

Mississippi State Department of Health

2012 Statewide Comprehensive HIV Plan and  
Statewide Coordinated Statement of Need

June 15, 2012

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## **Section I. Where are we now?**

This section provides an epidemiological profile that highlights specific target populations affected by the human immunodeficiency virus (HIV) in Mississippi. The section also provides an overview of the needs, gaps, and barriers experienced by HIV positive individuals in Mississippi based on data from organizations funded by Ryan White Parts A, B, C, D, and Section F and an estimate of unmet need in our state.

### **Sec. A. Description of Local HIV/AIDS Epidemic**

#### **Sec.A.1. 2010 HIV Epidemiological Profile**

According to 2010 Census data estimates, Mississippi's population was 2,967,297. Mississippi has 82 counties divided into nine public health districts. Table 1 shows the number of people living in Mississippi by public health district in 2010.

**Table 1: Distribution of Population by Public Health District, Mississippi-2010**

<b>Public Health District</b>	<b>2010 Population Estimate</b>
District I	319,959
District II	360,784
District III	216,708
District IV	246,970
District V	631,821
District VI	244,467
District VII	174,795
District VIII	304,893
District IX	466,900
Statewide	2,967,297

Acquired Immunodeficiency Syndrome (AIDS) has been reportable in Mississippi since 1983 and cases of Human Immunodeficiency Virus (HIV) since 1988. The Mississippi State Department of Health STD/HIV Office provides leadership and guidance for STD/HIV surveillance, prevention, and treatment. The STD/HIV Office strives to be a leader among southern states to implement evidence-based practices in STD/HIV surveillance, prevention and treatment; serve as a role model for the delivery of fair and equitable partner services; and provide an evaluation of STD/HIV prevention and treatment strategies to acquire public trust and respect.

The STD/HIV Office Surveillance Branch provides ongoing systematic collection and evaluation of data for STDs and HIV disease. HIV is a Class 1 reportable disease requiring any provider, including laboratories, to report confirmed cases of HIV within 24 hours of suspicion. All providers are required to report all confirmed HIV positive tests, persons with an AIDS defining illness, or anyone suspected of having an HIV infection to the MSDH STD/HIV Surveillance Branch. Information about potential new cases comes from a variety of sources including

hospitals, physicians in non-hospital based practices, public and private clinics, laboratories, routine matching to other registries (e.g. TB registry, death certificates), and active surveillance. Class I disease reports may be received only by phone. MSDH staff are required to make initial contact with HIV positive individuals within seven days of receipt of information to offer post test counseling, conduct risk ascertainment, offer partner services, and initiate linkage to care. In conjunction with post-test counseling during the first session, the client is asked to provide a second blood specimen for confirmator HIV testing by the Mississippi Public Health Laboratory and Serologic Testing Algorithm for Recent HIV Seroconversion (STARHS).

Free and confidential HIV testing is available at local health department clinics in all 82 counties in Mississippi. By the end of 2010, all 82 counties in Mississippi had at least one individual living with HIV disease, and the number of cases continues to grow annually. The total number of people living with HIV disease at the end of 2010 was estimated at 9,292 of which an estimated 4,367 (47%) people were living with AIDS. There has also been a decline in deaths due to HIV disease over the past five years which can be attributed to the increased use of highly active antiretroviral therapy (HAART).

HIV disease is distributed disproportionately in Mississippi. Most new HIV disease cases were identified in the West Central Public Health District V, which includes the metropolitan Jackson area, where 39% of all persons with HIV disease in Mississippi reside presently. In CY2010, the prevalence of HIV disease in District V was 565.8 cases per 100,000 persons. The Delta-Hills Public Health District III had the second highest case rate at 443.9 per 100,000 persons, followed by the Coastal Plains Public Health District IX, with a prevalence of 278.1 cases per 100,000 persons.

African Americans continue to be disproportionately affected by HIV disease. Although African Americans comprise only 38% of Mississippi's total population, they accounted for 78% of all newly diagnosed cases in 2010. The HIV diagnoses rate for African Americans in 2010 was nearly eight times that of whites. Since 2007, the proportion of cases of HIV disease among women in Mississippi has steadily declined. In CY2010, women represented 23.9% of newly diagnosed HIV disease cases. There has also been significant decline in HIV infection among infants due to effective treatment of pregnant women who are infected with HIV which prevents maternal transmission during pregnancy and at birth. This significant achievement in HIV prevention is attributed to the effectiveness of new HIV/AIDS therapies and the success of statewide perinatal case management activities.

Forty-five percent of males and females reported having "No Identified Risk" (NIR) as the mode of HIV exposure. Forty-one percent of men reported male to male sexual activity and eight percent (7.6%) reported heterosexual contact. Individuals age 15 and 29 years have been hardest hit by HIV. Since 2006, individuals age 15 to 19 years are the only age group to have an increase in the number of cases reported (e.g., 24% increase). Additionally, this age group has a high rate of African American men who have sex with men (MSM). In 2010, 67.8% of individual age 15 to 29 years reported MSM as the risk factor for their HIV infection.

Targeted HIV counseling and testing of those at risk is an essential component of high-impact HIV/AIDS prevention. Testing data samples for 2010 sent to the State Public Health Lab suggests that the majority of persons who tested for HIV/AIDS were African Americans (68%) followed by whites at 27%. Sixty-seven percent of individuals tested were female and 50% of females were between the 15 to 24 years of age.

### **Youth Risk Behavior Survey**

Studies show that alcohol and drug use are directly related to earlier onset of sexual activity and an increase in risky sexual behaviors, such as having unprotected sex. The combination of alcohol, sex, and drugs increases the chances of unintended pregnancies and exposures to sexually transmitted diseases.

#### *Alcohol and Drug Use*

The 2009 Youth Risk Behavior Surveillance System (YRBS) finds that 70% of Mississippi high school students had at least one alcoholic drink. Thirty-five have used marijuana, 5.3% have used ecstasy, and 2.8% have used methamphetamines. Eighteen percent were offered, sold, or given an illegal drug by someone on school property during the 12 months before the survey.

#### *Sexual Behaviors That Result in HIV Infection, Other Sexually Transmitted Diseases, and Unintended Pregnancies:*

Among Mississippi high school students surveyed, 61% have had sexual intercourse and 13% had sexual intercourse for the first time before the age of 13. Twenty-four percent of students had sex with four or more people during their lifetime. Nearly half (45%) of students had sexual intercourse with at least one person during the three months prior to the survey. Before the last sexual intercourse, 19% of high school students drank alcohol or used drugs and 82% of high school students did not use birth control pills or Depo-Provera to prevent pregnancy. In addition, 34% did not use a condom during the last sexual intercourse. Seventeen percent did not receive education about HIV or AIDS infection in school.

### **Teen Pregnancies and Births**

Increases in teen pregnancy and birth rates do not directly indicate an increase in HIV infection rates; rather they suggest an increase in unprotected sex. Teen pregnancy and birth are significant contributors to negative social outcomes in teen mothers and their children. Only half (50%) of teen mothers receive a high school diploma by age 22, compared to nearly 90% of women who had not given birth during adolescence. Children born to teenage mothers are more likely to have lower school achievement and drop out of high school, have more health problems, be incarcerated at some time during adolescence, give birth as a teenager, and face unemployment as a young adult.

In 2009, Mississippi's teen pregnancy rate ranked 1<sup>st</sup> in the nation among 15-19 year olds, with a rate of 73 per 1,000 females. Though the rate declined to 62.7 per 1,000 females between the ages of 15-19 in 2010, it remains above the national average. Teenage pregnancy rates among 15-19 year olds varied by public health district, ranging from 52.8 in District IV to 87.6 in

District III in 2010. The counties with the highest teenage pregnancy rates per 1,000 among 15-19 year olds include Tunica (125.7), Quitman (116.8), and Yazoo County (58.1).

Mississippi also had the highest teen birth rate among 15-19 year olds in 2009, with a rate of 64.1 per 1,000. However, the teen birth rate declined in 2010 to 55 per 1,000 females. By public health district, teen birth rates among 15-19 year old ranged from a high of 76.6 in District III to a low of 44.4 in District IV.

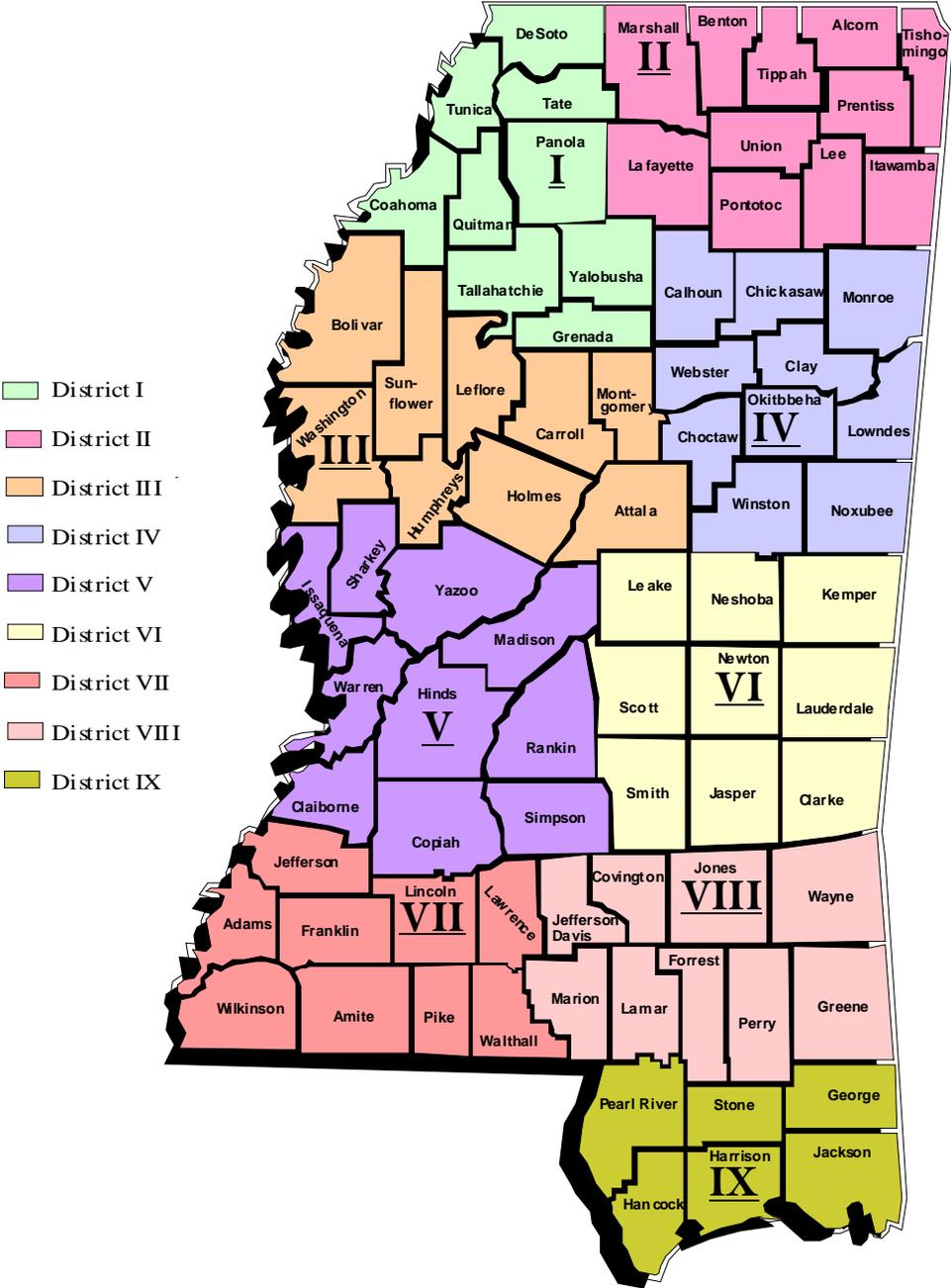
### **Adult Risk Behaviors**

Based on CDC recommendations, persons with high risk behaviors that increase their chances of acquiring HIV should be tested for HIV at least once a year. High risk behaviors include: having unprotected sex with men who have sex with men, multiple partners, and/or anonymous partners; injecting drugs or steroids with used injection equipment; having sex in exchange for money or drugs; and being diagnosed with or treated for hepatitis, tuberculosis, or a sexually transmitted disease.

The 2010 Behavioral Risk Factor Surveillance Survey asked respondents if they have ever been tested for HIV and whether they participated in high risk behaviors. Nearly half (44.4%) of Mississippi's population reported never having a blood test for HIV. More than half (55.6 %) of respondents between the ages of 18 and 64 reported that they had never been tested. More whites (63.1 %) reported never being tested than blacks (44.7%). Among white respondents, 66.9 % of males and 59.4% of females had never been tested. For blacks, nearly half (47.9%) of males and 41.8% of females had never been tested. When asked about high risk behaviors, black respondents were more likely to engage in high risk behaviors than whites (8.4 percent compared to 2.8 percent). The rate of high risk behaviors was higher among black males (9.6 %), followed by black females (7.3 %), white males (3.4%), and then white females (2.3 %).

# Geographic Guide to Mississippi Public Health Districts

## Mississippi State Department of Health Public Health Districts



## HIV Surveillance

Each year, Mississippi compiles an annual summary of sexually transmitted diseases, including HIV disease, by county and district and by race, gender, and age group. Individuals who are infected with any sexually transmitted disease are at least two to five times more likely than uninfected individuals to acquire HIV infection. The following section provides an epidemiological overview of HIV infection in Mississippi.

According to the 2009 National HIV Surveillance Report, among 40 states with a mature reporting system, Mississippi had the 6th highest rate of HIV diagnosis (Figure 1). The city of Jackson had the 3rd highest rate of HIV infection by city of residence in 2009 (Figure 2).

**Figure 1**

### HIV infection, by area of residence, 2009-United States (includes areas with confidential named based reporting since 2006)

Area of residence	No.	Estimated No.	Rate	Rank
Florida	5,775	6,120	33.0	1
Georgia	2,073	3,229	32.9	2
New York	4,649	5,765	29.5	3
Louisiana	1,247	1,295	28.8	4
New Jersey	1,252	1,986	22.8	5
<b>Mississippi</b>	<b>559</b>	<b>630</b>	<b>21.3</b>	<b>6</b>
South Carolina	789	906	19.9	7
North Carolina	1,719	1,844	19.7	8
Texas	4,291	4,563	18.4	9
Tennessee	999	1,080	17.2	10 (t)
Virginia	997	1,359	17.2	10 (t)

Source:

Centers for Disease Control and Prevention. *HIV Surveillance Report, 2009*; vol. 21. Published Feb 2011. Accessed Apr 2011.

**Figure 2:** HIV infection rates for metropolitan statistical areas in the United States in 2009.

**Diagnoses of HIV infection, 2009, by metropolitan statistical area of residence—United States and Puerto Rico**

Area of residence	No.	Estimated No.	Rate	
Miami, FL	2,741	2,883	52.0	1
Baton Rouge, LA	327	339	43.1	2
<b>Jackson, MS</b>	<b>189</b>	<b>212</b>	<b>39.2</b>	<b>3</b>
Memphis, TN–MS–AR	469	507	38.8	4
Atlanta–Sandy Springs–Marietta, GA	1,333	2,063	37.7	5
New Orleans–Metairie–Kenner, LA	426	442	37.1	6
Jacksonville, FL	459	483	36.4	7
Orlando, FL	687	723	34.7	8
New York, NY–NJ–PA	4,973	6,513	34.2	9
Charlotte–Gastonia–Concord, NC–SC	482	527	30.2	10

Source:  
Centers for Disease Control and Prevention. *HIV Surveillance Report, 2009*, vol. 21. Published Feb 2011. Accessed Apr 2011.

Comparing rates of infection among certain age groups, Mississippi tied with Florida for the highest rate of infection among 13-19 year olds and had the fifth highest rate of infection among 20-24 year olds (Figures 3 and 4).

**Figure 3**

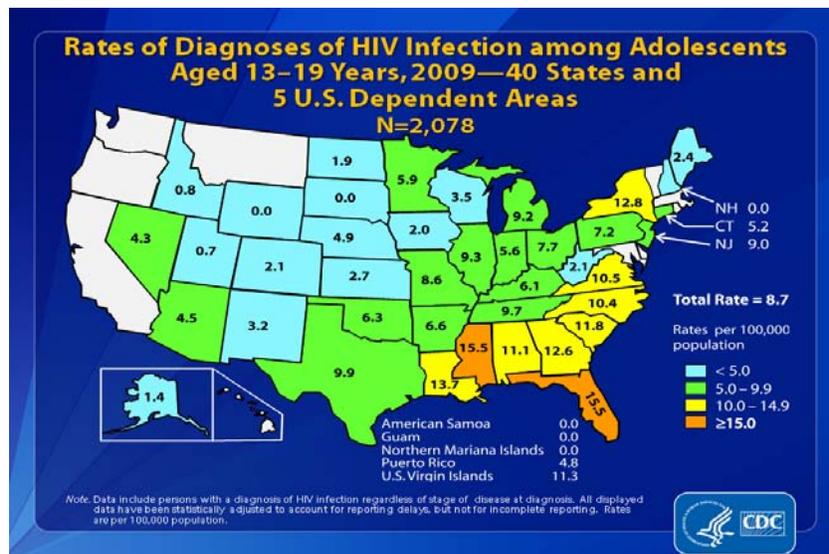


Figure 4

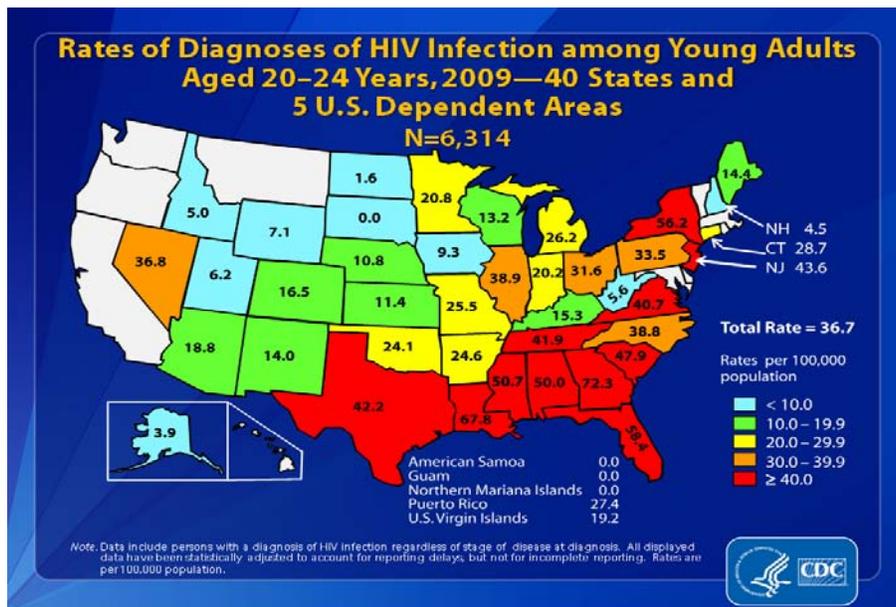
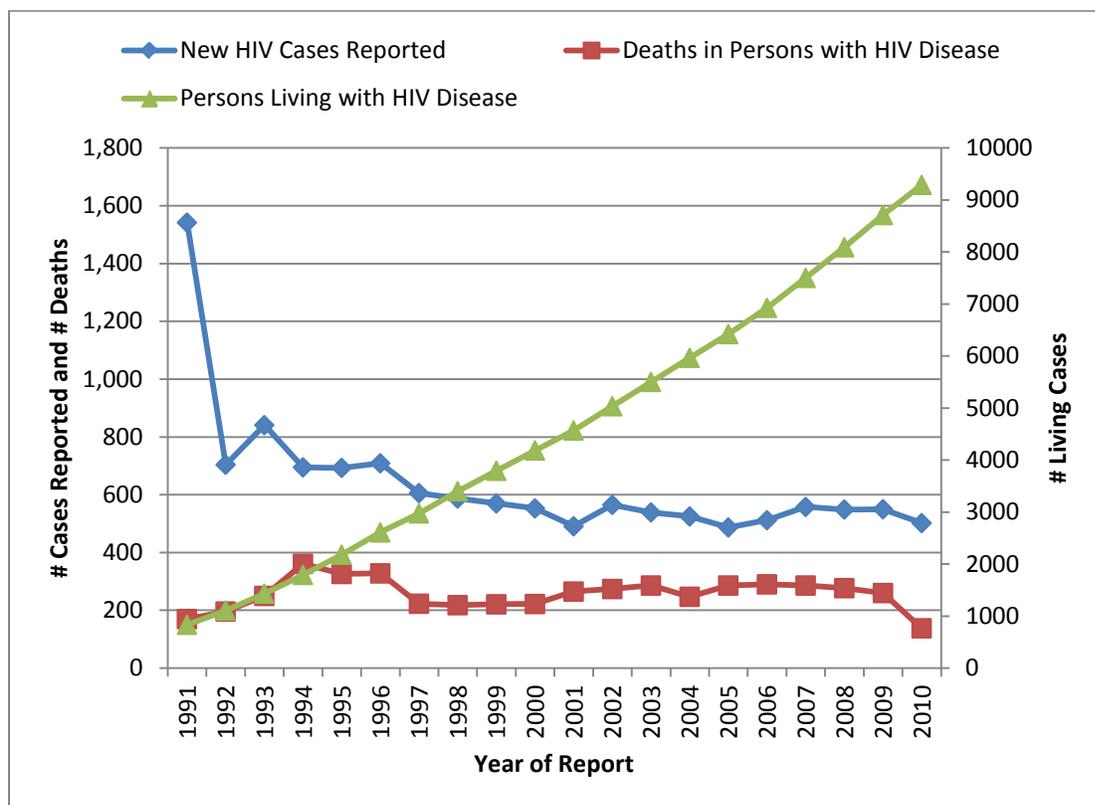
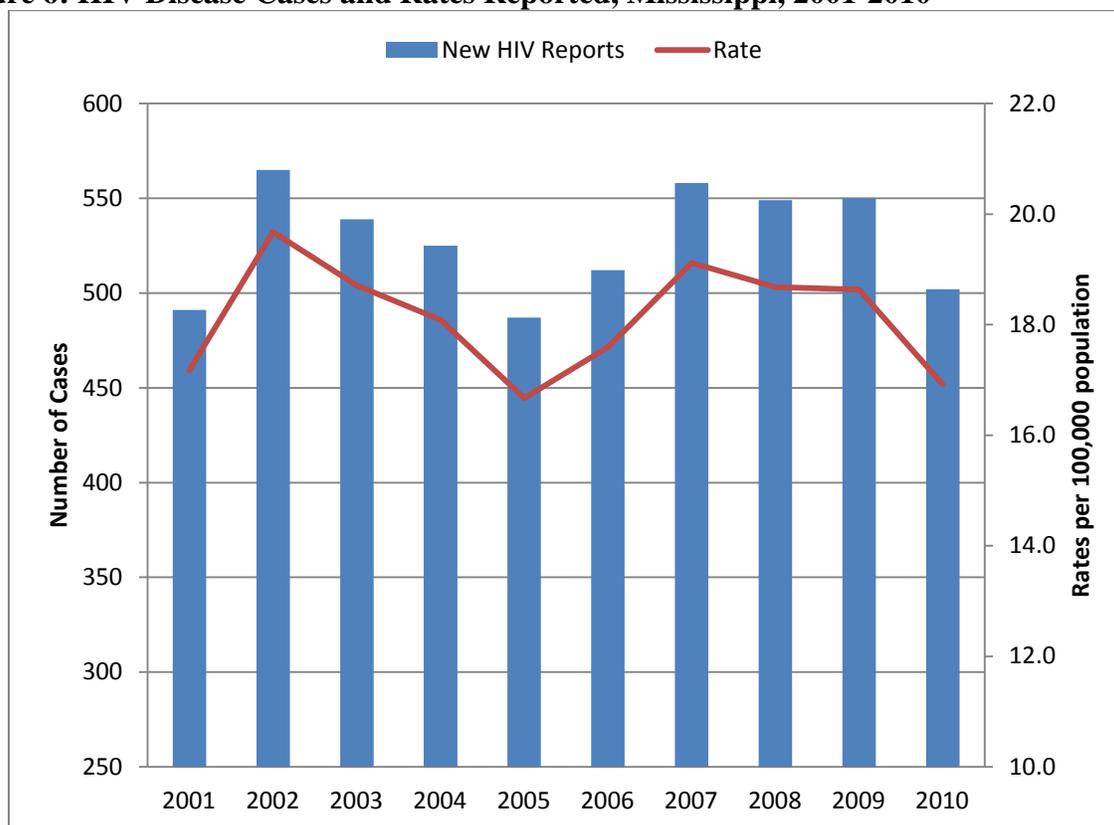


Figure 5: Number of HIV Cases Reported, Deaths, and Persons Living with HIV Disease, Mississippi, 1991-2010



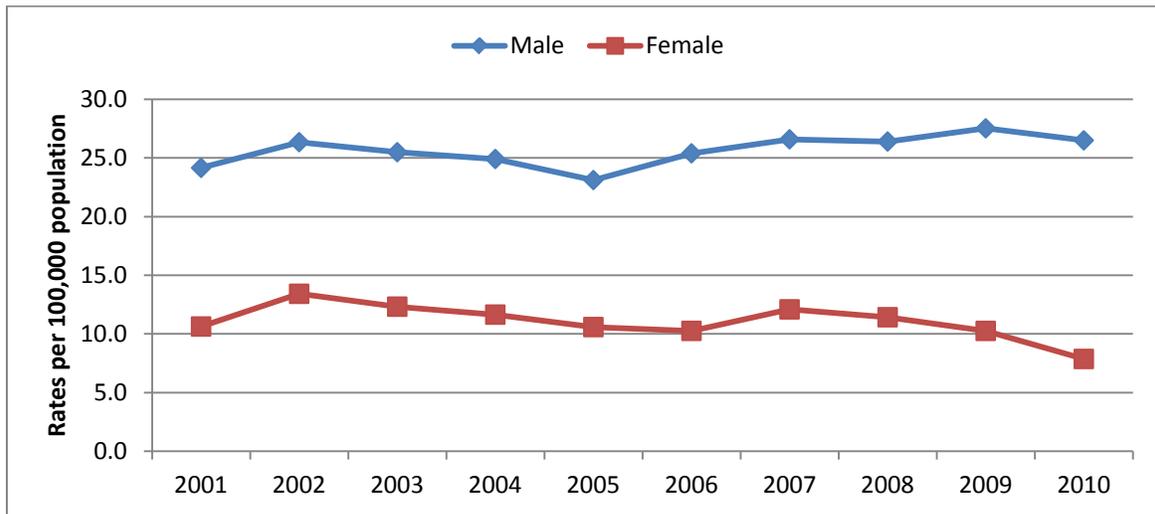
In 1991, there was a peak in new cases reported when HIV reporting was implemented; however a sharp downward trend is observed after and since 2006, there has been an average of 534 newly diagnosed cases each year. A peak in the number of deaths was observed in 1994, but has stayed fairly stable over the past ten years. The small decrease in deaths during 2010 is possibly due to the lag time in deaths reported from other states and national death databases (Figure 5). Over the past two decades, the number of persons living with HIV disease in Mississippi has increased each consecutive year.

**Figure 6: HIV Disease Cases and Rates Reported, Mississippi, 2001-2010**

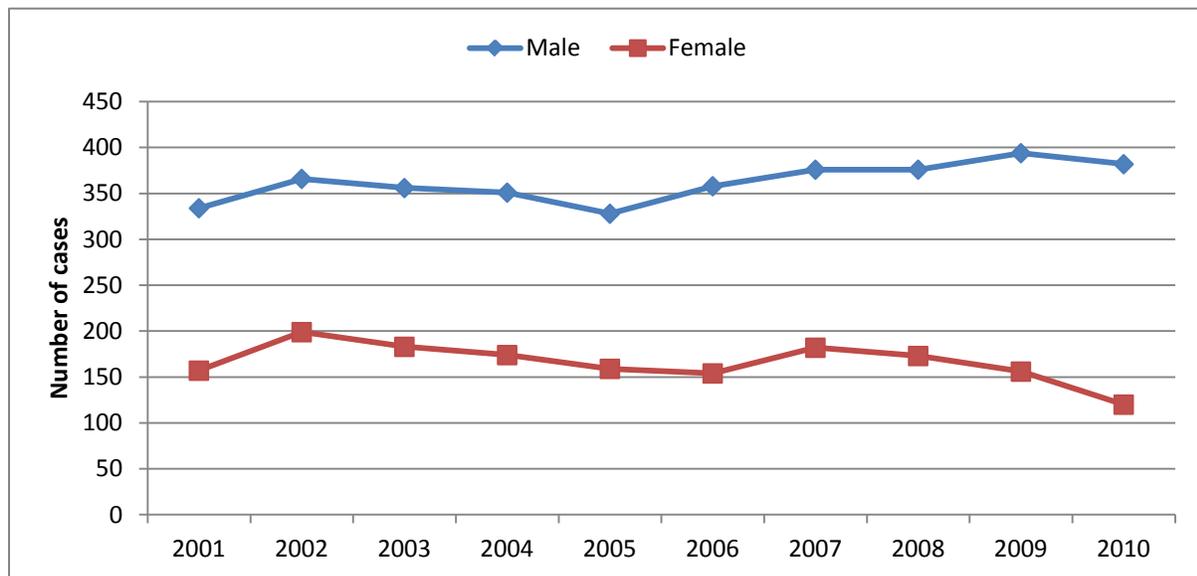


Over the past ten years, the average number of new cases reported in Mississippi was over 500 cases annually. Although there was an increase in cases reported from 2005-2007, cases remained steady until 2009. From 2009-2010, there was a nine percent decrease (from 550 to 502 cases). From 2006 to 2010, the case rate has decreased from 17.6 to 16.9 per 100,000 persons (Figure 6).

