MISSISSIPPI STATE DEPARTMENT OF HEALTH

2017-2021 Integrated HIV Prevention and Care Plan

September 2016

TABLE OF CONTENTS

2017 - 2021 Mississippi Integrated HIV Prevention and Care Plan

A) Introduction

The Integrated HIV Prevention and Care Plan will be a "living" document used to guide HIV care and planning. As such, it will be reviewed at least annually by the Mississippi Department of Health (MSDH) HIV/STD Office and the Mississippi HIV Planning Council (MSHPC) to assess if changes are needed at the jurisdictional level. If it is determined changes are needed, an updated Integrated HIV Prevention and Care Plan will be developed and submitted.

MSHPC used the socio-ecological model as a conceptual framework for the development of the Integrated HIV Prevention and Care Plan. Using this model assures that a multilevel, holistic coordinated approach—one that is both clinical and social—was used in order to address the social and environmental determinants to health in the Mississippi HIV prevention and care system.[1] It also assures that the findings of the Integrated Coordinated Statement of Need are addressed in the Integrated HIV Prevention and Care Plan. The needs assessment was used to identify the following key findings of the Integrated Coordinated Statement of Need:

#1. Efforts to implement the National HIV/AIDS Strategy (NHAS) in Mississippi are severely hampered by insufficient Federal and State funding.

- Participate in a coalition of southern states to advocate for a fair Federal funding formula to account for the burden of HIV disease in the south.
- Seek to expand State funding of prevention programs directed at the general community to enhance awareness, dispel myths, and support the public health agenda.

#2. Stigma, which is a complex and multifaceted phenomenon, when combined with fear of disclosure acts as a significant barrier to encouraging those at high risk from being tested and receiving care in Mississippi.

- Support evidence-based messages that reduce stigma and educate the general public about HIV and its transmission.
- Ensure that all employees of HIV care sites funded with Part B monies receive ongoing training in client-centered care, cultural sensitivity, and HIPAA requirements.
- Support early intervention services that utilize community outreach workers, peer or patient navigators to shorten the timeframe for linkage to care to less than the HAB standard, ideally to within one week of diagnosis. Peer navigators/community health workers may also serve to help build trusted relationships, support HIV testing, and physically bring new and repeat positives to their clinical appointments for at least six weeks following linkage to care.
- Public policy dictates the Department of Health's responsibilities for HIV surveillance and must ensure that notification of possible exposure will be confidential and that parties involved will not be prosecuted.

- Ensure that all Ryan White-funded sites have grievance provisions to investigate claims of HIPAA violations and that procedures existing to ensure disciplinary actions are taken against employees found to violate client confidentiality.

#3. Low health literacy levels compound the problem of HIV stigma in Mississippi and require a comprehensive strategy for HIV prevention, education and testing.

- Implement a program to improve health literacy for all receiving care and support services under RWHAP.
- Use multimedia campaigns (e.g. print, infographics, social media, TV and radio) to educate the general population as well as those at highest risk for HIV.
- The statewide educational strategy should promote routine testing for all persons and provide counseling about testing and results.
- Develop innovative strategies to educate mothers, wives, girlfriends and partners of those at risk about creating conversations with loved ones and friends about prevention.
- Support community-based organizations to bring the conversation to faith-based organizations, barber shops, beauty salons, AA and NA groups, and other groups within the community.

#4. As the major coordinating body for HIV funds, the Mississippi State Department of Health has an excellent opportunity to encourage collaboration, sharing of evidence-based best practices, and enhancing efforts to reduce mortality rates and increase viral load suppression.

- Coordinate all RWHAP-funded clinics in an expanded, more structured quality management program and utilize the clinical database for frequent reporting of quality indicators.
- Develop physician collaboratives with nursing and case management.
- Enhance data systems via the integration of surveillance, ADAP, care, and HOPWA data.

#5. Given resource constraints, Mississippi does an excellent job with stretching limited resources. Coordination among various other divisions with the Department of Health and other entities of State Government could enhance efforts to serve the needs of PLWH and those at risk for infection.

- Work with the State Board of Medical Licensure and Medical Society to ensure that all physicians abide by rules for reporting of all persons who test positive for HIV.
- Work with Mississippi Primary Health Care Association, Mississippi Department of Mental Health, and other agencies/organizations to encourage better coordination of primary medical care and community-based mental health and substance abuse services to PLWH and to provide routine testing for HIV on an opt-out basis.
- Encourage cooperation between State and local health departments and school districts to ensure high school students are provided with evidence-based, age-appropriate information about HIV and other sexually transmitted diseases as part of a health education program grounded in the benefits of abstinence, while ensuring that young people who are sexually active (nearly 50% of Mississippi high school students) have the

information they need to protect themselves from sexually transmitted infections (STIs) or other unintended consequences.

- Develop a comprehensive plan with the Department of Corrections for care and treatment of incarcerated PLWH and ensure those scheduled for release are promptly linked to care in the community.

#6. While 38% of Mississippi's PLWH live in the Jackson MSA, more than half are living in rural areas of the State that are not well served by medical and dental providers, and which lack transportation networks.

- Ensure that services are as equitably distributed as possible given the State's rural character, and enhance funding to provide transportation services
- Fund dental services in rural areas of the State.
- Fund HIV medical providers or FQHCs in areas lacking services, and consider the use of telemedicine services to link private physicians to infectious disease specialists in Jackson, including the University of Mississippi Medical Center.

#7. The high poverty rate in Mississippi adds to difficulties that PLWH encounter in getting into and staying in care.

- Fund HIV medical providers or FQHCs in areas lacking services, and consider the use of telemedicine services to link private physicians to infectious disease specialists in Jackson, including the University of Mississippi Medical Center.
- Fully fund ADAP to meet comprehensive pharmaceutical needs of PLWH.

#8. Funding shortages for HIV-specific services have been and are likely to continue. To ensure that PLWH receive their fair share of benefits, enhance communication and collaboration between RWHAP and community-based providers.

- Enhance referral relationships through the development of formal referral agreements or Memoranda of Understanding and, with the client's consent, sharing of patient health information (PHI).
- Establish coalitions to coordinate efforts that maximize HIV testing, linkage and retention in care.
- Seek counsel from non-funded community-based organizations, ASOs and PLWH on policies that impact prevention and care services delivery.

The specific activities and evaluation plans are outlined in the next section of this document, the **Integrated HIV Prevention and Care Plan**. These key activities represent a commitment by the Mississippi Department of Health HIV/STD Office and the Mississippi HIV Planning Council to reach affected populations and provide high-impact HIV prevention interventions. Over the next five years, MSDH in partnership with the MSHPC will continue to ensure that resources match disparities and findings in the Integrated Coordinated Statement of Need in order to align Mississippi HIV prevention and care goals at the community and state levels with the National HIV/AIDS Strategy goals.

