



RYAN WHITE HIV/AIDS PROGRAM

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BACKGROUND

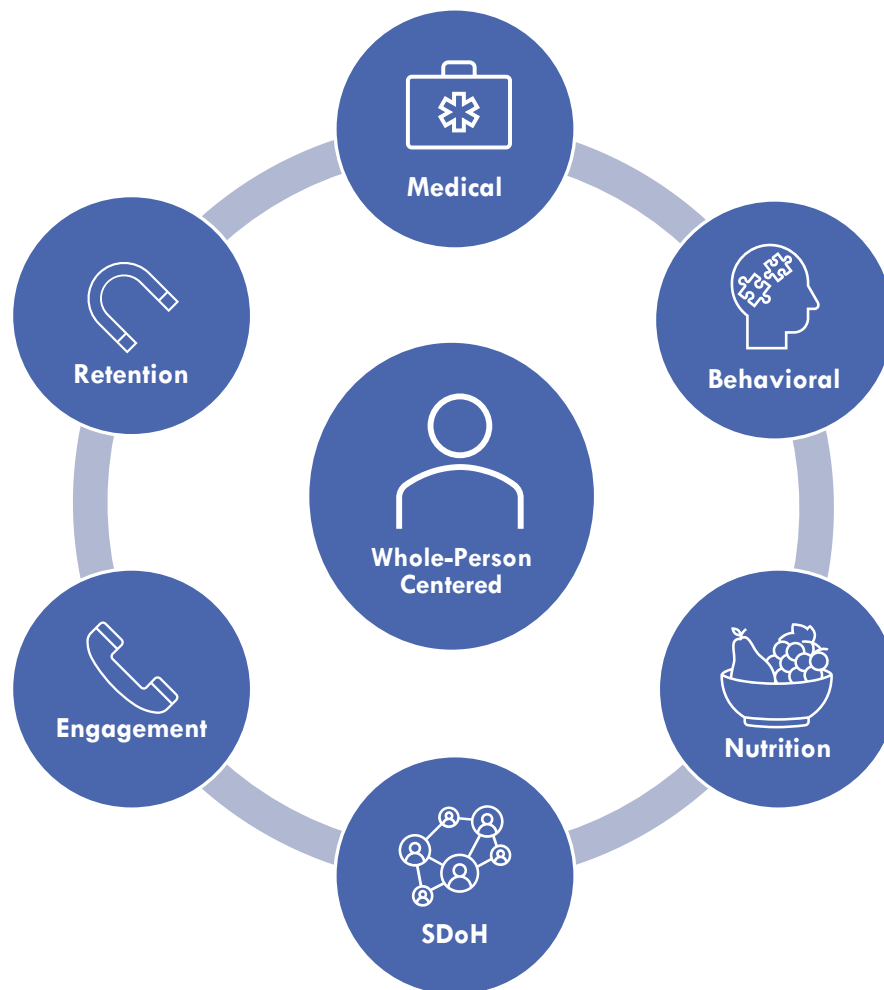
The Ryan White HIV/AIDS Program

- Federal program established in 1990 to provide funding for medical and support services for people living with HIV who are uninsured and underinsured
- It is the payor of last resort-not traditional insurance
- Goal is to improve health outcomes and reduce the spread of HIV



SNCHC RYAN WHITE MODEL

Whole-Person Approach to Care



SNCHC RW SERVICE CATEGORIES

Ryan White Part A

Early Intervention Services

Medical Case Mgt.

Medical Nutrition

Mental Health Services

EHE/Rapid StART

Ryan White Part B

Medical Case Mgt.

Non-Medical Case Mgt.

Eligibility

Outreach/Retention

LEVELS OF CASE MANAGEMENT

Non-Medical

- Support and retention to care
- Services provided by CHWs

Social & Medical

- For established clients to address ongoing medical & social needs
- Services provided by Care Coordinators

Intensive Medical

- High-level, hands-on approach to coordinating care for clients with complex, serious, or high-acuity medical conditions.
- Pregnant mothers and exposed infants
- Services provided by Nurse Case Managers

QUALITY IMPROVEMENT

- QI Initiatives
 - PDSA
- Ongoing Training
 - Monthly Meetings
 - Leadership Events



COMMUNITY IMPACT

COMMUNITY IMPACT

SNCHC Program Outcomes

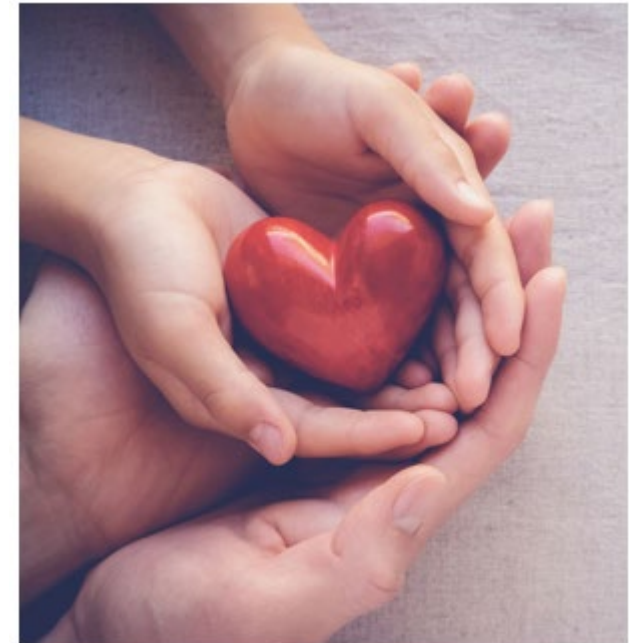


- HIV viral suppression rate for clients accessing OAHS services is consistently 95%+
- 570 unique clients received RWA MCM services during most recent quarter (Dec '25-Feb '26)
- 3000+ clients served within RWB NMCM category
 - Prior year 2,587 served