**Figure 7: HIV Disease Rates Reported by Sex, Mississippi, 2001-2010**

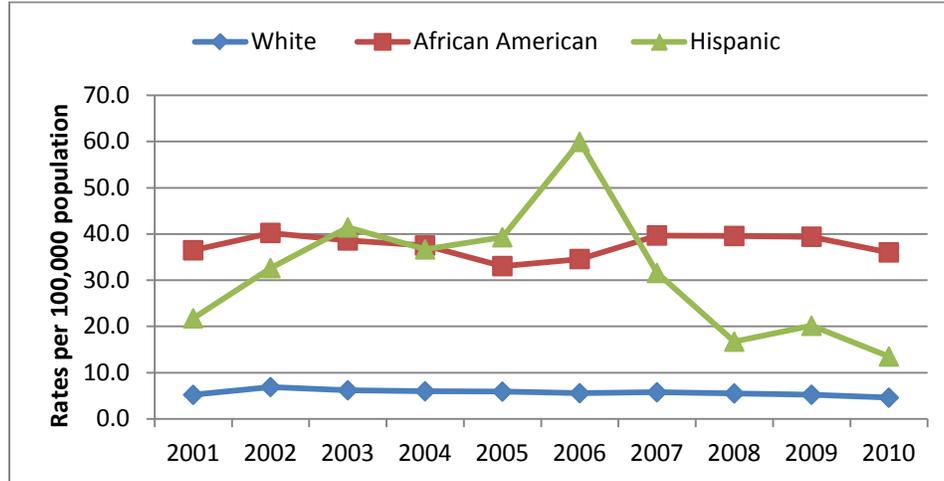


**Figure 8: HIV Disease Cases Reported by Sex, Mississippi, 2001-2010**

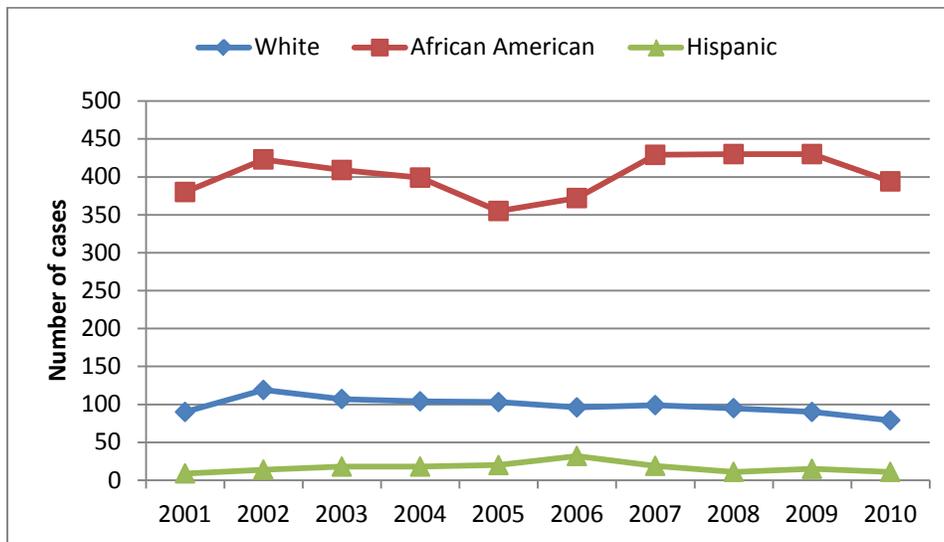


Males have consistently higher rates of HIV infection than females. Trends show that men are twice as likely to be infected with HIV. In 2010, males represented 76% of all reported cases. The rate among females has decreased slightly over the past ten years, from 10.6 to 7.9 per 100,000 females. Additionally, there was a 24% decrease in cases (from 157 to 120 cases) among females (Figures 7 and 8).

**Figure 9: HIV Disease Rates Reported by Race/Ethnicity, Mississippi, 2001-2010**

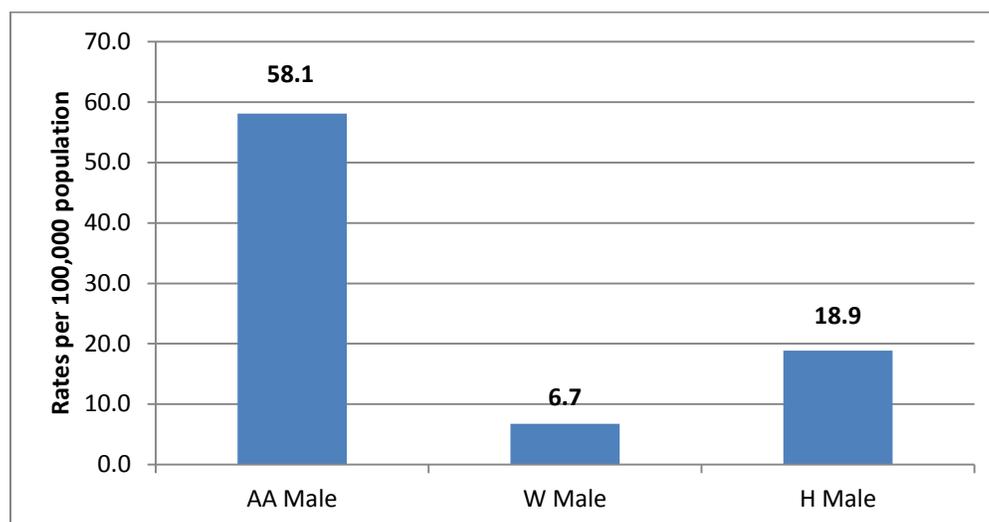


**Figure 10: HIV Disease Cases Reported by Race/Ethnicity, Mississippi, 2001-2010**



African Americans are most severely impacted by HIV disease. The case rates among African Americans decreased from 36.5 to 36.0, from 2001-2010, even though there was a 4% increase (380 to 394 cases) in cases reported (see Figure 9). Hispanics reported the second highest rates, but had fewer cases than whites each year. African Americans make up 38% of Mississippi's population, but represented 78% of cases reported in 2010.

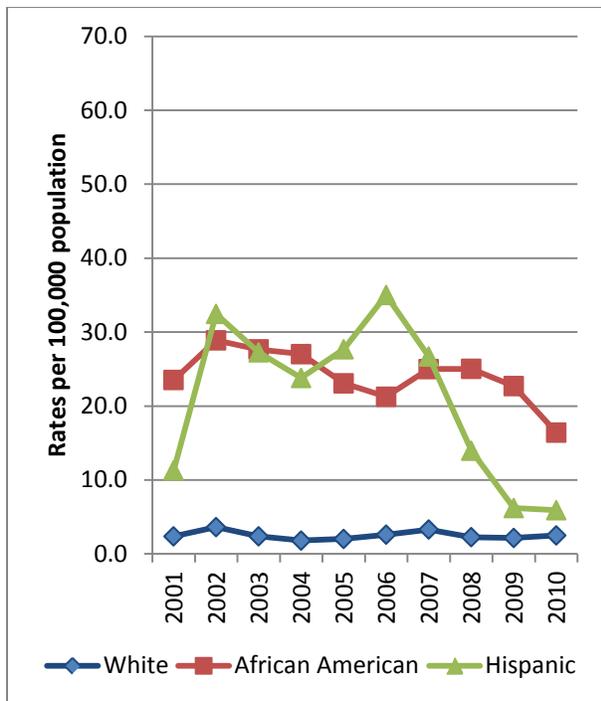
**Figure 11: HIV Disease Rates among Males by Race/Ethnicity, Mississippi, 2010**



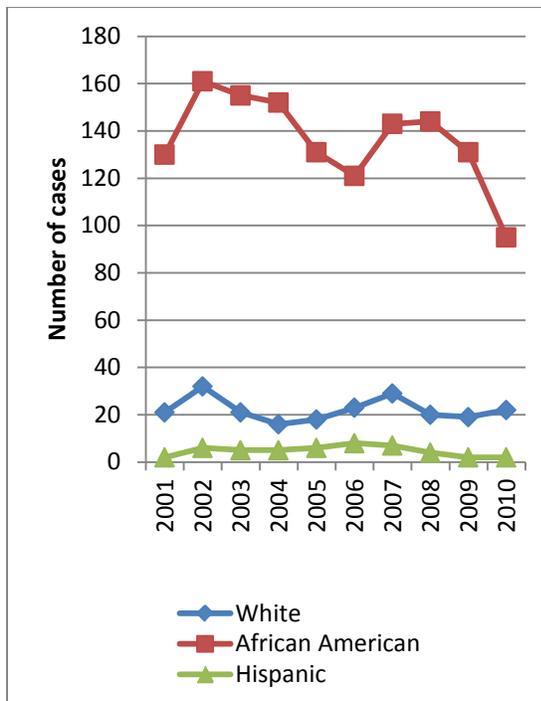
African American men have the highest case rate of HIV infection. There was a gradual decrease in reported cases in African American men until 2005, when cases started to increase (Figure 10). From 2005-2010, there was a 33.5% increase in cases (from 224 to 299 cases) and the rate increased from 44.3 to 58.1 per 100,000. In 2010, African American men had rates nearly nine times higher than white men (58.1 vs. 6.7) and three times higher than Hispanic men (58.1 vs. 18.9) (Figure 11). African American men represented 60% of cases reported in 2010 and are the only group to experience an increase in cases over the ten year period (2001-2010).

The case rate among Hispanic males was 2.8 times higher than white males. From 2001 to 2006 there was an increase in the cases and rates among Hispanics males but since 2006, there has been a decline in the case rate in Hispanic males. From 2002 – 2006, there were a higher number of reported cases in white males. Since then, there has been a decrease in the number of cases. From 2009-2010, there was a 20% drop in cases (from 71 to 57 cases) and white males represented only 11% of cases reported in 2010.

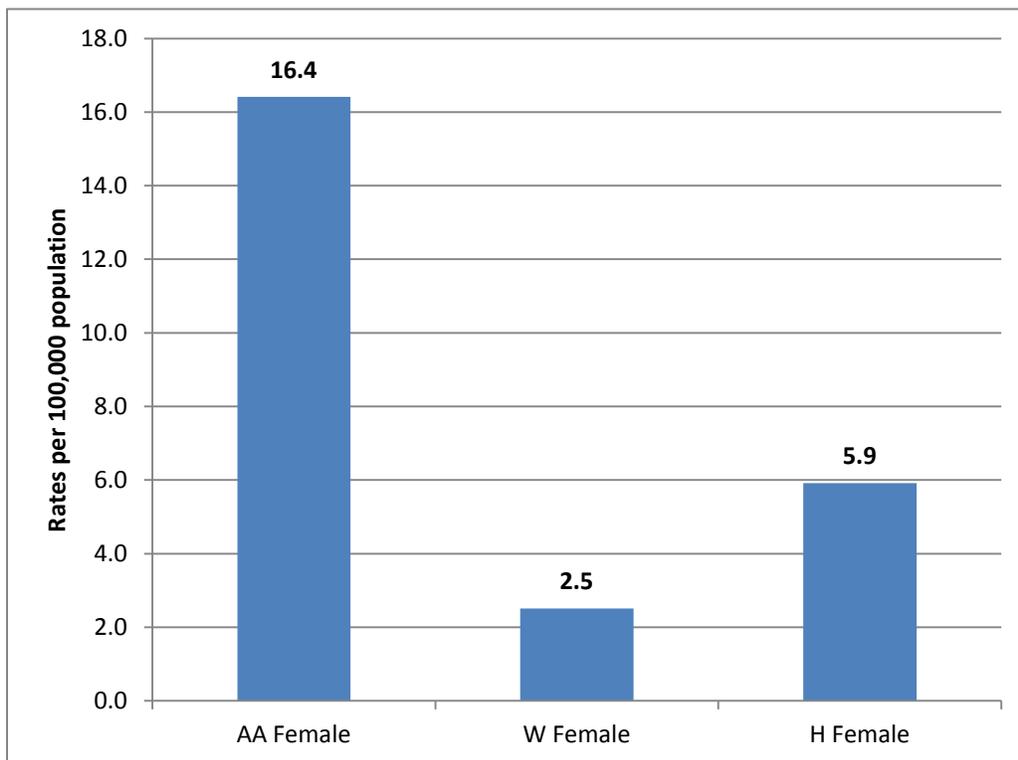
**Figure 12**  
**HIV Disease Rates Reported among**  
**Females, by Race/Ethnicity, Mississippi,**  
**2001-2010**



**Figure 13**  
**HIV Disease Cases Reported among**  
**Females, by Race/Ethnicity, Mississippi,**  
**2001-2010**

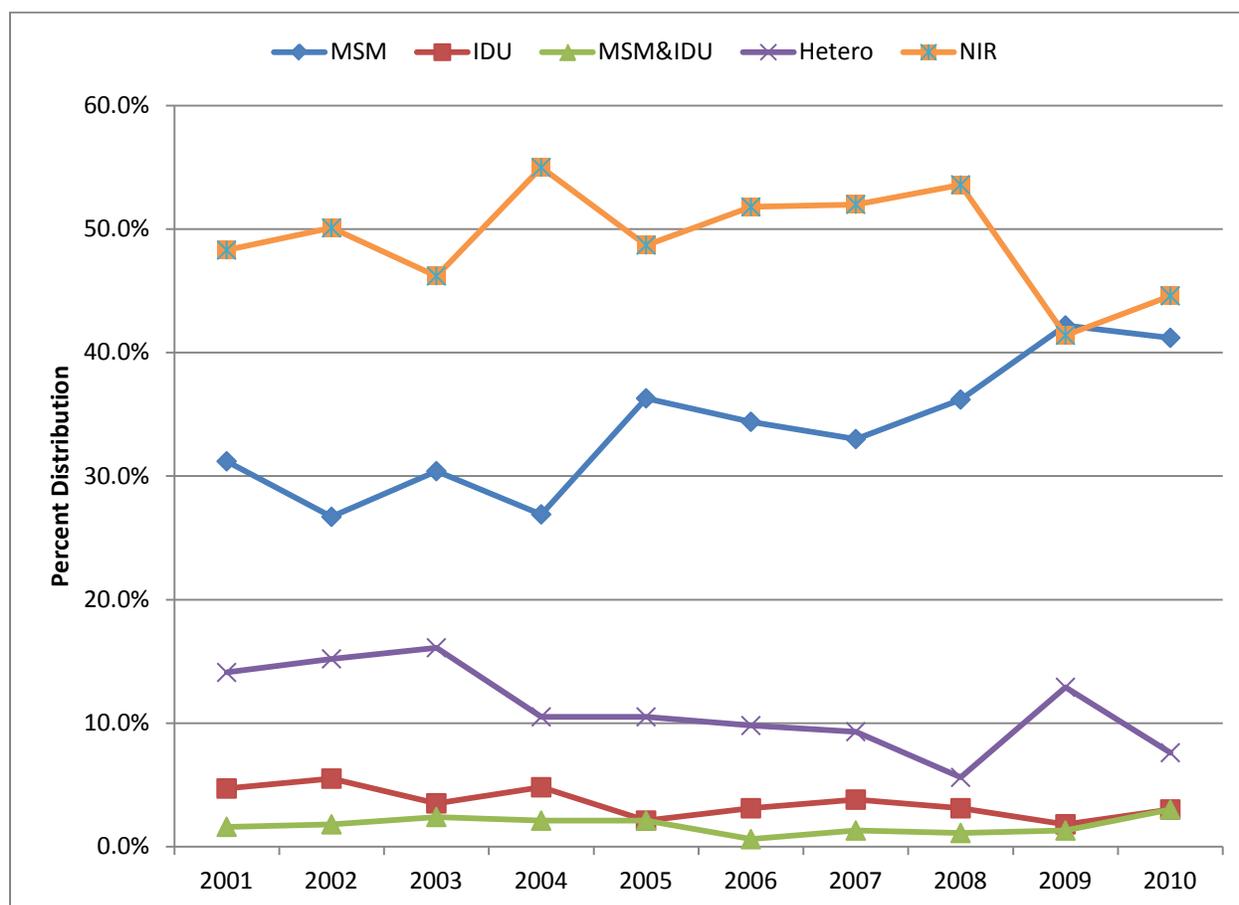


**Figure 14: HIV Disease Rates among Females by Race/Ethnicity, Mississippi, 2010**



Among females, African Americans have the highest burden of disease (Figure 14). During the past five years, cases peaked in 2007 and 2008. Since then, cases have decreased 34% (from 144 to 95 cases) (Figure 13). In 2010, African American females had rates nearly seven times higher than white females (16.4 vs. 2.5) and nearly three times higher than Hispanic females (16.4 vs. 5.9). The case rate among Hispanic females was 3.4 times higher than white females (5.9 vs. 2.5) (Figures 12 and 14). Over the past decade, rates among whites have remained stable. Cases among white females peaked in 2002 and again in 2007, but have since decreased 24% (Figure 13).

**Figure 15: Distribution of Risk Factors among Cases Reported, Mississippi, 2001-2010**

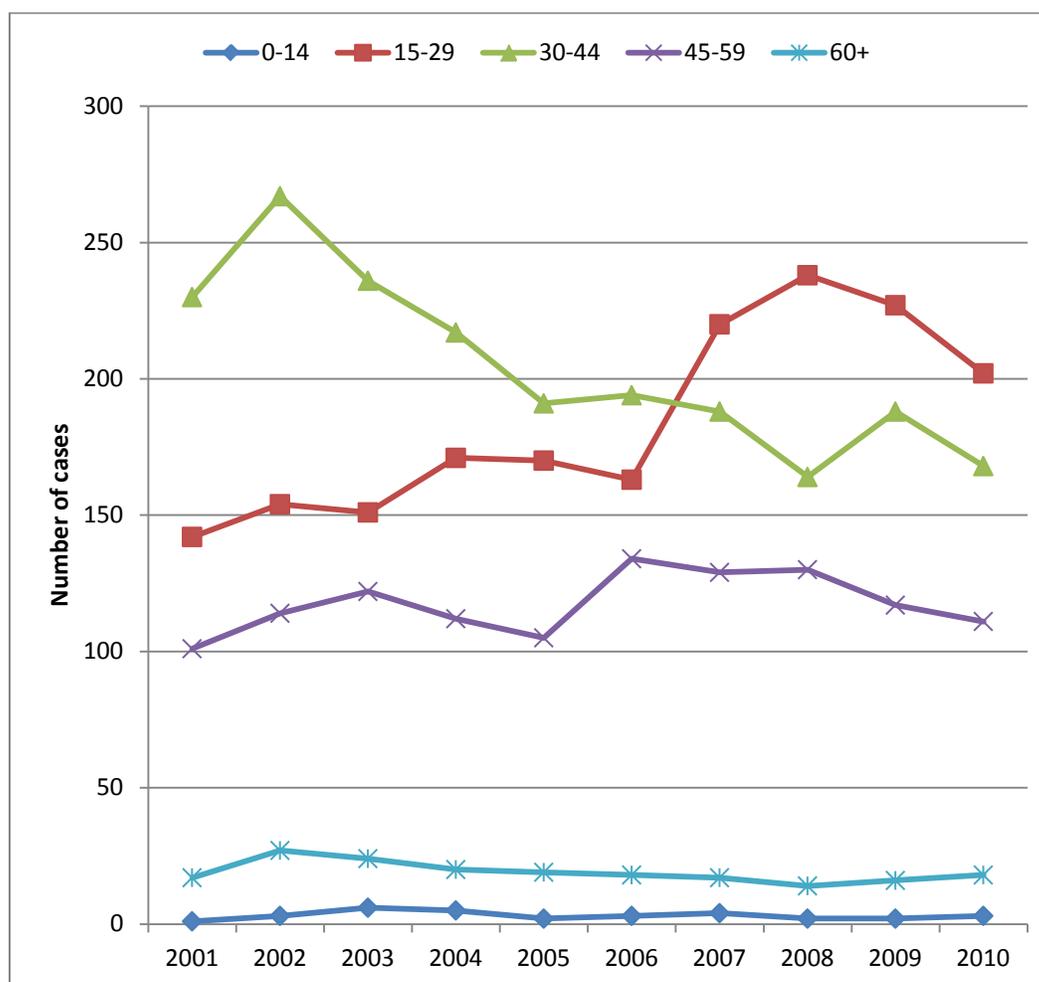


*Transmission category* is the term for the classification of cases that summarizes a person's possible HIV risk factors: the summary classification results from selecting the presumed hierarchical order of probability, the one risk factor most likely to have been responsible for transmission. For surveillance purposes, a diagnosis of HIV infection or AIDS is counted only once in the hierarchy of transmission categories. Persons with more than one reported risk factor for HIV infection are classified in the transmission category listed first in the hierarchy. The exception is men who report sexual contact with other men and injection drug use; this group belongs to a separate transmission category.

Persons whose transmission category is classified as male-to-male sexual contact (MSM) include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact). Persons whose transmission category is classified as heterosexual contact (hetero) are persons who report specific heterosexual contact with a person known to have, or to be at high risk for, HIV infection (e.g., an injection drug user). Cases in persons with no reported exposure to HIV through any of the routes listed in the hierarchy of transmission categories are classified as “no risk factor reported or identified” or (NIR).

Those with NIR continue to be the largest category reported by those infected with HIV (Figure 15). Since 2008, there has only been a dip in the proportion of cases reported that have no risk identified (from 53.6% to 44.6%). From 2001-2010, those who reported as MSM increased from 31.2% to 41.2%. MSM/IDU has increased slightly (from 1.6% to 3.0%) and both heterosexual sex and IDU categories have decreased.

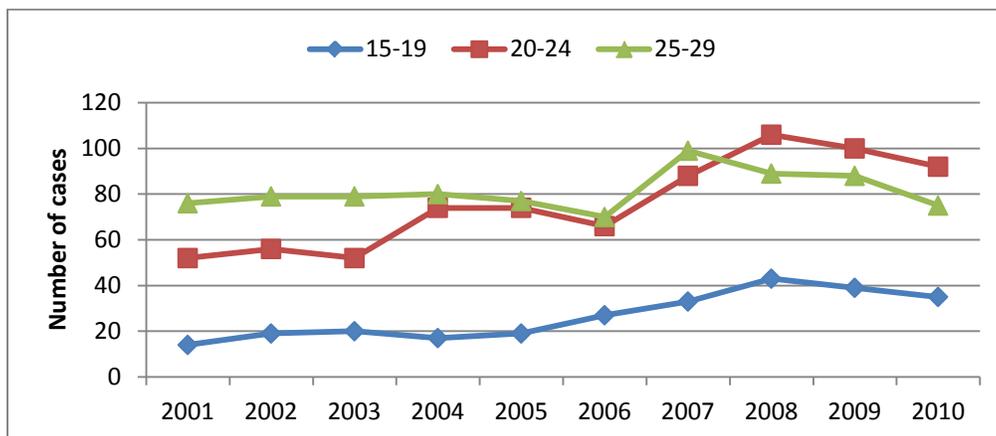
**Figure 16: HIV Disease Cases Reported by Age Group, Mississippi, 2001-2010**



Although there has been a 27% decline in reported cases among 30-44 year olds, this age group represented the highest number of reported cases from 2001-2006. Since 2006, cases among 15-

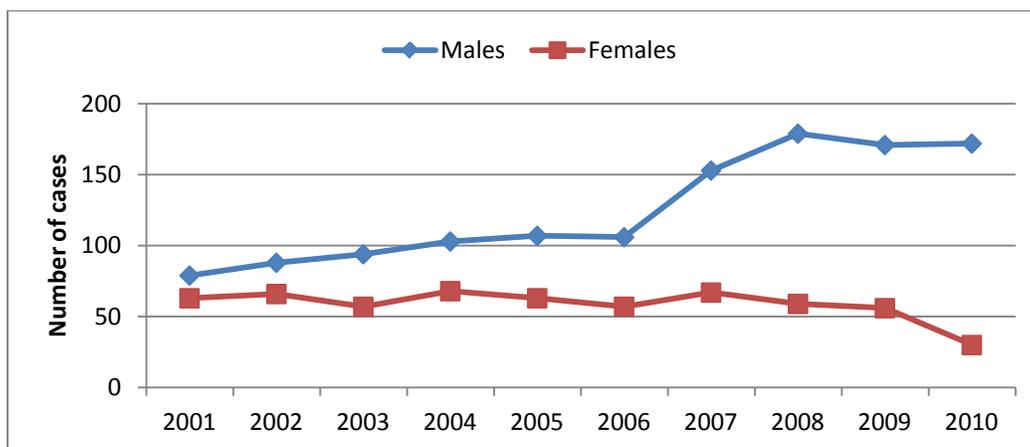
29 year olds have increased by 24%. Cases among other age groups have remained stable. In 2010, 15-29 year olds represented 40% of cases, 30-44 year olds represented 33% of cases, and 45-59 year olds represented 22% of cases (Figure 16).

**Figure 17: HIV Disease Cases Reported among 15-29 Year Olds, Mississippi, 2001-2010**



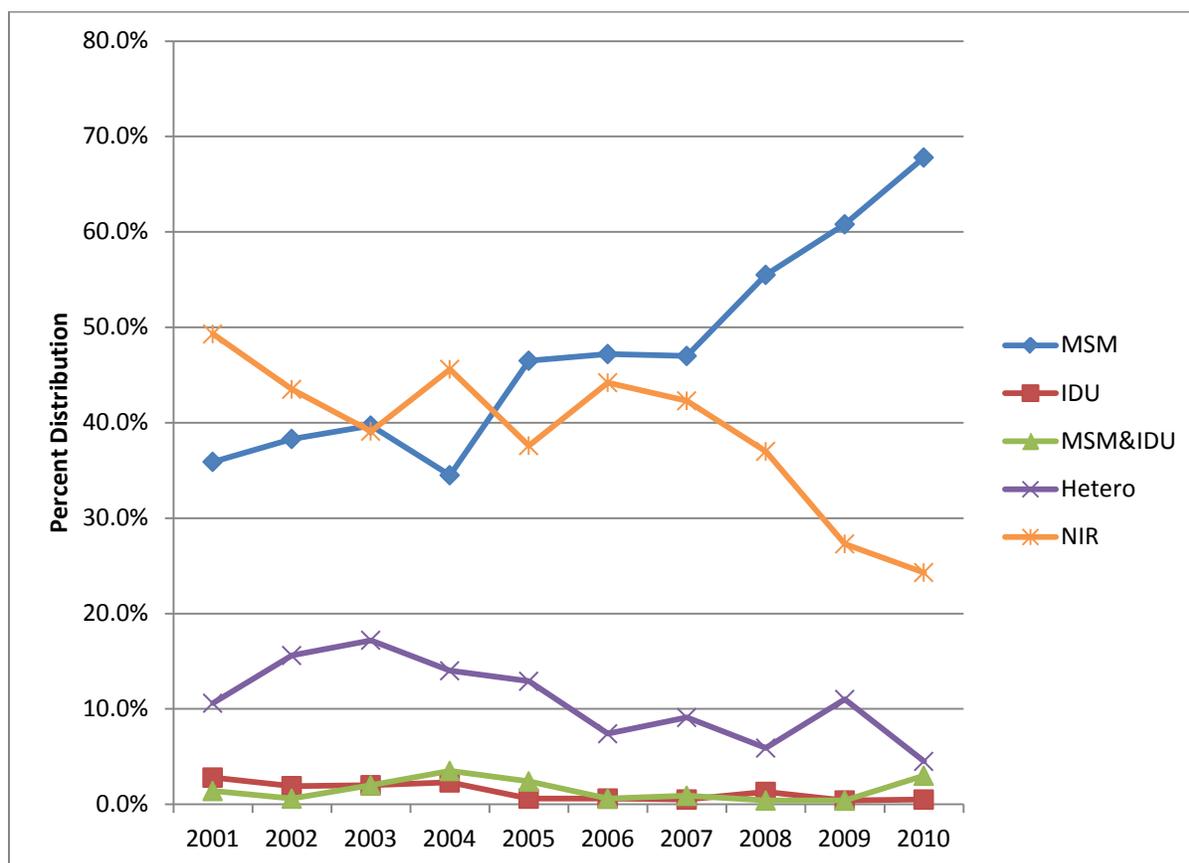
The increase in cases among 15-29 year olds is primarily occurring among 15-24 year olds. From 2001-2010, cases among 15-19 year olds have nearly tripled, and cases among 20-24 year olds nearly doubled. Despite a spike in cases from 2006 to 2007, cases among 25-29 year olds have since decreased to levels observed in 2001 (Figure 17). All age groups declined in cases in 2010.

**Figure 18: HIV Disease Cases Reported among 15-29 Year Olds by Sex, 2001-2010**



Since 2006, cases among males have increased 62% (from 106 to 172 cases) and at the same time, cases among females were nearly cut in half (47% decrease). Males represented 85% of all cases reported among 15-29 year olds in 2010 (Figure 18).

