services	Nutritional Services	Case Management Medical and/or non-Medical	Substance Abuse Outpatient Services	Child Care Services	Emergency Financial Assistance	Food Bank/Vouchers/Hot Meals	Housing Assistance	Legal Services	Translation Services	Transportation	HIV/Support Groups/Supportive Counseling	Referrals for Support Services	Substance Abuse Residential Services	OB/Gyn Services	Eye Glass/Eye Care	Health Insurance Premium & Cost Sharing	Co-Pays for Medical Services	Employment Assistance	Ombudsman	Clothing/Household Products	Home Health Care/Care Giver Respite
Nevada Treatment Center 1721 E. Charleston Blvd. Las Vegas, NV 89104 Phone: 702-382-4226 www.nevadatc.org																			X								
North Las Vegas Family Health Center 2320 McDaniel St. Ste A, B, & C N. Las Vegas, NV 89030 Phone: 702-214-5948	X			X																X							
Planned Parenthood of Southern Nevada 1-3220 W. Charleston Blvd. Las Vegas, NV 89102 2-3320 E. Flamingo Rd. Ste 54 Las Vegas, NV 89121 3-3940 N. Martin Luther King Blvd. Ste 105 Las Vegas, NV 89101 toll free 1-877-813-7710				X				X										X		X							
Pulmonary Associates 1-4 Sunset Way, Ste A-3 Henderson, NV 89014 Phone: 702-434-9690 2-2110 E Flamingo Rd # 100, Las Vegas, NV Phone: 702-731-9559 3-2000 Goldring Ave, Las Vegas, NV Phone: 702-384-5101	X																										
The Rape Crisis Center 741 Veterans Memorial Dr. Las Vegas, NV 89101 Phone:702-385-2153 www.therapecrisiscenter.org hotline:1-866-366-1640																	X										
Redeemed Christian Church 1555 E. Flamingo Rd. Las Vegas, NV Phone: 702-456-4527 (food pantry 10am-12pm Sat.)												X															
River of Life Ministries 3230 E. Charleston Street, #101 Las Vegas, NV Phone:702-220-5188 (food distribution T&F 11am-12pm)												X															

Figure 5.2 *non-Ryan White Funded Service Providers*	Ambulatory/Outpatient Medical Care	Assistance with Medication	Dental Care	HIV/AIDS Testing Services	Assistance with Medical Co-pays	Mental Health Services	Nutritional Services	Case Management Medical and/or non-Medical	Substance Abuse Outpatient Services	Child Care Services	Emergency Financial Assistance	Food Bank/Vouchers/Hot Meals	Housing Assistance	Legal Services	Translation Services	Transportation	HIV/Support Groups/Supportive Counseling	Referrals for Support Services	Substance Abuse Residential Services	OB/Gyn Services	Eye Glass/Eye Care	Health Insurance Premium & Cost Sharing	Co-Pays for Medical Services	Employment Assistance	Ombudsman	Clothing/Household Products	Home Health Care/Care Giver Respite
S.A.F.E House, Inc. 921 America Pacific Dr. Ste 300 Henderson, NV 89014 24 hour hotline: 702-564-3227 counseling & advocacy: 702-451-4203 (transitional and emergency housing)www.safehousenv.org								X									X	X									
Saint Therese Center HIV Outreach 1120 Almond Tree Ln # 201Las Vegas, NV 89104 Phone: 702-369-9276 100 East Lake Mead Parkway Henderson, NV Phone: 702-564-0604 www.sainttheresecenter.org ***haircuts offered												X						X									
Sai Baba Phone: 702-876-7684												X															
The Shade Tree 1 West Owens Las Vegas, NV Phone: 702-385-0072 www.theshadetree.org	***Provides: Emergency Shelter, Job Development, Children's Activity Center, Services for Victims of Violence, Safe Place for Women, Children, and their Pets.***																										
Sin Sity Sisters 1140 Almond Tree Lane Ste. 306 Las Vegas, NV 89106 www.sinsitysisters.org		X																									
Salvation Army 1-35 Owens Ave. Las Vegas, NV Phone: 702-657-0123 2-4001 W Charleston Blvd, Las Vegas Phone: 70- 878-8022 3-2900 Palomino Lane, Las Vegas - (702) 870-4430 (hot meal daily 2:45 pm) www.salvationarmy.org												X															
The Salvation Army Family Resources 1581N. Main St. Las Vegas, NV Phone: 702-649-8240 (food pantry M-Th 7am-4:30pm)												X															