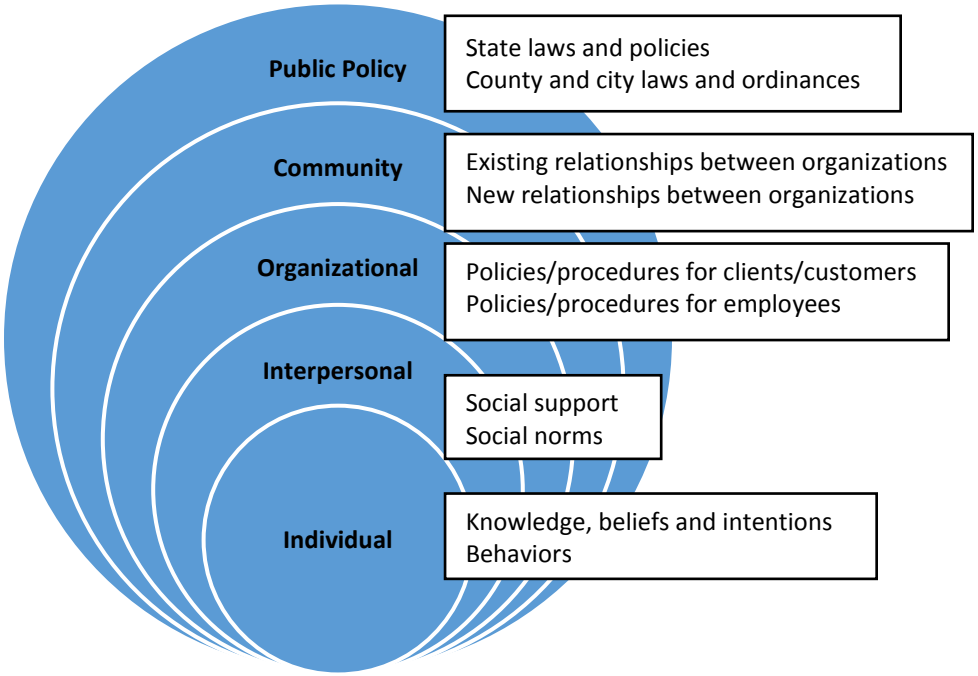
This will include regular reporting on surveillance and other data, review of the Integrated HIV Prevention and Care Plan objectives and progress, ongoing efforts to maintain the currently engaged partners such as the Mississippi Department of Mental Health, people living with HIV, and Ryan White Grantees from Parts A-F. Additionally, MSDH in partnership with the MSHPC will continue to determine what additional partners are needed and recruit them accordingly.

Four main themes emerged from the planning process, which is described below in the **Collaborations, Partnerships and Stakeholder Involvement** section**.** The themes were cross-referenced with the National HIV/AIDS Strategy (NHAS) goals in order to assure alignment. The four themes are:

- Preventing and reducing new HIV infections
- Improving access to HIV prevention and care services
- Increasing the capacity of clinicians and clinical settings to provide high quality, culturally competent and effective HIV prevention and care services
- Enhancing coordinated care efforts

The themes identified and the goals and strategies prioritized by the Mississippi HIV Planning Council were also cross-referenced with the Mississippi socio-ecological model to assure the strategies included in the plan address all five levels within the model.

Figure #1 - Mississippi's Socio ecological Model for Plan Development



Below are examples of how the Integrated HIV Prevention and Care Plan addresses the levels within the model.

- *Public Policy:* Advocating for funding formulas that account for the burden of HIV disease in Mississippi

- *Community:* Developing relationships with the Mississippi Primary Health Care Association to aid in increasing the number of HIV care providers across the state
- *Organizational*: Implementing opt-out HIV screening at annual wellness visits or other health visits
- *Interpersonal:* Quarterly training for health care staff and consumers on cultural sensitivity and competency according to the CLAS standards
- *Individual:* Enhancing Partner Services

Highlighted areas of focus included in the 2017-2021 plan are:

Increasing Mississippi's Capacity to Implement an Insurance/Third Party Payer Plan Approach

Many states are moving from being a significant provider of HIV direct services, to non-governmental models of service provision through local rural community health centers, private care sites community based organizations (CBOs) and AIDS Serving Organizations (ASOs) as the main providers of HIV direct care services. Mississippi's public health system has been impacted by a significant budget cut of 11%, a decrease of $4 million for FY17. As a result, MSDH has laid-off 64 clinical staff (physicians, nurses, nurse aids and clerks), 9 public health clinics across the state have closed, and additional 89 positions have been left vacant, and staff cuts at the Central office are expected to occur through attrition. These cuts in staffing and funding exacerbate the Health Department Barriers described in the Coordinated Statement Need. Given these realities the MSDH is no longer able to continue to afford to subsidize personnel at the state laboratory where HIV tests are processed, or the Cross Roads Clinic which is currently run by the MSDH. Instead, MSDH will develop a billing model to increase self-sufficiency. Other alternative sources of funding to support the HIV care system in becoming more self-sufficient are needed. In five years' time, it is possible there will no longer be county level clinics operated by the MSDH, underscoring the need for transitioning direct care services from the state to the community level.

The Mississippi Department of Health is actively restructuring its operations to focus on population level health services that it is best suited to address, chiefly surveillance and administration of funds to community level clinical, and supportive care (e.g., housing, case management, etc.) providers. As such, a significant focus of the MSDH, Office of HIV/STD's efforts during the 2017-2021 period will be on building capacity at the community level to assume responsibility for direct care provision including linkages to care, targeted population HIV testing, general population HIV testing, and medical care management. MSDH will also need to develop the structures for the state to utilize an "insurance model" wherein community level service providers bill for services provided, rather than being sub-recipients of Ryan White Care Act (RWCA) Part B funds. Infrastructure that needs to be developed in order to support this transition includes: community level provider organizations' logistical capacity to bill services; developing a billing system that is rooted in the Mississippi standards of care; and increasing individual community level clinical and service staff's insurance systems and coding literacy.

Fully Implementing Data to Care

Data to Care will also be of significant focus for MSDH to address the Mississippi HIV Care Continuum. Currently, viral suppression data is strong for people living with HIV (PLWH) who

are in care through RWCA sites (77.56% viral load suppression, State of Mississippi 2016). The same is not true for PLWH in other clinical settings or who are not in care. A Health Care Continuum is developed for each RWCA Part B funded clinic to aid in viral suppression performance improvement and direct resources to lower performers. Fully implementing a Health Department Model to use HIV surveillance data to support the HIV Care Continuum approach will further Mississippi's ability to improve health outcomes for PLWH and prevent new infections.

Strengthening the Standards of Care

Mississippi follows the national standards of HIV care as described in the HIV/AIDS Bureaus' Policy Clarification Notice #16-02 (#16-02). However, a clearly defined set of standards and specific services that can be billed for is lacking. Thus, a focus of this plan, especially in FY 2017, is to develop standards of care for Early Intervention, Medical Case Management, and Outpatient/Ambulatory Health Care Services. Doing so will ensure HIV care delivery is consistent throughout the state and that providers bill and code for services appropriately. Establishing these standards lays the foundation for conducting meaningful monitoring. Currently, with the exception of the internal monitoring done by the MSDH, it is not clear what elements of the Early Intervention, Medical Case Management, and Outpatient/Ambulatory Health Care Services, as outlined in #16-02, are being conducted and/or documented at Ryan White funded sites.