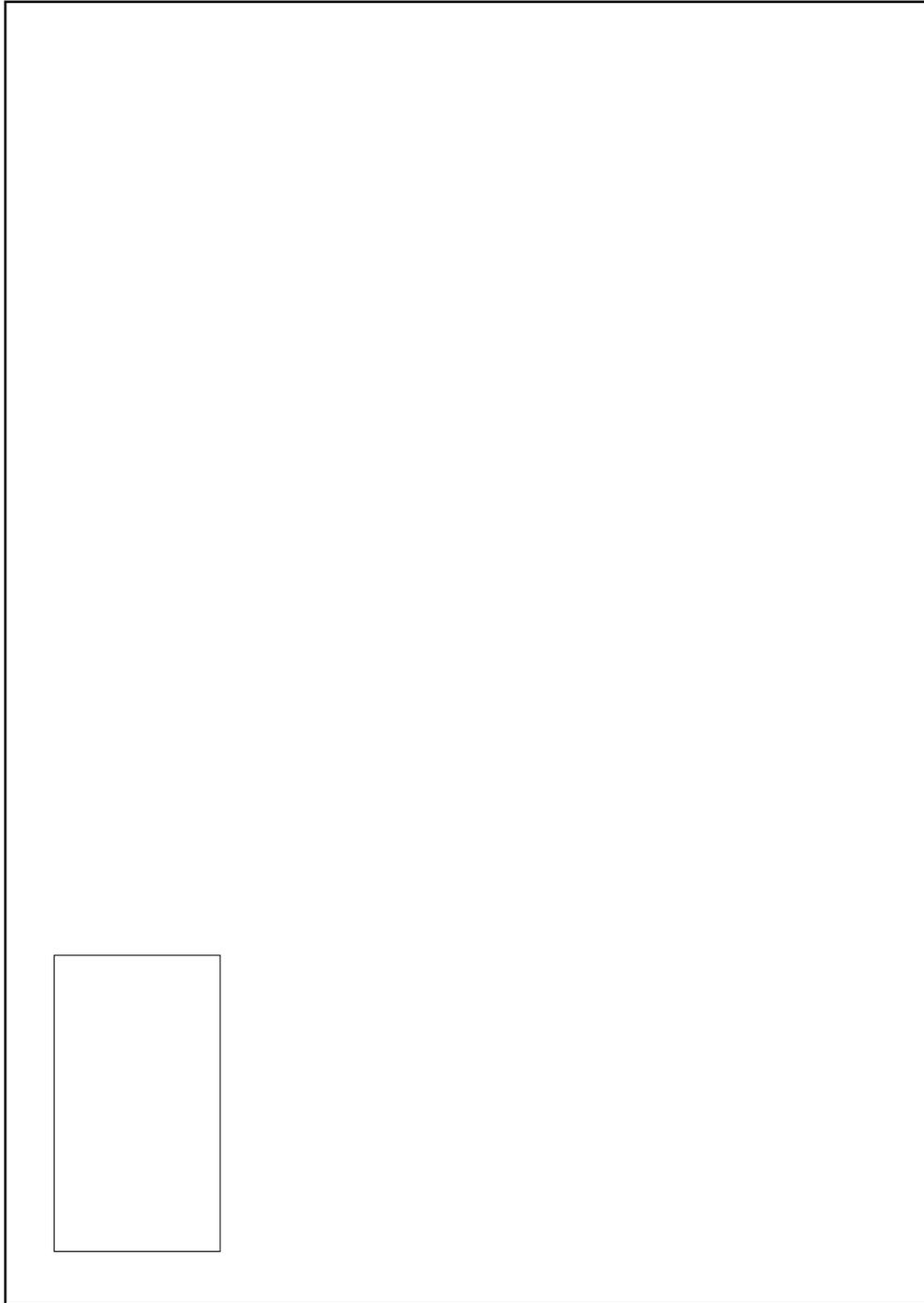
**Figure 19: Distribution of Risk Factors among 15-29 Year Olds, Mississippi, 2001-2010**



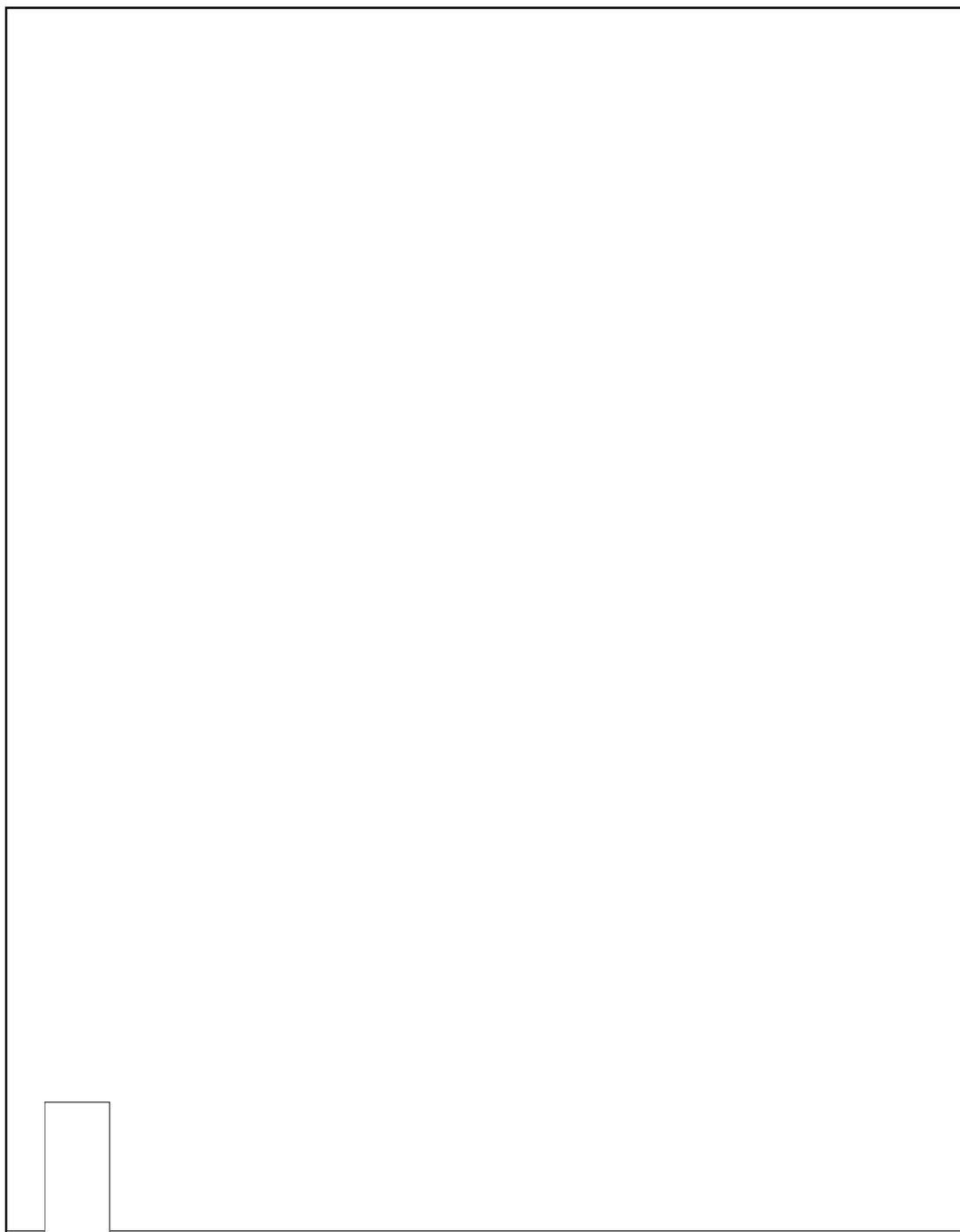
Over the past decade, the proportion of 15-29 year olds who reported MSM as a risk factor has increased from 35.9% to 67.8%. During the same period, the number of NIRs has decreased. The proportion of 15-29 year olds who reported heterosexual sex decreased from 10.6% in 2001 to 4.5% in 2010. Injection drug use (IDU) and MSM combined with IDU (MSM/IDU) have stayed below 5% during the same time period (Figure 19).

Young African American men age 15-29 years account for a disproportionate number of recent HIV infections, especially those who identify as MSM. African American men age 15-29 years account for 29% of all cases reported in 2010 and African American MSM between age 15-29 years represented 23% of all cases reported in 2010.

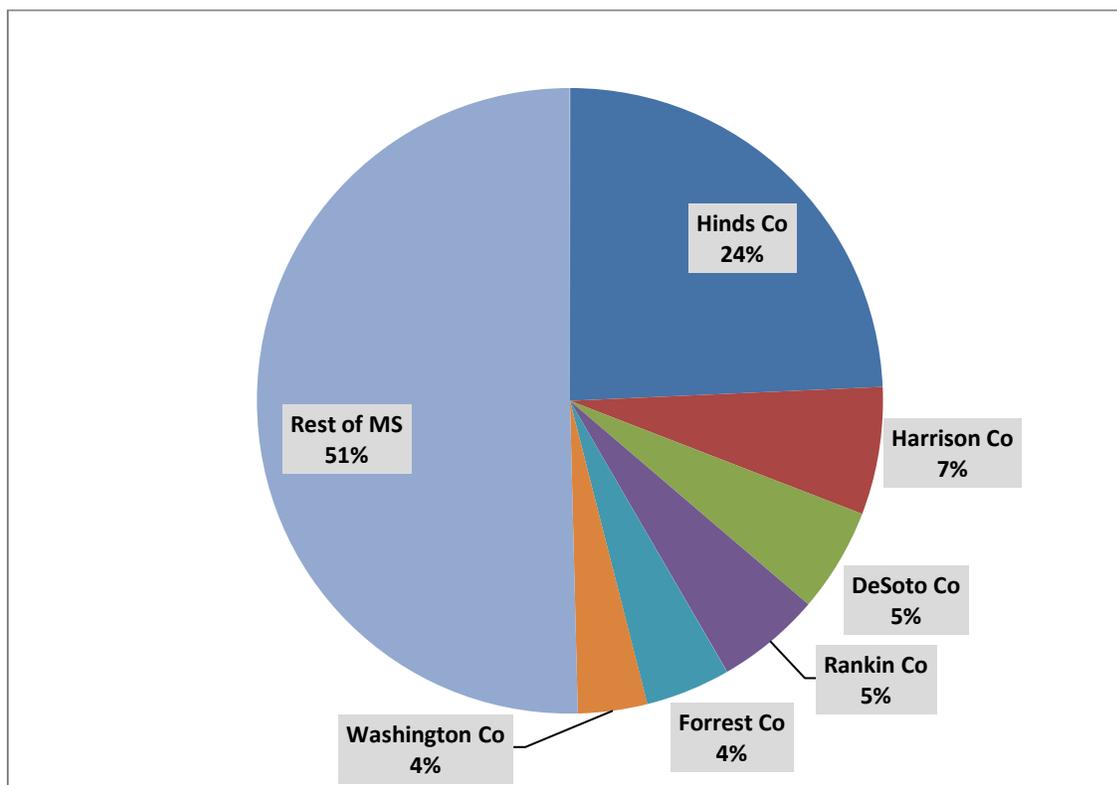
**Figure 20: HIV Disease Cases Reported by County in Mississippi, 2010**



**Figure 21: HIV Disease Cases Reported by Census Tract in Mississippi, 2010**



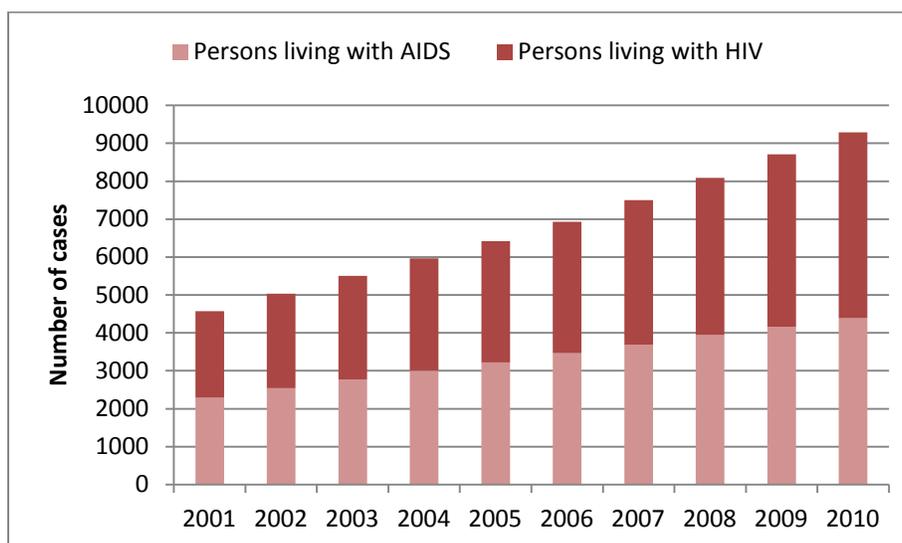
**Figure 22: Geographic Location of HIV Disease Cases Reported in 2010, Mississippi**



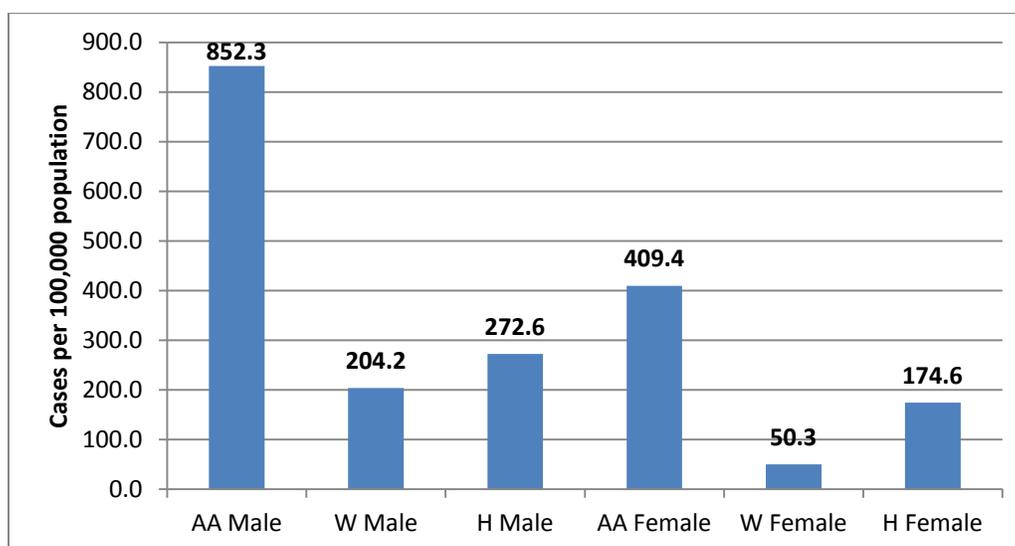
Figures 20 and 21 provide a distribution of HIV disease cases by county and census tract in 2010. In 2010, there was at least one report of HIV disease from each county in Mississippi, but nearly half of all cases occurred in six counties. These include Hinds (24%), Harrison (7%), DeSoto (5%), Rankin (5%), Forrest (4%), and Washington (4%) counties. These counties have population sizes greater than 100,000, with the exception of Washington and Forrest Counties (Figure 22).

As of December 31, 2010, there were an estimated 9,292 Mississippians living with HIV disease. These individuals have been either diagnosed in Mississippi or diagnosed elsewhere and currently reside in the state. Since 2001, there has been a gradual increase in the number of individuals living with HIV. As of 2010, the number of individuals living with HIV has doubled the number of cases reported in 2001 (from 4,570 to 9,292). Figure 23 shows that in recent years, the proportion of persons living with HIV is greater than the proportion of persons with AIDS. In 2010, 47% (4,385) of HIV-infected individuals had AIDS.

**Figure 23: Mississippians Living with HIV Disease, 2001-2010**

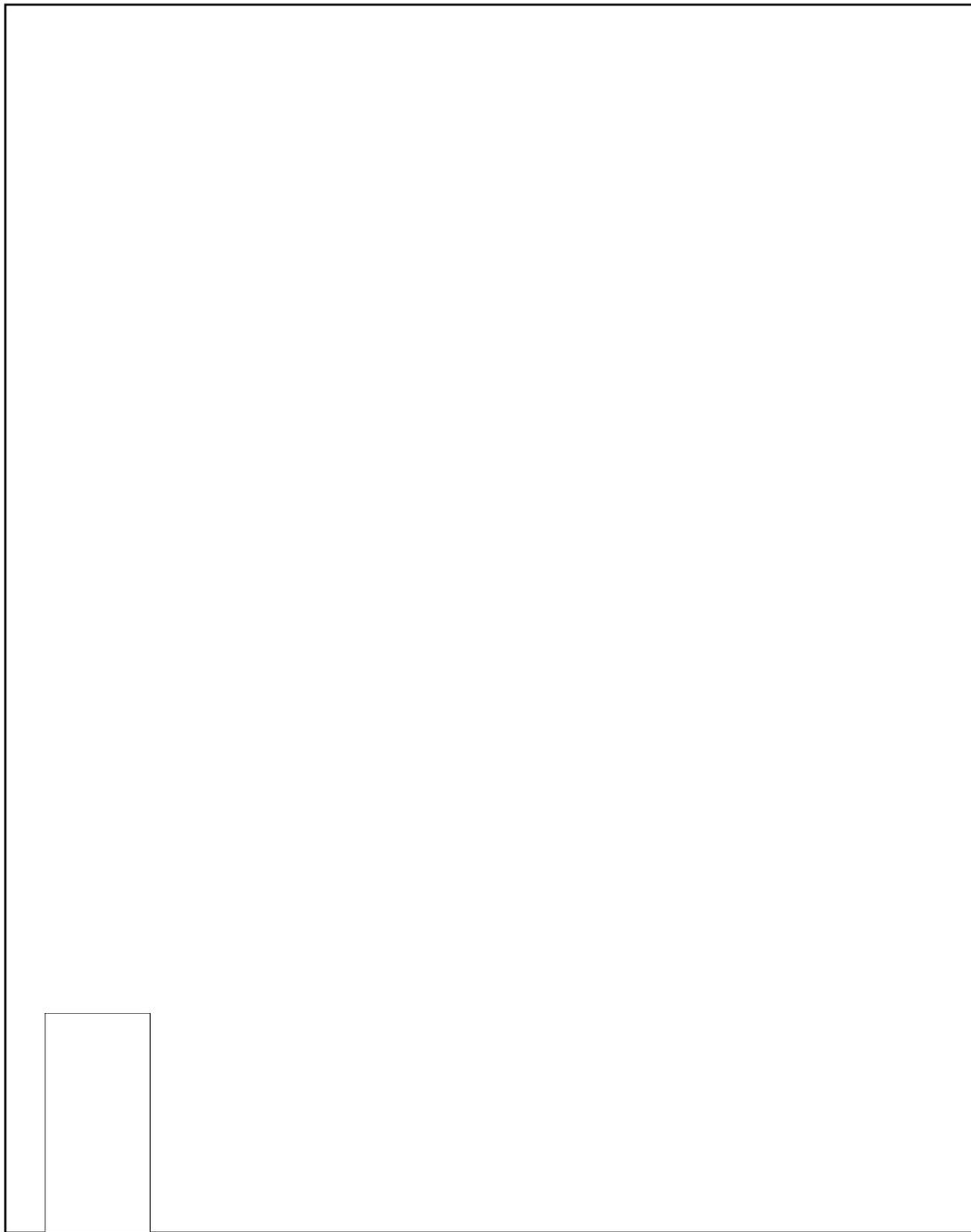


**Figure 24: Mississippians Living with HIV Disease, Rates by Gender and Race/Ethnicity, 2010**

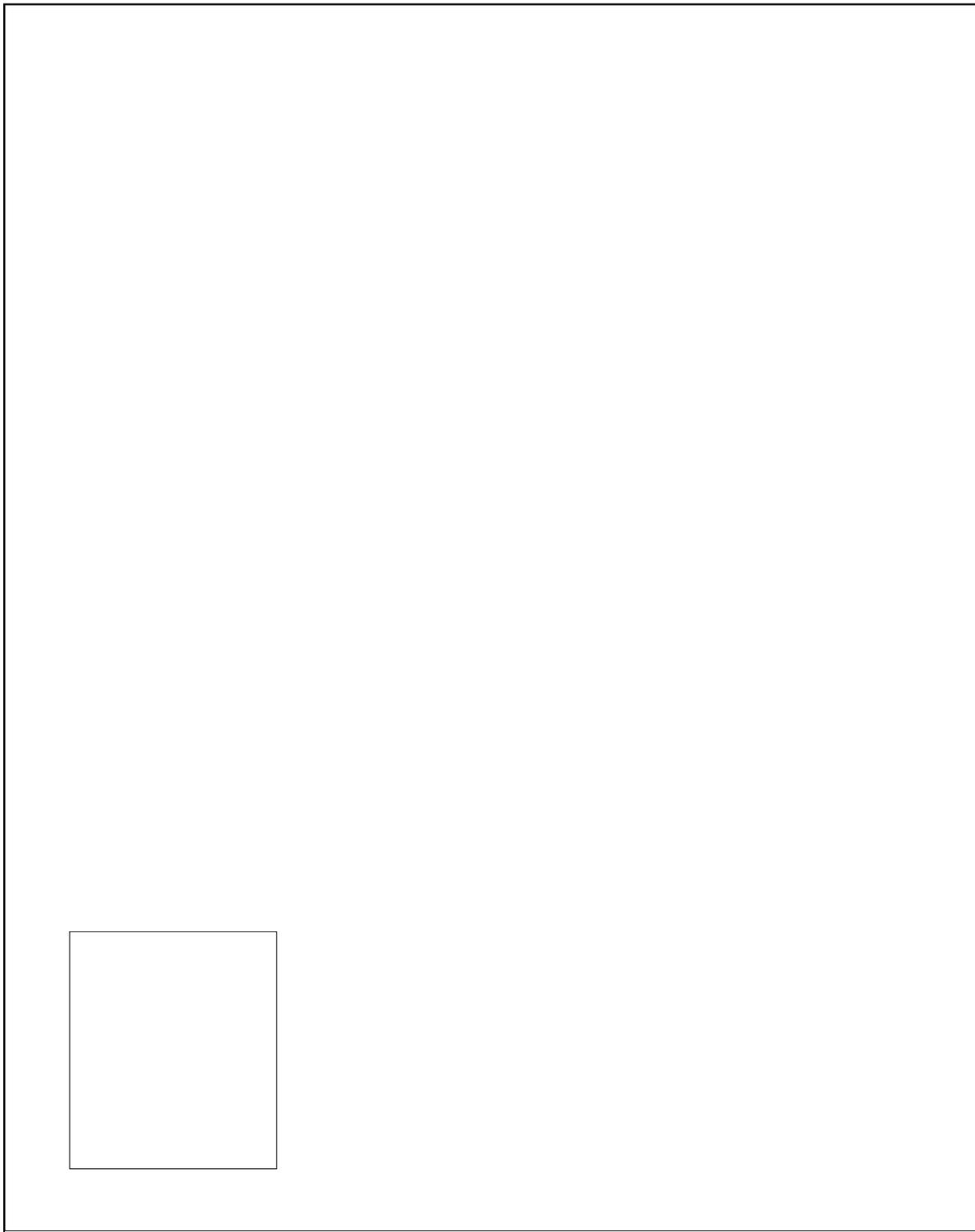


In 2010, among those living with HIV in Mississippi, African American men had the highest prevalence rates. African American men had rates 4.1 times higher than white males, and 3.1 times higher than Hispanic men (Figure 24). Among females, African Americans had the highest rates of living cases. Their rates were 8.1 times higher than white women and 2.3 times higher than Hispanic women. Figures 25 and 26 show the number of individuals living with HIV disease in 2010 by county and census tract.

**Figure 25: Mississippians Living with HIV Disease, as of 12/31/2010, by Census Tract**



**Figure 26: Mississippians Living with HIV Disease, as of 12/31/2010, by County**



**Table 2: Persons Living with HIV Disease and Cumulative Cases Reported in Mississippi through December 31, 2010**

Persons Living with HIV Disease as of 12/31/2010			Cumulative HIV Disease Diagnosis as of 12/31/2010	
	Cases	Percent	Cases	Percent
Sex				
Male	6366	68.5%	9830	71.1%
Female	2926	31.5%	3999	28.9%
Race/Ethnicity				
American Indian/Alaska Native	14	0.2%	20	0.1%
African American	6756	72.7%	10046	72.6%
Asian/Pacific Islander	19	0.2%	23	0.2%
Hispanic/Latino	189	2.0%	220	1.6%
White	2167	23.3%	3345	24.2%
Multi-race	108	1.2%	127	0.9%
Unknown	39	0.4%	47	0.3%
Age Group				
0-14	110	1.2%	135	1.0%
15-29	3406	36.7%	4472	32.3%
30-44	4124	44.4%	4576	33.1%
45+	1651	17.8%	2915	21.1%
Transmission Categ				
MSM	3267	35.2%	4862	35.2%
IDU	597	6.4%	959	6.9%
MSM/IDU	389	4.2%	557	4.0%
Hetero	1570	16.9%	2411	17.4%
Other	28	0.3%	125	0.9%
NIR	3330	35.8%	4774	34.5%
Pediatric	111	1.2%	141	1.0%
Public Health District				
I	761	8.2%	1019	7.4%
II	505	5.4%	655	4.7%

III	962	10.4%	1485	10.7%
IV	425	4.6%	670	4.8%
V	3575	38.5%	5556	40.2%
VI	559	6.0%	886	6.4%
VII	465	5.0%	670	4.8%
VIII	848	9.1%	1144	8.3%
IX	1189	12.8%	1739	12.6%
Total	9289	100.0%	13824	100.0%

### **Perinatal HIV Surveillance**

Perinatal HIV/AIDS surveillance program collects information on HIV-infected pregnant mothers, infants perinatally exposed to HIV, and HIV-infected children. Perinatal HIV incidence surveillance is intended to report new cases of perinatal exposures and HIV-infection among children. Between January 1, 2006 and December 31, 2010, an estimated 346 infants were born to women with HIV infection in Mississippi. There were 4 cases of perinatal HIV during this period. Two additional HIV pediatric cases were diagnosed in Mississippi, but were originally from outside of the United States.

Some women are unaware of their HIV status during pregnancy, which may lead to an underestimate of the number of births to HIV infected mothers. Perinatal surveillance data include only those women who have had a positive result from a confirmatory HIV test and their infants.

### **Effective Prevention of Mother to Child Transmission**

Preventing HIV infection in the interpartum period is critical. Diagnosing and treating HIV infections in women of child bearing age is one way Mississippi is preventing perinatal HIV transmission.

The Mississippi State Department of Health (MSDH) and local health departments work closely with The University of Mississippi Medical Center Pediatric Infectious Disease (UMMC Ped) Department. Mississippi has low perinatal infections due to being actively aggressive and involved in getting HIV (+) mothers in for care. Mothers who cannot make appointments are provided transportation through Ryan White funding, and are contacted by hospital staff if an appointment is missed. UMMC Ped staff also follows up with local health departments in the county where the patient resides.

### **Recommended HIV Testing Schedule for Infants Born to Mothers Infected with HIV**

HIV infection can be reasonably excluded in children <18 months if there are at least two negative HIV tests by PCR, when one test is after one month of age and another test is after four months of age. In Mississippi, most infants born to mothers with HIV infection receive care by UMMC Ped, including children born out of state. Infants seen at this clinic are tested using a more in-depth approach beyond CDC recommendations.

The recommended CDC periodicity schedule for testing infants with perinatal HIV exposure is to test at 14 to 21 days, at 1 to 2 months, and again at 4 to 6 months using virologic HIV test.

Virologic tests detect HIV antibodies in the blood. Table 3 provides the periodicity schedule for HIV testing of infants at UMMC Ped. UMMC Peds tests infants earlier and more frequently.

**Table 3: University of Mississippi Medical Center Pediatric Infectious Disease Testing Schedule**

Test Type	Age
DNA PCR	48 hours
DNA PCR	2 weeks
DNA PCR and RNA PCR	1 Month
DNA PCR	3 Months
DNA PCR and RNA PCR	6 Months
DNA PCR and RNA PCR	18 Months

### **Late Diagnosis of HIV Infection in the United States**

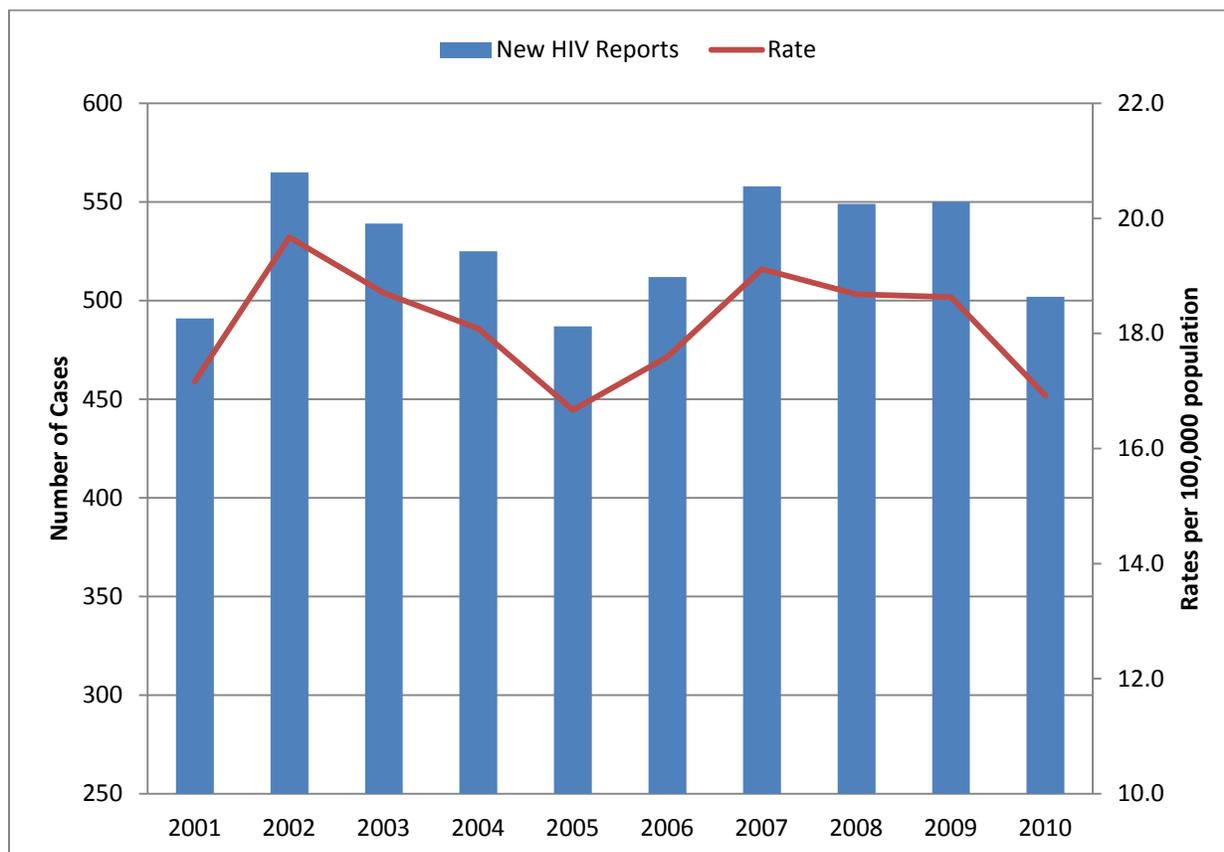
Late diagnosis of HIV infection is common. Among persons with newly diagnosed HIV in 2008, 33% developed AIDS within one year of initial HIV diagnosis. These persons likely were infected an average of 10 years before diagnosis. Persons with a late diagnosis of HIV infection are at greater risk for short-term mortality than those who receive an HIV diagnosis earlier in the course of infection. Initiation of care soon after diagnosis is recommended, yet a meta-analysis of 28 studies from multiple U.S. regions found that 28% of persons did not enter care within 4 months of HIV diagnosis. In addition, an estimated 41% of HIV-infected persons did not average at least two care visits in a year, as recommended by the U.S. Department of Health and Human Services.