Figure 5.2 ***non-Ryan White Funded Service Providers***	Ambulatory/Outpatient Medical Care	Assistance with Medication	Dental Care	HIV/AIDS Testing Services	Assistance with Medical Co-pays	Mental Health Services	Nutritional Services	Case Management Medical and/or non-Medical	Substance Abuse Outpatient Services	Child Care Services	Emergency Financial Assistance	Food Bank/Vouchers/Hot Meals	Housing Assistance	Legal Services	Translation Services	Transportation	HIV/Support Groups/Supportive Counseling	Refferals for Support Services	Substance Abuse Residential Services	OB/Gyn Services	Eye Glass/Eye Care	Health Insurance Premium & Cost Sharing	Co-Pays for Medical Services	Employment Assistance	Ombudsman	Clothing/Household Products	Home Health Care/Care Giver Respite
Second Baptist Church 500 W. Madison Ave. Las Vegas, NV 89106 Phone:702-648-6155 (food pantry T&Th 10am-12pm) www.secondbaptist.org												X															
Solid Rock Christian Church 8855 Spencer St. Las Vegas, NV Phone:702-795-7625 www.solidrockchristianchurch.com												X															
Southern Nevada Adult Mental Health 6161 W. Charleston Blvd. Las Vegas, NV 89146 Phone: 702-486-6000 www.mhds.state.nv.us/sn/									X										X								
Spring Mountain Treatment Center 7000 West Spring Mountain Rd. Las Vegas, NV 89117 Phone:702-873-2400 or 1-866-265-6117 www.springmountaintreatmentcenter.com									X										X								
United Labor Agency of Nevada 1201 N. Decatur Blvd. Ste 106 Las Vegas, NV 89108 (call for appointment) Phone: 702-648-3500 www.ulan.org								X				X						X					X				
United Methodist 6151 W. Charleston St. Phone: 702-870-4747 www.umc.org												X															
University Medical Center Women's Center 2231 W. Charleston Blvd. 2nd floor Las Vegas, NV 89102 Phone: 702-383-2403 www.umcsn.com	X																			X							
Vegas View Church 1906 Gilder St. North Las Vegas, NV 89030 Phone: 702-642-6211 www.vegasview.org												X															

Figure 5.2 non-Ryan White Funded Service Providers	Ambulatory/Outpatient Medical Care	Assistance with Medication	Dental Care	HIV/AIDS Testing Services	Assistance with Medical Co-pays	Mental Health Services	Nutritional Services	Case Management Medical and/or non-Medical	Substance Abuse Outpatient Services	Child Care Services	Emergency Financial Assistance	Food Bank/Vouchers/Hot Meals	Housing Assistance	Legal Services	Translation Services	Transportation	HIV/Support Groups/Supportive Counseling	Refferals for Support Services	Substance Abuse Residential Services	OB/Gyn Services	Eye Glass/Eye Care	Health Insurance Premium & Cost Sharing	Co-Pays for Medical Services	Employment Assistance	Ombudsman	Clothing/Household Products	Home Health Care/Care Giver Respite
Victory Ministry 500 W. Monroe Ave. Las Vegas, NV Phone: 702-648-2286												X															
West Las Vegas Family Resource Center 2859 S. Lindell Rd. (inside the Boys & Girls club) Phone:702-932-1880 ext 260												X															
Westminister Presbyterian Church 4601 W. Lake Mead Blvd. Las Vegas, NV 89108 Phone: 702-648-8437www.wpcvegas.org												X															
Women's Resource Center 1-2915 W. Charleston St. Ste 1Las Vegas, NV 89102 Phone: 702-366-1247 2-1490 East University Ave. Las Vegas, NV 89119 Phone: 702-366-1247 www.wrmcsn.com (baby formula when available)																		X		X							
Word of Life Christian Center 3520 N. Buffalo Dr. Las Vegas, NV www.wordoflifelasvegas.com												X															
WestCare www.westcare.com 1-Community Triage Center 930 N. 4th Street Las Vegas, NV 89101 Phone: 702-383-4044 2-Women and Children's Campus 5659 Duncan Dr. Las Vegas, NV 89130 Main Phone: 702-385-2020 3-Healthy Families Project - Residential Treatment Phone 702-385-2020 x256 3-Stepping Stones Phone 702-385-2020 x238 Runaway / Homeless Youth & Crisis / Detoxification 4-Young F.A.C.E.S. - Residential Treatment Phone: 702-385-2020 x275 5-Community Involvement Centers - Outpatient									X				X						X		***See website for a full range of services and the locations they are provided***						