Establishing clear standards of care and billable services will also aid in closing gaps identified in the Integrated Coordinated Statement of need. As examples:

- *Outpatient/Ambulatory Health Care Services* allowable services may include treatment and management of both physical and behavioral health conditions which would in turn support expanding access to services that are being impacted by the state budget cuts. The Mississippi Department of Mental Health has sustained a 4.4% cut or $8 million, in FY 16, on top of a 1.5% cut and a .43% cut in FY 16. As a result, no longer are there state run chemical dependency units for males, adding to the waiting lists of services at the community mental health units within the 9 public health districts. The Mississippi State Hospital 29-bed Acute Psychiatric Services Unit has closed, eliminating a resource to provide treatment for individuals with co-occurring mental disorders and complex medical conditions.

- A more uniform approach to delivering and reimbursing for *Early Intervention Services* can narrow the gap in people testing positive for HIV, then being linked to and retained in care, if there are clear guidelines to follow, codes to bill for, and monitoring requirements in place.

- *Medical Case Management* includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication); thus, the eventual standards of care may include increased use of telemedicine to address service gaps in rural Mississippi.

Enhancing Access to Transportation and Telemedicine
Rural Mississippi has gotten lost in the Mississippi HIV epidemic with the five county primary epicenter in the Jackson Metropolitan Statistical Area (MSA). There are sixteen additional counties of interest in the Mississippi HIV epidemic, only one of these close to the Jackson MSA. Outside of the Jackson MSA medical services are scarce as noted in the Coordinated Statement of Need.

Funding for transportation is lacking among both rural and non-rural areas. Determining a plan of action to best direct funding to support transportation options will increase access to care.

Through securing telemedicine sites closer in proximity to our patients' homes, we will address transportation barriers and ensure continuity of care for PLWH and those at risk who reside in rural Mississippi.

Reducing HIV Related Stigma for Consumers and Providers
Stigma reduction must continue to be a focus for both MSDH and service providers at the community level. Mississippi is a conservative state where religion and race are deeply woven into the social, cultural and political landscape in ways that can lead to stigma around HIV. The Coordinated Statement of Care referenced multiple concerns voiced by PLWH and clinical and service providers~~,~~ regarding being identified as HIV positive. This concern negatively impacts both at risk individuals' willingness to be tested for HIV, and PLWH's willingness to access medical care. Clinical providers' own lack of experience and attitudes toward HIV, MSMs and or other people at risk for or PLWH have a further deleterious impact on access to HIV testing and treatment.

There are HIV-related criminal laws in Mississippi that address~~,~~ sex, needle sharing, spiting/biting/blood exposure, tissue, organ, blood and semen donation. Mississippi has a broad HIV exposure law that can be applied to any sort of HIV exposure. Mississippi's felony exposure statute also includes Hepatitis B and Hepatitis C (Center for HIV Law and Policy, 9/4/16 Access at http://www.hivlawandpolicy.org/states/mississippi). Before HIV decriminalization can happen, capacity building and awareness raising first occur and will be the focus of our efforts for the first year of this plan. The Southern AIDS Coalition with other non-governmental entities will play a significant role in addressing this; for example, hosting a regional summit to develop a call to action for southern states~~,~~ and demand that national entities such as CDC, NIH and Congress respond fiscally to the needs of southern states by shifting funding according to need. In addition, we can work with the regional AIDS Education Training Centers to be a part of the summit and in the development of the call to action that results.

B) Integrated HIV Prevention and Care Plan

The 2017-2021 Plan strives to address ongoing needs and respond to emerging needs as they are identified. The three NHAS goals of the Plan are:

- Goal 1: Reduce new HIV infections.
- Goal 2: Increase access to care and improve health outcomes for PLWH.
- Goal 3: Reduce HIV related disparities and health inequities.

The objectives, strategies and activities contained within aim to address the needs, gaps and barriers already described in this document. The MSHPC may convene work groups as needed to discuss and monitor activities, challenges or barriers to implementation of the plan, with all the collaborating partners kept abreast of developments. Table 1 provides a list of the counties in each Health District and the total population. Target counties for plan activities are those within each district that had >20 cases of HIV diagnoses or an incidence rate of 16.2/1,000 population or higher in 2014.

Table 1 – Target Counties for HIV Prevention and Care Plan

District	Counties	2014 Population
District 1 Northwest 9 Counties	Coahoma, Desoto, Grenada, Panola, Quitman, Tate, Tallahatchie, Tunica, Yalobusha	322,559
District 2 Northeast 11 Counties	Alcorn, Benton, Itawamba, Lafayette, Lee, Marshall, Pontotoc, Prentiss, Tippah, Tishomingo, Union	365,596
District 3 Delta/Hills 9 Counties	Attala, Bolivar, Carroll, Holmes, Humphreys, Leflore, Montgomery, Sunflower, Washington	212,511
District 4 Tombigbee 10 Counties	Calhoun, Chickasaw, Choctaw, Clay, Lowndes, Monroe, Noxubee, Oktibbeha, Webster, Winston	245,987
District 5 West Central 10 Counties	Claiborne, **Copiah, Hinds, Madison, Rankin, Simpson**, Sharkey, Issaquena, Warren, Yazoo	638,862
District 6 East Central 9 Counties	Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Scott, Smith	243,058
District 7 Southwest 9 Counties	Adams, Amite, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall, Wilkinson	173,000
District 8 Southeast 9 Counties	Covington, Forrest, Greene, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne	307,606
District 9 Coastal Plains 6 Counties	George, Hancock, Harrison, Jackson, Pearl River, Stone	475,166

2017-2021 MISSISSIPPI INTEGRATED HIV PREVENTION AND CARE PLAN:

NHAS Goal: #1 Reducing New HIV Infections			
SMART Objective 1: Annually by December 31, add 5 new (unduplicated) sites to the total number of DMH certified residential alcohol/drug treatment clinics that perform opt out rapid HIV testing.			
Strategy relates to? Finding #3: Low health literacy requires a comprehensive strategy for HIV prevention, education, and testing.			
Who is responsible? Dept. of Mental Health & MSDH			
Activity	**Time Frame**	**Evaluation Measures**	**Data Source**
Provide training to support SAMHSA sub-recipients to focus testing for at risk populations- IUD, African Americans, MSM?	January – December 2017	# of participating clinics; # of participants who complete training per site; participant pre-post evaluation survey.	MSDH Training logs
Implement HIV screening at MS Dept. of Mental Health Alcohol and Substance Use clinics/programs.	January – December 2017	Obtain enrollment baseline Dept. of Mental Health for each clinic site.	DMH
Monitor testing progress and set annual goals for each successive year through 2021.	Monthly	# of tests performed; seropositive rate per site per month.	EvaluationWeb
Anticipated Barriers or Challenges			
Buy in from mental health staff			
Need for Planning Council Workgroup? Yes			
SMART Objective 2: Annually by December 31, add two (2) new sites that perform general HIV screening as a routine component of an annual wellness visit as per CDC recommendations. Sustain support annually for MSDH public health lab to perform at least 70,000 HIV tests			
Strategy relates to? #2 Stigma reduction ("normalize testing") and #6 improve rural access to services.			
Who is responsible? MSDH , AETC, MPHCA			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Meet with MPHCA to determine the use of opt out	May 2017	Meeting held	Meeting notes