### **Late Diagnosis of HIV Infection in Mississippi**

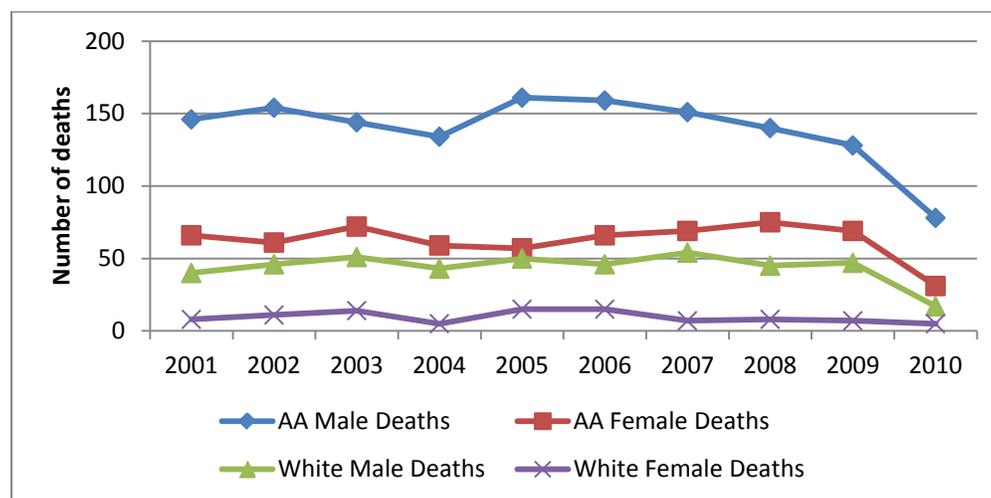
Among persons newly diagnosed with HIV in 2009, 41% developed AIDS within 1 year of initial HIV diagnosis. Among those who developed AIDS within 1 year of initial infection, 79% were males, 74% were African American, 26% were between the ages of 15-29, 34% were 30-44 years old, and 39% were over the age of 44. Thirty-seven percent (37%) were residents of Public Health District V and 15% were residents of Public Health District VIII.

### **Deaths Among Persons with HIV Disease in Mississippi**

Each year, data are collected on the number of deaths among persons living with HIV disease. Death data are obtained from vital records and national death data. While individuals may die from HIV-related illnesses, others may die from other causes, such as heart disease, motor vehicle accidents, or diabetes. Figures 27 and 28 show the number of cases of death among individuals infected with HIV from 2001 to 2010. African Americans have the highest number of deaths each year, accounting for nearly 80% of deaths annually. When considering race and sex, African American men have the highest number of deaths, followed by African American females, white males, and white females. White females reported 15 or fewer deaths each year.

**Figure 27: Deaths among Persons with HIV Disease, Mississippi, 2001-2010**

**Figure 28: Deaths among Persons with HIV Disease, by Race and Sex, Mississippi, 2001-2010**



In 2010, there were 138 deaths reported. The table below gives a breakdown of 2010 deaths. Deaths were among older individuals; 31.9% were among 40-49 year olds and 37.6% were among individuals 50 and older. There were more deaths among males (73.2%), African Americans (79%), and residents of Public Health District V (35.5%) (Table 4).

**Table 4: Deaths among Persons with HIV Disease in Mississippi, 2010**

	Number	Percent
<b>Age at time of death</b>		
20-24	2	1.4%
25-29	8	5.8%
30-34	16	11.6%
35-39	16	11.6%
40-44	25	18.1%
45-49	19	13.8%
50-54	17	12.3%
55-59	17	12.3%
60+	18	13.0%
<b>Sex</b>		
Male	101	73.2%
Female	37	26.8%
<b>Race</b>		
AA	109	79.0%
White	22	15.9%
Other	7	5.1%

	<b>Number</b>	<b>Percent</b>
<b>PH District</b>		
I	15	10.9%
II	3	2.2%
III	13	9.4%
IV	8	5.8%
V	49	35.5%
VI	5	3.6%
VII	8	5.8%
VIII	19	13.8%
IX	18	13.0%

The Mississippi Community Planning Group (MSCPG) selects prioritized populations based on epidemiological data reported from the MSDH STD/HIV Office as a requirement of the Centers for Disease Control and Prevention HIV Prevention Cooperative Agreement. The prioritized populations and geographical locations for 2011 as defined by Mississippi Community Planning Group (MSCPG) as listed in Tables 5 and 6.

**Table 5: 2011 MSCPG Prioritized Populations and Counties by Public Health District**

<b>Rank</b>	<b>2011 Prioritized Target Populations</b>	<b>2011 Prioritized Counties</b>	<b>2011 Prioritized Public Health Districts</b>
1	Persons living with HIV/AIDS (PLWHA)	Jackson Metro Area: Hinds, Madison, Rankin	V
2	African American Males (ages 13-44)	MS Gulf Coast: Harrison, Jackson	IX
3	African American MSM (ages 13-44)	MS Delta: Coahoma, Attala, Carroll, Sunflower, Washington	III
4	African American Females (ages 13-44)	Coahoma, Desoto, Tunica	I
5	Caucasian MSM (ages 25-64)	Clarke	VI
6	Hispanics	Benton	II
7	Correctional Facilities and Detention Centers	Forrest, Jones	VIII
8	Substance Users		

**Table 6: Estimate Population with HIV Infection in 2011 Prioritized Counties**

<b>2011 Prioritized Counties</b>	<b>Mississippians Living with HIV (2010)</b>
Claiborne, Hinds, Madison, and Rankin	3,185
Harrison and Jackson	1,011
Attala, Carroll, Sunflower, and Washington	585
Coahoma, Desoto, and Tunica	502
Kemper, Lauderdale, and Clarke	321
Lafayette, Lee, and Benton	277
Forrest and Jones	560

## **Section A.2. Unmet Need Estimate for 2010**

### **Unmet Need for Mississippi**

Unmet need for services by HIV-infected individuals during a 12 month period was determined using HRSA estimation modeling and data from the Mississippi Medical Monitoring Project (MMP), a CDC-funded HIV surveillance program. The MMP is used to obtain information about patients with HIV/AIDS receiving on-going medical care and the types of services they needed and received. A multi-stage sampling methodology is used to obtain a sample of 400 patients in Mississippi who received HIV care at any of the participating facilities between January 1 and April 30 of a given year. HIV-infected individuals who consent to participate complete a 30-45 minute in-person survey interview. Medical records for each subject are reviewed following the interview.

### **2009 MMP Results**

#### *Demographics*

The majority of participants were Black, non-Hispanic males (48.4%) and Black, non-Hispanic females (32.9%). White, non-Hispanics made up 15.5% of those interviewed. Thirty-four percent of those interviewed were age 45-54 years, 30.3% were 35-44 years 23.8% were 18-34 years, and 11.7% were age 55 or older. Over 43% of those interviewed received Medicaid during the previous 12 months, 29.4% received Medicare, 14% received private insurance, and 29.0% reported having no health care coverage.

#### *Substance Abuse and Antiretroviral (ARV) History*

Among the 214 participants, 21.5% had used non-injection drugs in the past 12 months, and 53.3% had used alcohol in the past 12 months. Among those who reported non-injection drug use in the past 12 months, the majority (82.6%) had used marijuana, followed by crack (30.4%), cocaine (10.9%) and ecstasy (6.5%). Among those interviewed, 83.6% were currently taking ARVs, while 9.4% had never taken ARVs. Additionally, 7.0% had taken ARVs in the past, but were not at time of interview.

### *Unmet Needs*

In 2009 and 2010, participants were asked whether or not they had received several different services during the previous 12 months (Table 7). Those who responded that they had not received the services were then asked whether or not they needed those particular services. The percentages reported are calculated by dividing the number who reported that they needed a service by the number who did not receive that service. The most highly reported unmet need was for dental services (50.9% in 2009 and 54.2% in 2010), followed by public benefits (39.0% in 2009 and 23.5% in 2010). Transportation, case management, meal/food services, and peer group support rounded out the top unmet needs. The main reason participants reported for not receiving dental, transportation, case management and meal/food services was that they didn't know where to go or whom to call. The main reason reported for participants not receiving public benefits was that they were in the process of getting the service or they were ineligible/denied.

**Table 7: Unmet Need Data Mississippi Medical Monitoring Project Data, 2009-2010**

<b>2009 Unmet Needs for Services in the Past 12 Months</b>		
<b>SERVICES</b>	<b>NEEDED BUT NOT RECEIVED</b>	
Dental Services	60 (50.9%)	
Public Benefits	39 (39.0%)	
Transportation	21 (13.0%)	
Case Management	14 (11.9%)	
Meal/Food Services	21 (11.6%)	
<b>2010 Unmet Needs for Services in the Past 12 Months</b>		
<b>Services</b>	<b>Needed but Not Received</b>	<b>Main Reason Not Received</b>
Dental Services	64 (54.2%)	Costs too much/Lack of insurance
Public Benefits	24 (23.5%)	In process of getting service; Ineligible/Denied
Meal/Food Services	19 (13.9%)	Ineligible/Denied
Transportation	21 (13.8%)	Didn't know where to go or who to call
Case Management	9 (9.6%)	In process of getting service

HIV Peer Group Support	16 (8.4%)	Didn't know where to go or who to call
Shelter/Housing Services	13 (7.7%)	In process of getting service/ Didn't know where to go or who to call

Please refer to Appendix A and Appendix B for additional information on the 2009 and 2010 MMP data.

Table 8 provides the total number of people diagnosed with HIV infection in Mississippi through 12/31/2010. The total number of people living with HIV was 8,126 and the total number of people not in care was an estimated at 5,590 or 69%. These numbers are an underestimate since CD4+ T-Lymphocyte cell counts and HIV viral loads are not reported to the health department.

**Table 8. Number and percentage of persons receiving HIV care<sup>c</sup> between 01/01/2010 through 12/31/2010**

Characteristics	No. of persons diagnosed with HIV infection through 12/31/2009 and living with HIV on 12/31/2010 (overall population) <sup>f</sup>	No. of persons who have $\geq 1$ care visit <sup>d</sup> between 01/01/2010 through 12/31/2010	No. of persons who have $\geq 2$ care visits between 01/01/2010 through 12/31/2010, at least 3 months apart <sup>e</sup>	% of persons who have $\geq 2$ care visits between 01/01/2010 through 12/31/2010, at least 3 months apart among the overall population	% of persons who have $\geq 2$ care visits between 01/01/2010 through 12/31/2010, at least 3 months apart among persons have $\geq 1$ care visit between 01/01/2010 through 12/31/2010
<b>Sex</b>					
Male	5464	1720	1062	19.44	61.74
Female	2662	816	450	16.9	55.15
<b>Age on 12/31/2009</b>					
13-24	523	214	115	21.99	53.74
25-44	4109	1303	748	18.2	57.41
45-64	3292	964	613	18.62	63.59
$\geq 65$	202	55	36	17.82	65.45
<b>Race/ethnicity</b>					
Black/African American	6008	1860	1077	17.93	57.9

Hispanic/Latino	145	51	29	20	56.86
White	1823	572	375	20.57	65.56
Other <sup>a</sup>	150	53	31	20.67	58.49

## Transmission category

Male-to-male sexual contact (MSM)	2754	968	596	21.64	61.57
Injection drug use (IDU)	496	139	85	17.14	61.15
MSM and IDU	280	74	40	14.29	54.05
Heterosexual contact <sup>b</sup>	1453	457	263	18.1	57.55
Other/unknown	3143	898	528	16.8	58.8

## MSM

Black/African American	1780	621	363	20.39	58.45
Hispanic/Latino	42	20	10	23.81	50
White	893	300	205	22.96	68.33

## Injection drug use (male)

Black/African American	194	49	33	17.01	67.35
Hispanic/Latino	6	2	1	16.67	50
White	85	19	17	20	89.47

## Injection drug use (female)

Black/African American	138	45	19	13.77	42.22
White	67	21	13	19.4	61.9

## Heterosexual contact (male)

Black/African American	392	126	82	20.92	65.08
Hispanic/Latino	12	3	3	25	100
White	37	10	6	16.22	60

## Heterosexual contact (female)

Black/African American	850	260	144	16.94	55.38
Hispanic/Latino	13	7	2	15.38	28.57
White	129	44	23	17.83	52.27

Public Health District					
1	590	256	155	26.27	60.55
2	386	212	148	38.34	69.81
3	822	255	139	16.91	54.51
4	349	139	107	30.66	76.98
5	3113	660	319	10.25	48.33
6	470	84	48	10.21	57.14
7	382	140	86	22.51	61.43
8	725	396	283	39.03	71.46
9	934	306	195	20.88	63.73
<b>Total (by sex)</b>	<b>8126</b>	<b>2536</b>	<b>1512</b>	<b>18.61</b>	<b>59.62</b>

<sup>a</sup>Multiple race, American Indian/Alaska Native, Asian, Native Hawaiian/Other Pacific Islander, and unknown race.

<sup>b</sup>Heterosexual contact with person known to have, or to be at high risk for, HIV infection.

<sup>c</sup>Persons who have at least one CD4 or viral load test are considered as receiving HIV care.

<sup>d</sup>CD4 or viral load tests that have been done in the same month are considered as one care visit, even two tests that one is CD4 test and the other one is viral load test are still considered as one care visit.

<sup>e</sup>Two care visits should be 3 months apart.

<sup>f</sup>The overall population is overestimated because cases are only followed up for 12 months after 12/31/2010. CDC suggests that every case should be followed up at least 18 months to collect death certificate information.

### **Memphis Ryan White Part A Program and Unmet Need**

The Memphis MSA, which mirrors the boundaries of the Memphis Transitional Grant Area (TGA), includes eight counties in three states: Tennessee, Mississippi and Arkansas. The city of Memphis, the urban hub of the region, is located on the Mississippi River in Shelby County, TN; it contains approximately 70% of the total TGA population (927,644). DeSoto County, located south of Shelby County in Mississippi, accounts for the second largest population just over 161,252 persons. The remaining counties range in size from 27,000 to 60,000 persons.

It is estimated that 42% of all persons living with a diagnosis of HIV or AIDS are not currently receiving primary medical care in the Memphis TGA. When excluding those PLWHA who receive services from Medicaid, it is estimated that 45% of persons living with AIDS and 62% of persons living with HIV disease are out-of-care.

The consistently high estimated unmet need rate within the Memphis TGA also was the impetus behind the development of the targeted Public Awareness Campaign first initiated through Minority AIDS Initiative funding in the summer of 2010. The Planning Council developed targeted outreach materials that have saturated areas in the TGA that are most disproportionately affected by HIV/AIDS. The associated HIV Hotline offers individuals information about available services and provides eligible individuals with a direct linkage into enrollment for Ryan White services.

The data indicates that there are some differences in the level of unmet need between those living with HIV (not AIDS) and those living with AIDS. When excluding those PLWHA who received pharmacy services from Medicaid, it is estimated that 45% of persons living with AIDS and 62% of persons living with HIV disease are out-of-care. The percentage of unmet need among PLWA decreased from 56% in 2008 to 39% in 2009, which has subsequently been followed by an increase to 45% in 2010. While this data source is also included in the 2010 unmet need framework, epidemiologic data reports recent increases in AIDS incidence. The increase in unmet need among PLWA indicates challenges with early identification of individuals unaware of their status and retention in primary care. The percent of unmet need among PLWH (not AIDS) increased from 52% in 2008 to 62% in 2009, and has remained relatively stable at 65% in 2010.

#### **Section A. 3. Early Identification of Individuals with HIV/AIDS (EIIHA)**

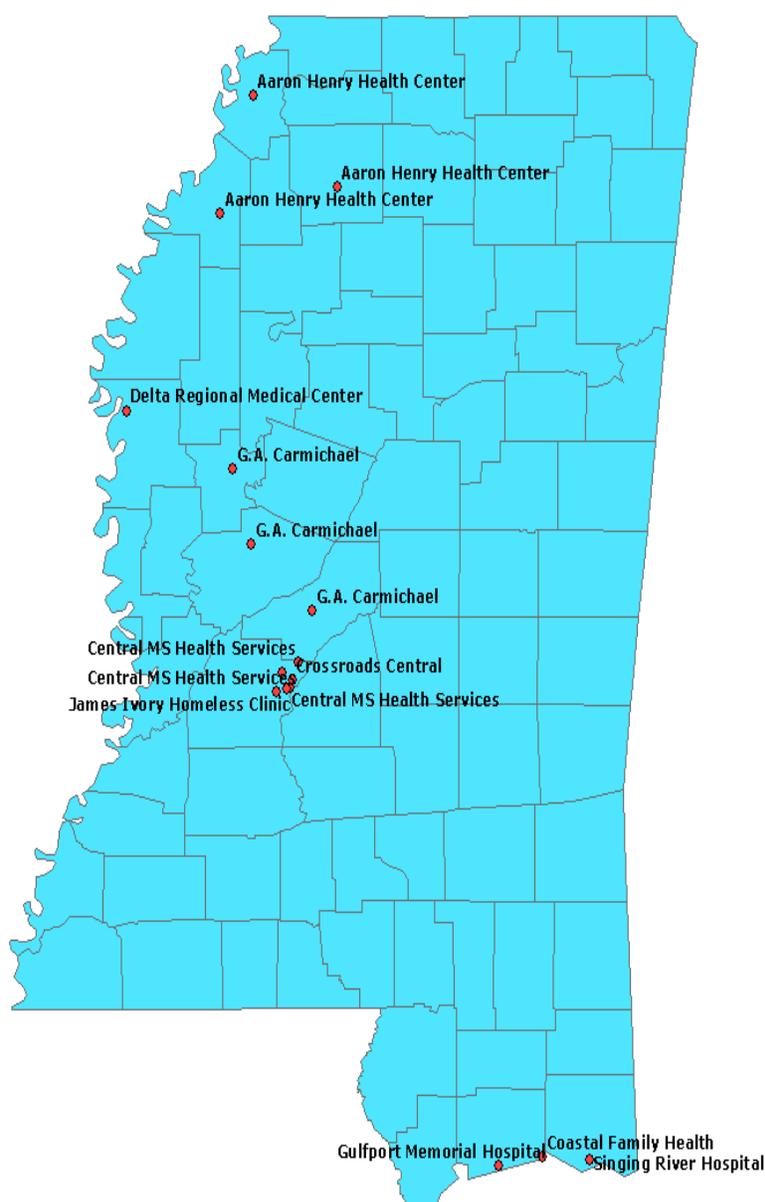
About 21% of persons infected with HIV are unaware of their status. To increase awareness of HIV infection, MSDH received CDC funding to establish the Expanding Testing Initiative (ETI). CDC provides funding to offer free HIV Rapid Testing in various clinical and nonclinical settings. As of December 31, 2011, the Expanding Testing program in Mississippi had 15 participating sites that offer rapid HIV test, free of charge to all their patients/clients (Figure 29). These sites include local emergency rooms, community health centers, mental health community centers, and homeless clinics. In the future, MSDH will branch out to correctional institutions, college health centers, and community based organizations.

In Mississippi, testing is performed at the point-of-care-site in which whole blood is collected by pricking the finger. The test usually takes 20 minutes to perform and protocols are in place to ensure confidentiality and post test counseling. Mississippi only offers confidential HIV testing,

requiring the testing center to record the person's name, social security number, risk factors, and other specified variables. If the test is negative, further testing is not needed. If the test is positive, a confirmatory test by a licensed laboratory must be performed to confirm that a person is HIV positive.

The rapid test ensures that high risk persons receive HIV testing and that newly diagnosed persons are linked to medical care and prevention services. DIS counsel newly diagnosed HIV positive persons about their status and a form is completed to document the counseling session. Disease Intervention Specialists refer HIV positive persons to case manager who will then provide additional resources.

**Figure 29: Expanded HIV Rapid Testing Sites in 2011**



## **Section B. Description of Current Continuum of Care**

Section B includes a description of the Ryan White Funded Programs and the types of services that are available for HIV-infected clients presently. These programs may receive Ryan White Parts A, B, C, D and Section F funding to serve HIV-infected Mississippians. Some Ryan White Funded Parts also shared their program-specific information regarding needs, gaps in services, and barriers, which is also included.

### **Sec. B. 1. Ryan White-Funded Continuum of Care**

#### **Ryan White Part B**

Presently, the Mississippi State Ryan White Part B Program directly operates two clinics for HIV-infected individuals. The clinics are Crossroads Clinic Central, which serves the metropolitan Jackson area, and Crossroads Clinic South which is located in the City of McComb in the southwestern part of the state. Both clinics provide HIV Early Intervention Services only. The Part B Program also supports three subgrant agreements with regional health institutions that provide primary HIV health care for men, women, and children. Two subgrant agreements support HIV clinics operated by the Division of Infectious Diseases and the Department of Pediatrics at the University of Mississippi Medical Center (UMMC) in Jackson which provide care to adults and children respectively. The third agreement is with the Delta Regional Medical Center (DRMC) in the City of Greenville in the Mississippi Delta Region. This agreement is used to operate an HIV clinic for a predominately low-income, African American community. The clinic is called Crossroads Clinics North (CCN) and medical care at CCN is provided by Dr. Satwinder Singh, who has an independent contract agreement with the Part B program. The Ryan White Memphis TGA Part A grant also provides HIV services for individuals that reside in four counties in Mississippi, which include DeSoto, Tate, Marshall, and Tunica counties.

The MSDH Crossroads Clinic Central (CCC) is located in an inner-city abandoned shopping mall that was transformed using enterprise development funds. This multi-use complex is known as the Jackson Medical Mall and other tenants include social/human service agencies, state and city government offices, university classrooms and retail shops. Ryan White Part B funding is used to provide one full-time nurse practitioner and two part-time medical physicians for Crossroads Clinic Central. Since April 2012, Ryan White Part B also funds a full-time dental clinic at Crossroads Clinic Central that provides comprehensive dental care to eligible patients.

The UMMC Adult Infectious Diseases Clinic is also located in the Jackson Medical Mall as is a branch of the Jackson-Hinds Comprehensive Health Care Center, a Federally Qualified Health Care Center that serves the metropolitan Jackson area. Adult and teenage patients are referred from the MSDH CCC to the UMMC Adult ID Clinic for HIV primary care as a component of their HIV Early Intervention Services. Pediatric patients under age 13 are referred from MSDH CCC to the UMMC Pediatrics Clinic located in Jackson.

Mississippi's AIDS Drug Assistance Program (ADAP) uses a centralized pharmacy approach in which the MSDH pharmacy in Jackson dispenses HIV medications prescribed by a health provider to the local health department clinics nearest the client for pick-up. No HIV medications

are mailed to the client's home. To be financially eligible for ADAP, an individual must have household income less than 400% of the federal poverty level, and meet certain medical requirements, which include a CD4+ T-Lymphocyte count less than 350 cells presently. People enrolled in Medicaid, Medicare, or private insurance that covers HIV medications are not eligible for ADAP. ADAP provides HIV medications for individuals in the Medicare Part D coverage gap ("donut hole") if funding is available, but does not assist with Part D cost-sharing (premiums, deductibles, and copays). ADAP also does not use funds to purchase or maintain insurance with prescription coverage for beneficiaries. ADAP is working to count an individual's true out-of-pocket (TrOOP) expenditures to assist clients to reach the other side of the coverage gap and obtain "catastrophic coverage" for HIV medications.

Mississippi Ryan White Part B also provides at least one HIV case manager for each public health district. Public Health District V presently has three HIV case managers. The HIV case managers are social workers who assist clients with non-medical case management services, such as obtaining housing assistance. This comprehensive plan seeks to enable the case managers to redefine their case management as medical to directly assist HIV-infected clients with linkage to health care services and retention in care.

### **Ryan White Part C – UMMC Adult Infectious Diseases Clinic**

The University of Mississippi Medical Center (UMMC) Adult Infectious Disease Clinic, known as the ASCC and located at the Jackson Medical Mall, is a Ryan White Part C funded program. Services contributing to the Continuum of Care for HIV-infected individuals include:

- **Medical Evaluation and Clinical Care:** With the presence of board-certified infectious disease physicians, along with nurse practitioners who have considerable experience in HIV disease, medical care is provided along the whole spectrum of disease, using guidelines from the Public Health Service and supported by frequent continuing education.
- **Other Core Medical Services:** The UMMC Dental Clinic is available next door to ASCC. However, only clients who have insurance or the ability to prepay are seen in this clinic. Payments are based on a sliding scale fee, just as with other UMMC services.
- **Referral System:** There are multiple specialty and subspecialty clinics available within the Jackson Medical Mall as part of UMMC, including cardiology, endocrine, gastroenterology, gynecology, hematology, orthopedics, ophthalmology, oncology, pain management, surgery, urology, and renal services. These referrals are made by telephone call or by written order which is sent from one clinic to another by fax.
- **Support Services:** The majority of new ASCC clients are referred from Crossroads Clinic Central located in Public Health District V, which has the largest proportion of population that undergoes HIV testing in the state. Other infected African Americans are recruited as direct referrals to ASCC from the state prison system, with the assistance of their clinic case management team. A third informal recruitment system is the shared consumer advocate position between the UMMC Ryan White Part C and D programs.

## **Ryan White Part C-- Coastal Family Health Center**

Coastal Family Health Center (CFHC) is a Federally Qualified Health Center located in Public Health District IX which serves residents of the Mississippi Gulf Coast region. Services contributing to the Continuum of Care for HIV-infected individuals include:

- **Outreach and targeted HIV testing**
  - CFHC recognizes that African-Americans make up a disproportionate share of the HIV-infected population. CFHC offers targeted testing by locating its clinics in neighborhoods that have minority populations. CFHC also works with the South Mississippi AIDS Task Force (SMATF), a local community-based organization, to help with support groups and provide HIV testing for minorities.
  - The Substance Abuse Counselor at Coastal Family Health Center works with homeless populations and coordinates with the Ryan White Part C Program to refer people for testing and services.
  - HIV testing is performed for pregnant women during their initial appointment as part of their routine prenatal lab work. Eligible female patients are also offered STD / HIV counseling and testing during their annual Pap appointments. HIV-infected pregnant women are referred to the High Risk OB clinic at the University of Alabama at Mobile or the University of Mississippi Medical Center in Jackson.
  - Case workers provide counseling services for men who have sex with men (MSM). MSM patients are counseled about secondary infection and their partners are offered testing.
- **Primary health care**
  - As of December 31, 2009, 277 cases of HIV infection were being treated at Coastal Family Health Center. This means that 730 HIV/AIDS patients in this district were being seen by private providers, the VA, traveling more than 65 miles to the Ryan White Part C Program in Hattiesburg, or are going without any care.
  - Former prisoners are referred to UMMC in Jackson for care.
  - CFHC has two Spanish speaking staff members in the Biloxi Clinic for Hispanic patients.
  - CFHC has a substance abuse counselor who accepts referrals from outside sources.

## **Ryan White Part C - SeMRHI**

Southeast Mississippi Rural Health Initiative, Inc. (SeMRHI) has served as the lead agency for Ryan White Part C Early Intervention Services (EIS) in a consortium of community health centers since funding was first received in 2000. Initially, SeMRHI and three other smaller centers were part of the consortium. One of the smaller centers has received EIS funding through a grant of its own. In addition, the other two consortium centers, Greater Meridian Health Clinic and the James Ivory Homeless Clinic of Jackson Hinds Comprehensive Health Center, are operating independently.