Services 401 S. Martin Luther King Blvd Las Vegas, NV 89106 Main Phone 702-385-3330 6-Pahrump Community Involvement Center 1161 S. Loop Rd Pahrump, NV 89048 Phone: 775-751-6990 7-Laughlin 3650 S Pointe Circle Laughlin, NV 89029 Phone: 702-299-0142 8-Harris Spring Ranch/Adult Services 4300 Harris Spring Road Las Vegas, NV 89124 Phone: 702-872-5382																					

Additional Data

Consumer Survey Responses

Survey Respondent Characteristics

- 93% of respondents indicated they are HIV positive or have been diagnosed with AIDS.
- 26% were female, 72% male, 1% transgender female to male, and 2% transgender male to female.
- 2% were 13-19 years of age, 73% were 20-49 years of age, 22% were 50-59 years of age, and 4% were 60 years of age and older.
- 23% were Hispanic, 43% were White, 41% Black, 5% Multi-racial, 3% American Indian/Alaskan Native, and the Asian, Asian Pacific Islander, and Unknown populations each represented 1% or less.
- 76% indicated they live in a house or apartment that they rent or own, 2% were homeless, 1% live in a shelter, and 1% live in a drug treatment program or halfway house. The rest reside with family or friends.
- 45% were heterosexual, 42% Gay or Lesbian, 10% Bisexual, and 3% still unsure.
- The number of year's positive range from 3 months to 29 years, with an average of 9.7 years.
- The majority of respondents, 39%, were MSM, followed by heterosexual contact at 28% and unknown 12%.
- 85% of surveys were completed in English and 15% in Spanish.

Most Indicated Barriers to Accessing Care

Consumers were asked to indicate what barriers in the Las Vegas TGA make it difficult to access any medical and supportive services on a regular basis. They indicated;

- Lack of transportation 30%
- Stigma 19%
- Depression or other mental health issue 17%
- Eligibility process too long and difficult 13%
- Hard time keeping appointments 13%
- Don't know where to find services 11%
- Language barrier 5%
- Side effects of medication 5%
- Substance use 3%

Respondents were also asked to indicate what services they are in need of but aren't offered, they indicated;

- More transportation 46%
- More housing assistance 45%
- Exercise classes/gym memberships/yoga classes 40%
- Job assistance 34%
- Massage therapy/reflexology 33%

- Hygiene products/household cleaning supplies 29%
- Hot meals program 21%
- Other 6%

Consumer survey respondents were asked to rate the overall level of care they receive for their HIV/AIDS status in the Las Vegas TGA, they indicated;

- Good 43%
- Excellent 35%
- Fair 16%
- Poor 6%

Consumer Focus Group 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.

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 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 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 great 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.

ACRONYMS

ADAP-AIDS Drug Assistance Program
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
GY-Grant Year
HIV-Human Immunodeficiency Virus
HRSA-Health Resources and Services Administration
IDU-Injection Drug User
MSM-Men who have Sex with Men
NALA-Nevada Association of Latin Americans
PLWA-People Living with AIDS
PLWH-People Living with HIV
PLWH/A-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