HIV testing protocols as part of annual wellness exams at the 21 FQHCs in Mississippi.			
Provide training and other support as needed for general HIV testing for FQHC clinics and implement opt-out testing at these sites. Include reimbursement for HIV screening to ensure that those who have insurance.	Quarterly	# of FQHC sites that offer HIV testing as part of general screening; # of tests performed monthly; seropositive rates	Training logs, EvaluationWeb or other testing database.
Continue to provide financial support to the Public Health Lab to perform confidential HIV testing for opt out tests done at public health clinics in all nine Public Health Districts.	Ongoing	# of tests performed by site; # of positive test results.	Apollo LIMS (lab results database)
Advertise a schedule of trainings to providers through professional associations – MSMA and MS Medical and Surgical Society. Expand to non-physician provider organizations (e.g., nurses, dentists, etc.)	Annual	# of advertisements; # of associations advertisements reached.	AETC
Through collaboration with MSAETC, contact urgent care centers in the Jackson MSA to determine their interest in offering HIV screening as a part of their intake for all clients.	June 2017	Meetings held	Meeting notes, MOUs
Meet with Walgreen's	June 2018	Meetings held	Meeting notes, MOUs

leadership in Mississippi to determine interest in identifying stores that serve counties that have 20 or more cases or a case rate of 16.2. to determine their interest in offering HIV testing.			
Anticipated Barriers or Challenges			
Payment of tests for those who are uninsured or underinsured			
Need for Planning Council Workgroup? Yes			
SMART Objective 3: Annually by December 31, add one (1) new health care or non-health care site that provides targeted HIV testing in the Mississippi counties with greater than 20 cases or incidence rate of 16.2 per 100,000 people.			
Strategy relates to? #5 Resource constraints and need to enhance efforts.			
Who is responsible? MSDH			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Release RFP to identify and support new sites to implement targeted rapid HIV testing for disproportionately affected communities at non-MSDH sites (e.g., healthcare or non-healthcare sites).	Release RFP August 2017 Identify new subgrantees by January 1, 2018.	# of sites that respond to RFP and submit proposals; # of selected proposals.	Program data
Provide HIV testing training at new sites	March 2018	# of new sites trained	Training logs
Monitor HIV testing activities at sites	Ongoing	# of tests performed; seropositive rate per site per month.	EvaluationWeb, eHARS
Discuss the need with Ryan White-funded Provider sites to expand HIV outreach testing and prevention activities. This could be implemented as a	June 2017		

standard of care for Early Intervention Services at these sites.			
Anticipated Barriers or Challenges			
Capacity of existing CBOs, non MSDH clinical sites and other sites to offer targeted HIV testing.			
Need for Planning Council Workgroup? Yes			
SMART Objective 4: Annually by December 31, identify at least one (1) new PEP/PrEP health provider in Mississippi and inform the public.			
Strategy relates to? #3 Low health literacy requires a comprehensive strategy for HIV prevention, education, and testing.			
Who is responsible? AETC			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Educate health care workers about PEP/PrEP services and the drug assistance programs and alleged availability of PrEP through the Medicaid Family Planning Waiver Program.	Bi-annually	# of training participants; type of topics covered at trainings	Training materials and logs
Create PEP/PrEP marketing messages to encourage the public to ask healthcare workers about access to these options.	Ongoing	# of marketing encounters (e.g., PSAs, etc.); # of impressions and interactions.	Media data
Distribute information to delegate Family Planning clinics to encourage PEP/PrEP counseling and prescriptions (offer training as needed).	June 2018	# of sites that receive information;	Distribution logs
Designate sites that provide PEP /PrEP and are meeting or exceeding standards of excellence which could	January 2020	# of center of excellence awarded versus # of sites.	Certificates issued

encourage other sites to participate.			
Anticipated Barriers or Challenges			
No Medicaid expansion in state; high prevalence of self-pay patients who are uninsured/underinsured make it difficult to recruit providers.			
Need for Planning Council Workgroup? Yes			
SMART Objective 5: Annually by December 31, add one (1) new health care or non-health care site that provides targeted HIV testing in the Mississippi counties with greater than 20 cases or incidence rate of 16.2 per 100,000 people.			
Strategy relates to? #5 Resource constraints and need to enhance efforts.			
Who is responsible? MSDH			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Release RFP to identify and support new sites to implement targeted rapid HIV testing for disproportionately affected communities at non-MSDH sites (e.g., healthcare or non-healthcare sites).	Release RFP August 2017 Identify new subgrantees by January 1, 2018.	# of sites that respond to RFP and submit proposals; # of selected proposals.	Program data
Provide HIV testing training at new sites	March 2018	# of new sites trained	Training logs
Monitor HIV testing activities at sites	Ongoing	# of tests performed; seropositive rate per site per month.	EvaluationWeb, eHARS
Discuss the need with Ryan White-funded Provider sites to expand HIV outreach testing and prevention activities. This could be implemented as a standard of care for Early Intervention Services at these sites.	June 2017		

Anticipated Barriers or Challenges			
Capacity of existing CBOs, non MSDH clinical sites and other sites to offer targeted HIV testing.			
Need for Planning Council Workgroup? Yes			
SMART Objective 6: Annually by December 31, increase by 15% organized community outreach activities (e.g., reproductive health education in community settings, etc.) using HIV-focused Community Health Workers and provide HIV education/prevention update trainings at least bi annually to CHWs.			
Strategy relates to? #3 Low health literacy and need for comprehensive strategy for HIV prevention, education, and testing.			
Who is responsible? MSDH, CBOs and FQHCs, AETC			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Continue to recruit, train and develop HIV focused community health workers and peer navigators that are from the community and reflect the various age groups, education levels, sexual orientation and genders of PLWH and at risk for HIV Infection in Mississippi. Collaborate with such as the Black Treatment AIDS Network, Mississippi Center for Justice, JMM and My Brother's Keeper, to provide training and/or identify possible individuals to become certified peer navigators.	December, 2018	# of individuals trained # of classes held # of trained individuals working as CHW 6-12 months post training.	CBO/ASO, etc reports
Develop an internship model for students and recruit from local HBCUs who may be interested in public health as a career.	December, 2018	Internship models, # of internships	MOU's, reports, pre-post interviews.
Provide training on HIV-	December, 2018	#of trainings conducted and	Training records

related Stigma to CBOs and faith based organizations to increase community mobilization to address HIV among LGBT people and reduce stigma associated with their sexual orientation and gender identity.		the number of participants who complete the trainings.	
Anticipated Barriers or Challenges			
Availability of trainers, stigma among students and institutions.			
Need for Planning Council Workgroup? No			