SeMRHI has the largest service area for the Ryan White Part C EIS program. The primary counties served by SeMRHI are Covington, Forrest, George, Greene, Jeff Davis, Jones, Lamar, Lawrence, Lincoln, Marion, Pearl River, Perry, Pike, Stone, Walthall, and Wayne counties. A significant number of HIV patients represent thirteen additional counties.

The HIV patients at SeMRHI are predominately African American (69% in 2010) with more males enrolled than females. Services provided include counseling and testing for high risk patients, diagnosis, lab work, case management, and treatment, both medical and dental, for positive patients. There is an estimated 40% of persons with HIV currently not in medical care. SeMRHI continues to increase outreach services and programs in order to reach the underserved patients in our service area.

There is no other provider of care for HIV positive patients in the sixteen county service area covered by SeMRHI's Ryan White Part C program. There is also no other provider of care available on a sliding fee scale basis in Hattiesburg or the surrounding counties. Other community health centers in the area (Family Health Center in Laurel and Coastal Family Health in Biloxi) refer HIV positive patients to SeMRHI's Hattiesburg Family Health Center for their care.

Other Ryan White Part C grantees in Mississippi include:

- Delta Region Medical Center is located in Greenville and is a partner with MSDH in Crossroads Clinic North and receives Part B funding.
- Deporres Delta Ministries is located in Marks, Mississippi.
- GLH Magnolia Medical Clinic is located in Greenwood, Mississippi.
- G.A. Carmichael Community Health Center is located in Yazoo City, Mississippi.

Ryan White Part D funded organizations in Mississippi are the UMMC Department of Pediatrics and SeMRHI.

### **Ryan White Section F - Delta Region AETC**

Delta Region AETC educates clinicians (physicians, dentists, nurse practitioners, physician assistants, nurses, pharmacists) in Louisiana, Mississippi and Arkansas about the rapidly-changing standards of care for individuals with HIV/AIDS. Delta Region AETC is part of a nationwide network providing HIV/AIDS training to health care providers.

### **Ryan White Section F – UMMC Community-based Dental Partnership**

In 2003, the University of Mississippi School of Dentistry agreed to manage a three-chair dental clinic located in Crossroads Clinic Central to provide dental care to ADAP-eligible clients at no additional cost to the patient. Over the years, the dental clinic provided services to over 200 unduplicated clients annually, with an average of 650 visits per year. The School of Dentistry also is eligible to apply for Ryan White Section F Dental Reimbursement funding. The dental clinic's location in Crossroads enabled collaboration with the medical services and both specialties shared a common waiting/reception area and clerical staff. Referrals and

communication between the medical and dental clinicians was literally as easy as a walk down the hall. The location offered patient privacy and convenient access to other services. In 2011, the School of Dentistry decided to leave Crossroads Clinic and relocate the Community-Based Dental Partnership program to a different location in the Jackson Medical Mall. The clinic now charges a fee for service for all clients. Crossroads Clinic Central decided to re-establish a Dental Clinic in 2012 using Part B funds.

### **State Medicaid Program**

Adult Medicaid beneficiaries receive 12 office visits, 6 emergency room visits, 30 days of inpatient hospital care, 25 home health visits, and a physical exam annually, while children may receive more various services with a physician plan of care. For prescription drugs, beneficiaries are limited to five prescriptions a month, including two branded prescriptions. Many individuals with HIV require considerably more medications every month, forcing them to make difficult choices about what to buy each month. Children may have more than five prescriptions with a physician plan of care.

Many key Medicaid services are limited. Dental services, an access challenge for many HIV-positive individuals, are limited to trauma care and emergency treatment, essentially, tooth extraction. Medical and surgical dental services are subject to the same restrictions. Medicaid does not cover physical or occupational therapy, psychologist services, dentures, speech therapy, prosthetic or orthotic devices, or hearing aids.

### **C. Description of Needs**

The following needs statements comprise the 2012 Statewide Coordinated Statement of Need. These were identified using several methods: 1) needs assessment completed by the Ryan White Part B Program in April 2012; 2) evaluation of data from the CDC Medical Monitoring Project; and 3) review of the needs assessments performed by other Ryan White funded programs in Mississippi. A detailed description of the methods used to conduct the 2012 needs assessment and a more detailed description of key findings is provided in section C.2.

#### **C1. 2012 Statewide Coordinated Statement of Need**

##### **Improve Access to Dental Care**

There are a limited number of dentists and dental care clinics that provide services to HIV-infected individuals. Many HIV-positive individuals have limited access to comprehensive oral and dental care. Our proposed goal is to increase the number of eligible PLWHA who receive dental care through targeted case management.

##### **Increase Availability of Medical Providers**

A limited number of doctors are available in rural communities.

**Provide Nutrition Services**

The availability of nutritionists and dieticians are lacking to address nutrition related issues and provide education on proper nutrition while HIV positive patients are on their medications. Increasing the number of people who receive dietary counseling is one goal to solve this issue.

**Improve Medical and Non-Medical Case Management**

Many HIV-infected individuals do not have a medical case manager and/or do not know their case-manager's name and contact information. Lack of and limited availability/access to non-medical case management that address conflicts related to housing, transportation, and other non-medical related services and resources is an issue.

**Increase Availability of Support Groups**

Only a handful of peer-driven support groups are available and there are limited funds to keep the support groups open to the HIV-positive individuals needing their services.

**Increase Availability of Housing Services**

Limited access and/or availability of reliable long-term housing is a common problem for many HIV-positive individuals who are aware of their status.

**Improve Health Insurance Coverage**

Health insurance companies deny policies to HIV-infected individuals as they learn about the applicant's HIV status.

**Increase Physician Training**

Primary care physicians lack knowledge regarding effective HIV treatment and care. There is a shortage of infectious disease physicians available to care for the number of HIV positive patients in Mississippi.

**Reduce Multiple Visits**

Multiple primary physician visits is an issue for HIV positive patients. People living with HIV/AIDS oftentimes visit more than one doctor to address their needs.

**Improve Access to Federally Funded Programs**

Federally funded programs such as Ryan White and Medicaid are very limited to certain communities and many HIV positive Mississippians are not qualified to receive the benefit due to the strict criteria.

**Strengthen Confidentiality**

Confidentiality is a major personal barrier to receiving appropriate care and treatment services.

### **Reduce Stigma**

Many individuals who are aware and unaware of their status become reluctant to receive and seek care due to stigma issues associated with HIV infection.

### **Increase Access to Mental Health Services**

Newly diagnosed patients oftentimes experience depression and have no reliable access to mental health services. People unaware of their HIV positive status may also be unaware the HIV-related services available.

### **Reduce Language Barriers**

Language barriers frequently prevent special populations who are unaware of their status from seeking and receiving adequate care.

### **Provide Transportation Services**

Limited transportation services (especially for long distance medical related visits) are an issue.

### **Improve HIV Awareness through Education**

Rural residents are unaware of their risks for contracting HIV. Knowledge on transmission, risks, and consequences is low among youth and rural communities.

### **Increase Case Management for Former Prisoners**

Locating former prisoners (including youth in detention centers) who may be HIV positive but unaware of their status becomes difficult after they are released from prison.

### **Provide Legal Services**

Existing problems are associated with limited access to legal services to assist PLWH to address discrimination.

### **Improve Delivery of HIV Medications**

HIV positive individuals face the burden of limited supply of medications and as a result, PLWH must travel on a frequent basis to receive their medications.

## **C.2. Detailed Needs Assessment Methods and Findings**

The following sections provide the detailed needs assessment methods and findings that contributed to the 2012 Statewide Coordinated Statement of Need. This includes the MSDH needs assessment methods and information shared by each Ryan White Part Grantee regarding their specific needs assessment and/or the description of what services are offered at their program. Methods used consisted of focus group discussions and self-administered surveys.

### ***2012 Ryan White Part B Needs Assessment***

## **Focus Groups**

The focus groups were conducted at the First Annual Mississippi Statewide AIDS Conference in Jackson on February 29 to March 1, 2012. Individuals attending the conference were asked to participate in focus groups. Those who agreed to participate in the focus group discussions were given an informed consent form and were asked to sign the form. Focus group participants were informed that the discussions would be tape-recorded in order to capture all ideas and concerns presented by everyone. A total of five key questions were asked with additional probing questions used whenever necessary to clarify or to capture additional information. A total of eight focus group sessions were completed with six to ten participants in each session.

Tape-recordings were verbatim transcribed for qualitative analysis. Qualitative data were analyzed and important categories and themes were recorded. To further validate the findings, the facilitator and moderator both read the transcripts and then collaborate together to compare the categories and emerging themes. Important quotes were abstracted to provide evidence for the emerging categories and themes included in this report. (Please refer to *Appendix C* to review the focus group consent form, rules, and questions)

## **Self-Administered Survey**

Self-assessment surveys were also distributed at the Statewide AIDS Conference. Community-based organizations also received surveys to distribute through their organizations and HIV case managers were asked to distribute the survey to clients. Surveys were collected between March 1 and March 31, 2012. A total of 351 surveys were returned to MSDH for analysis. The needs assessment survey included 14 questions addressing the following topics: demographics, frequency of receiving care, and access to care. Participants were also asked to rank the top five needed core services and supporting services. (Please refer to *Appendix D* to review the self administered survey.)

## **Demographics**

More males (53%) participated than females (46%). One percent of participants did not disclose their gender. Seventy-two percent of those participating were African American and 25% were white. One percent was Asian/Pacific Islander, Native American, or Other. Less than 1% indicated they were multi-racial. The majority of survey participants were age 40-49 years (31%), followed by age 30-39 years (25%) and age 20-29 years (23%).

A majority of participants (67%) were persons living with HIV. Thirteen percent were described as an HIV Service Provider and 19% were described as "Other". The "Other" category included individuals who identified as community advocates, family and/or friends of individuals who are living with HIV, and observers. Only 1% of participants self-identified as more than one participant type, such as an HIV Service Provider who is living with HIV.

## **Key Findings from Self-Administered Survey**

A majority of participants described the top five needed services as primary care physician services, prescription drug assistance services, laboratory test services, dental and oral health services, and medical case management services. Needed support services included non-medical case management.

Thirty-nine percent of HIV-positive individuals who participated in this survey indicate that it has been more than a year since they have been in dental care and 22% of individuals noted they received no dental care at all. Only 8% of HIV-positive individuals received any dental care within the prior three months. Survey write-in comments included:

- Holistic/comprehensive medical care that would address medical issues other than HIV-related.
- Increase access to dental/oral health care services and avoid delay in setting up medical appointments
- Re-structure qualification criteria for federally funded programs such as Medicaid, Medicare and Ryan White to include more populations
- Increase access to physicians, especially infectious disease physicians
- Increase access to transportation to medical care
- Education and training for medical professionals regarding HIV disease, proper disease management, and treatment
- Establish effective collaborations and communications between physicians to provide quality care
- Modify delivery system for HIV medications and increase supply amount
- Establish effective collaborations and effective communications between community organizations to utilize and share available resources
- Increase access to health insurance and life insurance
- Education and awareness among youth regarding HIV and its consequences
- Peer-driven support groups
- Effective strategies to reduce stigma
- Reach out to rural communities and educate on HIV risks
- Educate community members regarding risks, resources and services
- Assurance for confidentiality to promote comfortable environment for clients
- Community outreach programs
- Maximize funding
- Increase opportunities for medical and non-medical case-management services and promote effective relationships between clients and healthcare professionals
- Alcohol and drug assistance program
- Encourage people to get tested for HIV
- Better access to federally funded programs such as Medicaid and Ryan White Programs
- Provide more access to mental health services, especially personalized psychological evaluations for newly diagnosed individuals
- Provide access to nutritionist and dieticians and deliver educational trainings regarding proper food and nutrition
- Create job opportunities
- Increase access to reliable emergency and long-term housing

## Findings from Focus Group Discussions

### Resources or Services that HIV-Infected Individuals Need:

- Comprehensive Dental/Oral Health Care Services
  - Limited dental/oral care assistance through federally funded programs
  - Consequences of delayed dental/oral health issues
- Full Access to Federally Funded Programs
  - Rigorous criteria to qualify for Medicaid and Ryan White programs
  - Transportation to Medical Care
  - Lack of/limited transportation services and its impact on adherence to medical care
- Mental Health Services
  - Counseling for depression
  - Depression medications are costly
- Shortage of physicians
  - Inconsistent doctors in the community and its impact on adults and children
  - Not enough doctors
  - Delayed medical appointments
  - Infectious disease physicians
- Programs for HIV Medications
  - High cost of HIV medications
  - Delivery system for HIV medications – limited supply requires multiple trips
- Stigma Reduction
  - Fear of being recognized
  - Respect from the community
- Education and Awareness Services
  - Becoming aware of available resources
- Affordable Health Insurance
  - Improve working relationship with insurance agency representatives in making medication for HIV positive individuals more affordable
- Cultural Awareness
  - Respect from healthcare professionals
- Holistic Medical Approach
  - Inconvenience in visiting multiple medical professionals for multiple medical issues

- Meet the basic needs such as housing, food, transportation, and mental health services
- Nutrition Services
  - Education and training regarding proper food and nutrition
- Reliable Housing Assistance
  - Emergency housing
  - Long-term housing
- Education and Training for Medical Professionals

Resources or services that HIV-infected individuals are unable to access easily:

- Life Insurance
- Job Opportunities
- Housing
- Transportation
- Dental/oral health services
- Infectious disease physicians

Factors that serve as barriers to access resources or services needed by HIV-infected individuals:

- Perceived Lack of Confidentiality
- Lack of Transportation
- Limited/Lack of Housing Assistance
- Limited Funds
- Unaware of Available Resources
- Case-Managers/Social Worker
  - Limited access to non-medical and medical case management
  - Ineffective relationship between case managers and clients
- Dental/Oral Health Care Services
  - Limited access to oral/dental care and lack of referral services
  - Longer waiting period for dental service appointments

Services that HIV-infected individual is unaware of or do not understand the need for:

- Psychological Evaluation
  - Assistance with depression and other mental health issues
  - Challenges faced by newly diagnosed
- Effective Communication Between Physicians
- Legal services

Recommendations to help HIV-infected individuals understand the need for HIV-related services or resources:

- Increase Public Awareness thru
  - Social Media
  - Television
  - Public Library
  
- Improve Education
  - For both adults and children
  - Use simple language in educational materials and make it specific!
- Provide Peer-Driven Support Groups
- Reach out to Rural Communities
- Assurance for Confidentiality
- Increase Community Outreach
  - Reach out to schools
  - Reach out to community groups
- Expand Case Management
  - Enhance medical case-management
  - Shift non-medical case management to non-health sector (e.g., Community Based Organizations)

Suggestions to make it easier for people to obtain services and stay in health care:

- Maximize / distribute funding
- Effective collaborations among community organizations
- Support groups
- Alcohol and Drug Abuse Counseling
- Stigma reduction strategies/education to reduce stigma
- Getting tested for HIV
- Confidentiality
- Education and awareness
- Conferences and educational sessions
- Consequences of HIV medications
- Family support
- Support from other HIV-positive individuals
- Community collaborations

**Demographics and Location of PLWHA Not In Care in Memphis TGA  
(Ryan White Part A)**

Eighty percent of the total persons not receiving primary medical care are non-Hispanic Blacks, followed by 17% of White, not Hispanic persons and 2% of Hispanic persons. The majority (68%) of persons identified out-of-care are male, but this is significantly lower than the

percentage identified in 2009 (84%). Persons aged 35-44 account for 30% of persons not receiving primary medical care, while persons aged 45-54 represent an additional 30%. The reported transmission risk categories for those not in-care were male-to-male sexual activity (40%), heterosexual activity (29%), injection drug use (5%) and male-to-male sexual activity and injection drug use (2%).

The 2009 Comprehensive Needs Assessment identified differences in service needs and service gaps among three categories of PLWHA consumer groups. The three groups surveyed were consumers in care (N=160), consumers who had been in care in the previous five years but had at least a 12-month period of interrupted care (N=81), and consumers who are not and have not been in care (N=56). These three groups were surveyed separately so differences in need can be taken into consideration when determining how services are accessed. Table 10 summarizes the survey results below:

Service Category	% in Care		% Interrupted Care		% Out of Care	
	Need	Need, not Received	Need	Need, not Received	Need	Need, not Received
HIV Doctor	91	1	96	27	N/A	N/A
Dental/Oral Care	93	42	91	58	92	46
Prescription Drug Assistance	88	8	93	36	77	26
Health Insurance Assistance	79	19	88	48	78	19
Medical Case Management	68	8	79	49	61	25
Mental Health Services	43	12	68	43	55	22
Nutrition Therapy	37	16	60	42	57	42
Substance Abuse Treatment-OP	9	3	56	43	36	24
Substance Abuse Treatment-IP	8	2	56	44	34	21
Transportation to Medical Care	51	17	73	45	69	36
Food Pantry	78	12	91	41	82	26
Utility Assistance	63	37	79	59	54	27
Emergency Housing	43	30	77	59	39	35
Support Group	55	20	77	50	70	42
Non-Medical Case Management	46	9	74	50	59	31
Home Health Care	15	6	47	35	38	18
Respite Care	14	9	52	40	60	20
Hospice Services	12	6	44	34	33	15
Treatment Adherence	22	7	50	39	38	22

*Source: 2009 Memphis TGA Ryan White Needs Assessment, Consumer Self-Administered Surveys*

### **Major categories found:**

***Dental/Oral Health Care Services:*** More than 90% of individuals surveyed expressed the need for this service, with almost half reporting they do not receive it.

***Prescription Drug Assistance:*** Over 70% of respondents reported needing this service, while 26% of out-of-care consumers reported not receiving prescription drug assistance.

***Medical Case Management:*** PLWHA who are out of care and those with interrupted care are more likely to report needing but not receiving medical case management; difficulties with system navigation and documentation requirements for Part A and ADAP eligibility often become barriers to accessing medical case management services.

***Mental Health Services:*** Untreated mental health problems were identified as a barrier to care, and approximately 50% of consumers reported needing services related to mental health. Those consumers with interrupted care were more likely to report needing, and needing but not receiving, mental health services.

***Substance Abuse Treatment:*** Untreated substance abuse was identified as barrier to care, and approximately 50% of consumers reported needing services related to substance abuse treatment.

***Food Pantry:*** A high service gap rate for PLWHA with interrupted care was reported (41%), but this is much lower among people in-care (12%).

***Utility Assistance:*** Funding allocation for utility assistance during FY 2011 was insufficient to meet need, so allocation of additional funding was approved by the Planning Council. Despite allocations, 37% of people in-care reported needing but not receiving this service.

***Transportation to Medical Care:*** Over half of persons in care reported needing transportation services to medical care, and a higher percentage of need was reported in clients with interrupted care (73%) and those out of care (63%). Among those with interrupted care, 45% reported they did not receive the service. In response to these findings and as part of the 2009 Comprehensive Plan goals and objectives, the Planning Council coordinated a needs assessment in 2010 to identify specific services needs related to transportation. The assessment indicated that additional transportation services are needed, particularly in rural areas. Transportation services provided through Medicaid programs are not always reliable, and consumers expressed concerns about confidentiality.

***Emergency Housing Services:*** Almost 60% of clients with interrupted care reported needing but not receiving emergency housing services, while 30% in-care reported needing but not receiving this service.

### **Prevalence of Homelessness**

Stable housing is essential for successful treatment of HIV/AIDS. The high prevalence of homelessness and persons experiencing unstable housing conditions significantly increases the cost and complexity of HIV care in the TGA. In 2009, 6,217 people received services from homeless service providers in Memphis and Shelby County; this accounts for approximately

0.7% of the total Memphis TGA population. According to the Memphis Partners for the Homeless 2010-2011 Homeless Needs Assessment, approximately 8% (605) of homeless adults are HIV-infected. Additionally, the 2010 RDRs identify that 9% of clients lack permanent housing.

The out-of-care consumer survey conducted in 2009 by Ryan White funded Early Intervention Service (EIS) providers found that approximately 60% of respondents were living with friends or family, while 5.4% lived in a shelter. These figures are somewhat lower than those who identified housing as a need in the 2009 Needs Assessment; 30% of in-care consumers reported they needed but did not receive housing services, 59% of consumers with interrupted care reported they needed but did not receive housing services, and 35% of out of care consumers reported they needed but did not receive housing services.

### **The Uninsured**

**Table 11**

Area	Percentage of adults aged 18-64 years with no health care coverage
Memphis MSA	20.6%
Tennessee	19.7%
Mississippi	25.8%
Arkansas	26.2%

### **Assessment of Emerging Populations with Special Needs**

In 2011, the Memphis TGA identified **six special needs population groups** based on epidemiological and other health-related information. These populations are targeted in various ways through activities in the EIIHA Strategy and Memphis TGA Implementation Plan.

1. *Black Men*
2. *Black Women of Childbearing Age*
3. *PLWHA Who are Out of Care*
4. *Incarcerated Populations:*
5. *Youth*
6. *Hispanics*

*Lack of Primary Medical Care:* Another factor that affects the TGA is the general lack of primary and prenatal care found in both the urban and rural communities, which contributes to Memphis' high infant mortality rates. Lack of basic primary care also contributes to Memphis' historically high rates of sexually transmitted infections (STIs). These health disparities are outgrowths of the historic poverty within the Black/African American community and a health system that de-emphasizes publicly supported care. An additional contributing factor is a culturally based lack of trust in the medical establishment due to historic attitudes of racism and discrimination. Although efforts have been made among HIV medical service providers to bridge this divide, it continues to be a barrier for some individuals and communities.

Transportation Availability: Long travel times and difficulty accessing transportation can be barriers in rural and Southern areas. Even more, the lack of transportation has been associated with failure to retain consumers in care.

HIV/AIDS Stigma: Negative stigma surrounding HIV/AIDS is not isolated to the Memphis TGA, but is a challenge that affects PLWHA around the world.

Cultural/Religious Context: In a study by Dr. Jebose Okwumabua (2001), demonstration from a focus group study conducted with 36 men and women ages 18 to 56 reported cultural factors affecting perceptions of syphilis, HIV and other STIs among Black communities in the Memphis area. Study participants generally expressed a lack of accurate information about the etiology, modes of transmission, and susceptibility for HIV, and particularly about syphilis and other STIs. In addition, participants indicated that poverty, drug use, and men's reluctance to use condoms were barriers to safe sex. Fatalism (denial or depersonalization of a health problem, and belief that death is inevitable) was also identified as a cultural characteristic among some Blacks, which impedes them from taking an active role to protect themselves from infection by STIs. Such fatalism has been associated with conditions of poverty, lack of knowledge of the disease process, fear of hospitals and the medical establishment, and distrust of health providers and authority in general. Barriers to testing were also identified, including a strong perception that health workers had negative or judgmental attitudes towards clients.

Low Educational Levels/Functional Illiteracy: Literacy directly influences the ability of an individual to process information about health care and act upon services needed for care.

### **C. 3. Shortfalls in Mississippi Health Care Workforce**

Out of the state's 82 counties, 77 counties or parts of counties were designated as health professional shortage areas (HPSAs) in 2010. Mississippi's rate of residents living in primary care shortage areas was almost three times the national average (31.9% vs 11.8%).

There are approximately 5,606 "active licensed physicians" in Mississippi, 2,216 of whom are primary care physicians. This means that there is one primary care doctor for every 1,351 persons statewide; however, the geographic distribution of doctors across the state is not even. Approximately one-quarter of Mississippi's primary care doctors are located in and around the Jackson metropolitan area, with the next highest concentration in the Gulf Coast metropolitan area. As of August 2009, there were 29 infectious disease doctors in Mississippi, with the vast majority located in the Jackson area.

Mississippi had 37,105 active registered nurses (RNs) and 2,222 nurse practitioners (NPs) as of June 2009. Mississippi began licensing physician assistants (PAs) in 2000, under the State Board of Medical Licensure, which also regulates the licensing of physicians. Previously, Mississippi was the only state without such a licensing process. There were only 76 licensed PAs in Mississippi as of August 2010, and most counties have just one or none at all.

There are approximately 1,503 licensed dentists in Mississippi. Similar to the distribution of physicians throughout the state, most dentists are concentrated in the Jackson and Gulf Coast

metropolitan areas; 74 counties or parts of counties are considered dental HPSAs, and 14 counties have just one or no dentists at all.

There are 164 Medicare-certified Rural Health Clinics in Mississippi as of June 2010. The state also has 98 community hospitals, which amounts to 4.5 hospital beds for every 1,000 people. Additionally, as of 2009, there were 21 Federally Qualified Health Centers (FQHCs) in Mississippi, which operated at more than 170 service delivery sites throughout the state.

Although these facilities exist in the state, many people are still effectively left without regular access to care. According to a 2006 study by the National Association of Community Health Centers, one in three Mississippians is “unserved”—they have no usual source of primary medical care. Out of the 74 poor counties in Mississippi (defined as having a poverty rate higher than the national median of 35%), 26 poor counties had no FQHC. Over 20% of the state’s total population, as well as over 20% of the uninsured population, live in these 26 counties. In places like the Delta region, the lack of primary care providers leads people to seek such care in hospital emergency rooms.

The Mississippi Department of Mental Health (DMH) directly operates six psychiatric facilities and other facilities that provide inpatient mental health and substance use treatment. Additionally, DMH certifies and funds 15 regional community mental health centers (CMHCs) throughout the state. The CMHCs are operated by regional commissions that are appointed by the boards of supervisors of the counties within the service area. The CMHCs are the primary providers of mental health and substance use services within each of the 15 service areas, although the DMH may also provide funding to other nonprofit agencies for substance use services. Many CMHCs provide both inpatient and outpatient care, although they have a higher capacity for outpatient services. Services can include prevention services, employee assistance programs, counseling, outreach/aftercare services, primary residential services (including detoxification services), transitional housing services, vocational counseling, and emergency services. Sixty-nine “community-based ‘satellite centers’” affiliated with the CMHCs are located throughout the state. Thirteen of the 15 mental health regions are designated as HPSAs for mental health services.

DMH inpatient chemical dependency units are located at Mississippi State Hospital in Whitfield and East Mississippi State Hospital in Meridian. There are 16 community-based, residential substance abuse programs with a total of 432 beds for adults throughout the state, and 16 community-based, transitional residential programs with a total of 261 beds. The majority of these programs are operated by the regional CMHCs, with a smaller number of programs operated by independent nonprofit agencies. Additionally, there are 12 private substance use treatment programs operated by hospitals and other healthcare centers in the state and inpatient programs at two state and two VA hospitals.

The attached appendices include the following workforce documents:

- Active Dentists by County (Appendix E)
- Statewide HIV Community Service Delivery Network-by Ryan White Funded Facilities (Appendix F)
- Statewide HIV Community Service Delivery Network-(Number of People living with HIV disease by County (Appendix G)

### **E. Description of Priorities for Allocation of Funds**

- Primary care services to serve HIV infected Mississippians
- Transportation services-Many HIV positive people living in MS reside in rural areas. Some do not have access to a car and/or public transportation services are either limited or not available at all
- Oral and dental care
- Alcohol and drug rehab treatment
- Health insurance support (e.g., premiums, co-pays)
- Mental health care housing services
- HIV service provider trainings
- Education for HIV positive individuals on the services available (This includes HIV positive people in MS being informed on topics such as the location of the services and how they can qualify for those services)
- Education for target specific populations including adolescents, pregnant women, former inmates, MSMs, African Americans, the homeless, substance abusers, and Hispanics.

### **E. Gaps in Care**

- F. Primary Medical/Dental Care: Need to increase availability of physicians, dentists and nurse practitioners trained and willing to provide primary medical/dental care to people living with HIV disease. Expand the scope of dental services and measure the quality of care being given. Many HIV-positive individuals may have health insurance such as Medicare and Medicaid; however, many of these individuals are ineligible to receive dental health services and their insurance may not cover the cost of many of their medications. They also experience lack of third party coverage according to findings from staff at the Jackson Medical Mall Dental Clinic
- G. Integrated Service Delivery: Maximize existing resources into predictable networks of HIV service across organizational boundaries.
- H. Medication: Increase availability of medications and appropriate monitoring markers (viral load, CD4, resistance and Trofile testing).
- I. Mental Health Services: Increase access to mental health programs for indigent and underserved HIV positive clients. Support efforts to integrate mental health services with medical care services.
- J. Substance Abuse: Increase access to substance abuse treatment programs. Provide training for health care providers to identify patients with substance abuse problems and provide referrals for treatment.
- K. Correctional Institutions: Provide education to medical providers in correctional institutions about HIV/AIDS treatment and further develop networks to connect former inmates to care resources.
- L. Primary and Secondary Prevention Services: Incorporate primary and secondary HIV prevention services to minimize re-infection and reduce the incidence of HIV disease.
- M. Employment: Continue to focus on empowering people living with HIV disease by preparing them for employment, retention or rehabilitation and returning them to the workforce.