COMMUNITY IMPACT

HIV and Children

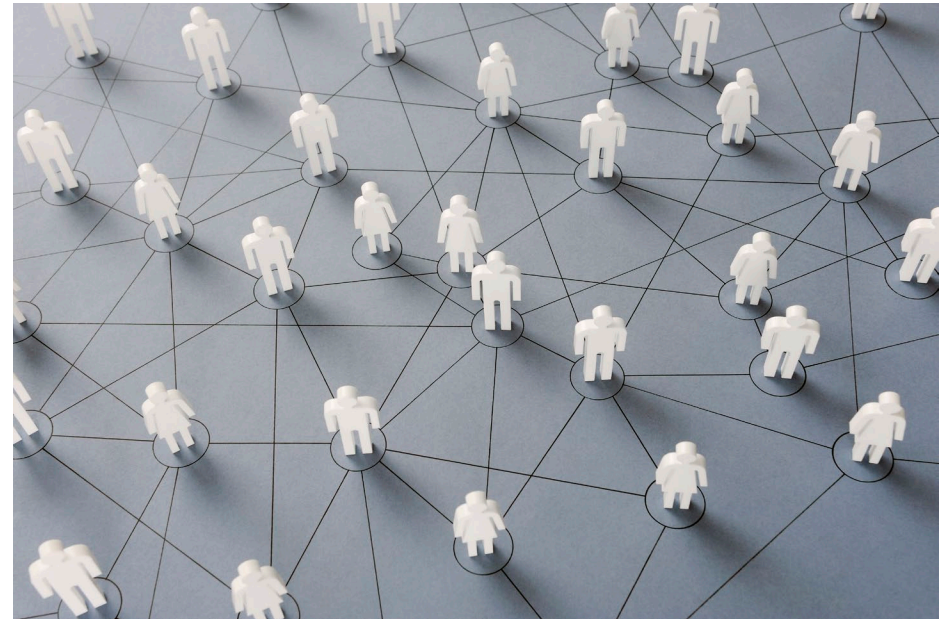
- Since the 1990's, perinatal HIV transmission has decreased by more than 95%.
- According to the CDC, 170 children younger than 13 years old were diagnosed with perinatally acquired HIV in the United States and Puerto Rico from 2018 to 2021.
- During this time, 12,139 children were born without HIV despite exposure to HIV during pregnancy, birth, or while breastfeeding.
- The use of HIV medicines and other strategies have helped to lower the rate of perinatal transmission of HIV to 1% or less in the United States and Europe.



COMMUNITY IMPACT

Education

- From March 2024-January 2026, SNHD conducted brief educational sessions across eleven hospitals in Southern Nevada, reaching over 400 nurses, providers, and staff.
- Messaging was tailored to unit-specific roles, including labor and delivery, neonatal intensive care units (NICU), post-partum, and EDs.



RSR DATA

| Population | 2023 | 2024 | 2025 |
|---|-------------|-------------|-------------|
| Total Unduplicated Clients | 958 | 1239 | 1150 |
| Received OAHS Services | 557 (58.1%) | 669 (54.0%) | 765 (66.5%) |
| Uninsured | 277 (31.8%) | 340 (33.0%) | 386 (34.8%) |
| Newly Diagnosed* | 24 (2.5%) | 107 (8.6%) | 86 (7.5%) |
| Outpatient/Ambulatory Health Services | 559 (58.4%) | 672 (54.2%) | 773 (67.2%) |
| Medical Case Mgt., including Treatment Adherence Services | 704 (73.5%) | 912 (73.6%) | 980 (85.2%) |
| Prescribed Antiretroviral Medications (ART) | 550 (98.7%) | 663 (99.1%) | 759 (99.2%) |

PATIENT TESTIMONIALS

Testimonial #1

Patient

- 35 YO; Female
- Newly Dx in 2nd Trimester
- Stage III (Aids)
- Refugee (Spanish-speaking)
- Linked to:
 - ID Care
 - High Risk OBGYN
 - ID Pediatrician
 - Pediatrician

Interventions

- Just One Project (Housing Assistance)
- Legal Aid (Domestic Violence)
- Car Seats for Christy
- Lullaby Connection (Children's clothing/supplies)

Outcome

- Client is now working fulltime
- Has stable housing
- Going to school part-time
- Infant is HIV negative and meeting milestones
- Client is virally suppressed and engaged in care at SNCHC.

PATIENT TESTIMONIALS

Testimonial #2

Patient

- 44 YO; Female
- Severe PTSD, high emotional distress, fear of social interaction
- Required significant accommodations (escorted into buildings, transportation)
- Unable to use public transit, relying on Uber and often missed appointments

Interventions

- Built strong rapport and provided consistent emotion support
- Scheduled and accompanied client to medical appointments
- Connected client to a support group and attended initial meetings with her
- Helped client learn and navigate the bus system
- Collaborated with Care Coordinator to secure income-based housing (Women's Development Center)
- Assisted with job interview preparation and encouraged career development
- Supported enrollment in CHW Certification Program
- Encourage attendance at a job fair

Outcome

- Became consistent with medical and behavioral health appointments
- Established care with providers at Decatur and Fremont locations
- Secured stable housing and employment
- Hired on the spot at job fair
- Maintained job and housing through CHW Certification Program
- Achieved independence and can now navigate systems on her own

THANK YOU