NHAS Goal: #2 Increasing Access to Care and Improving Health Outcomes for PLWH			
SMART Objective 1: Improve surveillance data to care analysis to reduce the number of erroneously identified out of care individuals by 5-10 % annually.			
Strategy relates to? #4 Encourage collaboration, sharing of evidence-based best practices, and enhancing efforts to reduce mortality and increase viral suppression.			
Who is responsible? MSDH			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Fully implement Data to care (DH).	August 2017	Out of care line listing produced and distributed to linkage staff.	eHARS, PRISM
Improve risk factor ascertainment and data quality.	Monthly	Fewer numbers of records needing correction in eHARS and Prism each month.	eHARS, PRISM
Develop a new model of MSDH employees as community-based DIS who can serve as "linkage counselors" and use data to care to reach out of care clients.	December 2018	Written policy and procedure manual for linkage staff. Revised policies in STD/HIV Manual.	Policies in Manual
Share epi data with prevention	Quarterly	# of presentations	EHARS, PRISM

and care sites.			
Conduct a focus group with providers to determine the best method for provider support.	December 2017	Focus group held	Focus group transcript
Facilitate a networking activity for providers that need support with HIV care and or testing.	Monthly	# of meetings and participants	Sign-in sheets
Provide medical case management training for case managers and social workers at all Ryan White funded care sites	Annually	# of people trained	Pre-post tests
Anticipated Barriers or Challenges			
Logistical concerns			
Need for Planning Council Workgroup? Create a Case Management workgroup			
SMART Objective 2: Increase by two (2) to five (5) annually, the number of DIS that provide enhanced Partner Services for high-risk HIV negative MSM to improve HIV outcomes.			
Strategy relates to? #3 Low health literacy			
Who is responsible? MSDH, CBOs and Clinics			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Ensure that culturally competent testing, education, and linkage services are offered to 95% of newly diagnosed persons and also patients are being reengaged in care. Collaboration: MSDH works with CBO and FQHCS.	2018-2021 5% each year	Baseline number of partners and baseline of those engaged and linked to care	MSDH
Ensure that HIV partner services are fully integrated into comprehensive linkage and reengagement strategies	Ongoing	Partner services reports	PRISM

throughout the jurisdiction			
Assess level of standardization of partner services throughout the state.	Ongoing	Partner services report	PRISM
Anticipated Barriers or Challenges			
Opportunity costs for DIS time			
Need for Planning Council Workgroup? Yes			
SMART Objective 3: By October 1 2017, provide Ryan White-funded health care workers with written standards of care for all available Ryan White core and support services.			
Strategy relates to? #4 Encourage collaboration, sharing of evidence-based best practices, and enhancing efforts to reduce mortality and increase viral suppression.			
Who is responsible? MSDH			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Define Standards of Care for all care and service categories.	May 2017	Proposed standards of care.	Proposal
Convene providers to compose and confirm MS specific standards of care. Build capacity of RWCA Provider organizations (?) to conform to Standards of Care. Implement EIS that includes confirmation of diagnosis, referral linkage to care, following linkage through first 2 visits to retain in care.	January 2017	completed standards of care	Completed documents
Increase the number of sites that provide Early Intervention Services. (Emphasis on priority counties and contact FQHC to see how to support	2017- 2018	# of new sites performing EIS	Contracts

EIS). Sites must provide all four HRSA required EIS components to receive RW payment.			
Anticipated Barriers or Challenges			
Any challenges anticipated?			
Need for Planning Council Workgroup? No			
SMART Objective 4: Annually by December 31, provide training on patient-centered HIV care for at least 25 new (unduplicated) health care workers.			
Strategy relates to? #4 Encourage collaboration, sharing of evidence-based best practices, and enhancing efforts to reduce mortality and increase viral suppression.			
Who is responsible? AETC			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Provide education to HIV services and care systems staff on the patient centered needs of those being served to create compassionate environments that are culturally competent, customer service-oriented and where meaningful patient feedback matters.	June - December 2017	Number of trainings held and numbers of providers who complete the trainings?	AETC training records
Develop patient centered care pilot . Collaborate with Open Arms Healthcare Clinic to foster a patient centered comprehensive model of HIV services.	December 2017	Pilot project	Written protocols
Create a secret shopper model where individuals are trained to go to clinics as patients and return to report their	May 2018	# of trainings; # of visits; types of site practices; satisfaction survey	Training materials, site visit reports

experiences as done in TN.			
Anticipated Barriers or Challenges			
Access to and willingness of health care providers to participate			
Need for Planning Council Workgroup? Yes			
SMART Objective 5: By March 31 2021, increase by 15% the number of PLWH who obtain health insurance and/or Medicaid coverage			
Strategy relates to? #5 Resource constraints and improving coordination of services			
Who is responsible? MSDH, MS Center for Justice			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Develop and Implement an Insurance/Third Party Payer Plan Pilot Program	Minimum of 1 year	Pilot program started	Insurance commission
Conduct an assessment of insurance plans offered in Mississippi for HIV coverage	December 2017	Assessment report	Insurance report
Conduct billing and coding capacity assessment of providers and CBOs	May 2018	Assessment report	Policy documents and formularies
Anticipated Barriers or Challenges			
Adequate funding for start of pilot. ACA plans may not be cost-effective.			
Need for Planning Council Workgroup? Yes			
SMART Objective 6: By December 31, after 2018 annually provide certification in medical case management and coordination of services by developing and implementing a formal medical case management program that meets state and federal standards for new and current case managers.			
Strategy relates to? #5 Resource constraints and improving coordination of services			
Who is responsible? AETC, MSDH and RW-funded Programs			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Create a case manager training curriculum that will be done face to face quarterly	December 31, 2018	# of individuals trained	Presentations and pre-post tests

Develop a web based training curriculum to be completed annually	December 31, 2018	# of individuals trained	Webinar materials
Identify potential trainers to conduct trainings	December 31, 2018	# of trainers recruited	List of trainers
Implement trainings	January 1, 2019	# of trainings	Sign in sheets and pre-post tests
Anticipated Barriers or Challenges			
Logistical difficulties convening statewide trainings. Lack of web conference technology in outlying areas.			
Need for Planning Council Workgroup? Case Management subcommittee			
SMART Objective 7: By December 2018, develop an action plan to improve access to Mental Health services to eligible PLWH in each Public Health District by.			
Strategy relates to? #6 PLWH in rural communities have little to no access to services needed			
Who is responsible? MSDH, DMH			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Convene subject experts in mental health in Mississippi to develop and propose a workplan to integrate HIV and mental health services	June 30, 2018	Workplan	Meeting notes, transcripts
Explore strategies to build capacity to expand access to mental health services by newly diagnosed individuals and PLWH including initial evaluation and follow-up Planning Counseling on a fee for service basis using Ryan White funds.	Ongoing	Workplan	Meeting notes, transcripts
Determine feasibility to expand substance use services to prevent HIV transmission	Ongoing	Workplan	Meeting notes, transcripts

and improve care continuum outcomes. Collaboration: CBO, FQHC, MSDH, and DMH			
Anticipated Barriers or Challenges			
Limited number of mental health and substance abuse providers in Mississippi, especially in rural areas			
Need for Planning Council Workgroup? No			
SMART Objective 8: Provide one telehealth outpatient ambulatory HIV healthcare site for eligible PLWH in at least 3 underserved areas by 2021.			
Strategy relates to? #6 PLWH in rural communities have little to no access to services needed			
Who is responsible? : MSDH with UMMC & North Mississippi Medical Center			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
MSDH to develop a contract with UMC telemedicine program to provide primary care providers in the state telemedicine and Part B services. Collaboration: University of Mississippi Medical Center	December 2018	Contract completed and signed	Contract records
Utilize telehealth capabilities of both North Mississippi Medical Center in Tupelo and University of Mississippi Medical Center in Jackson to provide medical care for PLWH through telemedicine.	Ongoing	Number of PLWH that receive services through telehealth; Types of services received	Encounter data form, CAREWare
Develop a consultation network for non HIV specialty providers	June 2017	Number of providers that agree to be consultants; number of consultations provided by provider	Encounter data form