- N. Ethnic and Racial Groups: Provide access to translators and printed materials for emerging Hispanic and Asian patients. Insure training is provided to care givers in cultural sensitivity.
- O. Primary medical and dental care is provided but dental services do not include partials, dentures or crowns. Referrals are made to local oral surgeons when necessary and patients can be referred to HIV dental clinic in Jackson. However, the HIV Dental Clinic limits its services to HIV positive patients who are eligible for ADAP.
- P. There is a Part C Program at the University of Mississippi Medical Center (UMMC) in Jackson. The purpose of this Part C Program, known as the Rural Area Network (RANN), is to provide an integrated service delivery system for those patients who would normally have difficulty connecting to care providers. Their target population includes patients living in rural areas or areas where there are no physicians that are willing to see HIV/AIDS patients. Another part of their target population is prisoners leaving incarceration that need to connect with services in the area in which they plan to live after leaving prison. This system is improving all the time but quite often the problem is communication with the patient. The Department of Corrections can only project a possible release date. Depending on the inmate population, the prisoner's behavior before release and other factors, the release date is never a certainty. This has made planning uncertain. Frequent no-shows for scheduled appointments has motivated us to discontinue pre-planning new patient appointments in favor of providing the telephone number for new patient appointments for the clinic closest to the prisoner's release address. Quite often the patient will not contact the clinic for an appointment until they are out of medication or have become ill. We have experienced having patients re-offend or violate parole or work release and be re-incarcerated before they make their first appointment.
- Q. Health clinics, hospitals, and health centers such as the Coastal Family Health Center is constantly undergoing changes in staffing that create instability for their patients.
- R. As the Hispanic and Asian population grows in this area there will be an increased need for translator and/or bi-lingual services.
- S. Productive Case Manager and Patient Relationship- Many HIV-positive patients do not have a productive relationship with their case managers. Some do not know the name of their case manager nor have kept an on-going relationship with their case manager.
- T. Prison Release- former prisoners may be tested for HIV while they are in the correctional facility but are not easily located for a follow-up test after being released from prison\

#### **U. Prevention and Service Needs**

This section includes the results of the qualitative research portion of Community Needs Assessment conducted by the Mississippi Department of Health and the Mississippi Community Planning Group for HIV Prevention. It includes the description of prevention and service needs including educating the youth, describing the effects of the church, raising awareness, and testing.

## Methods

Three focus groups and three key informant interviews were conducted in 2009; two focus groups were conducted in 2011. All key informant interviews and two focus groups were held in Washington County, Public Health District III. For these 2 focus groups in District III: one group was male only and the other was female only. All participants were African American. The other three groups took place in Hinds County, Public Health District V. One group was mostly male, the others were more diverse in gender. A fourth focus group held in 2009 was not analyzed at this time due to time and resource limitations. All focus groups and interviews followed a semi-structured format of questions asked by a facilitator (See Appendix B). In addition to discussion with the facilitator, participants in focus groups were asked to complete a demographic information sheet as well as handwritten answers to questions asked in the session. The purpose of the written questions was to make sure everyone had a chance to voice their thoughts even if they did not vocalize their thoughts in the group setting. No names or exact ages were provided. Digital recordings were made by facilitators/interviewers and transcriptions were produced.

Questions asked and documentation produced varied in each group/interview. For instance, for 2 focus groups a verbatim transcript was provided while for other focus groups, only selected discrete answers for each question were provided (See Appendix). Researchers at the Social Science Research Center (SSRC) at Mississippi State University (MSU) were provided the materials and conducted the analysis of focus groups and key informant interview data from mid January to mid March 2012. Recordings were not provided to the SSRC for the purposes of this evaluation. The SSRC was not involved in any capacity outside of data analysis of what was documented.

Based on data provided (see Table 1) researchers identified themes and patterns by data sorting and grouping. Some of the themes emerged in all groups (major themes) and interviews while others issues (minor themes) were more relevant to fewer groups. The responses from all the focus groups and interviews are combined and summarized to maintain a high level of confidentiality.

**Table 22. The type of data available for focus group and interview analysis by district and year**

	<b>FG1 PHD III 2009</b>	<b>FG2 PHD III 2009</b>	<b>FG3 PHD V 2009</b>	<b>FG4 PHD V 2011</b>	<b>FG5 PHD V 2011</b>	<b>Interviews PH 3 2009</b>
<b>Transcripts</b>	Abbreviated	Abbreviated	N/A	Verbatim	Verbatim	Abbreviated
<b>Demographics</b>	√	√	√	√	√	N/A
<b>Recording</b>	N/A	N/A	N/A	N/A	N/A	N/A

## Findings

### Services

When asked what services or programs are available to provide HIV/AIDS/STD related services in your community, the responses ranged from no answer to some participants being able to discuss several organizations or types of services such as testing. The majority of those in PHD III referenced health departments while PHD V listed the health department more often in 2009 compared to 2011. This question was worded differently among groups and with the key informant interviews. In all events, neither the facilitator nor the participants discussed the distinction between the term "services" and "programs." Responses to this question varied greatly by location reflecting the greater availability of community services by district. In some groups, participants named organizations and sometimes participants named types of services like testing.

Table 23. Services or programs named, by District.	
<b>District III (2009)</b>	Health department, Enviro Care, Southern Aids Commission, The SISTA project, sororities/fraternities, The Family Medical Center, doctors
<b>District V</b>	
<b>2009</b>	Health department, Building Bridges, Friendship Connection, Cross Roads Medical Mall, doctors, Grace House, A Brave New Day
<b>2011</b>	Health department, Building Bridges, Grace House, Cross Roads Medical Mall, A Brave New Day

In Hinds County, there were also several references to A Brave New Day, Crossroads, The Carmichael Organization, and The Medical Mall, Grace House, My Brother's Keeper, as sources for service and care. In addition, Washington County participants also referenced The SISTA Project, sororities/fraternities and The Family Medical Center as sources they know and trust. Support group services were cited as being the most important service the community provided.

“Support groups” were the most popular response when participants were asked “what is the best way to bring information to the community”, “what are the current programs available,” and “how to improve services, for increasing knowledge and promoting awareness.” This theme was cited in all groups and it was noted that in District V, support groups were cited more frequently as being effective programs in the 2011 focus groups than in 2009.

*"I believe the peer support groups, especially for people who are living with HIV, it's critical for the prevention because people who are living with HIV can get together and take a stand, and we have a community responsibility. We've got brothers and sisters. And it starts right here."*

*"One of the most effective programs in all the agencies is for them to have peer support groups, and many of them, (do)..."*

### **Risk behaviors identified by community**

Risk behaviors cited most frequently in both districts were unsafe sex practices, multiple partners and drug use. Prostitution and homosexuality were also identified in both districts with mental health only being mentioned in Hinds County. Focus groups conducted in 2011 touched very briefly on this question.

### **Health issues deserving immediate attention**

Focus group participants in Hinds County were asked what health issues deserved the most immediate attention. HIV/AIDS/STDs and related issues, such as testing availability and education, were most often cited. In addition, drug and alcohol addiction, mental health issues and suicide awareness were also discussed. Although Washington County was not asked this question specifically, there was consensus on the importance of testing availability and education in all groups and interviews.

### **Role of the church**

When asked what role the church plays in prevention or treatment of HIV/AIDS/STDs and substance abuse, extensive dialogue was generated. While several participants expressed positive experiences, most did not feel the church was playing an active role in prevention or treatment. Some felt the church was actually part of the problem as it was thought to foster stigma and exclusion. Despite the level of dissatisfaction with church participation all groups expressed a strong opinion that there is great need for the church to be involved in prevention and treatment. This question was not specifically asked to all groups yet the church was consistently mentioned in answers related to possible solutions. All key informants had worked with the church to provide outreach.

### **Barriers to Prevention and Treatment**

All groups and interviewees were asked what roadblocks to prevention and care are faced by their community. The answers did vary slightly by location but there was consistency and consensus on most answers given. Barriers mentioned are listed below and differences noted by districts.

#### **Lack of education or knowledge**

Both districts expressed lack of knowledge or education as a barrier to prevention and/or care. This challenge was mentioned in numerous responses in all groups and interviews. Both districts stated this was an area in need of resources and a significant factor to achieve progress. Much discussion was held regarding sex education and school policies creating barriers. Several participants expressed a willingness of schools to improve education but unable to do so because of perceived policy barriers or lack of resources.

#### **Transportation**

District III cited lack of transportation as a barrier to prevention and care. The rural landscape of this district can require extensive travel to access services. Lack of public transportation and the

cost of travel were also mentioned in this district. District V did not list transportation as a challenge in the community.

### **Stigma**

Stigma was felt to be a significant barrier in all groups and interviews. More discussion was focused around this in the 2011 focus groups, both in PHD V, than in 2009. The problems faced resulting from stigma presented across various questions and categories citing examples of obstructing progress for education, prevention, treatment and care. Participants voiced their own shame and fear about retribution from their family and friends. There was also some sentiment that stigma could be reduced if HIV positive and HIV negative folks worked together.

### **Confidentiality**

Confidentiality concerns were given by numerous participants in both districts. There was a sentiment of distrust expressed for MSDH. Examples were given of people driving miles to avoid being tested by the DOH for fear of disclosure. Others described MSDH employees coming to their home in easily identifiable vehicles, causing embarrassment. It was noted that these views were not expressed in the 2011 focus groups. PHD V did discuss confidentiality issues but it was in different areas. There was concern regarding confidentiality when participating in events for PLWHA. Their status was thought to be too easily revealed by the practice of allowing children under age 5 to attend because there was no childcare available. The children would unknowingly identify them in public places as being from a specific group which indicates their HIV status to any individual present. There was also dialogue regarding the inclusion of people who are not PLWHA in activities such as support groups. This co-mingling was thought to be a violation of privacy and would not be an acceptable practice.

### **Culture**

Cultural differences, beliefs and practices were seen as barriers by numerous respondents in PHD III. Examples of cultural barriers included the following: lack of service providers reflecting the black community limits efficacy, belief that it "can't happen to my community", lack of empowerment in women, stigma attached to homosexuality and lack of acceptance.

### **Lack of Financial Resources**

Key Informants, all involved in community outreach in PHD III, were in agreement that there are too few financial resources available for treatment and prevention efforts. It was also thought that there was duplication of services in certain areas. Little mention was made of financial

limitations in any focus group but it was agreed that funding for abstinence only education could be better utilized.

### **Education**

The most common theme in all groups and interviews was the need for increased education. In addition, all agreed that there was a significant need to begin education at a much younger age than is the current practice. Many expressed concern about the schools' abstinence only policies currently in place. There was little distinction between districts in this category. Increasing the level of education was seen as a key to raising awareness, testing numbers and safe sex practices in addition to reducing fear and stigma.

### **Awareness Campaign and Outreach**

Another area of great consensus among focus groups and interviewees was the need to increase awareness and "get the message out." The benefits of increased awareness included: reduction in stigma via increased visibility, to initiate conversation, allow for information to be received without risk of embarrassment or shame, and to reach people "where they are at." Many of the ideas to increase awareness overlap with areas previously addressed such as involving schools and churches in outreach. There was a show of strong support for increasing media coverage of HIV/AIDS prevention/intervention in both districts.

### **Communication/Collaboration**

Both districts expressed a need for increased communication and partnership to effectively impact change. Consistently, all focus groups and interviews referenced a strong need to communicate with youth. Many expressed concern that children were being over looked when they are at the root of the issues being faced. Communication with parents was also a concern cited in both districts. Many believed parents denial and/or lack of awareness was detrimental to the cause of prevention. Communication between agencies and organizations was also a major theme in both districts. The potential for positive change was thought to be increased by joining forces and working as a team. Examples of this include partnerships with churches, MSDH, schools, treatment centers, jails, community based organizations (CBOs), as well as people living with HIV or AIDS(PLWHA) and community members that are not HIV+ standing together publicly. Simply talking to others was repeatedly offered as a method to improve awareness, education and testing rates, as well as reduce stigma.

### **Focus on youth**

The youth were mentioned within the themes of education and communication/collaboration and the topic of youth were discussed for both years and in all locations, among focus groups and key informants. Participants also discussed that the abstinence only culture was hurting the education

of the youth. Many expressed concern that children were being over looked when they are at the root of current issues being faced. Key informants, all having worked with children in various capacities, agreed with this concept and discussed at length the level of denial present in today's youth. Many believed abstinence only education, parents' discomfort with the subject and/or lack of awareness was largely responsible for the current rates of HIV/AIDS/STDs among Mississippi's young. Community members suggested that education and training are directed to parents as well as their children and that this type of training was deemed necessary for change.

### **Testing**

Participants in District III were asked specifically, "what can be done to increase testing in your community?" while District V participants were not directly asked. Despite this difference, the discussion on testing was found to be similar in both districts. Many felt that providing more awareness of HIV and STDS would motivate young and old to get tested. It was thought this could be accomplished through numerous methods involving schools, churches, media, doctors, and public advertisements. There was also great consensus that the accessibility of testing had to be increased. Ideas to accomplish this included: offering rapid testing, mobile testing units, establishing local sites for testing days in schools, churches and other local establishments and to make this testing available at no cost.

### **Discussion:**

Education and awareness were the most important themes in these groups. Lack of education was cited as a barrier whereas education was stated to be a solution. Awareness and outreach, as voiced by the community, seems to be similar to 'education' but participants voiced a broader appeal to the MSDH to help reduce stigma through media campaigns.

It should be noted some of these themes arise simply because District III is rural and District V is more populous and urban. The rural community struggles with transportation and the need for culturally sensitive outreach. The needs of the community are complex as they request more providers who can reflect the community; however they also struggle with confidentiality issues as they realize that their providers are from the community, or that simply by being in a small town, people assume certain things when you go to the health department. Confidentiality can be breached simply by having non-HIV positive people in the same group as positive persons or also having children present.

In March 2011, two reports describing the HIV situation in Mississippi were released. In these two reports, investigators from institutions outside of Mississippi worked with the community to present the needs of the state. While each report provided unique insights, many of the themes that were found by the MSCPG/MSDH focus groups were echoed in these reports: collaborations, education, addressing mental health and substance abuse issues, reducing stigma through media, and addressing transportation. In December 2011, a report from the Center for

Mississippi Health Policy described the overwhelming response of parents of school-aged children agreeing to want sex education in schools.

In the next collection of key informant interviews and focus groups, we strongly suggest that research goals are clear and data collection methodology is standardized so that analysis can effectively describe changes over a time period and/or location. For example, the role of the church was specifically asked in early 2009 but not asked in later 2009 focus groups. On the other hand, District III did not have any focus groups in 2011. District III participants were rural and 100% African American while District V participants included some Caucasians. Variations in answers may reflect these differences.

### **Core Prevention and Service Needs**

- Programs directed towards increasing the education and comfort level of parents with the topic of sex, HIV/AIDS and STDs. This training would empower parents to engage and guide their children.
- Media campaigns that raise the awareness and the urgency of the matter with facts intended to reduce stigma, grounded in culturally sensitive messages.
- Partner with churches
- Focus on youth, including jailed and incarcerated youth and their sexual partners
- Provide mental health relief for HIV+ persons through support groups
- Mobile testing centers and more awareness of free testing
- Look to examples of prevention and testing programs that have worked in similar communities in southern states that are culturally sensitive. (example The Saved Sista Project)
- Address HIV care holistically by collaborating with drug and alcohol addiction treatment centers

### **G. Description of barriers to care**

- Stigma
  - prevents HIV positive Mississippians from seeking treatment because of negative attitudes associated with the virus
- Confidentiality Issues
  - HIV positive individuals may resent seeking treatment due to a mistrust of staff telling others about the individual's HIV status.
- Collaboration between HIV service providers including physicians
  - According to MSDH focus group findings, some HIV positive Mississippians have more than one health problem and often times visit more than one primary care doctor
- Assist HIV-positive individuals to qualify for health insurance programs:
  - Medicare

- Medicaid
- Transportation services
  - Very little or no transportation services to pick up medication for HIV positive individuals located in rural areas and/or those that do not have access to a vehicle,
- Locating Former Prisoners
  - According to a Ryan White funded organization included in this document, oftentimes, staff working in correctional facilities are not able to locate former prisoners for a follow-up test/results due to the prisoner's release.
- Lack of knowledge/education
  - Needs assessments included in this document suggest raising more awareness among members of target populations including but not limited to adolescents, MSM's, African Americans, and homeless individuals. Awareness includes educating HIV-positive individuals on HIV disease prevention and services available to appropriately link them to care.
- Prolonged process to receive/qualify for dental care services and housing services

## **H. Evaluation of 2009 Comprehensive Plan for Ryan White Care and Treatment Services**

### ***List of unmet needs, gaps and barriers addressed in 2009 comprehensive plan:***

- Transportation: This serves as a barrier that limits access to medical services and reduces the likelihood of medication compliance.
- Mental Health and Substance Abuse: Mental health serves as a barrier to remain in care and to comply with medications.
- Program Administration Requirements and Capacity: Shortage in program staff that would assist people living with HIV in tasks related to requirements for accessing Ryan White Services.
- Transitional Housing: Limited access and availability to long-term housing facilities for people living with HIV.
- HIV Related Stigma: This is a major barrier that creates challenges for people living with HIV to seek testing and treatment related services.
- Enhanced Linkage to Care: Longer waiting period for appointments increases dropout rates.
- Increased Public Awareness: Stigma can be reduced and societal attitudes can be changed through education and awareness.

***Evaluation of 2009 strategic plan:***

Strengths:

- A list of priorities was addressed under the strategic plan which included: 1. Availability of medical transportation services 2. Continuum of affordable care 3. Assure client privacy, confidentiality, dignity and respect at every stage of the care continuum 4. Enhanced collaborative initiatives between service providers 5. Ongoing efforts to raise public awareness and diminish stigma.
- Issue statements, goals, objectives, and related activities were clearly stated for each of those 5 priorities. At least three objectives were listed per each proposed goal.

Weaknesses:

- Activities were listed for each objective; however, monitoring and evaluation plan to measure program progress was missing in the 2009 plan. Also, most of the objectives did not include a measurable indicator.

***Successes and challenges during 2009 – 2011 fiscal years:***

Successes:

- During 2009 – 2010 fiscal years, MSDH opened Crossroads-South (CCS) in McComb, which is designed to replicate all Ryan White Part B services provided by the Crossroads Clinics-Central (CCC) in Jackson. The District Health Office at the clinic in South provides primary care to people living with HIV/AIDS.
- During 2009 – 2010 fiscal years, the MSDH established collaborations with the Ryan White Part C program at the Delta Regional Medical Center (DRMC) in Greenville in order to provide HIV related primary care through the Crossroads Clinics-North. The clinic combines Part C services that is available through DRMC with Part B funded services provided through the MSDH in underserved and high HIV-incidence northwestern part of the state.
- During 2009 – 2010 fiscal years, expansion of the CAREWare system has enabled the MSDH to access client level data and documentation to verify compliance with MSDH and HRSA requirements by UMC sub-grantees. Client level data provide opportunities to track medical treatment and medication compliance, and track referral appointments.
- During 2009 – 2010 fiscal years, the MSDH developed and implemented a Quality Management Plan, provided training to District HIV Social Workers, and initiated other activities including provision of pap smears for newly diagnosed HIV-positive

women at all three venues (Crossroads Clinics – Central, South, and North), and assessed the availability of medical transportation as well as other needs of people living with HIV/AIDS.

- During 2011, the Mississippi Ryan White Part B program implemented new medical case-management protocols at Crossroads Clinics Central and South.
- The fiscal year 2011 sub-grantee agreement with the Delta Regional Medical Center (Crossroads Clinics North) included priority services such as mental health (comprehensive psycho-social mental health evaluation), dental, and nutrition for individuals living with HIV/AIDS (Private dentist, nutritionist, and psychologist available).
- During 2011 year, the Ryan White Part B program established collaborations with the CDC-funded HIV Surveillance program to improve linkages to HIV care for newly diagnosed HIV-positive individuals.
- During 2011 year, training was provided for state's HIV non-medical case managers to enhance knowledge and awareness of existing Ryan White funded core and support services as well as on resources available in the state.
- During 2011 year, the MSDH Part B program participated in the national In+ Care Campaign to promote retention and adherence to HIV treatment.
- During 2011 year, the Mississippi Part B continued its efforts to expand and enhance the Ryan White Quality Management program. The program is divided into two phases: 1. Part B Program Assessment 2. Quality Management Plan Development. The program also established a quality management team, which includes care providers, people living with HIV/AIDS, and part C/D funded representatives.
- During 2011 year, the program continued its efforts to identify and bring into care persons who are unaware of HIV-positive status. To do so, the MSDH Ryan White Part B program established on-going collaborations with the CDC-funded Rapid HIV testing program for disproportionately affected populations to provide EIS and non-medical case management to newly diagnosed individuals. Participating sites include Emergency Departments at hospitals in high-morbidity areas including the University of Mississippi Medical Center, and several federally qualified health centers in the state. The Crossroads Clinics-Central has been providing confirmatory HIV testing for preliminary positive individuals as identified by HIV-rapid testing programs at non-healthcare settings.

- 91.6% of these individuals were informed of their status. All individuals who tested positive were informed for their HIV diagnosis. 90.6% of those who tested positive for HIV were referred to care.

Challenges:

- During 2009 – 2010 fiscal years, the MSDH Ryan White Part B programs faced hiring restrictions due to state budget reductions.
- During 2009 – 2010 fiscal years, the MSDH had to develop strategies to either avoid or eliminate ADAP waiting lists and service limitations.
- During 2009 – 2010 fiscal years, the MSDH experienced challenges to bring persons who are unaware of HIV-positive status into care; however, the agency has been working closely with the CDC Emergency Room Rapid HIV Testing program to provide Early Intervention Services (EIS) and Case Management services to newly diagnosed HIV-positive individuals.
- During 2009 – 2010 fiscal years, the MSDH was challenged to conduct timely site visits because of staff shortages.
- During 2010 – 2011 fiscal years, the MSDH appointed a new STD/HIV director, and re-structured the organizational chart.
- During 2011 year, the Mississippi Part B program did not receive notification for non-federal fund matching process in timely manner, which created a significant challenge for the MSDH Ryan White Part B program because the funds could not be encumbered for use without determining the corresponding match funding. Consequently, priority service projects including dental and mental health care services at Crossroads Clinics – Central, had to be put on hold. Additionally, at the end of fiscal year 2011, part B program experienced a hiring freeze.
- During 2011, the state had faced challenges in recruiting and retaining most capable and qualified personnel to administer the Ryan White Part B program primarily because of the state-sectors non-competitive salaries as compared with private sector salaries.
- Another challenge faced during 2011 year was the fact that the sub-grantees were not using the standardized programmatic reporting and fiscal tracking protocols. This specific issue had a negative impact on obtaining compatible data from all sites.
- Through continued efforts since year 2010, inconsistencies and inaccuracies in client level data had been improved as a result of CAREWare expansion and use of this database by all Part B-funded sites.

- At least 9.4% of HIV-positive individuals were not referred to care (7 individuals).

#### **Report on 2009 – 2010 fiscal years**

- Home-Based program served a total of 80 individuals (those who applied for home based services during 2009 year).
- AIDS Drug Assistance Program (ADAP) served a total of 1300 individuals to meet the objective of increasing ADAP medication compliance in year 2009.
- Community – Based Services: A total of 1500 individuals were provided with HIV primary care services; a total of 250 individuals were provided with statewide perinatal and pediatric case management and care in year 2009.
- State Direct Services: During 2009, a total of 14, 000 individuals were served with ambulatory/outpatient medical care through the Crossroads Clinics. A total of 250 individuals received basic dental care services at Crossroads Clinics. A total of 400 individuals received services related to treatment adherence and compliance at the Crossroads Clinics.
- The clinic provided early intervention services to a total of 80 high priority patients.
- A total of 1,000 individuals who applied in 2009 received HIV-case management services.

#### **Report on 2010 – 2011 fiscal years**

- Mid-year progress report for year 2011 indicates that a total of 824 Mississippians were tested for HIV infection. 91.6% of these individuals were informed of their status. All individuals who tested positive were informed for their HIV diagnosis. 90.6% of those who tested positive for HIV were referred to care. 9.2% of those who tested negative for HIV were not informed of their status.
- 4 agencies received Part B funds for outpatient care – MSDH (Crossroads Clinics-Central and South, the UMMC adult Infectious Disease, UMMC Pediatrics, and Delta Regional Medical Center (DRMC).
  - Goal was to enhance delivery and efficacy of outpatient/ambulatory health services.
- 1 agency received Part B funds for oral health care – MSDH Crossroads Clinics Central.
  - Goal was to enhance delivery and efficacy of oral health care.
- 1 agency received Part B funds to provide home health care – LinCare Infusion

- Goal was to enhance delivery and efficacy of home health care services.
- 1 agency received Part B funds to deliver medical nutrition therapy – DRMC
  - Goal was to enhance delivery and efficacy of medical nutrition therapy.
- 1 agency received Part B funds for mental health services - DRMC
  - Goal was to enhance delivery and efficacy of mental health services.
- 2 agencies received Part B funds for medical case management – MSDH Crossroads Clinics-South and Central, and DRMC.
  - Goal was to enhance delivery and efficacy of medical case management services.
- 2 agencies received Part B funds for non-medical case management – MSDH Crossroads Clinics-Central and South, and DRMC.
  - Goal was to enhance delivery and efficacy of non-medical case management services.
- 1 agency received Part B funds for housing services – MSDH.
  - Goal was to enhance delivery and efficacy of housing services.
- 2 agencies received Part B funds for ADAP services – MSDH – Crossroads Clinics-South and Central, and DRMC.
  - Goal was to enhance delivery and efficacy of ADAP services.

## **Section II: Where do we need to go?**

### ***A. Proposed care goals***

MSDH has set the following goals to be implemented for the next three years focused on HIV care and treatment services in the following ways:

- Improve HIV positive individuals’ linkage to care by helping them become more aware of services currently available and how to gain access to those services.
- Reduce the number of Mississippians infected with HIV by educating everyone on the risks of contracting HIV infection and sexual health.
- Encourage everyone to get tested by highlighting the benefits of early HIV positive diagnosis including better treatment options, managing their care, and have a healthier life.
- Collaborate with a variety of organizations including insurance companies to help improve the qualifications of HIV positive individuals to pay for necessary medications
- Set new and improved case manager standards

***B. Proposed Goals regarding individuals Aware of their HIV status, but not in care (Unmet Need)***

The following information specifically highlights the needs of individuals who are aware of their status and the proposed goals suggested to appropriately link them to care.

There are a limited number of dentists and dental care clinics that provide services to HIV-infected individuals. Many HIV-positive individuals have limited access to comprehensive oral and dental care. Our proposed goal is to increase the number of eligible PLWHA who receive dental care through targeted case management.

A limited number of doctors are available in rural communities. Our goal is to increase the number of providers with the competency to provide adult and peds HIV primary care in high impact jurisdictions.

The availability of nutritionists and dieticians are lacking to address nutrition related issues and provide education on proper nutrition while HIV positive patients are on their medications. Increasing the number of people who receive dietary counseling is one goal to solve this issue.

Many HIV-infected individuals do not have a medical case manager and/or do not know their case-manager's name and contact information. Our goal is to integrate medical and non-medical case management functions as appropriate to certification. We are proposing to quantify the benchmark number of clients served per case manager.

Lack of and limited availability/access to non-medical case management that address conflicts related to housing, transportation, and other non-medical related services and resources is an issue. Our goal is to increase the availability and access to non-medical case management workers that will help improve and eliminate specific barriers to care.

Only a handful of peer-driven support groups are available and there are limited funds to keep the support groups open to the HIV-positive individuals needing their services. A proposed goal is to increase the number of active support groups in high-impact jurisdictions.

Limited access and/or availability of reliable long-term housing is a common problem for many HIV-positive individuals who are aware of their status. Our goal is to develop a system where we can link HIV-positive individuals to more reliable housing services.

Health insurance companies deny policies to HIV-infected individuals as they learn about the applicant's HIV status. One proposed goal is to figure out a way to influence the health insurance exchange development process in Mississippi.

Primary care physicians lack knowledge regarding effective HIV treatment and care. There is a shortage of infectious disease physicians available to care for the number of HIV positive patients in MS.

Multiple primary physician visits is an issue for HIV positive patients. People living with HIV/AIDS oftentimes visit more than one doctor to address their needs. One proposed goal is to improve case management methods to address this issue.

Federally funded programs such as Ryan White and Medicaid are very limited to certain communities and many HIV positive Mississippians are not qualified to receive the benefit due to the strict criteria. Our proposed goal is to implement new health care insurance options per Affordable Care Act requirements.

Confidentiality is a major personal barrier to receiving appropriate care and treatment services. Our proposed goal is to develop systems that protect the confidentiality of the patient as well as alter the community perception of confidentiality issues.

### ***C. Goals Regarding individuals Unaware of their HIV Status***

Newly diagnosed patients oftentimes experience depression and have no reliable access to mental health services. People unaware of their HIV positive status may also be unaware the HIV-related services available. Our proposed goal is to increase access to mental health services as well as increase intensive case management to include mental health assessment during the first 3 months of diagnosis.

Another proposed goal is to implement a peer navigator system. The implementation of this system will help reduce stigma and motivate more individuals to get tested for HIV at their local health departments.

Language barriers frequently prevent special populations who are unaware of their status from seeking and receiving adequate care. A proposed goal would be to assure that all clinical HIV care sites have access to language interpreters

### ***D. Proposed Solutions for closing gaps in care***

- Educating and raising awareness to high risk populations including African Americans, MSMs, and adolescents/youth, on the risks associated with contracting HIV, and the importance of sexual health is a proposed solution for reducing the number of individuals being infected with HIV
- Set new and improved case manager standards for the purpose of properly linking and referring people to care.
- Raising awareness of current transportation services while at the same time developing a transportation service for HIV positive individuals without transportation to use for the purpose of being present on scheduled doctor visits and other related HIV related services.

### ***E. Proposed solutions for addressing overlaps in care***

None proposed

## **G. Proposed coordinating efforts**

Limited transportation services (especially for long distance medical related visits) are an issue. Our proposed goal is to use Part B support for non-Medicaid PLWHA

Rural residents are unaware of their risks for contracting HIV. Knowledge on transmission, risks, and consequences is low among youth and rural communities. Our proposed goal is to raise education and awareness regarding HIV disease prevention by collaborating with more community based organizations in rural areas and areas considered to have a great number of high risk populations.