Collaborators: UMMC & AETC			
Anticipated Barriers or Challenges			
Time constraints of telehealth contract, financial constraints			
Need for Planning Council Workgroup? No			
SMART Objective 9: Each year recruit at least one Oral Health Care provider to serve eligible PLWH in target counties with a case rate higher than 16.2.			
Strategy relates to? #6 PLWH in rural communities have little to no access to services needed			
Who is responsible? MSDH, MPHCA			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Determine which funded sites have dental capacity or dentists that can accept referrals.	March 2017	# of providers identified	report
Recruit dentist across the state to serve as "in network sites" for Ryan White patients needing dental services. Patients would have to be DCP(B) approved prior to scheduling an appointment; Patient's eligibility period would coincide with current eligibility standards of ADAP/DCP(B) with patient's recertifying in April and October.	Ongoing	# of providers recruited	Contracts, RSR utilization increase
Implement reimbursable service model for all sites. Implement a sliding scale fee schedule for patients whose income exceeds 400% Federal Poverty excluding them from	August 2017	# of individuals receiving services; number of services provided by type	contracts

DCP(B) eligibility.			
Anticipated Barriers or Challenges			
Health Care Provider shortages throughout the state			
Need for Planning Council Workgroup? No			
SMART Objective 10: By December 31 annually, train 25 allied health professionals in HIV prevention.			
Strategy relates to? #4 Encourage collaboration, sharing of evidence-based best practices, and enhancing efforts to reduce mortality and increase viral suppression.			
Who is responsible? AETC			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Develop HIV prevention and care service training for allied health professions including nurse practitioners and physician assistants. Collaborators: Various health professional programs around the state to include, Mississippi College PA Program, UMC Medical School, William Carey.	December 2017	# of trainings delivered and the number of participants who complete these; evaluation surveys	AETC training records and reports
Increase HIV 101 trainings per year to 4	2018	Number of trainings delivered and the number of participants who complete these	AETC training records and reports
Provide PrEP specific trainings to predoctoral and nursing students and web based for established providers	Biannually	Number of trainings delivered and the number of participants who complete these	AETC training records and reports
Create provider specialist resource guide	December 2017	Written guide	Distribution records
Speak with licensing board to see if HIV specific CEUs could be added to physician	December 2017	Passage of CEU policy	Notes, minutes

requirements			
Anticipated Barriers or Challenges			
Willingness to participate			
Need for Planning Council Workgroup? Yes			
SMART Objective 11: By September 30, 2019, expand the Peer HIV focused Community Health Worker program to assure at least one appropriately trained CHW that can provide linkage to care and re-engagement services at all Ryan White funded sites.			
Strategy relates to? #3 Low health literacy and need for a comprehensive strategy for HIV prevention, education, and testing.			
Who is responsible? Jackson Medical Mall Foundation, My Brother's Keeper, Inc.			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Needs assessment to determine number of CHWs in place/needed	December, 2018	Total number as determined by needs assessment	Needs assessment
Develop standards of care for linkage to care navigators	December, 2018	standards	Needs assessment, survey data, contracts, MOU's.
Advocate for certification model for CHWs to allow for reimbursement by Medicaid and insurance.	December, 2019	# of advocacy sessions, bills introduced.	Reports, MS state legislature.
Anticipated Barriers or Challenges			
Turfs and push-back from professional groups.			
Need for Planning Council Workgroup?			

NHAS Goal: #3 Reducing HIV-related Disparities and Health Inequities			
SMART Objective 1: By December 31, annually increase by 10% transportation services to eligible PLWH in two Public Health Districts by 2021.			
Strategy relates to? #6 PLWH in rural communities have little to no access to services needed			
Who is responsible? ASC, MSDH, JMMF			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Assess viable and cost effective DOT model for Rural	December 2017	# of resources identified; number of resources willing to	Working plan/report

locations		support transportation	
Develop a contract to provide transportation, and other assistance to clients in those hard to reach areas. Collaboration: Partner with CBO, FQHC, or Municipalities.	December 2018	# of clients receiving transportation services by county	CAREWare
Identify additional funding sources to support transportation options (e.g., van services, Uber) Jackson Area by analyzing current funding allocation (all RW parts, MDOT, Medicaid, Metropolitan Planning Organizations, DMH.	Ongoing	Change in allocation	State and program budgets
Anticipated Barriers or Challenges			
Cost of transportation is excessive. Silos and stigma			
Need for Planning Council Workgroup? Yes			
SMART Objective 2: Increase the number of health care workers and ASO staff that complete cultural competency training that includes working with low health literacy level consumers by 20% year over year until 2021.			
Strategy relates to? #3 Low health literacy and need for a comprehensive strategy for HIV prevention, education, and testing and #6 improve rural access to services.			
Who is responsible? MSDH and AETC			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Provide clinics with technical assistance to develop client friendly educational materials to increase patient/provider literacy.	Ongoing	# of people trained by provider type	MSDH and clinic records

Collaboration: The Fenway Institute; People's Institute for Survival and Beyond (PISAB) and Interaction Institute for Social Change			
Ensure that clinical staff has adequate literacy levels for working with African Americans, gay, bisexual and other MSMs with HIV/AIDS and those at risk to enhance prevention, education and treatment services. Collaboration: The Fenway Institute; People's Institute for Survival and Beyond. (PISAB) and Interaction Institute for Social Change	Ongoing	# of people trained by provider type, pre-post test	MSDH and clinic records
Implement case based discussions with health providers about privacy and cultural sensitivity.	June 2017 and ongoing	# of sessions and # of participants; evaluation surveys	Case conference and focus group sign-in sheets and notes.
Anticipated Barriers or Challenges			
Identification of groups to provide technical assistance.			
Need for Planning Council Workgroup? No			
SMART Objective 3: By December 31, 2020, advocate for sufficient state funding support for HIV prevention and treatment in Mississippi.			
Strategy relates to? #8 Funding shortages for HIV-specific services			
Who is responsible? Mississippi HIV Planning Council, Southern AIDS Coalition, AIDS Alabama, MS Center for Justice and My Brother's Keeper			
Activity	**Time Frame**	**Evaluation Measures**	**Data Source**
Contact Southern AIDS	December 31, 2018	# of attendees; types of topics	Registration data, meeting