Locating former prisoners (including youth in detention centers) who may be HIV positive but unaware of their status becomes difficult after they are released from prison. A proposed goal to eliminate/improve this issue would be to work with youth courts and detention centers associated with Ryan White funding.

Previously, state laws did not require Mississippi to teach sex education in public schools; however, schools that opt to teach sex education were required to teach an abstinence only until marriage curriculum.

As of February 2011, House Bill 999 requires each local school board to adopt a sex related education policy by June 30, 2012, in which either an abstinence-only or an abstinence-plus curriculum will be implemented. The Mississippi State University's Social Science Research Center surveyed parents and/or guardians of children attending Mississippi public schools to assess their attitudes and beliefs on implementing sex education in the schools. As a result, most parents (92%) are for sex education in Mississippi schools at an age appropriate grade level. The majority of parents (61%) believe that sex education classes should begin when children are in the 5<sup>th</sup> -7<sup>th</sup> grades and boys and girls should be separated during these classes. However, according to 61% of parents, parental permission should be required for a student to attend sex education classes. The topics parents strongly support to be included in the curriculum are discussions and teachings on the transmission and prevention of HIV, AIDS, and STDs and teaching what to do if someone is raped or sexually assaulted. Other topics include: how to deal with peer pressure to have sex, benefits of abstinence until marriage, date rape, and how to talk with a boyfriend or girlfriend about not having sex.

## **Section III: How will we get there?**

### ***A. Overall Strategy***

The MSDH realizes a number of challenges exist among HIV care and treatment services provided to those living with HIV in the state of MS. One of the many focuses of our strategy is to properly inform HIV positive Mississippians on the availability of HIV related services and how to gain access to those services and resources. Our strategy is to close the gaps, minimize and eliminate certain barriers, and improve existing services by collaborating with organizations

which include but are not limited to the community based organizations, Ryan White funded organizations, Non-Ryan White organizations, lawyers, school administrators, and insurance companies. Our specific proposed strategies, plans, and activities are outlined in the following information below. The timeline set to achieve the specified goals is summer 2015.

***B. Strategy, plan, activities (including responsible parties) and timeline to address the needs of individuals aware of their status, but are not in care***

*Limited number of Dentists:* Our plan to solve the issue of having a limited number of dentists providing services to HIV-infected individuals is to create a standard for dental case management. The proposed plan is to also train existing case managers to direct dental case management as part of global medical management and use the case managers to monitor the kept dental visits. We possibly will use the CAREWare system. Responsible parties for carrying out this task would be the Medical Monitoring Project Surveillance staff. The staff would be responsible for monitoring the statewide measurement. Monitoring the local visits would be the responsibility of the case managers. The case managers would keep a record of individual level data. The Delta Region ETC would be responsible for training the case managers.

*Limited Availability of Doctors in Rural Areas:* Our proposed strategy is to develop a task force with the main objective of getting additional training to FQHC. Rural medical scholars program would be used in developing the task force. Strengthening J-1 visa program waivers would be used to increase the number of doctors available as well. The proposed plan includes monitoring the number of new providers and number of visits per provider by observing CD\$ count reports through ELR. The percentage of known PLWHA who are in care will serve as a determinant of how we will monitor our progress. Responsible parties would include the Prevention Planning Council, MSDH, MSMA and other external partners such as the Office of Rural Health and Rural Health Association.

*Lack of or Limited Number of Nutritionists and Dieticians:* The proposed strategy is to define the standards for nutritional counseling possibly by the USPHS standards. Meet with staff from the WIC program regarding integrated dietician counseling for ADAP recipients at WIC. Training would be provided to WIC Nutritionists. To carry out this task, it would be important to investigate the dietician curriculum and identify the HIV-specific education curriculum. Dieticians would be offered training and other opportunities as well. The responsible for carry out this task would be the Delta AIDS Education and Training Center, MSDH, and School of Allied Health's dietician program.

*Improve Case-Manager and Patient Relationship:* For the future, a proposed strategy to improve the relationship between the case-manager and patient is to create the standards for case management and training the case managers to comply with the standards by specifically defining and streamlining the case management monitoring data collection methods. Responsible parties would include the Delta Region AIDS ETC, MSDH, and Schools of Social Work. The

responsible parties would meet and discuss with the Ad hoc committee to write the case management standards for the state. Part of the task would be to look at the current curriculum.

*Limited Transportation Services:* A proposed strategy to solve the issue of limited transportation services is to use GIS mapping technologies and develop a variety of different methods based on per mileage caps ( less than 50 miles, 51-100 miles). Gas cards and bus cards would be tracked and distributed to the patients based on the criteria. FOA would be used for contract driver services. Monitoring methods would be created for case managers to adopt. Rules and warning letters would be developed in the event a client declines a ride. Responsible parties would include MSDH and member organizations of Ryan White Programs.

*Limited Support Groups Available:* A proposed plan to increasing the number of active support groups in high impact jurisdictions would be to create individualized peer to peer navigator program with points of contact through a medical provider. A centralized competent trainer would be assigned to provide dedicated training to Community Based Organizations (CBOs) and peer navigators. The model base for the program would be created using the Delta Heart Study Model. Responsible parties would include the Department of Mental Health, CBOs and possibly a clinical psychologist. A meeting would be set up to meet with staff from the Preventive Health Program to learn more about Delta project as well.

*Denial of Policies by Health Insurance Companies:* A few proposed strategies would be to involve specific members from the MS Center for Justice and identify insurance representatives to participate in the planning council. United Healthcare for CHIP and Blue Cross Blue shield are the suggested insurance companies that our organization will aim to set up discussions for the purpose of figuring out how to minimize the number of HIV positive patients that are denied policies. Mental health assessment methods in case management standards and training would also be provided. A targeted meeting with DFA regarding EOBs and health insurance FOA's is highly recommended.

*Primary care physicians lack knowledge:* Proposed plans and activities entail working with professional organization and the medical school to increase education benchmarks.

*Multiple primary physician visits:* Currently, many HIV patients are suffering from the burden of seeing more than one doctor on various days which interrupts their daily lives. To minimize the time taken out of patients' everyday lives as a result of numerous doctor visits, proposed activities include improving case management methods to address the problem. The strategy would provide education on how the health care system presently works. The future proposed plan is to set up a meeting with the medical school in Hattiesburg through Dr. Thomas Dobbs to discuss (particularly with the school of nursing) their nurse practitioner program.

**C. Strategy, plan, activities (including responsible parties) and timeline to address the needs of individuals unaware of their status, but are not in care**

*Depression among those who were recently unaware and newly diagnosed patients:*

Implementing mental health assessments as part of the initial case management visits is a proposed strategy to improve and control this issue. Case managers would be responsible for identifying referral sites for mental health services.

*Stigma:* Those who are unaware of their status may be less likely to get tested for HIV at their local health department due to the fear of stigma and feeling as outcasts in our society. A proposed plan is to implement a peer navigator system and provide training to various HIV service providers on issues associated with stigma. Responsible parties would include MSDH, CBO's, and all other HIV service providers, their organizations, and individual staff members.

*Confidentiality:* Both individuals who have knowledge of their HIV positive status and those who are unaware of their status experience the uncertainty of confidentiality as a barrier to receiving appropriate care and treatment services including testing services. A proposed plan to minimize the inappropriate leasing of information is to educate both the patient and HIV service provider on how the DIS surveillance system works and how information is presently protected. Public health committee would make recommendations for medical education. Responsible parties would include MSDH, CBO's, and all other HIV service providers, their organizations, and individual staff members.

**D. Strategy, plan, activities (including responsible parties) and timeline to address the needs of special populations.**

*Adolescents:* Education and awareness regarding HIV disease prevention, transmission risks, and consequences is low among youth. A proposed strategy to solve this problem is to collaborate more with school administrators in educating the youth in public schools on topics related to sexual health and HIV prevention.

Locating Former Prisoners: *Refer to Section E below.*

***E. Activities to Implement***

*Limited Availability of Doctors:* Some proposed activities are to work with University of MS Medical Center administration to develop a telehealth consultation system for community providers as well as promote the availability of consultants through professional marketing (e.g, MSMA, MAFM).

*Federally funded programs including Ryan White and Medicaid:* Many HIV positive Mississippians do not qualify to receive benefits of Ryan White and Medicaid services as a result of the strict criteria. A proposed action to implement would be working with Medicaid policy makers to expand benefit benchmarks.

*Difficulty in locating former prisoners who are HIV positive:* Beginning July 1, 2012, the University Mississippi Medical Center will have responsibility for care of incarcerated patients. Discharge planning will be reinstated and UMMC will work with youth courts and juvenile detention centers. A proposed activity would be for MSDH to develop a monitoring to evaluate the effectiveness of the discharge planning system for the next three years.

*Separate HIV Planning Councils:* HIV planning councils are separated (Mississippi Planning Group Council and Ryan White). The National HIV/AIDS Strategy encourages high-impact HIV prevention which includes prevention through positives. A proposed activity to implement is to streamline processes and improve systems-level planning and communication methods. Specifically identifying and targeting skills expertise to participate in planning councils would be critical and beneficial.

## **F. Reflecting Healthy People 2020 Objectives**

### **Our plan reflects the Health People 2020 objectives in the following ways:**

1. *Reduce the number of new HIV diagnoses among adolescents and adults:* To achieve this Healthy People 2020 objective, our plan focuses on reducing the number of individuals in the state of MS including adolescents and adults through education and raising awareness on the risks associated with contracting HIV, highlighting the importance of sexual health to these specific individuals. Our goal specifically focuses on collaborating with school administrators and policy makers to education the youth in school on HIV infection and its impact on health.
2. *Reduce the number of new AIDS cases among adolescents and adult heterosexuals and increasing the proportion of new HIV infections diagnosed before progression to AIDS:* The strategy in our plan to solve this issue focuses on encouraging individuals including adolescents and adult heterosexual to get tested on a frequent basis by highlighting the benefits of getting tested early. Specifically, the plan highlights emphasized benefits such as increasing the individual's chance to a healthier life and linkage to care before the late diagnosis of AIDS.
3. *Increase the proportion of sexually active persons who use condoms:* Our plan addresses the Health People 2020 objective specifically proposing sexual health education and awareness among populations considered to be at high risk. High risk includes; however, not limited to MSM's, adolescents, and young adults.
4. *Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards:* The updated plan includes specific strategies of linking HIV-infected adolescents and adults receiving care

by proposing an improved relationship between the case manager and patient by redefining the new case manager standards. The improved relationship and new standards will help motivate the case manager to make proper referrals and linkage to care for the patient.

5. *Reduce deaths from HIV infection:* Our plan reflects strategies focused on reducing deaths from HIV infection by collaborating with other organizations including CBOs, other Ryan White organizations, and insurance companies to appropriately link those individuals who are positive in to care. Specific proposed strategies include the case manager properly understanding the qualifications of their patients in order to make beneficial referrals and working with insurance companies such as Medicaid to lighten their qualification criteria through expanding their benefit benchmarks.
6. *Reduce the number of perinatally acquired HIV and AIDS cases:* Our plan specifically highlights the importance of target populations including pregnant women to get tested and appropriately link them to care. Specifically, the plan focuses on educating pregnant women on HIV infection and how case managers can appropriately link them to care based on new case manager standards.

#### **G. Reflecting the Statewide Coordinated Statement of Need**

This updated plan includes goals, strategies, and objectives based on the needs outlined in the Section 1 of this document. The plan is based specifically on needs of target populations such as African Americans and MSMs, highlighted in the 2010 epidemiological profile, as well as adolescents, pregnant women, former prisoners, IDUs, and HIV positive individuals in MS. The information provided came from the following organizations including the Mississippi State Department of Health, Coastal Family Health Center, the Medical Monitoring Project, Southeast Mississippi Rural Health Initiative, Inc., University of Mississippi Medical Center, Delta AETC, Memphis TGA, and other Ryan White Part A, B, C, D, and Section F programs.

#### **H. Coordination with the future Affordable Care Act (ACA)**

Payments for Rural Health Care Providers:

Mississippi is a rural state and many of HIV positive individuals within the state reside in rural areas. The Affordable Care Act provides increased payment to rural health care providers to help them continue to serve their communities. To attract and retain healthcare providers within our state our plan involves us proposing objectives to provide travel support for pediatrician outreach visits to clinical sites. Part of the proposed strategy is aimed to work with family medicine programs to increase training opportunities.

## **I. Addressing the National HIV/AIDS Strategy Goals**

The three primary goals for the National HIV/AIDS Strategy include 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV and 3) reducing HIV-related health disparities.

The updated plan proposes specific goals and strategies in educating and informing both HIV positive people who are aware and unaware of their status on issues of sexual health and risks associated with contracting HIV infection. Proposed strategies include new standards of care for HIV case managers to properly link their patients to care and make appropriate referrals as well as motivating individuals at risk to frequently get tested. Proposed coordinating efforts in the plan suggest the MSDH's collaboration with organizations including insurance companies to work with HIV positive individuals and their eligibility for financial assistance for medications. Linking target populations (African Americans, MSMs, IDUs, homeless, former prisoners, and adolescents) to care and educating these populations would help to increase access to care and reduce the number of individuals suffering from the HIV-related health disparities.

**J. Strategic Response to Change**

**Refer to Appendix H: Ryan White Comprehensive Plan Matrix**

**Section IV. How Will We Monitor the Progress?**

The proposed goals and proposed strategies are expected to be achieved and/or implemented by the year 2015. Proposed goals and strategies will be tracked on a continuous basis as the organization creates semi-annual and annual reports. The reports are expected to reveal what has been accomplished and what has not been accomplished at the point in time the report (s) become complete.

## Appendices

## Appendix A: MMP 2009 Data



## What is the Medical Monitoring Project (MMP)?

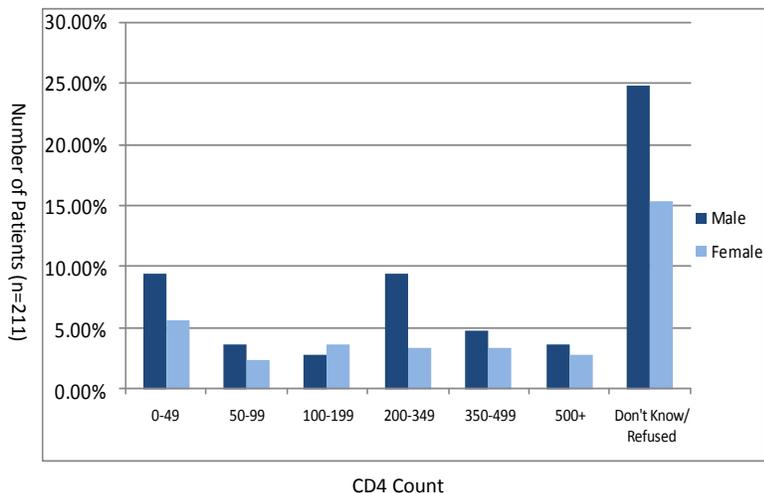
- MMP is a surveillance study implemented by the MS State Department of Health (MSDH) and the Centers for Disease Control and Prevention (CDC) to obtain information about patients with HIV/AIDS receiving on-going medical care and the types of services they needed and received. This information will help improve the delivery of programs MS.
- Information is gathered from randomly selected clinics with the goal to enroll 400 patients. MSDH is asking HIV primary care providers to share this fact sheet with their patients to encourage participation. Participation includes an interview and a confidential medical record abstraction for each patient.
- This data represents information collected from interviews performed during the 2009 cycle.

Patient Demographic Information			
Race/Ethnicity at the Time of Interview by Sex*			
	Male n=128	Female n=82	Total n=213
White, non-Hispanic	9.4%	5.6%	15.5%
Black, non-Hispanic	48.4%	32.9%	82.2%
Hispanic	1.9%	0%	1.9%
Age at the Time of Interview by Sex			
	Male n=129	Female n=82	Total n=214
18-34	14.5%	9.3%	23.8%
35-44	16.8%	12.6%	30.3%
45-54	22.4%	11.2%	34.1%
55+	6.7%	5.4%	11.7%

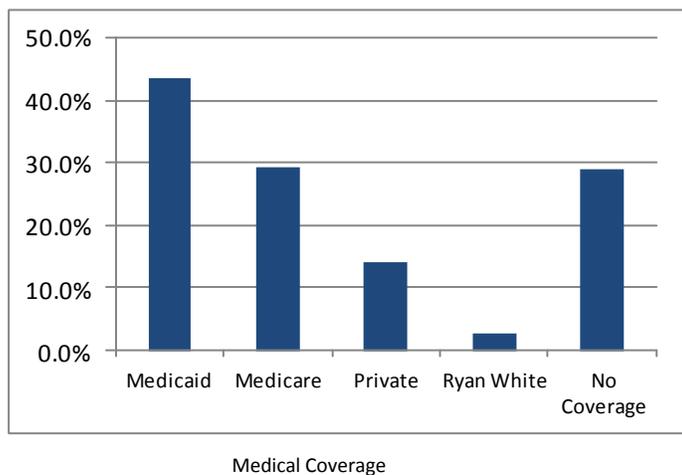
**Time between HIV Diagnosis and Entry into HIV Care (Among Participants Diagnosed in the Past 5 Years)**

- 51 (92.7%) entered into care less than 3 months after diagnosis
  - Of these, 54.9% were male.

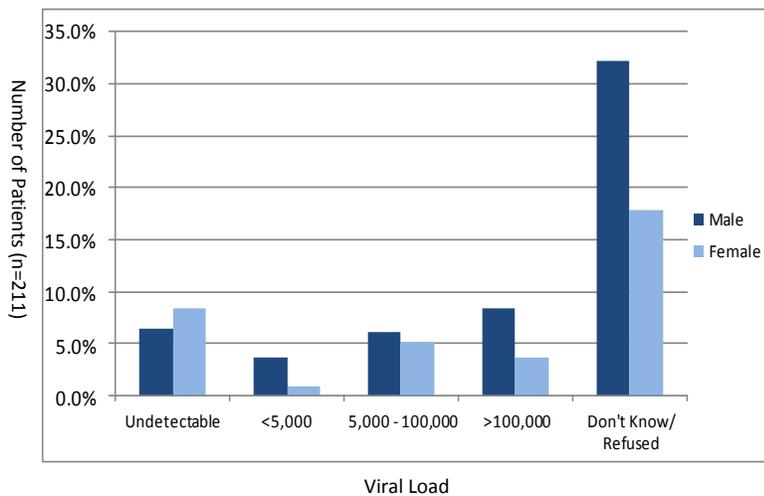
## Lowest CD4 Ever by Gender (Self-Reported)



## Types of Medical Coverage in the Past 12 Months\*\* (Self-Reported)



## Highest Viral Load Ever by Gender (Self-Reported)

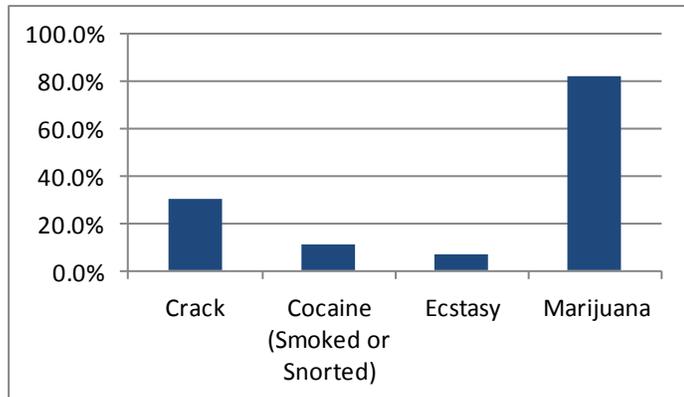


\* Participants who refused to report race are excluded from the Patient Demographic Information table.  
 \*\* Participants may have responded with multiple types of medical coverage.

### Self-Reported Substance Use in the Past 12 Months

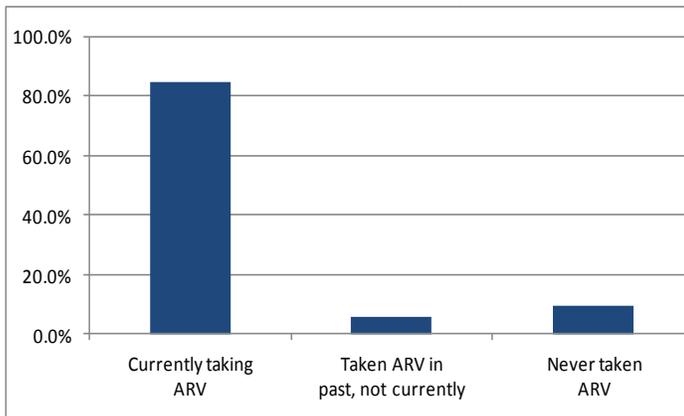
- 46 (21.5%) used non-injection drugs in the past 12 months
- 114 (53.3%) used alcohol in past 12 months
  - Of these, 88 (77.2%) used alcohol in past 30 days
    - Of these, 28 (31.2%) had at least 4 drinks on a typical day when drinking

### Non-Injection Drugs in the Past 12 Months (Self-Reported)



Percentages are of those patients who reported using non-injection drugs in the past 12 months.

### Patient History of Antiretrovirals (Self-Reported)



### Unmet Needs for Services in the Past 12 Months

Services	Needed but Not Received
Dental Services	60 (50.9%)
Public Benefits	39 (39.0%)
Transportation	21 (13.0%)
Case Management	14 (11.9%)
Meal/Food Services	21 (11.6%)

#### Main reasons participants didn't receive needed services:

- Dental Services, Transportation, Case Management, Meal/Food Services: **Didn't know where to go/who to call**
- Public Benefits: **In process of getting services; ineligible or denied services**

### Sexual Behavior in the Past 12 Months

- 110 (51.4%) participants reported having oral, vaginal or anal sex
- 32 males reported having oral or anal sex with at least 1 other male
  - Of these, 13 (40.6%) reported multiple male partners
- 37 males reported having oral, anal, or vaginal sex with at least 1 female
  - Of these, 9 (24.3%) reported multiple female partners
- 45 females reported having oral, anal, or vaginal sex with at least 1 male
  - Of these, 5 (11.1%) reported multiple male partners

### Unprotected Sexual Behavior (Among Participants Reporting Sex in the Past 12 Months)

- 6 males reported having unprotected oral or anal sex with at least 1 male
- 8 males reported having unprotected oral, anal, or vaginal sex with at least 1 female
- 14 females reported having unprotected oral, anal, or vaginal sex with at least 1 male.

## Why should I participate in MMP?

- MMP presents a unique opportunity to contribute to knowledge about HIV care in the U.S. and in Mississippi.
- MMP data will also be used by HIV prevention planning groups, clinicians, Ryan White consortia, and policy leaders to help advocate for additional resources.
- MMP's true success depends upon the participation of HIV care providers like you.



## 2011 Mississippi MMP Team

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 Leandro Mena, MD, MPH—Co-Principal Investigator  
 Joseph Grice, MPH—Project Coordinator  
 Imran Sunesara, MBBS, MPH—Statistical Analyst  
 Sudharshanam Karakala, MBBS, MPH—Senior Abstractor  
 Tiffany C. McDonald—Interviewer/Abstractor  
 Chara McGill—Interviewer/Abstractor

### Questions about MMP?

If you are interested in learning more about MMP or have any questions, please contact:

Joseph Grice, Project Coordinator  
 joseph.grice@msdh.state.ms.us (601)-987-4181

## Appendix B: MMP 2010 Data



## What is the Medical Monitoring Project (MMP)?

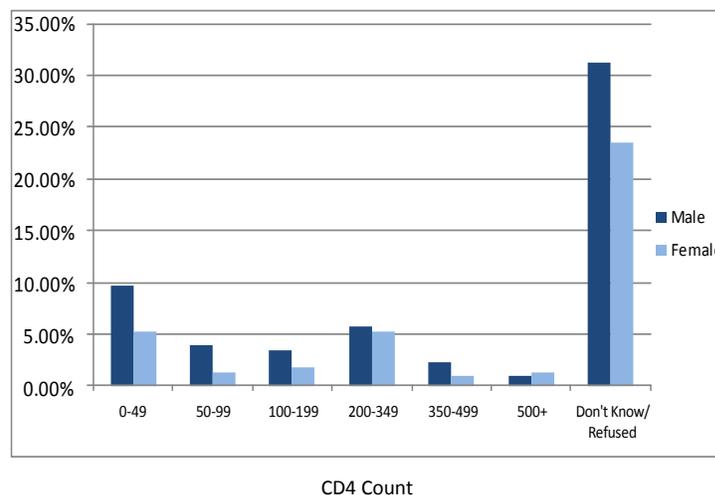
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- Information is gathered from randomly selected clinics with the goal to enroll 400 patients. MSDH is asking HIV primary care providers to share this fact sheet with their patients to encourage participation. Participation includes an interview and a confidential medical record abstraction for each patient.
- This data represents information collected from interviews performed during the 2010 cycle.

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White, non-Hispanic	10.4%	5.2%	15.7%
Black, non-Hispanic	46.5%	33.9%	81.7%
Age at the Time of Interview by Sex			
	Male n=134	Female n=93	Total n=227
18-34	12.6%	9.6%	22.2%
35-44	14.4%	14.8%	29.6%
45-54	25.2%	10.0%	35.7%
55+	6.1%	6.1%	12.6%

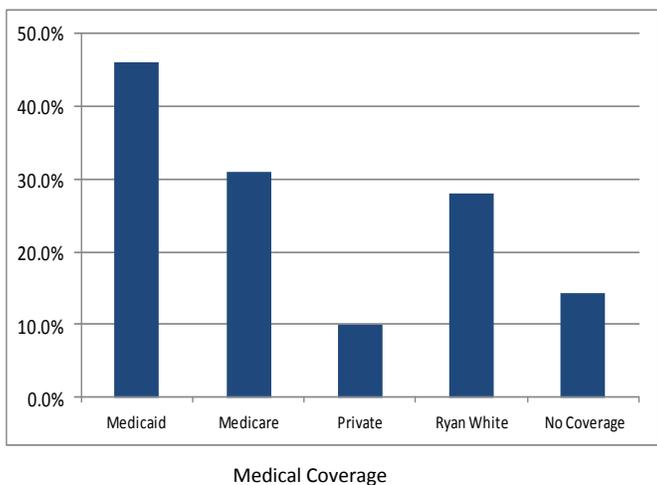
**Time between HIV Diagnosis and Entry into HIV Care (Among Participants Diagnosed in the Past 5 Years)**

- 50 (98.0%) entered into care less than 3 months after diagnosis
  - Of these, 56.9% were male.

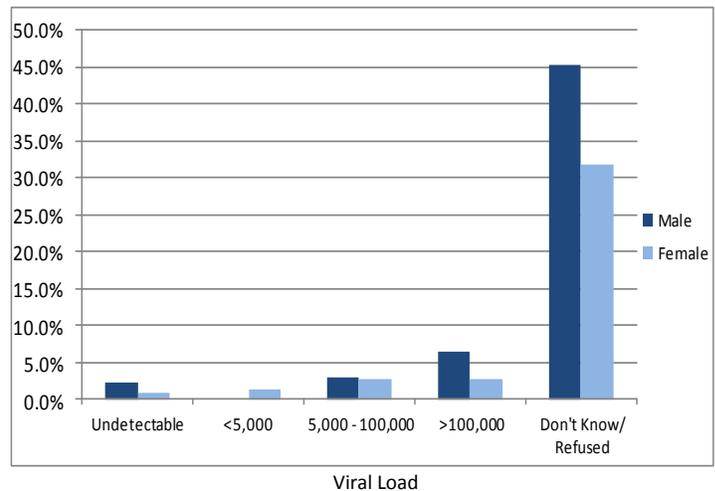
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## Types of Medical Coverage in the Past 12 Months\*\* (Self-Reported)



## Highest Viral Load Ever by Gender (Self-Reported)



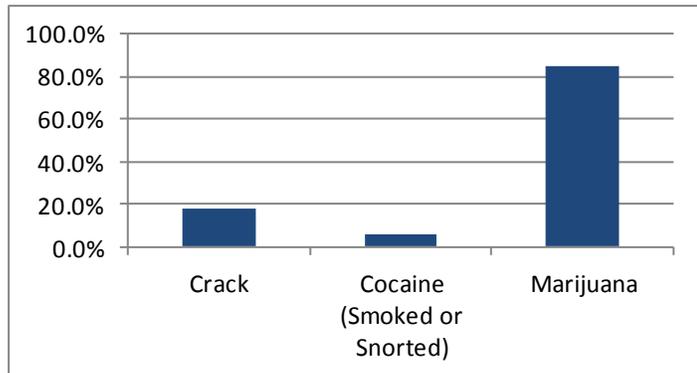
\* Participants who refused to report race are excluded from the Patient Demographic Information table.

\*\* Participants may have responded with multiple types of medical coverage.

### Self-Reported Substance Use in the Past 12 Months

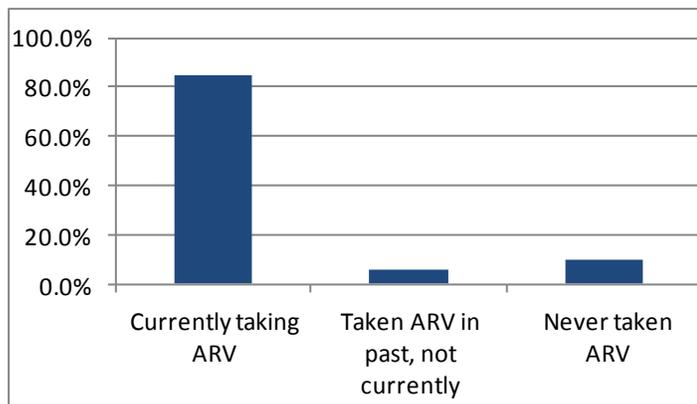
- 52 (22.6%) used non-injection drugs in the past 12 months
- 116 (50.4%) used alcohol in past 12 months
  - Of these, 79 (68.1%) used alcohol in past 30 days
    - Of these, 21 (26.6%) had at least 4 drinks on a typical day when drinking

### Non-Injection Drugs in the Past 12 Months (Self-Reported)



Percentages are of those patients who reported using non-injection drugs in the past 12 months.

### Patient History of Antiretrovirals (Self-Reported)



### Unmet Needs for Services in the Past 12 Months

Services	Needed but Not Received	Main Reason Not Received
Dental Services	64 (54.2%)	Costs too much/Lack of insurance
Public Benefits	24 (23.5%)	In process of getting service; Ineligible/Denied
Meal/Food Services	19 (13.9%)	Ineligible/Denied
Transportation	21 (13.8%)	Didn't know where to go or who to call
Case Management	9 (9.6%)	In process of getting service
HIV Peer Group Support	16 (8.4%)	Didn't know where to go or who to call
Shelter/Housing Services	13 (7.7%)	In process of getting service/ Didn't know where to go or who to call

### Sexual Behavior in the Past 12 Months

- 109 (47.4%) participants reported having oral, vaginal or anal sex
- 28 males reported having oral or anal sex with at least 1 other male
  - Of these, 7 (25.0%) reported multiple male partners
- 35 males reported having oral, anal, or vaginal sex with at least 1 female
  - Of these, 11 (31.4%) reported multiple female partners
- 48 females reported having oral, anal, or vaginal sex with at least 1 male
  - Of these, 2 (4.2%) reported multiple male partners

### Unprotected Sexual Behavior

- 3 (1.3%) males reported having unprotected oral or anal sex with at least 1 male
- 4 (1.8%) males reported having unprotected oral, anal, or vaginal sex with at least 1 female
- 12 (5.3%) females reported having unprotected oral, anal, or vaginal sex with at least 1 male.

## Why should I participate in MMP?

- MMP presents a unique opportunity to contribute to knowledge about HIV care in the U.S. and in Mississippi.
- MMP data will also be used by HIV prevention planning groups, clinicians, Ryan White consortia, and policy leaders to help advocate for additional resources.
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Appendix C: MSDH Focus Group Materials

&

Appendix D: Self-Administered Needs Assessment Survey

**Mississippi State Department of Health**

Office of STD/HIV

Phone (601) 576-7723 / Fax (601) 576-7909

**Survey for Needs Assessment of HIV-Related Services in Mississippi**

Due to MSDH by Friday March 23, 2012

Please circle the letter besides the appropriate answer for questions 1 through 8.

**1. Gender:**

- a. Male
- b. Female
- c. Other (Specify): \_\_\_\_\_
- d. Do not wish to disclose

**2. Age Category:**

- a. 13-19
- b. 20-29
- c. 30-39
- d. 40-49
- e. 50-65
- f. 65 +

**3. Race:**

- a. Black or African American
- b. Caucasian or White
- c. Hispanic/Latino American
- d. Asian/Pacific Islander
- e. Native American/Indian
- f. Other (Specify): \_\_\_\_\_

**4. Ethnicity:**

- a. Hispanic or Latino
- b. Not Hispanic or Latino
- c. Other (Specify): \_\_\_\_\_

**5. Participant Type:**

- a. HIV Service Provider
- b. Person living with HIV (if so please specify the month and year of diagnosis: \_\_\_\_\_)
- c. Other (Specify): \_\_\_\_\_

**6. Sexual Orientation:**

- a. Gay
- b. Lesbian
- c. Heterosexual
- d. Bisexual
- e. Asexual
- f. Do not wish to disclose

**7. Relationship Status:**

- a. Married
- b. Significant Partner (long-term)
- c. Single (includes Divorced/Widowed)
- d. Other (specify) \_\_\_\_\_

**8. Level of Education:**

- a. No schooling completed
- b. 8<sup>th</sup> grade or less
- c. Some High School
- d. High school graduate/GED
- e. Some college
- f. College Graduate
- g. Post-graduate/Prof. Degree
- h. Technical School
- i. Other (Specify): \_\_\_\_\_

STOP: ONLY COMPLETE THIS PAGE IF  
YOU ARE A PERSON LIVING WITH HIV.

1. When was your last HIV primary care visit?
  - a. Less than 3 months
  - b. More than 3 months but less than 6 months
  - c. More than 6 months but less than 1 year
  - d. More than one year
  - e. Not in care
2. How many visits in the past 12 months have you completed for HIV medical care?
  - a. None
  - b. One
  - c. Two
  - d. Three
  - e. Four or more
3. When was the last time you received dental care?
  - a. Less than 3 months
  - b. More than 3 months but less than 6 months
  - c. More than 6 months but less than 1 year
  - d. More than 1 year
  - e. Not in care

9. Please rate your perception of access to HIV-related services on a scale of 1 to 5 using the criteria provided.

<b>Core Services Table</b>	5=Easily accessible near home	4=Accessible but not near home	3=difficult to obtain/ not accessible	2= not available	1=not needed	Comments:
a. Primary HIV Doctor						
b. Prescription Drug Assistance						
c. Laboratory Tests						
d. Dental & Oral Health Care						
e. Early Intervention Services						
f. Health Insurance/ Premiums and Co-Pay Assistance						

g. Mental Health Care						
h. Medical Case Management						
i. Alcohol/Drug Outpatient Treatment						
j. Medical Nutrition Services (provided by a dietician)						
h. Hospice Care						

10. Please rate your perception of access to HIV-related services on a scale of 1 to 5 using the criteria provided.

<b>Support Services Table</b>	5=Easily accessible near home	4=Accessible but not near home	3=difficult to obtain/ not accessible	2= not available	1=not needed	Comments:
a. Case Management (non-Medical)						
b. Food Bank/Pantry						
c. Housing Services						
d. Legal Services						
e. Transportation to Medical Care						
f. Support Group						
g. Referral for Health Care Services						
h. Respite Care						
i. Alcohol/Drug Residential Treatment						
j. Treatment Adherence						

Counseling						
k. Emergency Financial Assistance						
l. Linguistic Services						
m. Pastoral Care/counseling						
n. Rehabilitation Services						

For the items in the Core Services table, please write the top 5 most important services for individuals living with HIV:

- 1.
- 2.
- 3.
- 4.
- 5.

For the items in the Support Services table, please write the top 5 most important services for individuals living with HIV:

- 1.
- 2.
- 3.
- 4.
- 5.

### Focus Group Consent Form

The MSDH is conducting a **30 minute** focus group to determine community/individual needs and barriers regarding HIV/AIDS services in Mississippi. Your participation is completely voluntary and you may choose to leave at any time. The purpose of the focus group discussion is to better understand the gaps in services in our state. The discussion should focus on the services and resources needed for people living with HIV disease to become healthier. Information discussed during the meeting will be kept confidential and each participant may choose a “false” name for use during the discussion to protect your privacy. The group discussion will be tape-recorded in order to capture all ideas and opinions from all participants.

*I read the above and understand the reason for hosting the focus group and agree to participate.*

Participant (print):

Participant (signature):

Date:

Witness (Signature):

## Focus Group Rules

Good morning ( or evening). My name is Vanessa Nicholson and today I will be serving as your facilitator during the focus group discussion. The purpose of the needs assessment is to learn and understand the needs of the community and individuals living with HIV infection. We also want to identify any barriers that exist for access to HIV/AIDS care and treatment services in our state. Your participation in this group discussion will help us to improve the delivery of HIV care and treatment services.

Thank you for your participation. Before we begin, I would like to go over a few ground rules. The rules are as follows.

- All cell phones need to be put on silent or off for the duration of the session.
- Please speak loud and clear.
- Remember to be respectful during the entire time. Remember, the goal is not to agree or disagree; however, it is about hearing and exploring different perspectives.
- Focus on the topic at hand
- Please keep in mind all ideas have value; therefore every idea counts.
- Remember everyone is encouraged to participate and express his/her honest opinion and thoughts to each question.
- Remember we have limited time so we need not stay on a question too long.
- Do not pass judgment on someone's comment
- Each individual's comments will be kept confidential
- Be conscious of body language and nonverbal responses; they can be as disrespectful as words.

### Focus Group Questions

1. What services or resources do people living with HIV infection need?
2. What services or resources do people living with HIV infection need which they are unable to access easily? What are the barriers that limit or restrict access to these services?
3. Are there any services that people living with HIV infection should receive but may not be aware of or understand the need for these services?
4. What do you believe can be done to help HIV infected individuals understand the need of these services?
5. If you had to prioritize services, what would be your top five priorities?
6. Overall, how do you feel about current services available to those individuals living with HIV?

## Appendix E: Active Dentists By County



Appendix F: Statewide HIV Community  
Service Delivery Network-By Ryan White Facilities

Appendix G: Statewide HIV Community  
Service Delivery Network-By Number of People with HIV per County

Statewide HIV Community Service Delivery Network - 2012  
9,907 reported living with HIV disease (12/31/11)

Area/Clinic:	Counties Served:	County Total:
<i>Area I</i> Adult Special Care - 1804 CMCF - 78	Warren	179
	Claiborne	23
	Hinds	2484
	Copiah	107
	Rankin	544
	Simpson	58
<i>Clinic Total (s): 1882</i>	<i>Area/County Total:</i>	<i>3395</i>
Area/Clinic:	Counties Served:	County Total:
<i>Area II</i> GA Carmicheal - 112	Issaquena	4
	Sharkey	12
	Yazoo	126
	Madison	255
	Leake	44
<i>Clinic Total: 112</i>	<i>Area/County Total:</i>	<i>441</i>
Area/Clinic:	Counties Served:	County Total:
<i>Area III</i> Crossroads North - 160 Parchman - 56	Washington	267
	Bolivar	126
	Sunflower	225
<i>Clinic Total(s): 216</i>	<i>Area/County Total:</i>	<i>618</i>
Area/Clinic:	Counties Served:	County Total:
<i>Area IV</i> Deporres Clinic - 301	Coahoma	165
	DeSoto	317
	Panola	64
	Quitman	39
	Tate	30
	Tunica	66
	Tallahatchie	29
<i>Clinic Total: 301</i>	<i>Area/County Total:</i>	<i>710</i>
Area/Clinic:	Counties Served:	County Total:
<i>Area V</i> Garfield Clinic - 550	Marshall	85
	Lafayette	90
	Yalobusha	28
	Benton	8
	Union	32
	Pontotoc	25
	Calhoun	18
	Webster	19
	Tippah	12
	Chickasaw	26
	Clay	50
	Lowndes	156
	Monroe	40
	Itawamba	20
	Lee	195
Alcorn	48	
Prentiss	21	
Tishomingo	8	
<i>Clinic Total: 550</i>	<i>Area/County Total:</i>	<i>881</i>

**\*\*\*Clinics listed are Ryan White Funded Facilities**  
**\*\*Clinic totals are based on AETC clinic needs assessments**  
**\*\*County Data is based on 2011 case reports to MSDH**

Area/Clinic:	Counties Served:	County Total:
<i>Area VI</i> Magnolia Medical Clinic -232	Humphreys	28
	Leflore	143
	Holmes	73
	Carroll	27
	Grenada	95
	Attala	42
	Montgomery	41
	<i>Clinic Total (s): 232</i>	<i>Area/County Total:</i>
Area/Clinic:	Counties Served:	County Total:
<b>** Currently there are no Ryan White funded or HIV Speciality clinics in this area</b>	Choctaw	11
	Oktibbeha	75
	Winston	23
	Noxubee	32
	Neshoba	41
	Kemper	14
	Scott	84
	Newton	42
	Lauderdale	267
	Smith	19
	Jasper	37
	Clarke	44
<i>Clinic Total: ----</i>	<i>Area/County Total:</i>	<i>689</i>
Area/Clinic:	Counties Served:	County Total:
<i>Area VIII</i> Southeast MS Rural Health - 678	Lincoln	65
	Pike	153
	Lawrence	48
	Walthall	32
	Jefferson Davis	37
	Marion	64
	Covington	39
	Lamar	43
	Pearl River	126
	Jones	170
	Forrest	431
	Stone	44
	Wayne	42
Greene	80	
George	23	
Perry	23	
<i>Clinic Total: 910</i>	<i>Area/County Total:</i>	<i>1420</i>
Area/Clinic:	Counties Served:	County Total:
<i>Area IX</i> Coastal Family Health - 406	Hancock	96
	Harrison	711
	Jackson	288
<i>Clinic Total(s): 406</i>	<i>Area/County Total:</i>	<i>1095</i>
Area/Clinic:	Counties Served:	County Total:
<i>Area X</i> <b>** Currently there are no Ryan White funded or HIV Speciality clinics in this area</b>	Jefferson	28
	Adams	115
	Wilkinson	32
	Franklin	11
	Amite	23
	<i>Clinic Total: ----</i>	<i>Area/County Total:</i>



## Appendix H: Ryan White Comprehensive Plan Matrix

Appendix H: 2012 HIV Comprehensive Plan Matix					
Problem /Needs Statements	Proposed Goals	Related Objectives	Key Actions Steps	Responsible Parties	Monitoring Timeline
<b>P1. Limited number of dentists (dental clinics)</b> that provide services to HIV-infected individuals; <b>Limited access to comprehensive oral health care</b> due to lack of dental insurance, inadequate or no Medicaid benefits and/or high out-of-pocket expense.	<b>G1.</b> Increase use of oral health care services by eligible PLWHA in Mississippi.	By June 30, 2013, increase by 10% the number of Ryan White clients who received an annual oral health examination.	1) Establish eligibility requirements to receive oral health care at Ryan White Part B-funded clinics. 2) Use Mississippi-specific Medical Monitoring Project data to establish baseline for objective. 3) Prepare FOA to encourage the implementation of oral health care programs at all Ryan White program sites. 4) Educate professional dental community regarding the need for basic oral health care for PLWHA. 5) Promote availability of FQHC clinics that have dental providers for referral. 6) Monitor kept dental visits using CAREWare or other databases as appropriate.	MMP Program will develop baseline report on dental care utilization. Delta Regional AETC will develop and provide training for oral health professionals. MSDH will develop FOA to increase access to dental care in priority jurisdictions that lack services, such as rural areas.	
		By March 31, 2013, increase by 25% the number of HIV-infected case management clients who had a dental case management plan developed and/or updated.	1) Create standards and methods for dental case management. 2) Train existing case managers to implement dental case management as part global medical management.	MSDH will develop case management standards and methods. Delta Region AETC will develop and provide training for case managers.	
<b>P2. Not enough doctors in rural communities;</b> inconsistency in availability of physicians; many communities have only one physician and that they don't stay there for long period of time.	<b>G2.</b> Increase the number of health providers with the competency to provide adult and pediatric HIV primary care in rural jurisdictions.	By June 30, 2013, increase by 10% the number of HIV-infected individuals that reside in rural settings who had two or more medical visits in an HIV care setting.	1) Provide travel support for HIV pediatrician outreach visits to rural clinic sites. 2) Work with UMMC Family Medicine program to increase training opportunities for family medicine physicians. 3) Develop rural health task force with main objective of getting additional training for providers at FQHCs and rural clinics. 4) Include rural medical scholars program in task force planning. 5) Strengthen J-1 visa program waiver for HIV providers. 6) Meet with UMMC administration to determine feasibility for developing a telehealth consultation system for rural community providers. 7) Promote the availability of specialty HIV consultants for primary care physicians using marketing strategies such as ads in professional journals (e.g, MSMA, MAFM). 8) Monitor number of new providers and number of visits per provider. 9) Review CD4+ cell count data reported through ELR. 10) Review percentage of known PLWHA who are in care. 11) Develop Ryan White Part B FOA to provide funds to increase access to medical services in rural communities.	Prevention Planning Council members will participate in task force. MSDH will convene task force and use Part B funds accordingly. Mississippi State Medical Association and Office Of Rural Health and Mississippi Rural Health Association will have significant roles.	

Appendix H: 2012 HIV Comprehensive Plan Matix					
Problem /Needs Statements	Proposed Goals	Related Objectives	Key Actions Steps	Responsible Parties	Monitoring Timeline
<b>P3. Lack of or limited number of nutritionists and dieticians</b> to address nutrition related issues and/or provide education regarding proper nutrition while on HIV medications.	<b>G3.</b> Increase use of nutritional services by eligible PLWHA in Mississippi.	By June 30, 2013, increase by 5% the number of Ryan White eligible clients who receive dietary nutritional counseling.	1) Define Ryan White eligibility standard for nutritional counseling (research USPHS Standards). 2) Meet with WIC program regarding integrated dietician counseling for ADAP recipients at district health departments. 3) Provide HIV training for WIC nutritionists. 4) Investigate the allied health education curriculum for dieticians and identify opportunities for HIV-specific education curriculum. 5) Offer HIV training opportunities to dietiticians. 6) Refer eligible clients to participating community health centers (FQHCs) for nutritional services.	Delta AIDS Education and Training Center will provide training. MSDH will partner with UMMC School of Allied Health (Dietician Program) and Mississippi Primary Health Care Association (FQHCs).	
<b>P4. Many HIV-infected individuals do not have a medical case-manager</b> that would address needs such as setting up initial medical appointments to link newly diagnosed into care, and providing enabling services to retain people in care.	<b>G4.</b> Increase the use of medical case management services by eligible HIV-infected individuals.	By December 31, 2012, increase by 15% the number of HIV-infected individuals who receive a medical case management work plan.	1) Create the standards for case management; training of case managers to comply with the standards. 2) Define and streamline the case management monitoring data collection methods. 3) Create ad hoc committee to write the case management standards for the state. 4) Review social work curriculum in collaboration with schools of social work in state. 5) Implement use of HIV RAN archiver. 6) Develop a site by site criteria for case management. 7) Engage FQHCs in targeted case management training. 8) Use DIS works to refer clients to FQHC facilities to meet the needs of the newly diagnosed individuals. 9) Quantify the benchmark number of clients served per case manager. 10) Conduct outreach activities to inform private providers about the availability of medical case management services for their HIV positive patients.	Delta Region AIDS ETC and MSDH; Schools of Social Work; Mississippi Primary Health Care Association.	
<b>P5. Lack of or limited availability and access to non-medical case management</b> that would address issues related to <b>housing, transportation</b> , and other non-medical related services and resources.	<b>G5.</b> Increase the use of non-medical case management services by eligible HIV-infected individuals.	By June 30, 2013, increase by 5% the number of community-based organizations that provide non-medical case management (e.g., housing assistance, food banks, etc.)	1) Develop Funding Opportunity Announcement to fund qualified community-based organizations to provide non-medical case management to clients. 2) Connect medical and non-medical case managers through annual or semi-annual training and/or conferences.	MSDH and Community Based Organizations	
<b>P6. Medicaid does not cover cost of dental/oral care related issues</b> other than simple tooth extraction.	<b>G6.</b> Educate policy makers about the benefits of providing basic oral health care for Medicaid beneficiaries with HIV infection.	TBD	TBD	TBD	

Appendix H: 2012 HIV Comprehensive Plan Matix					
Problem /Needs Statements	Proposed Goals	Related Objectives	Key Actions Steps	Responsible Parties	Monitoring Timeline
<b>P7. Limited transportation services</b> , especially for long distance medical related visits.	<b>G7.</b> Provide transportation services for all eligible HIV-infected clients.	By June 31, 2013, increase by 20% the proportion of HIV-infected clients who receive transportation assistance for core services.	1) Develop detailed guidelines for transportation services (e.g., what are the allowable visits? - medication pick-up, dental visits, medical visits). 2) Train case management personnel on process and auditing/accountability methods. 3) Use Part B support to fund transportation contracts for non-Medicaid PLWHA. 4) Use GIS mapping technologies and develop variety of different methods based on mileage caps (<50 miles, between 51 - 100 miles). 5) Distribute and track gas card & bus card use and distribution based on the eligibility criteria. 6) Prepare FOA for contract driver services. 7) Work with existing strategies (Part C, D) to fully support their methods. 8) Implement monitoring methods for case managers to adopt. 9) Develop rules if client declines ride, warning letter, etc.). 10) Investigate vehicle purchase, volunteer driver networks, or certification as a Medicaid transportation provider and explore coordination with other local and regional transportation options.	MSDH, Part C and D grantees, Community-based organizations of interest. Form Ad hoc committee to develop plan - include UMMC Part D case manager.	
<b>P8.</b> Only a handful of peer-driven <b>support groups</b> , and limited funds to support them.	<b>G8.</b> Increase the number of active support groups available in high-impact jurisdictions.	By June 30, 2013, increase by 15% the number of HIV-infected clients who participate in HIV support groups in targeted jurisdictions.	Develop individualized peer to peer navigator program with points of contact through medical provider. Centralized competent trainer to provided dedicated training to CBOs and peer navigators. Possibly model our program using Delta Heart Study model; Contact CFHC (Part C) to understand how they form partnerships with local ASO and other resources to develop a peer support group in the coastal area. (This action will take place in the next 6 months)	Department of Mental Health; CBOs; Meeting with Preventive Health Program to learn more about Delta project. ? Clinical psychologist ?; Coastal Family-Cindy Bruce	
<b>P9. Limited access or availability of reliable long-term housing</b> ; current program offers support to limited number of months rather than for a year.	<b>G9.</b> Enhance support for housing assistance while improving efforts to help clients become self-sufficient.		Enhance collaboration with health providers; Promote and monitor HIV medication adherence to improve health. Recruit members of COC and PTEH; Use SMATF services which offerers transitional housing up to 24 months. Conduct client education during coverage to plan. Model the HIV housing program in Alabama. Implement financial counseling and workforce development counseling for long-term urgent need housing applicants.	Coastal Family, MSDH, and other local agencies, such as Mississippi Department of Transportation	
<b>P10. Lack of or limited access</b> and availability to <b>emergency housing arrangements</b> .	<b>G10.</b> Develop alternate models to increase housing support options in state.	TBD	Provide Community Based Organizations with grant writing technical assistance to apply for competitive HUD grant applications to support housing options for HIV clients.	MSDH and HUD. Community Housing Organizations.	

Appendix H: 2012 HIV Comprehensive Plan Matix					
Problem /Needs Statements	Proposed Goals	Related Objectives	Key Actions Steps	Responsible Parties	Monitoring Timeline
<b>P11. Newly diagnosed patients</b> oftentimes experience <b>depression</b> and they have no reliable access to <b>mental health services</b> . These individuals also <b>may be unaware of HIV-related services available</b> .	<b>G11.</b> Increase access to mental health services.	By December 31, 2013, increase by 5% the number of clients who receive intensive case management to include mental health assessment during first three months of diagnosis and periodically as per periodicity schedule.	Implement mental health assessment as part of the initial case management visit. Identify referral sites for mental health services. Include in the mental health assessment methods in case management standards provide training, etc. Incorporate mental health into care and services	MSDH and Department of Mental Health (for T/A)	
<b>P12. Health insurance companies deny policies</b> to HIV infected individuals as they learn about applicant's HIV status.	G12. Provide coverage for Pre-existing Conditions.	TBD	Targeted meeting with DFA regarding EOBs and health insurance FOAs. How do we influence the health insurance exchange development process in MS? case management for PICA? Work with MS Center for Justice. Identify insurance reps to participate in planning council. United healthcare for CHIP? Blue Cross Blue Shield?	MSDH	
<b>P13. Primary care physicians lack knowledge</b> regarding effective HIV treatment and care and there are not enough infectious disease physicians.	G13. Implement educational benchmarks for targeted areas and provide education.	By December 31, 2013, increase by 25% the number of health providers who receive targeted HIV education and training.	Reference goal #2 also. Work with professional organizations and medical school to increase education benchmarks. Work with Delta Region AIDS Education and Training Center to increase education and training of DOs (Hattiesburg) and Physician Assistants (Mississippi College Program). Meet with medical school in Hattiesburg (thru Dr. Dobbs). Discuss with the school of nursing - nurse practitioner program. Check into the MC PA program.	MSDH	
<b>P14. Multiple primary physician visits:</b> People living with HIV/AIDS have to visit more than one doctor to address their needs and their agendas are full of multiple appointments to see multiple physicians.	G14. Integrate HIV/AIDS care into other systems of care, such as FQHCs, to improve coordination of services.	TBD	1) Explore the use of "Health Home" models such as is being piloted in Jackson and the Mississippi Delta for cardiovascular disease and diabetes. 2) Increase # of referrals to Part C grantee FQHC health clinics (e.g., Magnolia Medical Center in Greenwood); Influence HIV providers to encourage primary care providers access for non-HIV care. Provide education about the existing HIV Continuum of Care to HIV-infected clients and health care workers.	MSDH. Delta Region AETC.	
<b>P15.</b> People living with HIV/AIDS have limited access to <b>legal services</b> to address issues related to discrimination.	<b>G15.</b> Increase access to legal services for discrimination and rights violations.	TBD	1) Create legal information resource packets and toolkits for consumers and Community Based Organizations.	MSDH and MS Center for Justice.	
<b>P16.</b> Because of <b>stigma</b> , people are less likely to get tested for HIV at their local health department.	<b>G16.</b> Implement peer navigator system.	TBD	1) Create public anti-stigma campaigns, including social media, to increase awareness and understanding of HIV/AIDS, and involve target audiences in the development of stigma campaigns.	MSDH and Community Based Organizations	
<b>P17. HIV medications are very expensive;</b> and supply is limited to only 1 month therefore, people have to travel far away to get their medications every month (far because of confidentiality concerns)	<b>G17.</b> Improve the delivery of HIV medications to clients.	TBD	1) Create work group to explore co-pay and insurance premium payment system using Federal resources such as Ryan White Part B and/or state resources.	MSDH	
<b>P18. Federally funded programs such as Ryan White and Medicaid</b> are very limited to certain communities, and not everyone is qualified to receive the benefit (strict criteria).	<b>G18.</b> Implement new Health Care Insurance options as per Affordable Care Act requirements.	TBD	1) Meet with the Division of Medicaid to discuss implementation of HIV benefit benchmarks.	MSDH and Division of Medicaid	

Appendix H: 2012 HIV Comprehensive Plan Matix					
Problem /Needs Statements	Proposed Goals	Related Objectives	Key Actions Steps	Responsible Parties	Monitoring Timeline
<b>P19. Lack of resources and services in rural communities (including transportation services, alcohol and drug rehab services, and support services);</b> many CBOs provide similar resources and are not spaced out - duplication of effort occurs.	<b>G19.</b> Improve coordination of HIV services for clients statewide.	See objectives for improvement of case management system (P4 and P5)	1) See key actions for improvement of case management system (P4 and P5). 2) Meet with Mississippi Development Authority to explore collaborations to improve access to services for individuals with transmissible diseases.	MSDH and collaborative partners	
<b>P20. Confidentiality</b> is a major personal barrier to receiving appropriate care and treatment services.	<b>G20.</b> Adopt necessary systems changes to improve confidentiality and security for clients.	TBD	Work with the local ASO and staff of the health department to develop MOU or other policies sharing information without breach of confidentiality. Education of how the DIS surveillance system works and how informaiton is protected presently. Public health committee making recs for medical education.	MSDH and collaborative partners	
<b>P21.</b> Rural residents are unaware of their risks for contracting the disease and about <b>what's available for them to access in neighboring communities.</b>	<b>G21.</b> Improve marketing and public relations about HIV services in Mississippi.	TBD	1) Improve MSDH website information about HIV services. 2) Implement visible marketing information on public billboards and public transportaation vehicles, and implement use of radio/TV ads. 3) Promote and monitor use of mobile van in rural communities for HIV testing.	MSDH	
<b>P22. Education and awareness regarding HIV disease prevention,</b> transmission risks, and consequences is low among youth, and in rural communities.	<b>G22.</b> Increase public knowledge and awareness about HIV infection and tranmission.	TBD	1) Use assistance from social workers and DIS workers to refer clients to local rural HIV service providers. 2) Advocate for comprehensive, evidence-based sex and health education in Mississippi's public schools to give youth information to make appropriate behavioral choices.	MSDH, Delta Region AETC, MS Department of Education.	
<b>P23. Locating former prisoners</b> who may be HIV positive becomes difficult after they are released from prison.	<b>G23.</b> Reinstate case management services for incarcerated HIV clients on discharge from jail/prison.	By December 31, 2013, increase by 10% the number of released prisoners who receive an HIV case management care plan.	1) develop an incarcerated client case management care plan on discharge - UMMC beginning July 1 will have responsibility for care of the incarcerated patients - reinstate discharge planning that was discontinued before. Work with youth courts and juveline detention centers.		
<b>P24. Language barriers</b> frequently prevent special populations such as the Hispanic population from seeking and receiving adequate care.	<b>G24.</b> Assure that all clinical HIV care sites have access to language interpreters.	TBD	TBD	Work with Office of Health Disparities.	
<b>P25. Operational systems to achieve goals in Mississippi are ineffective and inefficient.</b> For example, Mississippi HIV Planning councils are separate (HIV Prevention and RW) and National HIV/AIDS Strategy encourages High-Impact HIV Prevention which includes prevention through positives.	<b>G25.</b> Streamline processes and improve systems-level planning and communciation to enhance impact.	By June 30, 2013, achieve at least 60% of HRSA corrective action plan benchmarks.	1) Fulfill Corrective Action Plan to improve Ryan White Part B services in state. 2) Identify and invite targeted skills expertise to participate in planning coucils. 3) Continue formal dialogue between the MSDH and community members to improve communication, transparency, and understanding. 4) Create a government interagency work group on HIV/AIDS to facilitate implementation of 2012 HIV Comprehensive Plan.		