Coalition AIDS Alabama and MS Center for Justice to plan and schedule a regional meeting of southern states to discuss federal funding allocations and strategies to improve equity of funding.		discussed; conference attendees survey.	agenda and notes
Prepare white paper on financial impact of HIV infection on economy of state as a whole, including treatment cost, opportunity costs, and productivity. (QALY model) Distribute at advocacy conf.	December 2017	White paper	Census , CMS, Social Security, State economist, CDC, State Insurance Commission
Provide education for local groups to engage in advocacy education with the appropriate policy makers.	Annual	# of participants in advocacy training sessions; pre-post survey questionnaire.	Reports
Identify a local organization that will monitor advocacy activities and prepare (at least an annual) report on advocacy efforts.	Annual	# of advocacy activities during the CY; # of advocacy participants.	Reports
Trained advocates will hold meetings with state legislators.	During Legislative Session annually	# of meeting held with legislators; # of participants; funding allocation change.	Bills and reports
Monitor advocacy activity (local lead organization)	During Legislative Session annually	# of meeting held with legislators; # of participants; funding allocation change.	Bills and reports
Anticipated Barriers or Challenges			
Political will and Mississippi's budget crisis			
Need for Planning Council Workgroup? Yes			

SMART Objective 4: By September 30, 2021, advocate for a 15% increase in general state funding support for HIV prevention and treatment services in Mississippi.			
Strategy relates to? Finding #1: Advocate for a fair Federal funding formula to account for the burden of HIV disease in Mississippi.			
Who is responsible? Mississippi HIV Planning Council, Southern AIDS Coalition, AIDS Alabama, MS Center for Justice & My Brother's Keeper			
Activity	**Time Frame**	**Evaluation Measures**	**Data Source**
Contact Southern AIDS Coalition, AIDS Alabama and MS Center for Justice to plan and schedule a regional meeting of southern states to discuss federal funding allocations and strategies to improve equity of funding.	December 31, 2018	# of attendees; types of topics discussed; conference attendees survey.	Registration data, Meeting agenda and notes
Provide education for local groups to engage in advocacy education with the appropriate policy makers.	Annual	# of participants in advocacy training sessions; pre-post survey questionnaire.	Advocacy activities, sign in sheets
Identify a local organization that will monitor advocacy activities and prepare (at least an annual) report on advocacy efforts.	Annual	# of advocacy activities during the CY; # of advocacy participants.	Activity reports
Anticipated Barriers or Challenges			
Lack of local organizations able to lead advocacy efforts.			
Need for Planning Council Workgroup? Yes			
SMART Objective 5: Annually by December 31, provide at least 100 health care workers (including ASO staff, HIV consumers, and advocates) with workplace health literacy and cultural sensitivity training on race, gender and sexual orientation according to CLAS standards.			
Strategy relates to? #2 Stigma reduction to overcome barriers to HIV care			
Who is responsible? AETC and CBOs			

Activity	Time Frame	Evaluation Measures:	Data Source
Develop training that address misperception and stigma and discrimination to break down barriers to HIV prevention, testing and care, by increasing cultural sensitivity and competency of HIV testing providers working with disproportionately affected populations, especially young black gay and bisexual men and transgender populations.	December 2018	Training materials	Training records
Provide training to healthcare staff at designated sites.	December 2019	# of health care workers who complete the training annually; pre-post evaluation survey	Training logs and surveys
Provide training to consumers	December 2020	# of PLWH who complete the training annually; pre-post evaluation survey	Training logs and surveys
Explore collaboration activities to the physician assistant school at Mississippi College, Nurse Practitioner programs, and the Doctor of Osteopathy program at William Carey.	January – December 2018	# of activities	Sign-in sheets, pre-post tests
Explore use of telehealth model in counties with no available providers	December 2018	# of clinics contacted	Meeting agendas, notes
Ask Office of Primary Care to present information on Rural Health Access Grants or other opportunities	Annually	# of presentations	Agenda, presentation materials
Meet with MS Rural Scholars	Annually	# of presentations and # of	Presentation materials, sign in

program to explore the expansion of HIV services		participants	sheets
Anticipated Barriers or Challenges			
Ability of training participants to operationalize the CLAS standard in a timely manner?			
Need for Planning Council Workgroup?			
SMART Objective 6: Annually by December 31, increase the number of impressions and interactions by at least 5% using a social marketing campaign to target disproportionately affected populations via social media which includes culturally competent messages about HIV Prevention Care and treatment resources			
Strategy relates to? #3 Low health literacy and need for a comprehensive strategy for HIV prevention, education, and testing.			
Who is responsible? MSDH and MHPC			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Deliver information on best practices and/or stigma reduction using social media to address health literacy and address HIV that is unique to Mississippi.	Ongoing	Volume of traffic to site or page; other measures to count visibility	Reports per suggested time frame.
Develop evidence-based infographics that provide the most current science, and information on state statutes and potential impact on HIV outcomes.	December 2017	# of items produced	CDC, eHARS, Mississippi Code
Develop an RFP for COBs to develop and implement an evidenced based social marketing campaign targeting young, black MSM.	June 2018	#of replies to RFP	RFP
Implement social marketing plan	December 2018	# of impressions	Facebook, Twitter, dating sites, contracts
Anticipated Barriers or Challenges			
Lack of capacity			

Need for Planning Council Workgroup? Yes			
SMART Objective 7: By September 30, 2021, approve at least one new policy or policy change through legislative action or administrative rule to reduce HIV discrimination in Mississippi.			
Strategy relates to? #2			
Who is responsible? ASC , Grace House, MS Planning Council			
Activity	**Time Frame**	**Evaluation Measures:**	**Data Source**
Bring together Center for Justice, ACLU, AIDS taskforce, NASTAD,HIV Advocacy Ambassadors, HRC etc. to collaborate to advocate for decriminalize HIV-related laws.	February 2018	Meeting held, # of workshops	Agenda, Minutes
Advocates will meet with legislators to encourage policy change.	Annually	Meetings held; bills introduced; bills passed	Notes, Mississippi legislative bills status system
Anticipated Barriers or Challenges			
Political challenges, lack of policymaker awareness			
Need for Planning Council Workgroup? Yes			

C) Collaborations, Partnerships and Stakeholder Involvement

The Mississippi Integrated HIV Prevention and Care Plan was developed jointly by the Mississippi Department of Health HIV/STD Program, the Mississippi HIV Planning Council, PLWH, persons at high risk for HIV infection, service delivery providers and other community stakeholders. Additional information about how PLWH, persons at high risk for HIV infection, service delivery providers and other community stakeholders were engaged in the development of this plan is described in the Needs Assessment section.

The specific contributions of stakeholders and key partners were vital to the development of this plan. The Mississippi HIV Planning Council's (MHPC) purpose is to provide recommendations and advice to the Mississippi Department of Health HIV/STD Office and its partners to develop the Mississippi Integrated HIV Prevention and Care Plan. Mississippi's HIV Planning Council membership represents a diversity of HIV infected populations, key stakeholders in HIV prevention, treatment and support services, as well as~~,~~ other organizations and agencies that can provide guidance and implementation of the Integrated HIV Prevention and Care Plan (Mississippi HIV Planning Council By-Laws).

For the development of the Integrated HIV Prevention and Care Plan three joint planning meetings were held with the MHPC and the Mississippi Department of Health HIV/STD Office. Participants from the MHPC included PLWH~~s~~, persons at high risk for HIV infection, Ryan White Parts B and C medical personnel, Ryan White Part F, staff, a representative from Ryan White Part A Memphis MSA which encompasses two counties in North Mississippi, case managers, social workers and other service providers, ADAPT staff, LGBTQ serving organization staff, HIV prevention, education and early intervention staff and housing care staff.

The first of the planning meetings was held August 19, 2016, during which the results of the needs assessment were presented. At this meeting MHPC members reviewed the results of the needs assessment, its key findings and recommendations. As a follow-up to the meeting the MHPC members were asked to undertake a more detailed review of Coordinated Statement of Needs and provide written recommendations for specific objectives and strategies that could be included in the 2017-2021 Integrated HIV Prevention and Care Plan. The MSDH HIV/STD office staff was tasked to do the same.

The second joint planning meeting was held on September 1, 2016, during which the written recommendations of both the MHPC and MSDH HIV/STD Office for specific objectives and strategies that could be included in the 2017-2021 Integrated HIV Prevention and Care Plan were presented. A facilitated process was used during the meeting for the MSPH membership to prioritize the proposed strategies and activities based on the following criteria:

- Feasibility based on existing capacity of the HIV Prevention and Care, including clinical and support services staff capacity, fiscal and technical resources, and gaps
- Evidence base for proposed strategy
- Cost effectiveness of a proposed strategy
- Programs/projects that would need to be put on hold or eliminated in order to implement a proposed strategy
- Programs/projects to continue for all RWCA Parts B-F grantees

- Challenges and barriers

Through the process outlined above MPHC and MSDH HIV/STD Office staff jointly developed the final set of objectives, and strategies for the Integrated HIV Prevention and Care Plan.

The third meeting was held on September 8, 2016. During this meeting, MHPC members and MSDH HIV/STD Office staff jointly reviewed the draft of the 2017-2021 Integrated HIV Prevention and Care Plan. During this meeting, final SMART objectives addressing the Plan Goals, and the identified priorities were developed by the responsible parties (e.g., MSDH, AETC, etc.).

After the final Integrated HIV Prevention and Care was developed the MHPC co-chairs and MSDOH representatives provided an attached letter of concurrence to the goals and objectives of this plan.

Stakeholders and partners not involved in the planning process but who are needed in order to fully and successfully implement the plan include, but are not limited to, the following: Department of Corrections, State Insurance Commission, Mississippi Primary Care Association, State Medical Board, State Department of Medicaid, and the Department of Education. Throughout the next 5 years, we will work to develop relationships and formal agreements with these entities. The MHPC will revisit determining which influential religious organizations it may be possible to engage in order to address stigma in the state.

D) People Living with HIV and Community Engagement

The HIV epidemic in Mississippi weighs heavily on males, young adults, Blacks, and men who have sex with men (MSM). A wide variety of individuals with first-hand knowledge of the epidemic in Mississippi participated in the development of this plan. Of particular note, *consumers of care from all nine public health districts across the state from North to South and East to West, and those within the Jackson MSA, were engaged in both the development of the Integrated Statement of Need and Integrated HIV Prevention and Care Plan*. Other individuals from across the nine public health districts and Jackson MSA who engaged in this process included Ryan White Parts B and C medical personnel, case managers, social workers and other service providers, ADAPT staff, Disease Intervention Specialists, faith-based groups, LGBTQ serving organization staff, HIV prevention, education and early intervention staff and housing care mangers, all of whom offered unique perspectives and nuanced understanding of the epidemic in Mississippi.

The *inclusion of the PLWH from all nine public health districts in Mississippi was vital to the development of the Mississippi Integrated HIV Prevention and Care Plan* and is reflected in two primary ways. One, PLWH were engaged in the development of the Integrated HIV Coordinated Statement of Needs through a consumer survey, the out of care interview process, and through the incorporation of the December 2015 MMP survey. Two, the MHPC membership includes PLWH individuals who were active participants in the Integrated HIV Prevention and Care Plan priority setting, decision making and approval process.

The focus groups and planning meetings described earlier were held in the Jackson Metropolitan Statistical Area which aided in ensuring PLWH from the state epi-center were included in the development of this plan.

Please see the above section on the development of the Integrated Statement of Need and Integrated HIV Prevention and Care Plan for a description *of methods used to engage communities, PLWH, those at high risk for acquiring HIV and other impacted populations to ensure the plan is responsive to their needs*.

Through the development of the Integrated Statement of Need previously described and the joint planning process undertaken to Integrated HIV Prevention and Care Plan, *critical insight about needs, as well as, objectives and strategies to address these from impacted communities, PLWH, those at high-risk for acquiring HIV and other impacted populations was gleaned*. Specifically:

- Consumers of care provided insights on gaps and barriers to prevention and care services, stigma, barriers and gaps in care and treatment, high risk populations such as MSM and Black Non-Hispanic PLWH, house needs, and out-of-care issues.
- Ryan White funded providers, AIDS Service Organizations and non-Ryan White funded service providers gave insights to issues to linkages to care after diagnoses, needs of the newly diagnosed, barriers to care and treatment, risk factors present in their respective region, housing needs, and out-of-care issues.
- Public Health officials, MSDH staff and Educators provided insights into structural issues, funding shortages, collaborations and partnerships, and the Affordable Care Act‘s impact.

Monitoring and Improvement

The Integrated HIV Prevention and Care Plan will become a standing item on the integrated council’s agenda the month following submission. As stakeholders, members of the council have been assigned to work groups. The work groups will meet/work in addition to the council meetings. This strategy allows the member to have direct input into the planning, implementation, data gathering and evaluation for specific goals and smart objectives. Work group minutes and progress reports will be submitted at each council meeting, which meets bimonthly, as a means to inform and document progress. Feedback, council input and decisions will be solicited during council meetings. Minutes of council meetings are sent to all council members and placed on the DOH website for public access in an effort to inform absent council members and the public.

A timeline database (database developed based on timeframe of activity) will be developed which will allow the council to focus on the identified goals and objectives in a timely manner. The review timeline will cover a two year period and advance as goals are accomplished and time lapses. The timeline database will be reviewed at each council meeting as a reminder of the focus areas and to ensure targets are met. Review of the timeline database is also necessary to be abreast of when to add new goals and objectives that fall within the two year span. On a monthly basis, MSDH staff will monitor and review the activity process measures that are

described in the plan. This will be done at monthly administrative staff meetings. A progress report will be shared with the MSHPC on a quarterly basis.

MSDH staff will use our Data2Care and surveillance data to identify outcomes in priority counties. Census tract level morbidity maps will be shared with staff and community partners to identify potential areas of focus for outreach activities and other program implementation activities. Testing data, which includes the number of tests performed and positivity rates are shared as tools for program evaluation. Annual reports are generated to provide insight on demographics and risk factors associated with new infections, in addition to discussion about changes in observed trends. Surveillance data, which includes linkage to care reports (linkage and reengagement rates and any issues related to the linkage to care process is shared with Disease Intervention Specialists and Case Managers. In addition, CDC-funded Medical Monitoring Project data is shared with staff and community stakeholders to discuss barriers to care and other unmet needs of those who are living with HIV in the state of Mississippi.

References:

1. Moynihan, R. A new deal on disease definition, British Medical Journal 2011; 342 doi: http://dx.doi.org/10.1136/bmj.d2548; Healthy People 2020 Accessed at: https://www.healthypeople.gov/2020/about/foundation-health-measures/Determinants-of-Health.